

# AAPL Newsletter

American Academy of Psychiatry and the Law



Spring 2020 • Vol. 45, No. 2

## 51st Annual Meeting: Wellness in Forensic Psychiatry October 22-25, 2020 Chicago Marriott Downtown Chicago, Illinois



## 2020 Annual Meeting: “Well” See You There!

*Trent Holmberg, MD and Ryan Wagoner, MD*

The 51<sup>st</sup> Annual Meeting of the American Academy of Psychiatry and the Law will be held in the windy city, Chicago, October 22-25, 2020. President William Newman’s theme for the meeting is a critical but oft-neglected topic in forensic psychiatry and medicine in general. The theme for this year’s Annual Meeting in Chicago is *Wellness in Forensic Psychiatry*. Accordingly, our distinguished speaker series guest lecturers will highlight and discuss the remarkable degree of resilience and determination that we humans can discover within ourselves when we face our most trying and challenging situations. We are very excited to announce that our lunch speakers will include Ms. Elizabeth

Smart, Professor Malissa Clark, and Dr. Anthony Giamberdino.

The abduction of Elizabeth Smart was one of the most publicized and followed child abduction cases of our time. At the age of 14, Elizabeth was abducted on June 5, 2002 in what must be the embodiment of every child’s worst nightmare. Under the cover of darkness, Brian David Mitchell cut the screen out of an open window in the Smarts’ Salt Lake City home, proceeded to the bedroom shared by Elizabeth and her sister Mary Katherine, and boldly abducted Elizabeth from her bed at knifepoint while the rest of her family slept and her younger sister froze in terror, feigning sleep. Eliz-

abeth’s captors, Mitchell and his wife Wanda Barzee, controlled her by threatening to kill her and her family if she tried to escape. During her time in captivity, Elizabeth was abused in almost every conceivable way, yet she found a way to stay alive. In March 2003, Elizabeth was able to convince her captors to return from their hideout in California to Utah. Witnesses recognized Elizabeth and her captors walking on a busy street in Sandy, Utah and called the police. The police safely returned Elizabeth to her family on March 12, 2003. In total, she was held prisoner for nine grueling months.

Perhaps as remarkable as her survival story is Elizabeth’s subsequent success story. Elizabeth triumphantly testified before her captors in a succession of court appearances during which psychiatric expert testimony also figured prominently. Since her return from captivity, Elizabeth has graduated from high school, completed a religious mission for the Church of Jesus Christ of Latter-Day Saints in France, graduated from Brigham Young University, married, and had three children. She has also become a powerful, articulate, and respected victim’s advocate. She founded the Elizabeth Smart Foundation and “Smart Defense,” a self-defense program for women and girls. She has also written two books. Her memoir “My Story” was a New York Times best-seller. In addition, she and other abduction survivors worked with the Department of Justice to create a survivors’ guide, entitled, “You’re Not Alone: The Journey from Abduction to Empowerment.”

Dr. Malissa Clark is Assistant Professor of Psychology in the Industrial-Organizational Psychology program at the University of Georgia. Her research interests fall under the broad topic of employee

*(continued on page 2)*



## American Academy of Psychiatry and the Law

### Editor

Joseph R. Simpson, MD, PhD

### Associate Editors

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

### AAPL Photographer

Eugene Lee, MD

### Former Editors

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

### Officers

#### President

William J. Newman, MD

#### President-elect

Liza H. Gold, MD

#### Vice President

Michael K. Champion, MD

#### Vice President

Charles C. Dike, MD

#### Secretary

Paul Fedoroff, MD

#### Treasurer

Stuart A. Anfang, MD

#### Immediate Past President

Richard L. Frierson, MD

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

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

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

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

© 2020 AAPL. ALL RIGHTS RESERVED.

## COVER STORY

### 2020 Annual Meeting

*continued from page 1*

well-being. She studies topics including workaholism, work-family conflict, women at work, and the effects of moods and emotions on individual and workplace outcomes. She will discuss the differences between “working hard” and being a workaholic and will offer ideas for fostering a healthy and productive relationship with work.

Dr. Anthony Giamberdino is an anesthesiologist who will be coming to the AAPL Annual Meeting to speak about his experience of being addicted to fentanyl in medical school and the process he went through to overcome addiction and become a successful practicing physician. He has indicated that he hopes that his story is an inspiration to others, conveying the message that by making one’s own health a priority and seeking out treatment, physicians can recover from “rock bottom” and go on to lead a happy and satisfying life.

Among other highlights of this year’s program, the traditional Thursday evening mock trial will be replaced by a members-only experiential exercise. Dr. John Bradford, a past AAPL President, will discuss the vicarious traumatization he experienced through years of working on forensic cases and the effect this has had on him. Other members will share and discuss their experiences with wellness challenges in forensic psychiatry, whether they be abuse, assault, vicarious traumatization, burnout, workaholism, or something else.

AAPL has received a record number of submissions for this conference. We are confident that the quality of the CME presentations this year will be top-notch. Some will be related to this year’s theme, but the usual wide array of topics will be covered. The Program Committee has its work cut out for it in helping the co-chairs determine which submissions to accept and we thank them for their hard work. Due to the high number of submissions, please do not take it personally if your presentation is not selected this year and consider trying

again next year. Also, remember that upon the submission’s author’s request, the Program Committee’s grades and comments regarding the submission will be provided.

Whether your goal is professional peer support, stimulating continuing education offerings, or simply a chance to experience the wonderful city of Chicago, we hope you will mark your calendars now and make the decision to attend the 51<sup>st</sup> annual AAPL Meeting this year. We look forward to seeing you there! ☺

### AAPL Awards Committee Seeks 2020 Nominations

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

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

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

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

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

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

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

## Chronic Stress in Forensic Psychiatry

William J. Newman, MD



Wellness in forensic psychiatry has received limited attention to date, despite the considerable risks to forensic psychiatrists. In this three-part

series, I aim to stimulate discussion about specific challenges to long-term wellness. This second entry is focused on the potential deleterious effects of chronic stress.

Acute stress is an expected physiological response to high-pressure situations and represents an important adaptive function. Releasing adrenaline and cortisol are natural responses to stress, designed to help the body address immediate needs. Chronic stress, by contrast, involves a prolonged stress response. Chronic stress is generally considered maladaptive and can be associated with long-term physical and emotional sequelae.

McCue's 1982 *New England Journal of Medicine* article describes stressors specific to medicine and the potential impact on physicians (1). It is astonishing how relevant the piece remains nearly 40 years later. In many respects, the medical system has added additional stressors - electronic medical records, social media, immediate patient access, among others - further heightening the degree of chronic stress experienced by physicians. Yellowlees suggested that chronic stress related to the medical system itself has contributed to the increasingly alarming rates of depression and suicidal ideation reported by physicians in recent years (2). Forensic psychiatry presents its own unique challenges within medicine, including frequent exposure to graphic and disturbing case content.

Public-speaking fears impact roughly one-third of the U.S. population and represents one of the most commonly reported anxieties (3). Many individuals report being more fearful of public speaking than of

death. Forensic psychiatrists *choose* a career that routinely involves public speaking. Beyond that, forensic psychiatrists enlist to be offered and questioned as experts about a range of complex topics, typically in front of large groups. Many would view that scenario as a living nightmare.

While the challenge and excitement of forensic psychiatry appeals to most practitioners, understanding the potential risks of chronic stress is imperative. Stress-related factors including deadlines, depositions, and trial testimony - will always remain a part of forensic psychiatric practice. Eliminating stress is therefore not feasible. Focusing on physical and emotional health therefore becomes the primary mitigating factor. Identifying outlets for stress relief and developing outside interests are essential aspects of maintaining wellness.

We are developing an improved understanding of the negative physiological effects of chronic stress. Neuropeptide Y (NPY) is a neurotransmitter that has a role in regulating mood, cognition, endocrine systems, and body weight regulation. There is growing literature that levels of neuropeptide Y are increased in individuals with various psychiatric diagnoses. A recent meta-analysis demonstrated that individuals who experience chronic stress have higher serum NPY levels than patients diagnosed with PTSD or MDD (4).

Forensic psychiatrists routinely experience stress at work, which can also directly or indirectly promote stress outside of work. Professional demands may directly infringe on personal relationships and obligations. Workplace stress and frustrations, when not adequately addressed, may additionally be carried home and indirectly displaced onto unsuspecting loved ones. We all realize we would benefit from individual interventions to promote wellness, including eating better, sleeping better, and exercising more. Is there anything AAPL members can do as a group to help mitigate

the impact of chronic stress?

Peer support can be a valuable tool to mitigate risks of chronic stress. Psychiatry residents routinely develop peer support networks within residency classes and programs. That camaraderie becomes a valuable tool for surviving residency. For several reasons, many practicing psychiatrists gradually lose the benefit of peer support, despite continuing to work in emotionally taxing environments. Forensic psychiatrists as a group seem even less accustomed to seek peer support, seemingly based on concerns of being perceived as weak or soft.

Peer support programs are an important initiative being implemented within medical systems (5, 6). Although institutions are implementing peer support programs to varying degrees, AAPL has the potential to provide its members with formal and informal opportunities to receive peer support from colleagues who have shared professional experiences. Adding an element of peer support to AAPL will require a steady effort by the organization and its members. We owe it to our members to do anything we can to help promote wellness and mitigate risks related to chronic stress.

### References: ④

- (1) McCue JD: The Effects of Stress on Physicians and Their Medical Practice. *New Eng J Med* 306: 458-463, 1982
- (2) Yellowlees P. Why is Physician Well-being Declining? It's the System, Stupid. 2019. Available at: <https://www.medscape.com/viewarticle/917693>. Accessed February 21, 2020
- (3) Stein MB, Walker JR, Forde DR: Public-Speaking Fears in a Community Sample: Prevalence, Impact on Functioning, and Diagnostic Classification. *Arch Gen Psych* 53: 169-174, 1996
- (4) Tural U, Iosifescu: Neuropeptide Y in PTSD, MDD, and Chronic Stress: A Systematic Review and Meta-Analysis. *J Neurosci Res* 11 Feb 2020 [E-Pub]
- (5) Shapiro J, Galowitz P: Peer Support for Clinicians: A Programmatic Approach. *Acad Med* 91: 1200-1204, 2016
- (6) Trent M, Waldo K, Wehbe-Janek H, et al.: Impact of Health Care Adversity on Providers: Lessons Learned from a Staff Support Program. *J Healthcare Risk Mgt* 36: 27-34, 2016

## Coleman v. Newsom: The Important Role of a Psychiatrist Whistleblower

Jeffrey S. Janofsky, MD



In 1990 *Coleman v. Newsom* (1) was filed as a federal class action alleging constitutional and civil rights claims related to the provision of

mental health care to patients in the California prison system. The Federal District Court found the California Department of Correction and Rehabilitation (CDCR) had violated prisoners' Eighth Amendment rights, in part because of chronic understaffing of mental health professionals including psychiatrists. (2) The Court ordered injunctive relief and appointed a Special Master to monitor CDCR's compliance. The Special Master works with a team of monitors and experts, some of whom are AAPL members.

In 1997, parties in *Coleman* agreed to a "Program Guide" to outline appropriate delivery of mental health services to the California prison population. The initial Program Guide was the Court-ordered remediation plan, setting the minimum level of care the CDCR must provide to mentally ill persons in custody. Material deviation from the Program Guide requires a court order. The process to change the Program Guide involves an initial discussion between CDCR staff and the Special Master with subsequent involvement of plaintiff's counsel and the Court. Once CDCR began using an electronic medical record, "business rules" were used to translate program guide requirements into an electronic dashboard that could be used to monitor compliance with the Program Guide requirements.

In October 2017, after more than two decades of remedial effort, the *Coleman* court issued an order requiring defendants to come into complete compliance with psychiatry staffing ratios delineated in the 2009 Staffing Plan, with a maximum ten percent

staffing vacancy rate as required by a prior court order. Compliance was ordered to be achieved by October 2018. In that same order the *Coleman* court granted defendants' request to explore with the Special Master whether there was data to support a change in the prior psychiatrist staffing levels. Plaintiff, defendants, and the Special Master then began negotiations. Ultimately, defendants presented a staffing proposal that would have cut by approximately twenty percent the total number of line psychiatry staff positions allocated throughout the prison system. Plaintiffs considered accepting the proposal for reduced psychiatric staff.

Dr. Michael Golding is the Chief Psychiatrist of Statewide Policy Oversight at CDCR headquarters. On October 3<sup>rd</sup>, 2018, before plaintiffs accepted the CDCR's proposal for reduced psychiatrist staff Dr. Golding, acting as a whistleblower, submitted a document entitled "CDCR Mental Health System Report" (the "Golding Report") (3) to the Court. Dr. Golding alleged that the CDCR had presented misleading information to the Special Master and to the Court in order to justify the proposed reduction in psychiatric personnel under the Program Guide. To investigate this matter, the Court appointed a neutral expert to investigate Dr. Golding's allegations. The Court's order appointing the neutral expert's team limited the investigation to "identifying 'whether facts exist raising a question whether defendants committed fraud on the court or intentionally misled the court or the Special Master' regarding seven specific issue areas raised in the Golding Report." (4) The neutral expert interviewed multiple witnesses, reviewed 12,000 documents and took four months to complete their investigation.

On October 15<sup>th</sup>, 2019 Judge Kimberly J. Mueller began four days of hearings on Dr. Golding's allegations.

Judge Mueller issued her order on this matter on December 15, 2019. (5) She wrote:

Under no circumstances may remediation be accomplished by end runs and hiding the ball to create a false picture for the court, as has happened here. Given the constitutional deprivations underlying this case, and the court's monitoring by way of a Special Master, defendants' expenditure of so much time and effort to create records designed to advance litigation as the primary way to achieve a complete remedy or termination by other means is confounding. This court's predecessor carefully constructed a process supervised by a Special Master that was intended to moderate court intrusion into defendants' own remedial efforts. Such a process is arguably more respectful of defendants' knowledge of their operations and their management prerogatives than a process whereby oversight is transferred to a receivership; it also is more hopeful that defendants can best determine how to meet their constitutional obligations to the seriously mentally ill inmates in their custody. At the same time, given the authority that here remains vested in defendants themselves, the importance of defendants' transparent and accurate reporting is paramount: the court and the Special Master must be able to rely fully on defendants' representations. *As explained in this order, the court has concluded the reliability of those representations at multiple levels of the Coleman case structure is in serious doubt.* If the approach of monitoring by a Special Master has contributed to play in the joints allowing for those misrepresentations, the court may need to revisit that structure in future proceedings. For now, that is a question for another day. (6) [emphasis added].

(continued on page 18)

## Information Overload

Joseph R. Simpson, MD, PhD



The massive amount of information that surrounds us today is truly amazing to contemplate. In many parts of the world, a substantial

percentage of the population has been accessing the Internet on a daily basis for a quarter-century. It has been thirteen years since the release of the first iPhone introduced the era of the smartphone. That span of time also roughly coincides with the emergence and exponential growth of social media platforms such as Facebook, Instagram, Twitter and many others. For many people, it seems like everywhere we turn we encounter a “YouTube phenomenon” or a “Twitter sensation” whom we’ve never heard of before.

Among the numerous trendy acronyms and shorthand terms of the 21<sup>st</sup> Century, FOMO (Fear of Missing Out) and the less-common but perhaps even more telling FOBO (Fear of a Better Option) are apt descriptors of the feeling of not wanting to make the wrong choice, a feeling induced by the sheer glut of input and the frenetic pace of information transmission. Many people also complain that the instant gratification of every demand for information seems to be shortening attention span and reducing overall patience. TLDR (Too Long, Didn’t Read) is another new acronym, reflecting the feeling of being constantly deluged with more than we can absorb. Among the many consequences of the endless cascade of information is the fact that many who seek attention or recognition choose to express extreme opinions or engage in extreme or bizarre behaviors in an effort to “cut through” and be heard above the din.

The new torrent of information isn’t only accessible through the use of a web browser or a social media application. Until just a few years

ago, commuters had limited options for what to listen to during their drive – music or talk radio, a music CD, or perhaps a book on CD or even cassette tape (I fear younger readers may never have used such an archaic medium). Now, we have the podcast explosion. The number and diversity of podcasts is mind-boggling, with new ones being created every day, in every conceivable genre. Episodes on literally thousands of topics range from a few minutes to a few hours long, with some long-running series having already recorded two or even three hundred installments, clocking in at an hour or two apiece. Imagine saying to yourself that you’re going to plow through the entire collection of just one such (relatively speaking) well-established series. Even with a long commute, it could easily take a year to get through a single such series. And chances are there are dozens of podcasts each of us would find interesting enough to listen to regularly, if somehow there was enough time to do so.

In other words, there is quite simply *too much* “content” out there.

Of course, in addition to the gargantuan scale of the multimedia library that is the Internet, one of the most vexing characteristics of our age is the fact that so much of the information being purveyed is incomplete, misleading, or just completely false. Sorting legitimate facts from deliberate misinformation or well-meaning but misguided repetition of untruths can be extremely difficult. Conspiracy theories of all stripes easily travel around the globe.

Physicians should have an affinity for the principles of science, such as the critical importance of controlled experiments, replication of results, willingness to change one’s mind when new facts emerge, and so on. One could certainly make the argument that our experience as psychiatrists, and especially as forensic psychiatrists, with gray areas and shades of meaning and interpretation gives

us an advantage when we’re evaluating new information, especially of a biological or other scientific character. But I think most would agree that, with the dizzying amount of data that is being produced, and in some cases massaged or spun to meet certain agendas, figuring out what is legitimate has become very challenging.

I don’t believe there are any easy or simple answers to this problem. But striving to keep an open mind is always a good idea, and of course is the mark of a true scientist. Also, identifying some sources that you know you can generally trust, as well as what sources tend to be less reliable, should assist in paring down the amount of “data smog” in your daily life. (1)

This is a short column, but if you’ve read this far, then you may be someone who puts each issue of this Newsletter in your “to-read pile” when it arrives. We want to keep it that way, but, as my musings should make clear, the competition for your attention is always increasing. ☹

**To assist us in ensuring that we meet the informational/educational needs of the majority of our audience, we have designed a very brief survey, which we would very much appreciate if you could fill out today. Just scan the QR code below, or go to this link: <https://www.surveymonkey.com/r/CVDZZVM>**

### Reference:

(1) Shenk D. *Data Smog: Surviving the Information Glut*. San Francisco, CA: Harper Edge, 1997.



## Ask the Experts

Neil S. Kaye, MD, DFAPA

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

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

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

**Q:** There is one lawyer I run into whom I find especially challenging. Do you have any tips or “comebacks” that might help me manage cross-examination?



**A. Glancy:**

While examination-in-chief (direct examination) is an intricate dance with the lawyer who has called you,

cross-examination can be particularly challenging. In examination-in-chief it is often a matter of assuming the role, which does come naturally to most of us, of the professor explaining concepts to a student. Depending on whether the student is a judge or jury a different manner may be appropriate. If it is a judge, it is helpful if you have some information about him or her, and can adjust your language accordingly. For instance, if you’re aware that this judge has run the mental health court for five years, they will be familiar with terms such as schizophrenia, delusions, or hallucinations, and it would be redundant to explain these. Many judges however, will have little experience in these matters and will appreciate explanations, as will the jury.

Cross-examination is a different situation. A good lawyer will be trying to elicit evidence that helps their case or elicit evidence that harms their opponent’s case, or they simply

want to make you look bad or biased in front of the trier of fact. The best cross consists of a series of one-bite facts, delivered in a nice rhythm. The patient lawyer will gradually walk you down his desired path by slowly working up to the conclusion. A really good lawyer will know when to stop, having established their viewpoint, without being too greedy and asking you the final question. The final question usually begins with “So Doctor, you do agree that you were completely wrong previously?”

Even if the buildup has been excellent, this final question does give you an opening to say “No, my reading of the facts is somewhat different and although you have made some good points, I still hold my original opinion that...”. If they are really good, you may not get a chance to say this, and you hope that you can say it later on in the cross, or on redirect examination, if the lawyer who called you is aware of the issue.

One of the most effective techniques, which I think happens fairly rarely, is when the lawyer is able to impeach to witness. This usually happens when they can find a prior statement where the witness said something contrary to what they said on direct examination. For an expert witness, the material statement often comes from something we have published or from a previous case. If it is from the previous case, the situation demands quick thinking, in order to be able to explain why the previous case was different from the present case. If it is from something one has written, this can be particularly difficult, and takes some explaining. Even if you do not adopt the statement previously made, which the lawyer will want you to adopt, they may be able to use it to damage your credibility. A good lawyer will save this for their closing argument. Sometimes a rude or arrogant lawyer will again be too greedy and make a provocative, snide comment, such as, “So it depends who

is paying does it doctor?” This is the mark of a bad lawyer, and could result in a rebuke from the judge, or give you an opening to say, “No I gave you my objective and honest opinion based on the facts of this particular case.”

It is generally held that no matter how rude and sarcastic the lawyer is, it behooves us to keep calm and not get angry. Sometimes this has the effect of actually frustrating the lawyer and they get more angry and vitriolic. This will often damage their own credibility. Dr. Emmanuel Tanay used to say that you should be yourself and “if the lawyer makes you angry then get angry.” I think each person has to find their own style in this regard. If you are going to say you’re angry, be sure to keep control of the situation. I was in a case involving a battered woman syndrome defense, when the lawyer said “this abuse was only trivial wasn’t it doctor?” I answered that I was outraged that he would trivialize domestic abuse in this manner. However, I did not allow myself to actually display anger, but only to express my outrage.

As noted above, a good lawyer in cross-examination uses one-bite facts to gradually lure you into what I call the vortex of cross-examination. Sometimes the facts are difficult and there is no way out. Often, early in a sequence, the lawyer will train you that he just wants a yes or no answer.

For instance:

Lawyer: You did a PCL-R?

GG: The PCL-R stands for psychopathy checklist revised and was devised by Dr. Robert Hare. It is a 20-item checklist...

Lawyer: You did a PCL-R?

GG: I had the opportunity to attend a lecture by Dr. Hare in 1998 in Vancouver and in fact we went out for a very nice dinner afterwards....

Lawyer: You did a PCL-R?

GG: Well as I was saying, during dinner the doctor, who is a psychologist by the way...

(continued on page 7)

## Ask the Experts

*continued from page 6*

Lawyer: You did a PCL-R?

GG: Yes.

The lawyer has now trained me to answer yes or no. If they confine their cross-examination to accurate one-bite facts there may be no way out of this vortex. However, be alert to the question when the lawyer gets it wrong and asks an open question:

Lawyer: "Please describe the PCL-R and how it predicts dangerousness."

GG: (Now is my chance) "Well as I was saying during my dinner with Dr. Hare, he explained to me the theoretical rationale for the PCL-R, which was as follows..."

Another trick lawyers frequently use is to throw a quotation at you from a paper, a book, or your prior testimony. There are a couple of important points here. First, you should find out the source of the quotation. Ask to see the actual text. If necessary, ask for short adjournment in order to read it. The first point you should analyze is whether you recognize it as an "authoritative treatise." If the text is from, for instance a political consensus paper, or a newspaper, you should say you do not recognize it as an authoritative treatise. The lawyer is then not entitled to pursue the matter any further and ask you any questions about this quotation. If the quotation is from, for instance the American Journal of Psychiatry, or DSM-5, you should say that you do recognize it but do not necessarily agree with every sentence; at this stage, you can then analyze the statement and discuss whether or not it applies to the case at hand.



### A. Kaye:

Dr. Glancy's wise words are to be heeded. Many of us struggle with a particular lawyer and there

are likely personality issues that lurk behind these difficult encounters. Every expert has her own personal style and what works for one person might not work for another, but here are some ideas that you might find helpful as well as some rejoinders I have used:

1. Remember the power of the one-down position. Some lawyers want to be "alphas" and don't understand that you can lead from behind. I like to say "I'm sure the jury understood your question, but I'm having trouble, so can I ask you to rephrase it?" I take every opportunity I can to compliment the jurors.
2. "I'd be happy to answer your questions honestly and truthfully, but that was a compound question and if you can tell me which question you want me to answer first, I'd be pleased to do so."
3. I like to point out what the lawyer is doing so that it's clear that I know and that the jurors know. "I see what you're trying to get me to say, but that wouldn't be the truth and I took an oath to tell the truth."
4. "I can't answer with just a yes or no. I'm sure these attentive jurors remember I took an oath to tell the whole truth, and the whole truth can't be answered with just a yes or no. Your honor, can I tell the whole truth?" or "I wouldn't like to mislead the court/jury by not giving a complete answer."
5. Look at the jurors, smile, and make them wish that if they needed a psychiatrist that you would be their doctor. As long as they'd rather have you as their doctor, you're winning.
6. Sometimes I'll preface an answer with "Let me try to teach it to you (the jurors) the same way I explain it to the residents, nurses, and medical students I teach..."

7. Keep your pace slow from the beginning. That way when you need time to think of a response, it's not as obvious that the lawyer has you and you're thinking. If the pace of your answers doesn't vary the jury isn't tipped off to your discomfort.
8. Tell your lawyer that she should object to "badgering" if this is really happening.
9. If the lawyer is trying to mislead or mischaracterize, I call her on it. "I think you just mischaracterized my testimony, but I'm sure the jury will remember on direct examination when I was asked a similar question, I said..."
10. "I've answered this question three times already and my answer is still....and if you ask it a fourth time my answer will still be...." or "I'm sure the jury remembers I answered this same question 15 minutes ago, but I can repeat my prior answer if you don't remember..."

Dr. Glancy noted that your prior testimony can be used against you and I agree. But that can be dangerous as well. I had a defense lawyer read me an outtake from a prior case. My response was: "Oh, I remember that case, the jury awarded the plaintiff 2.7 million dollars!"

### Take-Home Points:

Being firm and steadfast in court is helpful. Still, one must remember to show respect for the process and act with suitable decorum. While trials are adversarial by design, there is no reason for civility to be disregarded by any of the participants. We each have our own style and personality and over time, finding your footing will instill confidence. Learning something about the cross-examiner's style from hiring counsel and from reading transcripts of the lawyer from depositions or prior trials can be very helpful. Remaining professional is critical, but in reality, you may be caught by flying mud. ☯

## The Heartbreak

Stephen P. Herman, MD



We are professionals who often see the dark side of human behavior. People on death row, mothers who kill their babies, Internet stalkers, children

who kill their classmates, parents fighting to the death over custody, victims of torture, addiction, survivors of war and abuse, the incoherent and the incarcerated, the dejected and demoralized.

I've been thinking about this after having been involved in a horrifying case that ended in the disappearance of one parent and the suicide of the other. I was left emotionally drained for months, questioning my decades-long fascination with human behavior and the law.

I thought of how many times people say to me, "I could never do what you do! How do you keep from being overwhelmed - especially when children are harmed?" And my answer is always the same: some version of "Well, we learn how to care without getting too close and losing our professional perspective. We have to maintain some distance to help people and sometimes move the legal system." Sometimes the tenuity of our responsibilities all but drags us down. But with experience comes familiarity and familiarity militates against fear.

Or not. A few cases tested my strength. Social services had dropped the ball and a child had died. Her mother had starved her to death. She was five and weighed no more than a two-year-old. Whenever a social worker had visited the family, her mother hid her in a dresser drawer. I saw the video of the crime scene and the drawer. While the mother was serving her prison time, a judge asked me for guidance. Could the five surviving siblings live safely with their grandmother? And . . .

A foster mother of two brothers, who had raised them since infancy,

was about to adopt them. She was the only parent they had ever known. The court ordered one final background check. Something horrifying had been overlooked. When she was a teenager, she had murdered her next-door neighbor for calling her fat. She had served her time and had never gotten into trouble during or after prison. The court asked if the boys would be safe with her. I reminded her that two boys, one nine and the other twelve, could get very rambunctious and infuriate their caretaker. How would she deal with that? She said, "I listen to my Christian tapes, and they calm me down." I wondered if that would be enough. So did the court . . .

And then there was Justin. When he was thirteen years old, he strangled a four-year-old in a park. And just to make sure, he dropped a rock on the child's head. On Saturday it was on the front page of *The New York Times*. On Sunday, his lawyer called me. Would I evaluate this child and help him with the defense? I said I'd evaluate the kid, sure, but I couldn't guarantee that what I found would help the lawyer. I saw this child in detention and went to his home to meet his family. One of his aunts just had a new baby. I barely saw the infant through the heavy nimbus of cigarette smoke. On a wall in the 13-year-old's room was a poster of his favorite rock group. Now almost forty years old, he has been denied parole ten times. When he comes before the parole board, the victim's parents sit in the front row and stare at the panel. And the prisoner is taken back to his cell for a repeat performance in two years . . .

Two years ago, I made a new friend, a forensic psychiatrist who wanted to refer cases to me. He did not evaluate children. He did see some pretty frightening adults. Would I be interested, he asked over lunch, in getting referrals? I told him I would be delighted. He had to get back to work. We decided to meet two weeks later. But during that time, this well-respected doctor was shot to death by an angry parent. The psychiatrist had warned the court nine years before that the man was dangerous. That he

could harm his ex-wife. The psychiatrist recommended he be hospitalized and evaluated. He was committed by the court - and was out six days later. Lost to follow up. Disappeared. But his anger festered until his fury boiled over. He killed the forensic psychiatrist, the two paralegals that worked with his ex-wife's lawyer, a man he mistakenly thought was his son's prior therapist and two people who he thought might turn him in. Discovered in a seedy hotel, he shot himself in the head just as the police burst into the room.

It was a terrifying story, right out of a novel. Except it was true. I was horrified. I began to watch my back, hoped there were surveillance cameras in my office neighborhood and, finally, bought a canister of pepper spray. It is just near my left hand, on the table it shares with my glasses and pens . . .

And then there were the two 10-year-old girls, BFFs. Let's call them Caitlyn and Sarah. Sarah's mother was outside the apartment, trying to find the location of gunshots and whether anyone had been wounded. At the kitchen table, the two girls got into an argument over a ball. Caitlyn grabbed it from Sarah's hand. Sarah grabbed the biggest knife in the kitchen and plunged it into Caitlyn's heart.

I visited Sarah several times in a safe house. She was mute and just this side of catatonic. And when she cried, it seemed as though the room shook like an aftershock from a powerful earthquake. The court wanted to know, what should be done with this girl? And then there was . . .

The teenager who celebrated Christmas morning delivering newspapers and setting fire to creches along his route. Finally caught by the police, he lunged at one, suddenly collapsing as 50,000 volts from the officer's taser found their mark. And . . .

The 18-year-old who had murdered his grandmother and whose lawyers were hoping for an insanity defense. During our talk, he said, "You can't help me, Dr. Herman. I wasn't insane when I shot her. I knew exactly what

(continued on page 19)



## The Faces of AAPL: Philip Candilis, MD

Joseph Penn, MD



Ethics, research, Greece, opera, a Rappeport Fellowship, the AAPL Vice-Presidency. What's the common theme? Dr. Phil Candilis.

Phil's trajectory from his parents' immigrant experience to a role in the refugee crisis marks his development as a thoughtful and creative AAPL leader.

Phil's parents came to the US at a time of unrest in Greece. Fascists and communists clashed there long after World War II. Phil was subsequently born in Washington, DC, where his economist father worked for the federal government and his mother for the Greek community. His parents loved philosophy – an integral part of Greek culture – and traveled back frequently. Phil was completely taken with Aristotle's ethics as a student at the National Institutes of Health, where a young cousin was the last surviving member of a leukemia protocol. Phil saw first hand the importance of cross-cultural ethics at the end of life.

With psychiatry emphasized heavily in medical school, Phil completed residency at Massachusetts General Hospital, travelling to AAPL for the first time in 1996 as a Rappeport Fellow. He already knew that the AAPL *Bulletin*, now the *Journal*, explored the unique combination of law, medicine, and ethics that intrigued him. During his chief resident year, he completed Harvard's ethics fellowship, noting, "This was clearly for me." Ron Schouten, MD, a veteran Harvard educator, was his training supervisor, and introduced Phil to "first-rate critical thinking; how to dissect even the most convoluted cases."

Phil completed his fellowship at the University of Massachusetts Medical School. Led by two psychiatrists both coincidentally named Appel-

baum (Ken and Paul), the fellowship was "deeply committed to teaching. Ken couldn't have been a better mentor," he says, "I still call him."

Phil stayed on as a faculty member, relishing the opportunity for a balanced career: "In the mornings I got to run a unit in the state hospital; in the afternoons I worked on NIH grants on decision-making." He consulted to the Massachusetts Board of Medicine for many years, especially on boundary and professionalism cases.

For AAPL, Phil has been a long-standing Research Committee member and Ethics Committee and task force chair, *Journal* and *Newsletter* associate editor, Councilor, and founding member of the Forensic Neuropsychiatry committee. He became Vice-President in 2016, introducing the idea of an annual AAPL research breakfast. His growing expertise in ethics brought him the case that would define his career: a paralyzed young woman of Greek ancestry who was refusing to eat and drink. Phil worked with her, her Greek-American family, and the Orthodox Archbishop to reconcile clinical closure with the court-ordered capacity evaluation. Of course, Phil memorialized the case in a series of articles and a book, incorporating narrative, cross-cultural formulation, and clinical precepts into forensic work.

Phil joined his long-time collaborator Rick Martinez, MD in developing the AAPL *Journal's* "Reflections and Narrative" section, underscoring narrative ideals espoused by Ezra Griffith, MD, to whom he remains indebted. Narrative was a seminal part of Phil's introduction of the *Faces of AAPL* feature to the newsletter too. Phil re-conceptualized forensic cases with Rick as part of a "robust professionalism," an idea that pulled medical professionalism into court by integrating personal, professional, and community values. Current writing with his fellows on social justice and feminism are direct outgrowths of this idea.

His parents now quite elderly, Dr. Candilis moved back to DC. He was thrilled to establish a forensic fellowship at the national landmark, Saint

Elizabets Hospital. "There is no apostrophe in the hospital's name," he laughs, "Because it was named before grammar was invented!"

Now the hospital's Medical Director and a professor at his *alma mater*, George Washington University, Phil is part of the medical school's Global Mental Health Program. Its faculty teaches resilience and trauma-informed care, talking with refugees, advising NGOs and government agencies. The recognition that "we are all immigrants" colors many of Phil's recent efforts. A Hippocratic Oath for humanitarian aid-workers unites public health principles with self-care, while studies of radicalization arise from work with colleagues who have access to imprisoned terrorists. The team is completing a text on the ethics of global mental health, applying ideas from forensic psychiatry to support the dignity of persons as a core professional value.

Preventing burnout among physicians is a critical aspect of professionalism for Phil. As a forensic expert, he consulted to the first class-action suit against a medical board and its physician health program, appearing for the state of Michigan in 2016. A healthy work-life balance matters for physicians as it does for aid workers, he says. Phil exemplifies this by spending time with Greek family and colleagues by Zoom and FaceTime. As president of the Washington Psychiatric Society, he underscores "vulnerable people and values," a theme of AMA ethics he incorporates into both professionalism and resilience.

Phil's deep baritone signals a poorly kept secret: he was once an opera singer, reviewed by both the *Washington Post* and the *Boston Globe*. He still keeps his notes from studies with Todd Duncan – Gershwin's first Porgy (*Porgy and Bess*). Performing in major concert halls, Phil was once slaughtered in Boston's Jordan Hall as Banquo in Verdi's *Macbeth*. In Mechanics Hall in Worcester – where Sony and Telarc record – he recalls performing Handel's *Messiah* and hearing the audience exhale after a particularly muscular aria. But the

(continued on page 19)

## Revitalizing AAPL's Special Committees

Liza H. Gold, MD

AAPL's Special Committees are an integral and vibrant part of our organization. AAPL has three types of committees. Administrative Committees, such as the Bylaws Committee, and Standing Committees, such as the Membership Committee, address specific organizational needs and functions. In contrast, AAPL's Special Committees are organized around subjects of interest and importance to AAPL members and forensic psychiatry. One of the benefits of AAPL is the opportunity to participate in Special Committees, network with AAPL members with similar interests, and collaborate on projects and proposals.

In the early years of AAPL, joining a Special Committee did not require much in the way of formal process. In fact, the biggest issue often was finding enough people who wanted to be on Special Committees. If AAPL members wanted to join a committee, all they had to do was ask the Committee Chair if they could attend and show up for the next Committee meeting. Committee Members and Chairs were appointed by AAPL's President as the need arose.

The good news is that AAPL has been so successful as an organization that we now have 30 Special Committees, covering a wide array of topics. Over time, it became apparent that the growth of AAPL and our committees required more than the historically informal approach to committee membership and participation. Dr. Richard Frierson, AAPL's Immediate Past President, prioritized streamlining the Special Committees to encourage member participation and help Committee Chairs keep their Committees current and active.

Dr. Frierson appointed a Task Force in 2018 to review the structure and processes of the Special Committees. I chaired the Task Force; Anna Glezer, Rick Martinez, Britta Ostermeyer, Karen Rosenbaum, Charles Scott, Joe Simpson, Renee Sorrentino, Barry Wall, Tobias Wasser, Patricia Westmoreland, and Hal Wortzel

graciously volunteered their time and expertise to this project. AAPL's Governing Council reviewed our proposal at the Annual Meeting in October 2019. After lively discussion and some vigorous debate, Council adopted several of the Task Force's recommendations.

The following is a summary of Council's October 2019 decisions.

*Committee Administration:* AAPL's President appoints all Special Committee Members and Chairs. AAPL members interested in joining a Special Committee should contact and communicate exclusively with the Committee Chair. *Requests to join Special Committees should be made to Special Committee Chairs between October 15 and December 1 of each calendar year. Requests for committee membership will not be considered after December 1.* If members miss the "enrollment period" deadline one year, and are still interested in joining the Committee, they can ask the Committee Chair to put their names forward in the subsequent year's "enrollment period."

Special Committee Chairs will forward their recommendations for appointments to the President no later than December 1. The President will work with Committee Chairs in December to make appointments recommended by the Special Committee Chairs and to ensure the accuracy of the listed members of the Special Committee. Special Committees should have a minimum of six active members. The establishment of a new Special Committee requires a minimum of twelve members.

Upon appointment, Committee Members shall be advised in writing of their term on the Committee, Committee responsibilities, requirements for maintaining Committee membership, and the process for seeking reappointment for additional three-year terms. All Committees meet on the day prior to the commencement of the AAPL Annual Meeting. Some Committees also meet during the American

Psychiatric Association (APA) Annual meeting. Each Special Committee is responsible for providing, on a yearly basis, an article for the AAPL newsletter and two self-assessment questions for AAPL's MOC program. Committees are also responsible every two years for submitting at least one proposal for a presentation at the Annual Meeting.

*Committee Membership:* A Committee member is appointed for a three-year term, which commences at the next Annual Meeting in October. At the end of a three-year term, a member who wishes to be reappointed to the committee should direct a request for reappointment to the Committee Chair. *Initiating a request for reappointment is the member's responsibility.*

AAPL members should bear in mind that they may attend a Committee meeting, with the permission of the Committee Chair. Even if they are not members of the Committee, attending Committee meetings is a good way for members to familiarize themselves with the Committees in which they have interest and the projects currently underway.

*Reappointment:* Committee Chairs will make recommendations regarding reappointments to the President. *The President will generally not reappoint members to Committees without the approval of the Committee Chair.* The Committee Chair's recommendations for a Committee Member's reappointment to each additional three-year term will be based on the Member's attendance and participation. At a minimum, a member requesting reappointment should have attended half of the committee meetings held within their three-year term and should have participated in at least one committee activity.

*Committee Chairs:* Each incoming President appoints Committee Chairs on a yearly basis for a term of one year. Upon request by the Chair, and unless evident reason exists for appointing a different member as Chair, incoming Presidents should consider up to five additional and consecutive one-year appointments for

(continued on page 18)

## Charles v. Orange County: A Constitutional Claim for the Discharge and “Dumping” of Mentally Ill Detainees

Monika Pietrzak, MD, JD; Ashley VanDercar, MD, JD;  
Jacqueline Landess, MD, JD; and Susan Hatters Friedman, MD

The United States has the world’s highest incarceration rate (1). People diagnosed with mental illness are significantly overrepresented within the correctional population. The U.S. Constitution requires the government to provide necessary medical care to individuals they confine (2, 3). There have now been at least two Federal Circuit cases that have extended this to psychiatric discharge planning. The most recent was *Charles v. Orange County*, decided by the Second Circuit Court of Appeals in May of 2019 (4).

The plaintiffs, Michelet Charles and Carol Small, were lawful U.S. residents detained by Immigration and Customs Enforcement (ICE) officials on immigration charges. They were held at the Orange County Correctional Facility as civil detainees while they awaited their deportation hearings. They both had serious mental illness and required psychiatric treatment while incarcerated. After they prevailed in their immigration hearings, both were immediately released – without a supply of psychotropic medications, a discharge summary, or follow-up care. Their mental health quickly deteriorated, and both required acute psychiatric treatment shortly after their release (4).

Charles and Small filed a civil rights action under 42 U.S.C. § 1983 alleging that the detention facility, clinical directors, and other defendants had violated their 14<sup>th</sup> Amendment substantive due process rights. Specifically, they alleged that the defendants had been deliberately indifferent to their serious medical needs: their mental illness. The lower court dismissed the case, finding: “the claims are more akin to negligence or malpractice claims than constitutional violations” (5). The Second Circuit subsequently vacated that lower court ruling, holding that failure to provide psychiatric discharge planning could “plausibly” state a constitutional claim.

The Second Circuit’s holding hinged on the importance of discharge planning. There is broad consensus and data supporting discharge planning as an integral component of effective mental health care in a correctional setting. Discharge planning enhances post-release outcomes of mentally ill detainees, and is critical in preventing relapse or re-incarceration. In fact, a detainee’s risk of death during the first two weeks after release is 12.7 times higher than that of the general population (e.g., via drug overdose, homicide, or suicide) (6). These statistics, and their relevance, were just one part of the *amicus* brief that AAPL joined the APA in filing. (7). AAPL’s medical director, Jeffrey Janofsky, summarized the brief in these pages in April 2019, emphasizing the importance of discharge planning when reintegrating detainees with serious mental illness into the community (8).

As explained in *Estelle v. Gamble* and *Youngberg v. Romeo*, when someone is incarcerated, the government has a certain affirmative, constitutional, duty to provide basic services (2, 3). U.S. Code Section 1983 allows prisoners to sue state or local officials in federal court, alleging a violation of their constitutional rights. A constitutional violation for inadequate medical care requires more than medical malpractice. It requires deliberate indifference to a serious medical need. Nonetheless, the *Estelle-Youngberg* analysis was limited in *DeShaney v. Winnebago County*, which explained that the government’s affirmative duty does not generally carry over once the state releases its physical control of the inmate (9). In *Charles*, The Second Circuit relied heavily on the “special relationship,” and the obligation arising from the clear restriction on the individual’s liberty and ability to seek care.

The Second Circuit’s ruling hinged in part on its recognition that although discharge planning relates to what happens after custodial control ends, the process of discharge planning must begin *during* incarceration. It is, therefore, “in-custody medical care.” This framework changed the standard used to determine whether the detention center’s actions rose to the level of deliberate indifference (4).

This was a case of first impression for the Second Circuit. However, in 1999 there was a similar case in the Ninth Circuit: *Wakefield v. Thompson* (10). *Wakefield* was a criminal detainee who had been released from prison without psychotropic medications. His Section 1983 claim was initially dismissed. The Ninth Circuit then reversed and remanded the case, noting a viable claim of deliberate indifference.

The constitutional framework was slightly different in *Wakefield* than in *Charles*. Because *Wakefield* involved a criminal detainee, the Ninth Circuit used *Estelle’s* 8<sup>th</sup> Amendment cruel and unusual punishment framework; *Charles* involved civil detainees and used *Youngberg’s* 14<sup>th</sup> Amendment substantive due process framework. They both came to the same conclusion. As enunciated in *Wakefield*: “the state has a responsibility under the [Constitution] to provide outgoing prisoners being treated for a medical condition with a sufficient supply of medication to cover their transition to the outside world ...” (10).

In summary, an allegation that a correctional institution failed to provide psychiatric discharge planning can, at least in those jurisdictions answerable to the Second and Ninth Federal Circuits, rise to the level of an *Estelle* or *Youngberg* constitutional violation. To underscore this point: in November 2019, ICE and Orange County reached a \$1.725 million-dollar settlement with the plaintiffs in the *Charles* case (11). ☐

### References:

(1) Sawyer W and Wagner P. Prison Policy Initiative. Mass Incarceration: The Whole Pie 2019. Available at: <https://www.prisonpolicy.org/reports/pie2019.html#slideshow/slide-show/1>. Accessed January 17, 2020.

(continued on page 20)

# 2019 ANNUAL MEETING PHOTO GALLERY



2019 Rappeport Fellows with Chairs Drs. Friedman and Ostermeyer



AAPL Councilor Dr. Wortzel and Newsletter Editor Dr. Simpson catch up at the Friday reception



AIER Board



Diversity Committee



Drs. Felthous, Rosmarin, Ciccone and Weinstock enjoy reminiscing



Great turnout for inaugural Women's Committee meeting



Lively discussion at the Women of AAPL reception



Pres. Frierson, Medical Director Janofsky and Exec Director Coleman at the Friday reception

## Dual Agency in Detox: Privacy vs Malfeasance in Mandated Reporting

Jessica Morel, DO and Dean De Crisce, MD  
Liaison with Forensic Sciences Committee

Requirements to report a broadening list of concerning circumstances can be a source of discomfort among psychiatrists and other healthcare providers. Reporting mandates can challenge medical ethics, breach the traditional notion of the doctor-patient relationship, and compromise patient confidentiality and trust. There can be ideological resistance to increased reporting beyond the established standard reporting to protect vulnerable populations, such as is the case with child abuse, elder abuse, human trafficking, and domestic violence. In other instances that may require reporting, such as duties to warn, firearms laws such as the New York SAFE Act or “red flag laws,” cases involving pregnant adolescents or adolescents with sexually transmitted infections, or other circumstances based on jurisdiction, there might be more ethical ambiguity; this includes reporting of active substance use in certain settings.

In substance use treatment, privacy concerns and trust are particularly important for treatment engagement. Substance use treatment, and perhaps even forensic evaluation, may require reporting, although many psychiatrists are unaware of such obligations. There are several substance use circumstances requiring reporting in many jurisdictions. One such requirement, mandated in various states, is for suspected or diagnosed drug use during pregnancy, or alternatively after a finding of a positive drug screen of an infant or diagnosed neonatal abstinence syndrome after birth. (1, 2) Another, similar circumstance might involve reporting of substance-using parents when there is a concern for abuse or neglect of their children simply as a result of the use (as might be the case in a daily PCP user, for example). (3) A third circumstance, which could be mandated through court order or patient consent rather

than by statute, involves communicating drug use and treatment compliance to a parole or probation officer in a circumstance of mandated and supervised treatment. This can create an adversarial environment for treatment.

Finally, a fourth circumstance of reporting of substance use, provided for by a vast majority of states, involves reporting of impaired healthcare professionals when it appears that they represent some threat to public safety (including impaired nurses, dentists, physicians, psychologists, and even non-healthcare, public transportation professionals such as pilots and bus drivers). (4) Approximately 10-12% of physicians will have a substance use disorder over their career, with alcohol as the most often reported abused substance. (5) If a state does not have specific guidelines, professional licensing organizations might require the reporting. Some states even reprimand providers who do not report such concerns. Fortunately, the success rate of treatment in these populations is higher than average. (5)

The foundation for all these laws is perceived increased public health safety and protection of a vulnerable class. Successful intervention is not necessarily at the forefront of some of these statutes.

Aside from the necessity to follow legal mandates, these reporting burdens come with ethical challenges. Some of the arguments against reporting of such circumstances include placing psychiatrists in the burdensome role of public health officials, preventing individuals from seeking help because of a fear of reprisal, “punishing” positive treatment engagement, and interference in an open treatment dialogue.

In considering arguments supportive of mandated reporting (again, aside from the fact that it is the law

in many cases), it is important to note that substance use and intoxication, even outside of a direct care responsibility, may lead to complications of impaired judgement and cognition, impairing withdrawal symptoms, and preoccupation with use. Psychiatrists can be seen to carry a special obligation to prevent harm in the community, as we are privy to personal information that other providers might not have. Further, psychiatry has always had a public safety role and paternalistic relationship to patients, as evidenced in commitment laws and treatment over objection; therefore, in many ways it could be argued that mandated reporting is nothing particularly new.

As psychiatrists, we often have to balance patient needs with public safety. While we have obligations to ensure patients’ wellbeing and successful treatment and to “do no harm,” the safety of others is always a concern. Many states and organizations have unfortunately taken a punitive rather than a supportive approach, which should be reconsidered. Physicians can advocate with state licensing boards and diversion programs to make those necessary changes. The answer is not to stop reporting. With recent increases in substance use trends, now is the time to become familiar with state reporting laws, as well as treatment resources available for patients. ☯

### References:

- (1) Guttmacher Institute (2020, January 1). Substance Use During Pregnancy. Retrieved from: <https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy>
- (2) Miranda, L., Dixon, V., and Reyes, C. (2015, September 30). How States Handle Drug Use During Pregnancy. *Pro-Publica*. Retrieved from: <https://projects.propublica.org/graphics/maternity-drug-policies-by-state>
- (3) Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2000. (Treatment Improvement Protocol (TIP) Series, No. 36.) Chapter 6—Legal Responsibilities and Recourse. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK64892/>

(continued on page 19)

## Recent Cases and Why They Matter

Adrienne Saxton, MD and Connor Darby, MD  
Judicial Action Committee

The AAPL Judicial Action Committee (JAC) stays abreast of the latest appellate level and higher court decisions impacting the field of forensic psychiatry, focusing primarily on local jurisdictions. JAC strives to conduct careful and methodical analyses of these decisions with an emphasis on significant trends and future implications. This article reviews the salient points from the 2019 JAC-sponsored panel “Recent Cases and Why They Matter.”

In *Dzung Duy Nguyen v. Massachusetts Institute of Technology*, 96 NE 3d 128 (Mass. 2018), the Supreme Judicial Court of Massachusetts established that universities have a special relationship with their students and a corresponding duty to take reasonable measures to prevent them from committing suicide in certain circumstances. The Supreme Judicial Court of Massachusetts laid out clear and concrete criteria for what triggers a university’s duty to protect students from self-harm. They held that a university has a duty to take reasonable measures to protect students from self-harm when it has either actual knowledge of a student’s suicide attempt occurring while enrolled or right before matriculation or when it has knowledge of a student’s stated plan or intent to commit suicide. The court defined how universities could satisfy a triggered duty: 1) Initiate a suicide prevention protocol if the university has one, 2) Contact university officials empowered to assist the student in obtaining clinical care from medical professionals or, if the student refuses such care, notify the student’s emergency contact, and 3) In emergency situations, contact police, fire, or emergency medical personnel.

The California Supreme Court in *Regents of the University of California v. Katherine Rosen*, S23058 (Cal. 2018), ruled that universities have a special relationship with their

students and a corresponding duty to protect them from foreseeable violence during curricular activities. The California Supreme Court did not explicitly define what constitutes “foreseeable violence” and how a university would discharge a “duty to protect.” While the Supreme Judicial Court of Massachusetts in *Nguyen v. MIT* distinguished that universities are “non-clinicians” and thus held to a lower standard, the California Supreme Court, by being vague about what triggers a duty to protect, effectively created a higher standard for universities than psychotherapists. In fact, the psychiatrists and psychologist involved in the care of the student who attacked Rosen were immune because of a California *Tarasoff*-limiting statute, which was created to correct problems of excessive liability for psychotherapists by clearly defining what triggers and satisfies a *Tarasoff* duty. Ironically, UCLA was found potentially liable because the California statute was specific and only applied to psychotherapists.

*Kahler v. Kansas*, 139 S. Ct. 1318 (Kan. 2019) (certiorari granted) – which was argued in front of the US Supreme Court in October of 2019 – concerned the constitutionality of a Kansas statute enacted in 1996 that abolished insanity defenses. Kansas is one of only five states (Alaska, Idaho, Montana, and Utah being the others) that precludes insanity defenses. All other jurisdictions (albeit with varying language in their insanity tests) prohibit punishment of defendants who at the time of the crime and as a result of a mental illness did not know their conduct was wrong. *Kahler* argued that Kansas violated the 8<sup>th</sup> Amendment’s prohibition on cruel and unusual punishment and the 14<sup>th</sup> Amendment’s due process requirement by not permitting testimony that he lacked the capacity to understand the wrongfulness of his actions as a result of a mental illness. *Kahler* did

not dispute the murder charges that led to his death sentence but disputed intent and premeditation. In *Clark v. Arizona* (2006), the US Supreme Court upheld the constitutionality of Arizona’s insanity test, declaring that insanity laws are “substantially open to state choice,” but did not address whether the Constitution requires states to have an explicit insanity defense. The question before the Supreme Court now in *Kahler v. Kansas* is whether the Due Process Clause provides a constitutional minimum standard that states must bar criminal punishment of defendants who did not know that their conduct was wrong due to mental illness.

*Smith v. Aroostook County* 376 F.Supp.3d 146 (1<sup>st</sup> Cir. 2019) is a First Circuit case from April 2019 involving the right to medication-assisted treatment (MAT) for opioid use disorder in jail. Ms. Smith filed suit alleging that a jail’s refusal to allow her to continue buprenorphine violated the Americans with Disabilities Act (ADA) and the 8<sup>th</sup> Amendment. The court granted a preliminary injunction forcing the jail to continue Ms. Smith’s buprenorphine based on likelihood of success on her ADA claim. The defendants appealed to the First Circuit. The decision was affirmed due to no clear error in interpreting the applicable legal principles and no abuse of discretion. This case is significant because substance use disorders are highly prevalent in incarcerated populations and inmates are at high risk of overdose upon release. Currently, few correctional facilities offer medication-assisted treatment. Growing concern about the risk of federal lawsuits for ADA violations, similar to this case, may lead to policy changes expanding MAT access in jails and prisons.

The Ninth Circuit case of *Gordon v. County of Orange* 888 F.3d 1118 (9<sup>th</sup> Cir. 2018) involved the standard under which alleged violations of a pretrial detainee’s right to adequate medical care are assessed. In this case, Mr. Gordon was jailed

(continued on page 20)

## Bail Reform and Psychiatric Populations

Abhishek Jain, MD and Grace Lee, MD  
Community Forensic Psychiatry Committee

Pending a referendum vote in November 2020, California may become the first state to fully eliminate cash bail for defendants awaiting trial.

(1) Washington, D.C. had already abolished the use of monetary bail in 1992, and New Jersey had largely ended the practice in January 2017. (2) Other states, such as Alaska and New York, have recently passed legislation to reform their bail system. Coming at a time of wider criminal justice reforms, these changes could have important implications for patient populations who have psychiatric or substance use disorders, and for detainees awaiting court-ordered examinations.

Cash bail is intended to help guarantee that the defendant will return to court to face their legal charges. Through the years, those in support of the bail system have argued that it holds individuals accountable. They may also postulate public safety concerns with proposed reforms. Additionally, the consideration that the current bail system does not burden taxpayers to pay for alternatives, like pre-trial monitoring services, is often raised. Opponents of the bail system have criticized it as favoring the wealthy and unfair to those with low socioeconomic status who cannot afford the required payment. They argue that pretrial detainees face further consequences, such as loss of employment, housing, and relationships - despite not yet having been convicted - and in turn could be more vulnerable to the pressure of accepting a plea bargain. Similarly asserted is that the bail system may especially have an unfavorable impact on those with a history of mental illness. (3)

The current movement to reconsider the bail process has been described as the third-generation of bail reform efforts in the United States, with the first occurring from the 1920s to 1960s, and the second from the 1960s to 1980s. (4) In January 2018, the constitutionality of California's bail

system was formally challenged and ruled by the First District Court of Appeal as violating due process and equal protection. (5) While this case, *In re Kenneth Humphrey*, is still being reviewed by the California Supreme Court, in August 2019 Governor Jerry Brown signed state Senate Bill No. 10 into law. Although now on hold until the November 2020 referendum vote, the law would repeal the existing bail laws and require "persons arrested and detained to be subject to a pretrial risk assessment conducted by Pretrial Assessment Services... to assess the risk level of persons charged with the commission of a crime, report the results of the risk determination to the court, and make recommendations for conditions of release of individuals pending adjudication of their criminal case." (1)

In general, supporters of non-monetary bail often cite the success of Washington, D.C., in which 88% of arrestees released without cash bail made all scheduled court dates and 99% were not re-arrested on violent crimes while in the community. (6) However, others caution that judicial decisions about who may be too high-risk for pretrial release are often discriminatory. Even with the increasing use of formal risk assessment tools, critics question their accuracy and argue that these instruments reinforce racial biases. The coming years are expected to yield important information that may help inform the debate about bail as more states implement legislative changes. Although the exact implications are not yet known, they are likely to have a significant impact on communities and justice populations. For instance, in one analysis before New York's bail legislation was officially effectuated on January 1, 2020, 43% of the almost 5,000 pretrial detainees in New York City would have been released if the state's law were already in place. (7)

While discussions for and against bail reform continue, the potential

impact on individuals with mental illness needs to be carefully weighed. Though the reported prevalence of psychiatric disorders among those in pretrial detention varies, studies consistently find a disproportionately high rate of mental illness in correctional settings. For example, in an oft-cited 2009 study of Maryland and New York jails, the rate of serious mental illness was 14.5% for male inmates and 31.0% for female inmates. (8) Additionally, an estimated 60,000 defendants nationally are ordered for competency to stand trial assessments each year. (9)

Thus, the role of mental health treatment in bail reform efforts should particularly be considered. Consistent with the steps outlined in the Sequential Intercept Model (10), provisions for diversion programs, pre-trial forensic examinations, availability of community-based services, and maintaining continuity of care may each offer means of supporting fairer judicial decisions, such as appropriate pretrial release conditions, in this vulnerable population. By collaborating with the court system, mental health professionals can continue to inform and help reduce bias and stigma (e.g., assumptions about the relationship between mental illness and violence). Involvement with developing valid risk assessment tools, along with collection and careful review of outcomes data, can also help guide their appropriate use when making release decisions.

Questions stemming from recent criminal justice reforms are similar to those raised during de-institutionalization movements of the 1960s and 1970s, like the 1966 *Baxstrom v. Herold* decision in which 967 "criminally insane" patients were transferred from correctional settings to civil state hospitals. (11) Reforms might provide opportunities to improve funding and build services for less restrictive settings. This highlights the importance of multi-disciplinary collaboration with community providers who will likely be working more closely with this population. For example, important legal and ethical nuances,

(continued on page 19)

## Facing the Elephant in the Evaluation Room: Confronting Bias and Striving for Objectivity (Part II)

W. Connor Darby, MD and Robert Weinstock, MD  
Ethics Committee

Ezra Griffith, M.D. identified that forensic work that ignores the cultural context and specifically the dynamics of dominant versus non-dominant groups of people in society will inherently be biased against nondominant individuals. (1) It can be argued applying Griffith's reasoning that a "culture-free" model of forensic psychiatric ethics would fall short in maximizing objective truth-telling and respect for persons. Griffith outlined that ethical forensic work calls for efforts to discover, understand, and convey an individual's narrative within a cultural context recognizing the power dynamics at play in society. (1) Griffith's approach can be understood as one method for combating certain types of implicit bias that are incompatible with one's conscious values but nevertheless lead to prejudice forensic opinions.

Drs. Shadravan and Bath illustrate the difficulty of meeting the goal of objectivity in forensic psychiatry if practitioners are blind to the pervasive racism in the history of the United States and field of psychiatry. (2) They argue that previous attempts at mitigating this bias have been too narrow in focus because bias was seen as an individual instead of a broader structural problem. They promote structural competency, as a more systems-based approach, to combat the racial bias that threatens the objectivity of forensic work. Such bias is evidenced by numerous studies showing racial disparities in outcomes due to implicit bias (e.g., violence risk assessments, competency to stand trial evaluations, and clinical triage dispositions). (2)

Drs. Weinstock and Darby have developed dialectical principlism as a method to analyze ethics dilemmas. (3) In this methodology, duties are prioritized according to the role of the

psychiatrist (e.g., forensic, treatment, researcher, managed care reviewer, etc.). Competing obligations are weighed and balanced in order to help each practitioner determine the most ethical action. For example, in the forensic role, the primary duty principles are derived from Appelbaum's model: (4) truth-telling and respect for persons. Secondary duty principles, which are traditionally associated with the treatment role that Appelbaum looked to separate from forensic psychiatry, exist and are considered for purposes of determining whether or not to accept certain cases in rare contexts. Under the model, these secondary principles are rarely determinative of the psychiatrist's most ethical action in the balancing process. They are considered nonetheless just as these traditional physician principles may operate in the background as secondary duties in the research or managed care roles. Additionally, Griffith's cultural formulation as well as Shadravan and Bath's structural competency are incorporated into the model by assigning the appropriate weight to secondary duty principles as well as adding substance to the primary principles: objective truth-telling and respect for persons.

Dialectical principlism may inform ethical behavior when deciding, for example, whether to accept a case for the prosecution at the penalty phase of a capital case when the defendant is black and the victim was white. Substantial evidence exists regarding racial disparities in the application of the death penalty. Black defendants were found to be close to four times more likely to be sentenced to death than white defendants while controlling for case differences and backgrounds. (5) Defendants convicted of killing white defendants were four times more likely to be sentenced

to death than if the victim were black. (6) It is therefore not a leap to surmise that forensic psychiatrists are likely to be susceptible to the same unconscious bias that affected the triers of fact. This is a point asserted by Shadravan and Bath regarding the inevitability of certain types of racial bias historically reinforced by society.

Applying dialectical principlism to this hypothetical, a forensic evaluator would prioritize Appelbaum's truth-telling and respect for persons as the primary duty. If any conscious bias existed, then this would be clear grounds to decline participation. This concept is undeniably just, as being honest is a prerequisite to practicing as an ethical forensic psychiatrist. Similarly, following Appelbaum, forensic psychiatrists need to go beyond subjective truth-telling to meet the objective truth-telling component. This can only be accomplished if unconscious biases are addressed and combatted as much as possible. Being aware of common unconscious biases that affect our conclusions is similar to using the most current scientific literature in formulating opinions. Basing our opinions on current evidence-based science instead of pseudoscience, antiquated psychiatric practices, or debunked theories promotes objective truth-telling.

Employing Griffith's approach to address implicit biases against nondominant groups would require a thorough examination of the cultural context intertwined with the defendant's unique narrative. This work could unmask a hidden mitigating factor that would have otherwise remained hidden if the forensic psychiatrist were to take a more traditionally narrow and "culture-free" approach to the evaluation.

Under the dialectical principlism framework, treatment role considerations take a back seat to the aforementioned primary forensic duty principles. However, this hypothetical case raises the complicated dilemma of using medical and psychiatric training for purposes of advocating for a death sentence when the alternative is life without the possibility of parole.

(continued on page 20)



## Woke Women of Forensic Private Practice

A. Natasha Cervantes, MD; Camille LaCroix, MD;  
and Carla Rodgers, MD  
*Private Practice Committee*

This article is a multi-generational view of women in forensic private practice, and how we all got into private practice. The experiences are as unique as each of the authors, and hopefully will be helpful to both men and women looking to make the transition to private practice.

### A. Natasha Cervantes, MD

When I interviewed for the psychiatry residency at Johns Hopkins, the then-training director said, “Our graduates do whatever they want, wherever they want.” That sounded a bit grandiose, but, I figured, they’re trying to sell their program.

Fast forward five years to graduating from said program and finishing a fellowship in forensic psychiatry. My first job was at the state’s only maximum-security hospital, informally considered “finishing school” for our forensic program. The year I started, a non-forensic psychiatrist was hired at a higher salary than forensically-trained psychiatrists. It created great discord and requests for pay equality, in a system where everyone knew exactly how much everyone else made. There did not appear to be room for negotiation. Also, being so new, it was difficult for me to threaten to leave if the situation wasn’t remedied. Ultimately, psychiatrists began leaving. It was a mass exodus, but at a trickle.

There were other factors, like my husband’s new job in another state. So, I left what I thought was my “do what you want, where you want” job. Except, in retrospect, it wouldn’t have continued in that fashion.

Next came the academic position at the university that was somewhat desperate for another forensic psychiatrist. It started well. It was correctional work with no restrictions on private forensic practice. I was able to build

my private practice and was doing well, until the county had an issue with the private work, which was then restricted. Because private practice was too significant a part of my work to just “give up,” I left the jail and tried running a partial hospitalization program and extended observation ER unit. I was expected to be in two places at once plus supervise mid-level professionals.

Although I really knew private practice forensic was where I wanted to be, it was difficult to leave the security of predictable, guaranteed pay. But something had to give.

Members from the AAPL Private Practice Committee were instrumental in encouraging the transition. The most valuable pearls of wisdom included a recommendation for a billing/hours tracking software program; kicking unprofessional attorneys to the curb, because they need us more than we need them (frankly this was mostly men), and orders to immediately increase my rates, which, I learned were way too low. Two women that were very helpful to me were Camille LaCroix and Carla Rodgers.

Two years later, I am still chief psychiatrist for the well-run jail, which I go to once a week. I still run the forensic fellowship. The anxiety about the “guaranteed paycheck” proved unnecessary. I logged half the hours and made twice as much after leaving first the jail, then academia and clinical outpatient.

And the rest of the time being available for private forensic work...is not just “whatever I want, wherever I want” but also “how I want.”

### Camille LaCroix, MD

As most women in medicine do, I juggle a lot in my roles as doctor, wife, mom of three, good citizen, daughter of aging parents, friend. I

came to forensic psychiatry quite accidentally and it has saved my sanity, so to speak.

As a psychiatrist for over 20 years, I’ve worked in many settings. After residency I repaid my loans from the military and served as a psychiatrist in the United States Navy. As a military psychiatrist, you are given duties regardless of interest or training; I became the assigned psychiatrist in the military brig (prison). I was apprehensive to say the least, however I instantly loved it.

Serendipitously, the AAPL Annual Meeting was being held up the road in Newport Beach, California the year I decided I needed more education and training in the legal aspects of psychiatry. Attending the AAPL Review Course was revelatory and helped me set a course for the future. I recall sitting next to a more established psychiatrist who had a private practice who encouraged me to “Be brave—go into private practice when you’re done!” His thoughts stuck with me, as we had been ingrained to serve patients in institutions that need you, and private practice seemed selfish to me.

I did my fellowship at UC Davis with Charles Scott, MD and felt armed with skills and resources as well as excellent mentorship. I learned that there were folks who needed us desperately in a different way. And the dream of private practice to choose how and where to contribute simmered on the back burner for a few more years, in favor of a “stable job with good benefits” while starting my family.

For the next several years I worked as a staff psychiatrist with the Veterans Administration. I taught medical students, helped start a community psychiatry residency track and saw patients that really needed me. I also started getting calls from attorneys in the community begging for help on cases. I started a small private forensic practice on the side. For a bit it seemed I had achieved the dream and had it all and could help them all. But it wasn’t enough—not enough time, not enough flexibility, not enough of me to go around.

*(continued on page 21)*

## Coleman v. Newsom

continued from page 4

Judge Mueller found that while there was not enough evidence to support fraud, the “...defendants have knowingly presented misleading information to the court in numerous areas critical to the remedy in this case and measuring compliance with that remedy.” (6) Most revolved around how data was collected from and interpreted in an electronic medical record that included the dashboard to monitor compliance with Program Guide rules. For one example, the Program Guide requires that psychiatrists see all patients every 30 days in confidential (not cell side) visits. However, the electronic medical record defaulted to confidential visits and psychiatrists had no way to indicate non-confidential contacts, so that many non-confidential visits were counted as confidential. This led in part to CDCR’s argument that fewer psychiatrists were needed.

Judge Mueller found that:

...the record created through the evidentiary hearing demonstrates a marginalization of psychiatry that impedes defendants’ ability to achieve full compliance with the constitutional requirements embodied in the court-approved remedy. ... testimony explains the pressures and disincentives created by reliance on automation and electronic data: Psychiatrists are being made to practice in an environment that, among other things, “causes data to have to be massaged in certain ways to allow information to be more presentable to say we don’t need psychiatrists so we can get out of the lawsuit. And the more you automate this process to make sure that compliance happens, the more you take control out of the clinician to be able to determine what’s clinically relevant for the patient.” [internal citations omitted] (6)

Perhaps most importantly, Judge Mueller further found that psychiatric input for critical policy decision making was “severely constrained”:

Psychiatrists are critical to appropriate mental health staffing, given that they are medical doctors bound by the Hippocratic Oath (“Psychiatrists as physicians do have the Hippocratic Oath to do the best we can for our patients.”). This does not mean psychiatrists must always prevail in internal policy- and decision-making processes. But they must be meaningfully consulted; their professional views must be heard, considered and accounted for. Defendants’ marginalization of psychiatry and their clumsiness in the process reflects a significant lack of good judgment and bureaucratic dysfunction that, if allowed to continue, presents a major obstacle to successful remediation in this action. [internal citations omitted]. (7)

Judge Mueller wrote that as of December 2019 psychiatrist staffing vacancies were at 30%. While she acknowledged there were many market difficulties in hiring psychiatrists for sometimes remote California prisons, “these hearings have provided additional explanations and identified other contributors to the challenge in identifying psychiatrists, including an uninviting dysfunctional workplace that does not value the essential treatment perspectives that psychiatrists have to offer and creates an atmosphere where morale is low.” (8)

This part of the *Coleman* case highlights several important issues. First it reminds us how data gleaned from electronic medical records can be manipulated and lead to misinterpretation. It is imperative that managers, who rely on such data, check to see if the data collected reflects clinical reality. Dr. Golding did so and uncovered many problems with the electronic dashboard that had been used to measure compliance. Second it is important that the Court in this case

highlighted the importance of psychiatrists providing treatment in the correctional system. The court pointed out significant administrative barriers and “bureaucratic dysfunction” within CDCR that made it difficult for line and manager psychiatrists to successfully treat patients and also interfered with the recruitment of new correctional psychiatrists. (9)

### References:

- (1) (formerly *Coleman v. Brown and Coleman v. Wilson*), No. 2:90-cv-00520-KJM-DB (E.D. Cal.),
- (2) *Coleman v. Wilson*, 912 F. Supp. 1282, 1307 (E.D. Cal. 1995)
- (3) Case No. 2:90-cv-00520-KJM-DB, ECF No.5988-1
- (4) Case No. 2:90-cv-00520-KJM-DB, ECF No. 6147 page 2
- (5) Case No. 2:90-cv-00520-KJM-DB, ECF 6427
- (6) Case No. 2:90-cv-00520-KJM-DB, ECF 6427 page 41
- (7) Case No. 2:90-cv-00520-KJM-DB, ECF 6427 page 42-43
- (8) Case No. 2:90-cv-00520-KJM-DB, ECF 6427 page 48

## Revitalizing

continued from page 10

a Committee Chair. Barring unusual circumstances and at the discretion of the President, *it is anticipated that members will serve as Committee Chairs for no more than six consecutive years.*

To be eligible to be appointed as Committee Chair, an AAPL member, if possible, should have served at least one three-year term on the Committee. An AAPL member is limited to being Chair of only one Special Committee at a time.

Committee Chairs should consider requests for appointment and reappointment during the “enrollment period” of October 15 to December 1. Lists for membership appointments or reappointments should be forwarded to the President by December 1, and the President will work with Committee Chairs to make recommended appointments.

Committee Chairs are responsible for ensuring that their Committee meets its obligations. If Committee

(continued on page 19)

## The Heartbreak

*continued from page 8*

I was doing. Had the whole thing planned out.” And I’m thinking, Damn! He remembered my name! What if he gets out someday?!

Of course, most of our cases are not this dramatic. And sometimes - especially when working with children - the outcome can be quite agreeable. Remember that grandmother who wanted custody of her five grandchildren whose mother spared from starvation? The court said she could raise them. And the foster mother whose teen years were interrupted after she killed her friend’s mother? She was allowed to adopt those boys.

Sometimes, though, our cases take their toll. Sometimes we need to talk with our colleagues and friends and partners, unfasten our professional carapaces, read a good book. Talk about feeling smothered by a case. Talk about the occasional heartbreak and horror . . . and fear. And remind us that despite everything, we are privileged to be let inside people’s minds and hearts. And, we hope, do some good. ☯

---

## Bail Reform

*continued from page 15*

such as confidentiality of protected health information of pretrial defendants, ought to be reviewed. Similarly, distinguishing the roles of providing forensic evaluations (e.g., competency to stand trial or criminal responsibility) from mental health treatment may need to be clarified with those who request these services.

Monetary bail has recently become a prominent component of the broader debate surrounding criminal justice system reform. With recent legislative trends towards elimination or limited use of cash bail, consideration should be given to how this impacts individuals with a history of psychiatric illness, substance use disorders, and mental health treatment needs. While

the precise outcomes of pending legislative provisions remain to be seen, this could present an opportunity for ongoing collaboration among mental health professionals, court personnel, researchers, and policymakers to serve the needs of the justice system and at-risk patient populations. ☯

## References:

- (1) California Senate Bill No. 10: <https://www.courts.ca.gov/pretrial.htm>
- (2) Executive Order No. 211: Criminal Justice Reform Study: <https://www.nj.gov/oag/library/Executive-Order-211--FINAL-REPORT--11.30.16.pdf>
- (3) American Civil Liberties Union, Northern California, May 22, 2017. Accessed November 9, 2019: <https://www.aclunc.org/blog/mental-health-month-advocates-demand-bail-reform>
- (4) National Task Force on Fines, Fees, and Bail Practices: Bail Reform: A practical guide based on Research and Experience: <https://www.ncsc.org/~media/Files/PDF/Topics/Fines%20and%20Fees/format%20revisions/Bail%20reform%20guide%203%2012%2019.ashx>
- (5) *In Re: Kenneth Humphrey*, 417 P.3d 769 (Cal. 2018),
- (6) Kennedy, S. Pretrial Services Agency for the District of Columbia: Freedom and Money – Bail in America. Accessed November 9, 2019: <https://www.psa.gov/?q=node/97>
- (7) Rempel M & Rodriguez K. (2019). *Bail Reform in New York: Legislative Provisions and Implications for New York City*. New York, NY: Center for Court Innovation.
- (8) Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60(6), 761-765.
- (9) Poythress, N. G., Bonnie, R. J., Hoge, S. K., Monahan, J., & Oberlander, L. B. (1994). Client abilities to assist counsel and make decisions in criminal cases. *Law and Human Behavior*, 18(4), 437-452.
- (10) Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric services*, 57(4), 544-549.
- (11) Steadman, H. J. (1973). Implications from the *Baxstrom* experience. *Bulletin of the American Academy of Psychiatry & The Law*.

## Faces of AAPL

*continued from page 9*

highlight of his career was singing with his school-age daughter for an Albany Records recording of Shaker music. “Nothing better,” he says. Kudos to a colleague who has found a true professional and personal balance. ☯

---

## Dual Agency

*continued from page 13*

- (4) Mossman, D. (2011) Physician impairment: When should you report? *Current Psychiatry* 10: 67-71, 2011
- (5) Berg, K., Seppala, M., and Schipper, A. Chemical Dependency and the Physician. *Mayo Clinic Proceedings*, 84: 625–631, 2009.

---

## Revitalizing

*continued from page 18*

Members do not volunteer to participate in meeting Committee obligations, Committee Chairs may assign these tasks if they so choose. Committee Chairs are also responsible for tracking Member attendance and participation at each Committee meeting and keeping a record thereof.

*Communication:* AAPL’s website has a Committee page. The website’s Committee page will provide the general information about Committee administration and governance. Committee Chairs will provide a short description (5-7 sentences) of their Committee, including activities undertaken, to be posted on the website. This description will be available on the Committee page and should be updated on a yearly basis, after the Annual Meeting. The Committee page will be updated on a yearly basis, after the Annual Meeting, with the names of the Committee Chairs, and a list of committee members and their terms of appointment.

AAPL’s Special Committees are part of what makes AAPL a unique and “user-friendly” organization. We hope that making the governance and administration of the Special Committees as transparent as possible will

*(continued on page 22)*

## Recent Cases

*continued from page 14*

on heroin-related charges. He had been using three grams of heroin per day. Despite some monitoring, Mr. Gordon was found unresponsive and pronounced dead shortly thereafter. The issue before the 9<sup>th</sup> Circuit was whether the objective standard for evaluating excessive force applied to medical monitoring in a 42 U.S.C. § 1983 claim. The 9<sup>th</sup> Circuit held that yes, when determining deliberate indifference for pre-trial detainees, the defendant's conduct must be objectively unreasonable. The pre-trial detainee must "Prove more than negligence but less than subjective intent--something akin to reckless disregard." The potential implications of this case include applications to psychiatric care and suicides. The *Gordon v. County of Orange* decision creates a lower *objective standard* for pretrial detainees to prove that jail officials were deliberately indifferent (i.e., should have known of the risk even if not subjectively aware). This is in contrast to the *Farmer v. Brennan* (1994) US Supreme Court decision that required a *subjective standard* in which prisoners must prove that prison officials knew of the risk (i.e., they were subjectively aware) and disregarded it.

***People v. Contreras* 411 P.3d 445 (Cal. 2018)** is a 2018 California Supreme Court case involving juvenile sentencing. In this case, two defendants who committed serious non-homicide offenses at age 16 were sentenced to two consecutive terms of 25 years to life. The issue before the California Supreme Court was whether it violates the 8<sup>th</sup> Amendment to sentence juvenile offenders to lengthy terms when parole eligibility would come near the end of their lives. The California Supreme Court ruled that such lengthy sentences violated the 8<sup>th</sup> Amendment and remanded the case for resentencing. The court reasoned that "children are different" from adults for sentencing and that lengthy sentences reflect judgment that defendants are incorrigible. This

case highlights the trend of evolving standards in juvenile sentencing and how advances in the scientific understanding of brain development are influencing law and policy. ☞

## Charles v. OC

*continued from page 11*

2. *Estelle v. Gamble*, 429 US 97 (1976).
3. *Youngberg v. Romeo*, 457 US 307 (1982).
4. *Charles v. Orange County*, 925 F. 3d 72 (2<sup>nd</sup> Cir. 2019).
5. *Charles v. County of Orange*, No. 16-CV-5527 (S.D.N.Y. Sep. 29, 2017).
6. Binswanger IA, Stern MF, Deyo RA, et al: Release from prison – a high risk of death for former inmates. *New Eng J Med* 356(2):157–165, 2007.
7. Brief amici curiae of American Psychiatric Association et al. in support of Plaintiff-Appellants, *Charles v. Orange County*, 925 F. 3d 72 (2<sup>nd</sup> Cir. 2019).
8. Janofsky JS: *Charles v. Orange County*: the importance of discharge planning on release from custody. *Newsletter Am Acad Psych Law* 44(2):5-6, 2019.
9. *DeShaney v. Winnebago Cty.* DSS, 489 US 189 (1989).
10. *Wakefield v. Thompson*, 177 F.3d 1160 (9<sup>th</sup> Cir. 1999).
11. NYLPI Press Release. ICE and local officials pay \$1.725M after "discharging and dumping: immigrants with mental health diagnoses. Available at: <https://nylpi.org/ice-and-local-officials-pay-1-725m-after-discharging-and-dumping-immigrants-with-mental-health-diagnoses/>. Accessed January 17, 2020.

## Facing the Elephant

*continued from page 16*

Furthermore, the forensic psychiatrist is in a situation where it is known that there is a high likelihood that their opinion may be less objective because of unconscious bias against the defendant even if efforts are made to reduce this bias.

The American Medical Association (AMA) is unambiguous on where they draw the line for what constitutes physician participation in legally authorized executions, which is forbidden by both the AMA and American Psychiatric Association (APA). (6, 7) The AMA forbids all treatment role actions (e.g., prescribing, preparing,

administering, or supervising lethal injection drugs), (7) but permits physicians in forensic roles to participate in various aspects of capital trials including opining on aggravating circumstances. Dialectical principlism uses the context of the situation to apply greater or less weight to certain principles. In this situation, when asked to opine on the presence of aggravating circumstances at the penalty phase that would support a death sentence, one may assign greater weight to the secondary duty ethics considerations against harming evaluatees because the harm here is the ultimate and irreversible kind – death.

One may, when balancing the competing ethics principles and considerations, decline the case for the prosecution. It is unrealistic that the prosecuting attorney would be interested in the "whole truth" that would include presenting potential mitigating circumstances. Given the extremely high stakes of a death penalty sentence and risk for unconscious bias against the defendant, one may argue that despite being "honest and striving for objectivity," accepting a case for the prosecution is a much different endeavor from an ethics standpoint. That is, the context of a capital case and the known implicit bias against black defendants at the penalty phase may be enough to tip the scales to favor refusing to accept such a case for the prosecution in this hypothetical. This ethics analysis and hypothetical action differs from the bias (conscious or unconscious) described previously in part I of this article, which could lead an unethical forensic psychiatrist to distort her psychiatric opinion for the defense in a capital case because they believe the death penalty is a societal injustice. ☞

### References:

- (1) Griffith EEH: Ethics in forensic psychiatry: a response to Stone and Appelbaum. *J Am Acad Psychiatry Law* 26:171–84, 1998
- (2) Shadravan SM and Bath E: Invoking history and structural competency to minimize racial bias. *J Am Acad Psychiatry Law* 47 (1):2-6, 2019
- (3) Weinstock R: Dialectical principlism: an approach to finding the most ethical action.

*(continued on page 22)*

## Woke Women

*continued from page 17*

After 10 years of federal service I plunged into private practice. It was scary at first, but it ultimately saved my sanity. AAPL has been an important part of my journey from my first introduction at the 2002 review course to attending and presenting at the annual meetings over the years. The Private Practice Committee in particular has been an invaluable source of support and friendship that was most unexpected.

I still teach with the residency, I still see patients who need me via telepsychiatry to remote areas of my state, but my private forensic practice has given me the ability to use all my skills in ways that are deeply satisfying.

Private forensic psychiatric practice is challenging, fun, rewarding, cool, and I get to do it with an extended network of colleagues that I admire and know I can rely upon for support and advice. What more could a gal ask for?

### Carla Rodgers, MD

I was a happy little academic in C/L psychiatry at Thos. Jefferson Kimmel School of Medicine in Philadelphia about 30 years ago. It was a second career, after being a clinical anesthesiologist. I loved C/L. I expected to have a long and happy career at “Jeff,” and was enjoying my first real experience with clinical research. And then came (drum roll!) managed care! They refused to pay for residency training/teaching so our division was being cut back. I did not like the politics of what was being done to the older “less productive” members of the division, and my distaste led me to leave academia and join a pal and his senior partner in clinical private practice. And then came (drum roll!) managed care! The practice, which had been going strong for about 40 years, went bust, and I was on my own. It was scary times for me since I had always had a “job,” but a best friend forever, unfortunately now deceased, was a successful

non-medical businessman who mentored me in my first year and helped make financial survival possible through his advice and wisdom.

I always enjoyed forensics, and wanted to make it part of my professional life, so I did things like cold-call attorneys, offer to do all the forensic work that any of my colleagues found distasteful and refused to do, and took a couple part-time gigs. I would also speak at the opening of a door, or wherever I could, on forensic topics.

I was the first female member of the Private Practice Committee, and its first female chair. I had and have mixed feelings about my experience. One of the members said, when I first introduced myself, that it was great to finally have a woman on the Committee to handle all the child custody matters, which he found distasteful. He would refer them all to me. I did not ask for this favor. I found the relationships between the members alternating between chummy and one-ups-man-ship. I felt there was a lot of pontificating going on (still is), and in AAPL in general, and I decided that I would have to join in this activity to be heard. I am now a great my-own-horn-tooter. On the other hand, I have learned so much from my colleagues and had a lot of good fun over the years. I’ve made some life-long friendships. The current and future “crop” of female forensic psychiatrists are superstars.

Now in my 8th decade, my primary mission is to mentor other women physicians, younger or not, and encourage them to follow their hearts, and jump into the deep end of the pool. The water’s fine. ☺

**See Page 2 for  
2020 Award  
Nomination Criteria**

## CONGRATULATIONS 2019 AAPL AWARD WINNERS



**Red Apple Award  
Aimee C. Kaempf, MD**

.....

**Golden Apple Award  
Gregory B. Leong, MD**

.....

**Howard Zonana  
Best Teacher in a  
Fellowship Program  
William C. Darby, MD**

.....

**Seymour Pollack Award  
Raymond F. Patterson, MD**

.....

**Amicus Award  
Sara L. Elsdon**

.....

**Young Investigator Award  
Andrew Tuck, MD**

.....

**2018 Poster Award  
Greg Iannuzzi, MD**



## Facing the Elephant

continued from page 20

*J Am Acad Psychiatry Law* 43 (1): 10-20, 2015

(4) Baldus DC, Woodworth G, Zuckerman D, and Weiner NA. Racial Discrimination and the Death Penalty in the Post-Furman Era: An Empirical and Legal Overview with Recent Findings from Philadelphia, 83 *Cornell L. Rev.* 1638 (1998)

(5) Appelbaum PS: A Theory of Ethics for Forensic Psychiatry. *J Am Psychiatry Law* 25: 233-47, 1997

(6) Available at: <https://scholarship.law.cornell.edu/clr/vol83/iss6/6>

(7) Baldus DC, Pulaski C, and Woodworth G (Fall 1983). "Comparative Review of Death Sentences: An Empirical Study of the Georgia Experience". *J Crim Law & Criminol* 74 (3): 661-753. doi:10.2307/1143133

(8) American Psychiatric Association: The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry (2013 Edition). Available at: <http://www.psychiatry.org/practice/ethics>. Accessed November 14, 2019

(9) American Medical Association Code of Medical Ethics. Available at: <https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview>. Accessed November 14, 2019

## Revitalizing

continued from page 19

facilitate members' involvement in at least one Special Committee as a means to get the most benefit from AAPL membership and to give AAPL the benefit of each member's interests and experience. ☪

## MUSE & VIEWS

### Truth in Advertising

In 2015, a Florida man was arrested for possession of marijuana and methamphetamine after deputies observed him handing a small bag to another individual. The man likely was already under a high degree of suspicion, though, because his T-shirt read, "Who needs drugs? No, seriously, I have drugs."

Submitted by  
Ryan Wagoner, MD

## YOUR SPECIALIZED PRACTICE IS SAFE WITH US

### WE PROTECT YOU

PRMS' psychiatric malpractice insurance program is tailored with rates that reflect your specific risks and expert risk management materials relevant to your specialty.

VICTORIA WATKINS, RPLU  
ASSISTANT VICE PRESIDENT, INSURANCE SERVICES



Specialty-specific protection is just one component of our comprehensive professional liability insurance program. Contact us today.

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



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

## CALL FOR AWARD NOMINATIONS

### Manfred S. Guttmacher Award

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

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

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

**Deadline:** June 1, 2020

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

### Isaac Ray Award

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

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

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

**Deadline:** June 1, 2020

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

Learn more about how to make a nomination at:

[psychiatry.org/awards](https://www.psychiatry.org/awards)

AMERICAN  
PSYCHIATRIC  
ASSOCIATION



**INTERESTED IN  
ADVERTISING IN THE  
AAPL NEWSLETTER?**

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

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

A 50% discount will be given to nonprofit organizations. No other discounts or commissions are allowed. Example ads are available upon request.

Advertising deadlines:  
November 15 (Winter issue)  
March 1 (Spring issue)  
July 1 (Fall issue)

Contact the AAPL Executive Office to obtain the order form.

## Now hiring psychiatrists!

The **California Department of State Hospitals** operates the largest forensic psychiatry hospital system in the nation, offering an unparalleled quality of practice while providing care to some of the most complex patients found anywhere.

### Salary:

\$247,644 - \$296,772/year (Board Eligible)  
\$261,312 - \$305,376/year (Board Certified)

### Practice and Benefits:

- Flexible workweek options may be available
- Substantial CME allowance
- Generous defined-benefit pension
- Psychopharmacology support by leading experts and established protocols
- Relocation assistance may be available
- Telepsychiatry available at some locations

To find out more, please contact **Juan Arguello, DO.**

☎ (916) 654-2609  
✉ [careers@dsh.ca.gov](mailto:careers@dsh.ca.gov)  
🌐 [www.dsh.ca.gov](http://www.dsh.ca.gov)



California Department of  
**State Hospitals**



Oregon Health & Science University (OHSU) has an outstanding opportunity for a BC/BE forensic or general psychiatrist for clinical work, teaching, and research at Oregon State Hospital (OSH). We offer a unique 80/20 schedule which, upon approval, allows faculty one day per week to pursue academic projects. Opportunities include competency and insanity evaluations, court testimony, medical student and resident supervision, patient care, and, depending on skill and experience, a possible administrative position. The Oregon State Hospital is a robust institution with ample support from the state in its goal of providing high-quality care and forensic evaluations in a state of the art facility. The leadership teams of OHSU and OSH provide strong support for professional development and career advancement.

Academic rank begins at the level of assistant professor and may be higher depending on credentials and experience. We provide competitive pay and benefits, which may be substantially supplemented with voluntary call at OSH's twin campuses.

We invite your interest in this unique and rewarding opportunity.

If you would like more information, please contact Maya Lopez, M.D. We look forward to hearing from you.

Maya Lopez, M.D., Administrative Chief, Oregon State Hospital  
[lopezst@ohsu.edu](mailto:lopezst@ohsu.edu)



## AAPL Newsletter

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

Joseph R. Simpson, MD, PhD, Editor

Non-Profit Org  
U.S. POSTAGE

**PAID**

HARTFORD, CT  
PERMIT NO. 5144