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AAPL Debate: Should the USA Adopt Infanticide Laws?

Nicole Graham MD, Daniel Hackman MD, Cortney Kohberger MD, Susan Hatters Friedman MD and Phillip Resnick MD

More than 40 nations have Infanticide Laws[1], including Great Britain and Canada. The United States does not. The debate focused on whether the US should adopt legislation similar to the Canadian Infanticide Act as a basis: *A female person commits infanticide when by a willful act or omission she causes the death of her newly-born child (under 1 year), if at the time of the act she is not fully recovered from the effects of giving birth to the child or the effect of lactation her mind is then disturbed*.

In the US, homicide is in the top five causes of death for children aged 1 to 14 years old[2]. In 2011, 54% of child homicide victims under the age of five were killed by their parents in the US[2]. Over a quarter of all filicides end in filicide-suicide (when a parent kills their child and then takes their own life); often these are driven by altruistic motives[3]. While the majority of the literature on filicide involves mothers, fathers do commit about half of all such crimes.

When studies looked at mothers who kill their children, several common characteristics were identified: single, young (mean age in their 20s), of low income, poorly educated, socially isolated, had the full-time caregiver role, presence of domestic violence and/or relationship problems, and sometimes child factors were the precipitants (such as colicky infants or developmentally delayed children)[4]. Additionally, a significant proportion of these mothers experienced psychiatric symptoms. Peripartum mental illness was a major factor in many of these filicides. In fact, over a third of the maternal filicides occurred during pregnancy or the postpartum year. These mothers often experienced symptoms consistent with post-partum depression and post-partum psychosis. These findings are in contrast to those found with neonaticide, child homicide within the first 24 hours. Here, the mothers were often free of major psychiatric disorders, had absent prenatal care, and the pregnancy was often unwanted[5].

There is reason to believe that infanticide has existed in every human culture since the beginning of society. However, it wasn't until recently that specific laws were passed to punish women who committed infanticide. In 1623, Great Britain passed the "Act to Prevent the Destroying and Murthering of Bastard Children." This Act presumed guilty the mother who was found to have concealed the death of her bastard child. Women found guilty under this Act were executed. Thus, there was a strong incentive for women who were accused of concealing the death of a bastard child to find a way to prove their innocence. One method was called the "Benefit of Linen" defense. This defense consisted of the mother demonstrating to juries that she "wanted" her baby by showing them baby clothes and bed linens she had made in preparation for the baby's birth. Jurors, feeling sympathy for the plight of the accused mothers, were quite willing to accept this defense in order to find these mothers not guilty.

In 1803, British lawmakers revised these statutes. The 1803 revisions included the following: 1) A mother found to have concealed the death of her bastard child was no longer presumed guilty; 2) If it was proven that

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CHAPTER NEWS

Tri-State AAPL 40th Anniversary Conference
Forensic Psychiatry: Past, Present, and Future

Manuel Lopez-Leon MD

On Saturday January 24, committed guest speakers and devoted AAPL members made their way through the first snowstorm of the year to the New York State Psychiatric Institute where the Tri-State Chapter's 40th annual conference was held. The program offered 6.25 hours of Category 1 CME credits and it was held in cooperation with the New York State Office of Mental Health and the Forensic Psychiatry Clinic for the Criminal and Supreme Courts of the State of New York.

The first presenter was Petros Levounis, M.D. Chair, Dept. of Psychiatry, Rutgers New Jersey Medical School. Dr. Levounis spoke on *The Behavioral Addictions* and went on discuss how and why certain behaviors are currently being understood as addictions, and their forensic implications. For instance, he explained how a few years ago a controversial dermatology publication characterized sun tanning as an addiction. Despite the strong disagreements within the Addiction Medicine community, most addiction specialists agree that a behavior such as sun tanning could indeed be a form of addiction. To illustrate the point more clearly, Dr. Levounis pointed out that gambling addiction has been widely accepted as an addiction within the general psychiatric community, and is the most researched form of behavioral addiction to date. Dr. Levounis explained the neurophysiology of addictions and how the activation of these systems is equally valid in behavior addictions. The underlying dopaminergic paths involved in behavior addictions help explain how it is human nature to avoid risks to ensure gains, even small gains, and on the other hand, people also take risks, even big risks, to avoid definite loses. Other examples of behavioral addictions that are still being classified and researched include some of the following: exercising, eating, Internet surfing, texting/emailing, sex, love, shopping, tanning, working, and kleptomania, to mention some. Dr. Levounis believes that some criminal behaviors may be construed as behavior addictions, which may play a role on recidivism of the criminal conducts, even overriding punitive consequences of such behaviors already experienced in the past.

Dr. Levounis explained how the introduction of the internet became "the perfect storm" for behavior addictions; "sex, both virtual and real, both safe and unsafe, is only a click away!" The way the Internet activates the reward centers of our brains is through the concept of "Variable Intermittent Reinforcement," a powerful mechanism of "teasing" our dopaminergic system by stimulus and release mechanisms. Nevertheless, humans also have the capacity for "Mentalization" as explained by Viktor E. Frankl: "Between stimulus and response there is space. In that space is our power to choose our response. In our response lie our growth and our freedom." This quote pinpoints the basis for the treatment of behavior addictions through Cognitive-Behavior Therapy and Motivational Interviewing techniques. In conclusion, Dr. Levounis pointed out that Behavioral Addictions fall within an Impulsivity-Compulsivity spectrum of illness, and that important treatment points to keep in mind are the following: that psychology trumps probability in gambling, that psychosocial interventions do work, that medications have fallen short in studies, and that current knowledge directs us to focus our efforts on increasing people's internal motivation and ability for mentalization.

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Terrorism and Mental Illness

Charles C. Dike MD, MPH, FRCPsych

No one is saying it loudly but everyone knows and agrees; the Third World War has begun. The world is at war with a common enemy: Islamic radicals, fundamentalist Islam, or, as some would rather say, Islam itself. In Nigeria, Somalia, Kenya, Mali, Egypt, Tunisia, France, Yemen, Iraq, Iran, Syria, Canada, Pakistan, Afghanistan, Niger, Chad, Cameroon and Australia, these so-called Islamic radicals have struck with brutal and deadly force causing tremors not just in countries affected but all over the world. Denmark, India, the USA, Algeria, Libya, Russia, Belgium and China have all also experienced brutal attacks from Islamic radicals. After the horrific taped beheadings of 21 Egyptian Coptic Christians in Libya, ISIS proudly warned; "Today we are south of Rome. We will conquer Rome with Allah's permission." No country appears immune to attacks or threats from Islamic radicals. And, all countries have come together, not only to condemn them but to mount a coordinated military offensive against them. Yes, the war on terror has gone global!

But, who are these Islamic radicals? Why are they readily killing themselves through suicide, taking hundreds of people with them? Does mental illness play a role? Is it enough to state that a major motivation for sacrificing their lives is to have 72 virgins in paradise? What about female suicide bombers of whom their numbers have been steadily creeping up; does the purported promise of virgins in paradise apply to them as well?

The American public was stunned, then alarmed when it was reported that dozens of American-Somali men left the comfort of their homes and cities in the US for Somalia from 2007 to 2010 to fight with Al-Shabab, a ruthless Islamic terrorist organization that recently slaughtered 147 innocent victims in a college campus in Kenya. Another group of American men have recently travelled to Syria to join ISIS. These young men were said to have become "radicalized." A father whose American son died in such a battle described the situation as madness. But, was it? Is it enough to blame extreme marginalization and hopelessness due to the triple curse of being immigrant, black and Muslim in the US, coupled with the sharp narrowing of opportunities following a stint in prison as reasons to voluntarily join a radical organization? How different is this from inner city youth in the US who experience the same marginalization, helplessness and hopelessness and who in response, turn to violence with catastrophic consequences for themselves and the society at large? It seems the same circumstances that drive individuals into gangs drive others into radical organizations. Add religious fervor and zealousness and a radicalized youth emerges. How difficult would it be to lure these youth to Islamic radicalization in the misguided belief they are fighting for something glorious and bigger than themselves? That they have a chance at last to become important, contributing and idolized members of a society, albeit a radicalized Islamic one, becomes a strong motivator to join. Some join to redeem themselves from previous failures and irresponsible lives, while yet others join for the thrill of being in combat. The added fantasy of basking in the embrace of 72 virgins in paradise upon their death is nothing but icing on the cake.

To complicate matters further, it would be a mistake to assume that all who join Islamic fundamentalist organizations are themselves steeped in the Islamic faith or are religious fanatics. As observed by Max Abrams, a Northeastern University professor who studies jihadist groups, "The vast majority of Westerners joining up with ISIS are extraordinarily ignorant when it comes to religion." Mubin Shaikh, a former Taliban recruiter concurred: "There were certain things we looked for; people who didn't know the religion as much; people who were converts, because converts would probably have problems with their parents at home, so they were more likely to stay in our company." Does this superficial understanding of Islam answer the baffling question of why young women from all over the world put themselves at risk to join an Islamic fundamentalist organization such as ISIS? Why would ISIS treat them any differently from the brutal oppression of women by the Taliban purportedly supported by Islam? Equally as baffling is ISIS' success at recruiting doctors, medical students, engineers and other professional groups from upper middle class families, some of whom did not speak Arabic, and some of whom subsequently took up arms to fight for ISIS.

Of note, Islamic scholars have stressed that committing suicide is one sure way of depriving oneself of paradise, according to the Quoran; it is a forbidden act. In fact, they dispute the notion of 72 virgins, stating that it is un-Islamic, a propaganda propagated by anti-Moslems to tarnish practitioners of the Islamic religion.

In our society, individuals who carry out extreme acts of violence against others are quickly labeled as crazy. As forensic psychiatrists, we may be called to opine on the role of mental illness in acts of violence carried out by Islamic radicals. According to John Horgan, a psychology professor at the University of Massachusetts Lowell's Center for Terrorism and Security Studies, "Trying to explain terrorism as mental illness is misleading." While we cannot completely rule out mental illness offhand, caution should be exercised before ascribing violent behaviors emanating from a distorted interpretation of religion as secondary to mental illness.

Correctional Psychiatry and its Relationship to Psychiatry and the Law

Graham D. Glancy, MB ChB, FRCPsych, FRCP(C)

At a recent meeting of the Correctional and Institutional committee of AAPL, we discussed the format of a course in correctional psychiatry for forensic psychiatrists. This is one of the biggest committees in the organization and the response was enthusiastic. A number of suggestions were made and a number of people volunteered to participate. At one point in the discussion an experienced forensic psychiatrist said, "This sounds great but what is the forensic angle?"

In this article, I'd like to attempt an answer to my colleague's question. Several aspects of correctional psychiatry make it unique when compared to general practice.

These unique aspects, together with the special significance of mental health issues in a correctional context, argue in favor of a strong role, played by forensic psychiatrists, because many of the skills needed to face these unique issues fall squarely within the scope of our discipline.

Before making the case that forensic psychiatry is uniquely situated to meet the demands of correctional psychiatry, I want to briefly touch on the general importance of psychiatric care in corrections. It has been estimated that there are about ten times more people suffering from serious mental illness in US jails than in US psychiatric facilities.[1]

In a large 2007 survey, 64% of US inmates reported one or more symptoms of mental illness, while 30.4% affirmed having five or more symptoms of major depression within the previous year.[2] Patients with mental illness stay in jail longer and may recidivate more quickly.[3]

The U.S. constitution guarantees incarcerated patients the right to treatment for serious medical conditions. The courts have interpreted this to include adequate care from trained mental health professionals.[4,5] I would argue that the particular challenges arising in correctional psychiatry mean that forensic psychiatrists should take a leadership role in providing, planning, and coordinating this care. Like the profession of forensic psychiatry, correctional psychiatry occurs at the intersection between psychiatry and the law, creating unique challenges for professional practice and implying particular competencies and types of training. Training in forensic psychiatry builds competency specifically in these areas and is, thus, of great relevance to the provision of care in correctional settings.

"The answer to the distinguished forensic psychiatrist who asked 'what is the forensic angle of a course on correctional psychiatry?' is that correctional psychiatry is situated within the body of forensic psychiatry."

First, forensic psychiatrists are well versed in the unique ethical issues arising from the dual obligation to patient care and public or institutional security. Special challenges are encountered in corrections, for example, regarding confidentiality and informed consent. When a patient is at risk of harming him or her self, or others, it may be necessary to inform security staff. If the patient represents a significant risk of escape or a threat to the security of the institution (e.g. illicit drug use or smuggling of contraband), the psychiatrist needs to be aware, and is required to make the patient aware, that confidentiality may be breached. Moreover, the psychiatrist needs to be skilled in providing care within these constraints.

Second, forensic psychiatrists have skill in maintaining boundaries, breaches of which are frequently threatened in corrections. The correctional psychiatrist may provide care to a patient who attempts to manipulate him or her. Navigating this terrain is not easy, calling for an attitude of objectivity, some skepticism and neutrality, balanced against "forensic empathy". This may be a difficult skill to learn, but it is vital in order to safely survive in this setting. As an expert in balancing the obligation to the patient with the obligation to evaluate for the justice system, the forensic psychiatrist can, and should, play a central role in correctional psychiatry.

Third, forensic psychiatrists have a good knowledge of the relationship between the correctional setting and the forensic psychiatric setting. While the practitioner's duties are multiple, one and the same individual with a serious mental disorder may present as both an evaluee in a forensic psychiatric clinic, and as a patient in a correctional treatment setting. Patients are often confused about the mechanics of this relationship and can be reassured by the forensic psychiatrist about how mental health assessment will take place, because he or she can knowledgeably discuss the likely outcomes and implications for the patient. Whenever possible, a single practitioner should avoid playing both the forensic and treatment roles for the same patient, except in extenuating circumstances (remote areas for instance). Nevertheless, even when a practitioner's role is primarily therapeutic for a given patient, knowledge of the legal implications of care, and skill in explaining these to patients, are vital.

Fourth, forensic psychiatrists have expertise in the relationships between mental disorders and crime. Patients with serious mental disorders often have comorbid substance use disorders, placing them at risk of recidivism. Other issues such as housing,

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Arrests and the Police: Does the ADA apply?

Jeffrey S. Janofsky MD

In *Sheehan v. City & Cnty. of San Francisco*[1] the United States Court of Appeals for The Ninth Circuit in a case of first impression for the Circuit, held that Title II of the Americans with Disabilities Act applied to arrests. In November 2014 the US Supreme Court granted cert. APA, through its Committee on Judicial Action, drafted an amicus brief. The AAPL Council reviewed the proposed amicus brief[2] but chose not to sign on.

Sheehan was a resident of a group home in San Francisco that provided housing for persons with mental illness. She had been diagnosed with schizoaffective disorder and had been prescribed psychotropic medications. She had cut off contact with her psychiatrist and had not taken her prescribed medications for many months. Other residents in the home noted that she was behaving erratically, had not changed her cloths for weeks, and had stopped attending community meetings.

Sheehan had also become verbally hostile towards her case manager. Sheehan's group home supervisor attempted to perform a welfare check on Sheehan in her room at the group home. The group home supervisor knew of Sheehan's prior history of violent threats and aggressive behavior.

The supervisor knocked on Sheehan's door. There was no answer. The supervisor then used a key a let herself in. Sheehan was lying on her bed and did not at first answer. Sheehan then jumped out of bed and threatened, "I have a knife, and I'll kill you if I have to!" The supervisor left the room before seeing a knife. He filled out a 5150 form indicating the Sheehan was both a "threat to others" and "gravely disabled." The 5150 form authorized police to detain Sheehan and take her to a psychiatric facility for a 72 hour hold. The supervisor called police. Responding officers talked to the supervisor and all went to Sheehan's room. Police officers attempted to speak to Sheehan through her door. Sheehan did not answer and police officers used the supervisor's key to enter.

Sheehan was lying in bed but immediately grabbed an 11 inch knife with a 6 inch blade. She came at the officers with the knife, threatening to kill them. Officers asked Sheehan to drop the knife but she instead came towards the officers at the door with the knife in hand. Police officers backed out and Sheehan closed the door.

"The brief also argues that the ADA provides an incentive for police officers, 'to mitigate risks to individuals with mental illnesses and law enforcement personnel during arrests'."

One of the police officers attempted to talk with Sheehan through the door, "telling her we're the police department, we're here to help her, we need to talk to her, put the knife down."[3] The police officer "had hoped that I could verbally communicate with her. Once the door was closed, that took it to a completely different level because she had just tried to stab us."[4] There is a conflict in the factual record before the Court on whether or not police officers knew whether there was another exit to Sheehan's apartment.

Police officers called for back up but they were late arriving. The officer made the decision that they needed to force their way back into Sheehan's room. They planned to open the door, use pepper spray and take her into custody.

When the apartment door was forced open Sheehan came at the officers with her knife yelling that she was going to kill them. The officers used pepper spray but it had no apparent affect. Sheehan continued to come at the officers with her knife, who then shot her several times. Sheehan survived. She was tried criminally. The jury hung on felony assault charges and acquitted Sheehan for her threats against the police officers.

Sheehan then sued the police officer and the City of San Francisco. She alleged violations of the Fourth Amendment under 42 U.S.C. § 1983 and violations of the reasonable accommodation requirement of Title II of the Americans with Disabilities Act.

As part of her claim Sheehan submitted a declaration regarding police tactics from a former deputy police chief who opined that after, "Sheehan forced the officers out of her room, the officers should have backed up, formed a perimeter to confine Sheehan in her residence and waited for backup,"[5] and that "the officers should have respected Sheehan's comfort zone, engaged in nonthreatening communications and used the passage of time to defuse the situation rather than precipitating a deadly confrontation."[6]

After discovery the defendants moved for summary judgment on all claims, which the District Court granted. As to the ADA claim the trial court held that, "it would be unreasonable to ask officers, in such a situation, to first determine whether their actions would comply with the ADA before protecting themselves and others."[7] The trial court also held that none of the officers' conduct violated the fourth amendment.

Sheehan appealed. A panel of the Ninth Circuit Court of Appeals remanded Sheehan's ADA claim for

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Ask The Experts

Robert Sadoff MD
Neil S. Kaye MD

Neil S. Kaye, MD, and Bob Sadoff, MD will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send question to 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.: Is it appropriate to "Google" an evaluee?

A. Kaye: The Internet has certainly made it easier than ever for forensic psychiatrists to conduct research. However, there is nothing in the role of the forensic psychiatrist that would put one in the position of fact investigator; that task belongs to police, lawyers, or professional detectives. Nonetheless, there is nothing in the APA/AAPL Code of Ethics that precludes doing an Internet search on an evaluee or patient.

First, I would encourage you to seriously consider why you are so doing, and for what intended purpose. One problem of Internet searching is that it could introduce information not otherwise made available into an assessment and this bias would need to be addressed. If this is done, it would be incumbent on the examiner to specify the source of the information and to be prepared for cross-examination on both the reasons for the search and the results, as well as what was and wasn't included in a report and why.

Currently, the standard of practice for forensic psychiatry does not include doing Internet searches, but this could well change as the general acceptance of the Internet and erosion of privacy enters American society. The majority of divorce cases now include information gleaned off of social media sites such as Facebook, and so some familiarity with this media is expected of an expert. However, it is usually supplied by retaining counsel.

"One problem of Internet searching is that it could introduce information not otherwise made available into an assessment and this bias would need to be addressed."

Internet based information raises potentially serious credibility issues and should be viewed with a healthy grain of salt, particularly if the source listed is unknown or "anonymous." However, government run databases containing information such as birth records, death records, marriage records and arrest records should be seen as credible sources and so cited. Further there is a rapid proliferation of state run mandatory reporting sites for prescription drugs and checking these databases may be helpful in a case, particularly is opiate abuse is suspected and an issue in the case.

A. Sadoff: The Internet has changed everything! I agree with all the cautions presented by Dr. Kaye and answer the question that it is neither appropriate nor inappropriate. The question I would ask is "Should the forensic examiner Google an evaluee?" What can be gained by doing so? What restrictions apply? How would one use the information obtained in the search?

Having asked those questions, I would stress that I am an investigator as a forensic evaluator and want all the information I can get before I examine the defendant in a criminal case or the plaintiff in a civil matter. I have written many times that the personal examination is necessary in forensic work (when possible) but not sufficient. One needs a variety of records, including but not limited to medical, psychiatric, mental health, school, work, and legal. One hopes to obtain collaborative information from other sources, including friends, relatives or eyewitnesses. Why not utilize every possible source including the Internet to gather as much legal authorized data as is available in order to do a thorough assessment and evaluation?

Not all information gleaned needs go into the report nor be presented at deposition or trial unless requested. One does need to verify the veracity of the information gathered before utilizing it in forming opinions "with a reasonable degree of medical or psychiatric certainty."

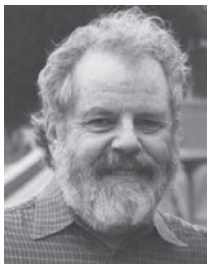
Thus, judicious utilization of all information obtained is appropriate and can and should be included in one's final report. It is not unethical to Google the evaluee, but it is inappropriate to use unverified information in forming a forensic opinion; this can be harmful to the plaintiff or criminal defendant. Cross-examination is helpful in determining sources of data and their relevant application in specific cases.

Whether you Google your evaluee or not, be assured the evaluee is most likely to Google you. I have determined that in the past decade, more than half of the individuals I have examined have Googled me before the examination.

Take home point:
This is an interesting area and one in which the standards are rapidly shifting. Acceptance of the Internet as a fact source in litigation has always occurred. A modern forensic psychiatrist should be prepared to deal with information from the Internet that may come through the referring party or may be discovered by evaluators' own searching.

Looking Backward; Looking Forward

Stephen P. Herman MD



It's March up here in New England, and the snow still covers the roads and fields. Trees bend from the weight of ice and snow, and we all pray in our own way that we will not become victims of yet another power outage. Well into the New Year, though, power or not, it's a good time to think of one's career from the perspective of a senior forensic child psychiatrist rounding seventy, reviewing the past and looking toward the future.

Certain cases stand out as I go through a mental Rolodex. There was the one about the Roma community in Brooklyn who excommunicated a young woman who refused to give up her baby to his father. In the Roma culture, the father simply announces he is divorcing his wife and automatically gets custody of any children. Civil laws are not recognized.

In an astonishing show of courage, though, the mother went to Family Court and filed papers for custody. Her only support was her own mother, who was also thrown out of the clan. Even before the custody matter was decided, the father announced he had remarried. Mother eventually won custody, and father and his new bride moved on. The mother and grandmother, deprived of their culture, courageously started a new life.

A nine-year-old New York City girl stabbed to death her 11-year-old best friend in a fight over a ball. She was the youngest child to commit a homicide in modern New York history. I visited her in a safe house and interviewed her several times. She was remorseful and said she never meant to kill her friend. She knew she would never see her again. She was not psychotic and was terrified of what would happen next. She talked about living in the projects, hearing gunshots regularly and once witnessing her mother in a fistfight with a neighbor down the hall. When her lawyer and I visited her apartment, it was completely infested with roaches. A brilliant Family Court judge – also a clinical psychologist – set up a program with our help for the child to be in a special school, receive intense psychotherapy and live with a therapeutic foster family. Last June, the child graduated from high school. Looking forward, she wanted to attend college and become a good citizen. She's on her way.

"He was so dangerous he was cuffed and in leg irons with the Correctional Officer standing right next to him. After the interview he said he wanted to kill me."

I received a call from a Family Court judge. It seemed he was about to enter an order allowing a 46-year-old mother to adopt two children she had fostered their entire lives. Then Child Protective Services found out about an overlooked bit of history: when the foster mother was 17, she killed her friend's mother over a comment she took as insulting. She served 7 years in prison, was in a drug treatment program and had stayed out of trouble while incarcerated.

After an intense evaluation revealing how the foster mother dealt with anger and frustration now, and the intense bond amongst the boys and their foster mother, the adoption was granted. The judge would not have granted it without the forensic assessment.

A drug-addled mother who was already the subject of a child protective investigation, kept her three-year-old daughter in a dresser drawer whenever the caseworker made a home visit. In her notes, she only counted five children and never knew about the sixth. Neither did the grandmother who lived across the street. The child died of malnourishment and was discovered. The mother was arrested and the grandmother was denied custody of the other five children.

It was the belief of Child Protective Services that she had to have known about the abused and neglected child. But the facts were that she did not. Neither did the other siblings. After my forensic evaluation, the grandmother was awarded the surviving children. She sent me a grateful message saying the family had gone on with their lives and the children were very happy and secure.

A kind-looking man with a Biblical name cleaned a house as part of his job and eventually insinuated himself into the personal life of a family. The parents were divorced and the father lived on the West Coast. The cleaner convinced the mother that the father had sexually abused her daughter and they should flee, because he would come back. He was sent to me and I judged him to be a sociopath and very dangerous. Nevertheless, they moved down South where the housecleaner had a farm.

The man initiated adoption proceedings. The mother agreed. Once all had moved, the man regularly raped the 14-year-old daughter, kept the mother away and forced the teenager to drink mouthwash to get her drunk. I suggested to the lawyer for the child back North to call in the FBI. The Bureau became involved. They set up a sting operation in which an agent called the man and said child authorities had decided the adoption should proceed. However, he would need to come down to the local court with the girl to sign some papers. Upon entering the courthouse, the man was tackled by an agent, handcuffed and taken away. The girl was freed and she and her mother returned home. They both required intensive therapy but the child went

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Arrests and the Police

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trial. The Court held that "Title II of the Americans with Disabilities Act applies to arrests and on the facts presented in this case, there was a triable issue whether the officers failed to reasonably accommodate plaintiff's disability when they forced their way back into her room without taking her mental illness into account or employing generally accepted police practices for peaceably resolving a confrontation with a person with mental illness."[8]

The Appellate Court also found that while the initial actions of the police officers were valid under the fourth amendment, the validity of the police officers' second warrantless entry into the room was a triable issue for a jury to decide.

In San Francisco's Petitioner's brief to the USSC, Petitioners argued that Sheehan was not entitled to accommodation under the ADA because she posed a threat to the safety of others. Petitioners argued that "given these risks, the officers made a reasonable judgment, as the ADA permits, that Sheehan posed a significant risk to safety – and that delaying her arrest was an unacceptable option because it would not eliminate the significant risk she posed."[9]

Petitioners argue that "reasonable judgment" about safety means different things in different situations"[10] and point out "when a police officer in the field is confronted with an armed and violent individual, what is a "reasonable" judgment is considered from the officer's standpoint."[11]

The APA's brief focused exclusively on the ADA issue. It argued that the ADA requires reasonable accommodation for mental disorders at the time of arrest, and that such accommodation is practicable. It emphasized that many police encounters with the mentally ill, like this matter, start with the person's need for treatment.

The brief also argues that the ADA provides an incentive for police officers, "to mitigate risks to individuals with mental illnesses and law enforcement personnel during arrests."[12] The brief then goes on to describe the lack of adequate training police have in dealing with mentally ill individuals, and that traditional police tactics may make interactions with the mentally ill worse. The brief described methods for educating the police on how best to deal with the mentally ill, and how to team with mental health professionals to minimize bad outcomes.

The APA brief also addressed petitioners' argument that Sheehan was not a qualified individual under the ADA because she came at police officers with a knife. The brief argued that "the reasonable-accommodation inquiry should examine the entire course of the encounter between law enforcement and the individual with a disability,"[13] not just the purported incident of violence. The brief essentially argued that poor police procedures under the facts in this case facts, as seen in the light most favorable to the respondent, led to the Sheehan's threatening behaviors, at least when police officers re-entered Sheehan's apartment a second time.

The USSC heard oral arguments in this case on March 23, 2015; decision was pending at the time this article was published.

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Looking Backward

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on to a special school and eventually graduated from college.

The man with the Biblical name died in prison. The girl reconnected with her father and realized he had never abused her. It was a gratifying ending – and beginning.

Reviewing your forensic cases is a good way to appreciate the winners and the losers. They don't always turn out the way you like. They may be terrifying: there was Eric, who, at age 15, executed his grandmother after he lay in wait at her house with an arsenal of weapons and ammunition; Casey, who was in the midst of a custody battle and shot to death the mother and caseworker; And Johnny, who, while in prison for a previous crime, threatened the life of the judge who had put him away for life. Johnny was a dead ringer for Charles Manson. He was so dangerous he was cuffed and in leg irons with the Correctional Officer standing right next to him. After the interview he said he wanted to kill me.

This work is not easy. It's sometimes all consuming, complicated and even frightening. But for me, there's nothing I'd rather be doing.

And what of the future? At this writing the Supreme Court has agreed to hear the matter of same-sex marriage. My guess, on this snowy New England day, is they will vote for it. Reading Miranda Warnings to 14-year-olds? Will that be deemed useless and developmentally unsound? The death penalty? Will we ever leave the exclusive club we share with China, Syria, Saudi Arabia and other countries? Will we learn about why seemingly "normal" kids end up fighting for ISIS? And what about suicides prompted by Facebook entries or Twitter conversations. School shootings?

For me, forensic child psychiatry is the most fascinating area within the field of forensics. Rounding 70, true, but no time and no yearning to retire. There's still too much to do.

Correctional Psychiatry

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work force participation, association with antisocial peer groups, and lack of follow-up may all influence the relationship between mental illness and recidivism. Expert in these relationships, the forensic psychiatrist can lead multi-disciplinary care teams, working with patients to identify, and develop, plans to mitigate such risks, to prevent relapse and recidivism.

Fifth, forensic psychiatrists have particular training in the assessment and treatment of a number of disorders common to the correctional setting and not well known to the general psychiatrist. Forensic psychiatrists are accustomed to dealing with those with antisocial personality disorders, psychopathy, and paraphilias, alone or comorbid with other disorders. Management of patients with these disorders requires specialist knowledge that is part of the training in forensic psychiatry. This means that forensic psychiatrists are more comfortable in dealing with these issues and can either directly deliver the treatment or discuss the options for further referral for specialist treatment.

There is already recognition that correctional psychiatry is a crucial aspect of forensic psychiatry and that forensic psychiatric practice and training are particularly applicable to correctional psychiatric care. The AAPL explicitly states that correctional psychiatry is one of the 12 domains in which psychiatry and the law share a boundary[6], which makes it central to our mandate. Fellowship programs in forensic psychiatry generally include exposure to correctional psychiatry. The Accreditation Counsel on Graduate Medical Education explicitly requires this, and correctional psychiatry is included in the curriculum for forensic psychiatric subspecialty training in Canada.

As honored president, and proud member of the AAPL, I wish to make one final point about the great benefits that the forensic psychiatric *community* can have for the individual practitioner practicing in the correctional setting, and for the practice of correctional psychiatry in general. Correctional psychiatry can be an isolating experience. While some facilities have multidisciplinary teams, the other members of these teams may be full-time staff, whereas, characteristically, the psychiatrist attends for short periods of intense consultation and then leaves. Forensic psychiatrists, playing a role in corrections, can benefit from each other's experiences, and shared expertise in the medico-legal context underlying care in this setting. Sharing experiences, ideas, and advice with each other, at the annual AAPL conference for example, provides a rich opportunity for our own development as individual practitioners, but also for the development of correctional psychiatric practice.

The answer to the distinguished forensic psychiatrist who asked "what is the forensic angle of a course on correctional psychiatry?" is that correctional psychiatry is *situated within* the body of forensic psychiatry. The unique ethical and practical challenges arising in correctional psychiatry, and the knowledge and skills needed to provide adequate care is a sub-set of the broader challenges and scope of expertise of the forensic psychiatrist.

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One Head, Multiple Hats

Tobias Wasser MD

I pursued a fellowship in forensic psychiatry because it seemed that the legal arena was one in which our patients can become particularly vulnerable and I was excited by the opportunity to better understand and advocate for those with mental illness within this system. What I had not recognized though, prior to starting my fellowship, was that training in forensic psychiatry involves adapting to a new role very different from any of those experienced during general psychiatry training. In residency, we serve in clinical roles in various settings, learning to advocate for our patients, and our primary responsibility is to those patients. As a forensic psychiatrist, you often serve a very different function. You are asked to objectively and impartially evaluate an individual for a legally-related purpose, for whom you will not be providing treatment, and reach an opinion on the particular question you have been hired to answer. In fellowship, you are taught to advocate for your opinion and that your primary responsibility is to respond to the questions posed by the individual or agency who hired you. While I initially thought that this would require a transformation from clinician to unbiased evaluator, I am now starting to see that it is more a process of learning how to wear these hats simultaneously.

This lesson became particularly poignant for me during one of my first evaluations this year. I was hired to evaluate a young woman to determine whether she could proffer a defense of not guilty by reason of mental disease or defect (NGRI). I met with the defendant in prison for several hours, reviewed pages of collateral records, and discussed the case with supervisors in an effort to reach an opinion on the NGRI question. Over the many hours of work I poured into the case, reading about the defendant's sad and troubled upbringing full of abuse, neglect, and repeated psychiatric hospitalizations, I began to feel a great sense of sympathy for her. I wanted to find some way to be helpful. However, as the evaluation continued, I started to realize that despite her troubled past and clear history of mental illness, I did not think she had a strong NGRI defense. I desperately kept looking for a different angle through which to examine the case to see if I could find support for an NGRI, but continued to find that I did not have the data to conform to the defense's statutory language.

"Her particular history reminded me a great deal of many of the patients I treated in residency and pulled at the clinician in me to want to somehow 'save' her."

I scheduled one more visit, hoping to find some additional piece of information that might change my mind, but unfortunately no such revelation came. As I wrapped up this final interview, the defendant turned to me and asked, "So doc, do I have a case? You think I got an NGRI?" I didn't know what to say. Several thoughts rushed through my mind. The part of me that had trained to be a clinician and an advocate for my patients these past four years pulled deeply at me to want to be helpful to her. I started to reconsider my opinion and wondered whether there was some way that I could alter my thinking sufficiently to support an NGRI. I worried that telling her that I didn't think she had enough for an NGRI might cause her to be depressed, even suicidal. Fortunately, I remembered the sage advice given to me by a supervisor that "You haven't reached your final conclusion until you send in your report." With that in mind, I told her that unfortunately I hadn't reached an opinion yet because my evaluation was not complete, and that I would be in touch with her attorney.

In the following days, I spent a lot of time thinking about and replaying this interaction in my mind. Had I been dishonest? Had I done the "right" thing? Technically, there was nothing untrue in what I said – I had not yet reviewed all the information available to me and my report was not yet complete. Still, I couldn't shake a concern that I had been deceptive in some way, as I had essentially known the direction my opinion would go. My ruminations led me to discuss the topic with supervisors to get outside perspective. Through these discussions, I came to realize that my choice had been guided by a principle frequently reiterated by faculty at our institution – that, as forensic evaluators, it is our responsibility to ensure we don't leave an evaluee worse off than when we met them. It was ultimately my concern for her safety and my clinical experience that guided my decision-making in that moment. Even in this role, we are psychiatrists first and "objective" evaluators second.

Evident in the retelling of this story is also the strong countertransference I developed toward the defendant. Her particular history reminded me a great deal of many of the patients I treated in residency and pulled at the clinician in me to want to somehow "save" her. Issues of countertransference are certainly not new in forensic psychiatry, as discussed by Sattar, Pinals and Gutheil,[1] as well as several others; but as trainees we may be particularly vulnerable to their influence given our lack of experience in tackling them in the forensic realm. These countertransference feelings may be positive, such as seeing an evaluee as a "patient," or negative, when contending with defendants who are charged

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A Day at the US Supreme Court

Victoria Dinsell MD, on behalf of Martin Nau MD, Lianne Morris-Smith MD, Jessica Silberlicht MD

At five o'clock in the morning on October 15th, 2014, we, the New York University Forensic Psychiatry fellows, armed with court briefs and strong coffee, met our program directors, Drs. Subedi and Lewis, under the "Departures" board in a sleepy New York Penn Station. We boarded the 5:30am "Northeast Corridor" train to Washington, DC in what is becoming our program's annual ritual of attending oral arguments in a Supreme Court case. The ride there was spent hoping for an on time arrival (two years ago the train went out of service in Philadelphia and the group had to bundle into a cab and race down the interstate to arrive on time) and catching up on sleep.

We arrived on time at a bustling Union Station and commandeered a corner of a ubiquitous Au Bon Pain, commenting to each other that it was only slightly busier than the one in the lobby of Bellevue Hospital. We reviewed the case briefs together over breakfast. *Jennings v Stephens*, an appeal on the grounds of ineffective assistance of counsel in the punishment phase of a death penalty trial was of interest to the Supreme Court because of a procedural question regarding whether a defendant, after prevailing in the district court on two of three theories of ineffective assistance of counsel, is required to file a cross-appeal or seek a certificate of appealability in order to rely on the third theory as part of his defense against the state's appeal.

In 1989, Jennings was convicted of shooting and killing a police officer in Texas and later, he was sentenced to death. The case had already been unsuccessfully appealed through the state courts and was subsequently brought through the federal courts on a writ of habeas corpus. A writ of habeas corpus, as we have learned in our Law and the Legal Process class, is a collateral legal action by which a defendant may seek his release after having exhausted his rights on direct appeal on the grounds that the state court proceedings violated federal Constitutional law.

Jennings had argued on appeal that he was ineffectively represented by his attorney on three grounds: (1) that he failed to bring in past psychological reports reflecting mild mental retardation or call for another psychological evaluation; (2) that he failed to present testimony from Jennings' mother who could have introduced mitigating evidence; and (3) that he made statements in the closing arguments that alluded to overwhelming evidence and the likelihood that the jury would choose the death penalty. With the guidance of our program directors, we were able to understand the details of the case in the context of the larger legal landscape of the death penalty and the Antiterrorism and Effective Death Penalty Act (AEDPA).

Introduced by Senator Bob Dole following the World Trade Center and Oklahoma City bombings in the mid-1990s, the AEDPA reduces the availability of habeas corpus and limits the ability of individuals convicted of capital offenses, like Jennings, to make multiple appeals. President Bill Clinton signed it into law in April 1996.

Arriving at The Supreme Court of the United States (SCOTUS), we were struck by its beauty, solemnity, and efficiency. For the last three years, our program has secured seats for fellows and faculty through a contact in the Court Marshal's Office. Though we received a confirmation letter from the office a month before, we held our collective breath while we were processed through the multiple layers of security, stored our belongings in lockers and waited on various lines until we were finally assembled in front of the court's vast doors waiting for our 11am case to start.

The Court term runs from October until June or July. During the term, cases are heard for two-week sessions followed by two-week recesses. During sessions, usually two cases are heard per day on Mondays, Tuesdays and Wednesdays, one at 10am and one at 11am. Each case heard in front of the Court is allotted one hour: thirty minutes for each side, argued by one attorney, to make its case. The petitioner starts, followed by the respondent, and then the petitioner is given a brief period for rebuttal. A large clock hanging from the ornate ceiling above the nine justices keeps track of time. In order to argue in front of SCOTUS, an attorney has to be admitted to The Supreme Court's bar. Though the bar has some 200,000 members, only several hundred attorneys actually plead cases.

When it was time for *Jennings v Stephens* to be heard, we were shuttled into the packed courtroom. The justices were already seated on the bench: Chief Justice John Roberts was in the center flanked by the eight Associate Justices in order of seniority. The case began a few minutes after 11am with the attorney for Jennings.

While soaking up the grandeur of our surroundings, we sat shoulder to shoulder on wooden benches and tried to focus on the nuances of the oral argument and understand the rapid-fire questions from the justices. Later we talked of how impressed we were by the eloquence, poise and mastery of the attorneys who seemingly glided through their arguments in the midst of the equivalent of a nine-person stress interview. Throughout this process the personalities of the justices were revealed as well as the seamless way in which they work together. The hour went quickly and then we stood as the nine filed out. We discussed the hearing over lunch and then returned to New York: seven hours of traveling for one special hour in the court room.

SCOTUS issues its decisions by the end of each term. On January 14, 2015, Justice Scalia delivered the opinion in *Jennings v Stephens* for

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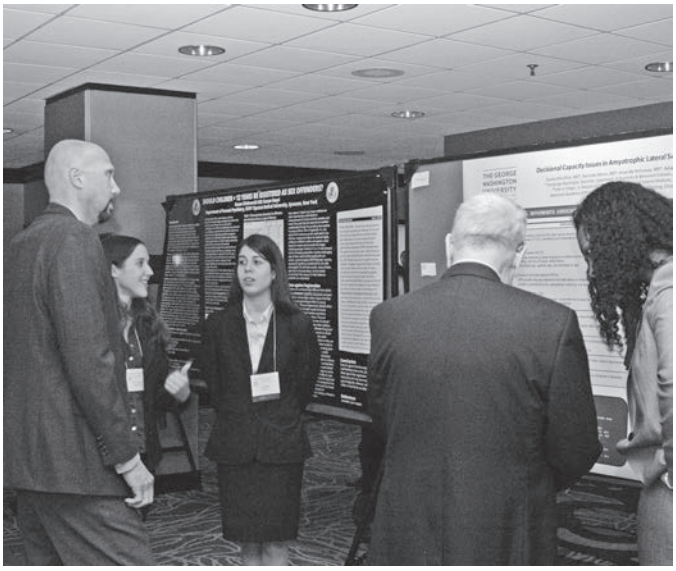
PHOTO GALLERY

Mentors responding to questions at the Early Career Breakfast.

Executive Director of AAPL, Jackie Coleman with President-Elect, Emily Keram.

Question time!



Vibrant Poster Sessions as always!

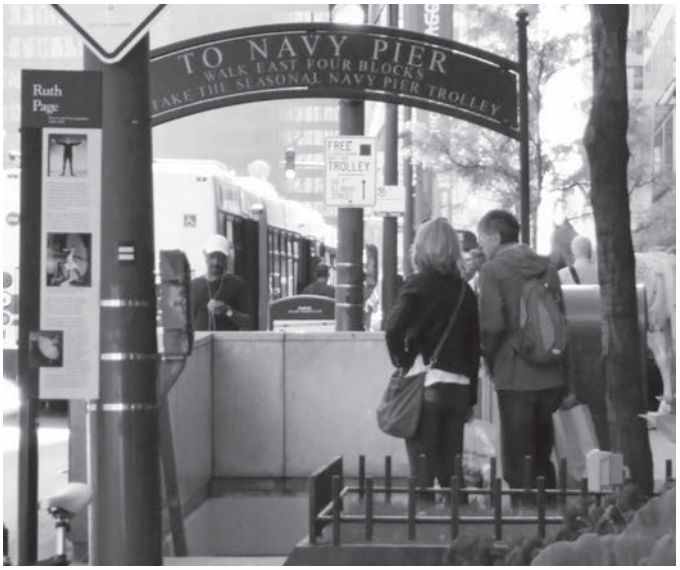
2015 NYU Forensic Psychiatric Fellowship Program at the U.S. Supreme Court. (see article on page 11)

Chicago's Magnificent Mile!

PHOTO GALLERY

Tom Gutheil and Renée Binder at the Early Career Breakfast.

Coffee break!



A chance to visit Chicago's Navy Pier and other wonderful attractions.

Catching up with old pals.

Mentoring early career psychiatrists.

Lunch time!

Photo credits: Eugene Lee MD; Alan Newman MD; Roni Seltzberg MD; James Wolfson MD

24th Annual Meeting of the International Association of Forensic Psychotherapy

Recovery from Violence: Victims, Perpetrators & Communities

Michael Chan MD, International Relations Committee

The 24th Annual Conference of the International Association for Forensic Psychotherapy was coming back to the US for the second time in 15 years and this time I was not going to miss it. The first time was in Boston in 2000.

Forensic Psychotherapy is not an often covered topic at AAPL meetings. This is in contrast to UK Forensic Faculty Annual meetings where it usually has a spot in the proceedings.

But forensic psychotherapy has a long history in the UK since the founding in 1931 of the Psychopathic Clinic, now the Portman Clinic. Its emphasis has been solidly psychodynamic with the psychoanalyst Edward Glover involved in its early development. Forensic psychotherapy as a subspecialty area in forensic work is now recognized in the UK context with five residency positions nationally.

The 24th Annual Conference was hosted by the Yale Law and Psychiatry Division co-sponsored by the Yochelson family whose patriarch was a psychiatrist a generation ago, and also the Connecticut Department of Mental Health and Addiction Services.

AAPL's own Dr. Reena Kapoor as the Conference Chair and incoming President of IAFP, together with her Yale colleagues (special mention – Madelon Baranoski, PhD.), put on an excellent conference from March 18 - 20.

The first day of the meeting focused on two out of town site visits to the Women's York Correctional facility and the Secure Forensic Hospital (the Whiting Division of the Connecticut Valley Hospital). I was impressed by the emphasis on recovery in both these settings and on skills development for life beyond the institution.

The next two days were the presentations. The format involved two plenary talks daily with interspersed parallel sessions of 90 minutes or two 45-minute talks. The conference theme was "Recovering from violence – victims, perpetrators and communities."

The opening plenary was the Yochelson keynote address, delivered jointly by Drs. Reid Meloy and Jessica Yakely, both psychoanalysts. The topic was "Antisocial personalities – psychotherapy and risk management." After the suggestion that some prominent current terrorist leaders were likely psychopathic, Dr. Meloy mentioned some notorious serial killers. However, he emphasized that the poorer prognosis psychopaths be more intensely supervised whereas the better prognosis ones be considered for more therapeutic approaches. The benefit of therapeutic community approaches were not as clear cut and more research was needed. CBT had been used with some efficacy noted but MBT (mentalization based therapy) may show promise and is currently being researched in UK settings. MBT was originally developed for borderline personality treatment, and has a basis in psychoanalytic thinking. Dr. Yakely elaborated on this treatment modality within the DSPD Program in the UK, which is a variant of the SVP detention approach in the US.

The afternoon plenary session was on the Stockholm Syndrome with presentations by Drs. Judge and Bailey, and Jaycee Dugard who had experienced traumatic captivity for years. Her story of survival was not rooted in any positive feelings towards her captors but the sheer will to survive nourished by positive childhood memories.

The parallel session topics on the first day included recovery in forensic work, the importance of supervision of offenders, PTSD female group therapy, and creative art/music therapies.

The second parallel sessions on the first day covered a range of topics. These were sexual capacity in a developmentally disabled woman, children who commit sexual offences in the South African context, coping emotionally with trauma, women who attack their children, violent women and anti-Semitic group thinking links to sexual assault on college campuses.

The second day's morning plenary was more a policy presentation by Dr. J. F. Pelletier of Montreal, on political approaches to including offenders in their mental health work and its progress. The model is shifting from Recovery to Citizenship with the associated language to reflect this. He has also been involved with virtual reality technology as a new tool in therapeutic work. This holds much promise for future research on violent offenders.

The final plenary was presented by AAPL's own Dr. Gutheil sharing his courtroom wisdom of the dynamics of being an expert witness. He reminded us that Freud himself recommended that psychoanalytic content stay in the consulting room and not the courtroom.

The parallel session topics on the last day included institutional services, spousal violence, homicide, death penalty work, developmental disability offending, ego defenses, and social defenses in a secure unit setting.

The topic of social defenses against anxiety in institutional settings is rarely presented at forensic meetings yet it is, in my view, one of the most important in understanding the dynamics of organizations and what happens with staff-patient relations, morale, etc.

It was suggested that the highlight of the conference was the Large Group debrief dynamic process of each day's presentations at the very end of each full day. This was led by Dr. Estela Welldon, the IAFP Hon-

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The Big Bounce Theory: Reestablishing Hubs for Efficient Decentralization

Carolina A. Klein MD, Chair, International Relations Committee

"The Big Bounce theory takes out singularity: space and time become infinite at the bottom of a black hole."

We have all spoken about the deinstitutionalization movement of the 70's, and the continuous efforts since then to move mental health services into the community. We have all seen these "decentralization" efforts across a broad spectrum of relevant areas: expansion of academic standards into community institutions, facilitation of local services and labor opportunities in suburban or rural areas, and dissemination of resources into each and every person's home through the Internet. Just as we started conceptualizing our world in terms of true globalization with the blurring of boundaries and frontiers, we find ourselves craving the concept of an all-encompassing home base. Just as we were starting to conceptualize the Big Bang and continuous expansion theory, we learned about the contraction period that preceded and will follow it – and physicists established the Big Bounce theory. In fact, I find that our matrix will be strongest if we are able to operate within this framework of bouncing movement between spreading and collecting, between diffusion and gathering.

We pulled together once again in October. The 2014 AAPL Annual Meeting in Chicago provided another fantastic opportunity for ideas to be explored and shared, and for our members to establish a collective and cumulative well of resources for projects and development of the field. We came together from all areas in the country and the world, and numerous operating areas within psychiatry, to a home base. We aimed for the International Relations Committee to become a hub, a comprehensive and up-to-date repository for references and opportunities of all international efforts.

The International Relations Committee organized the Annual Site Experience - an opportunity to have an up-close and in-depth roundtable discussion regarding disability evaluations, with emphasis on the similarities and the differences between the American Social Security Disability evaluations and those conducted abroad. The discussion was led by Dr. Henry Conroe, Midwest Director and Regional Medical Advisor to Social Security Medical Disability Program - Region 5.

The committee also researched and developed a comprehensive resource of upcoming meetings and educational opportunities for members interested in matters of international psychiatry and forensic psychiatry. We developed a database of opportunities that included International Meetings, such as the International Academy of Law and Mental Health, International Association of Forensic Mental Health Services, Royal College of Psychiatrists Residential Meeting and International Congress, World Psychiatric Association Meeting, International Congress and Thematic Congress, Proceedings of the American Academy of Forensic Sciences, International Association for the Treatment of Sex Offenders and the Association for the Treatment of Sexual Abusers, and others. The database also includes appropriate information for international journals and publications, membership, and access. It also consolidates information regarding other opportunities, such as the recently established International Council of the American Psychiatric Association, the American Academy of Forensic Sciences International Educational Outreach Program, and the Massachusetts General Hospital Division of International Psychiatry. This ever-growing consolidated resource will allow for timely submissions and for more adequate planning and participation. It has been made available to all International Committee members for reference and construction through a web-based group that will maintain ongoing communication throughout the year. When information is coming from all different directions, having a one-stop searchable engine is the new method of communication efficiency.

Just as news channels have a central network studio, they also depend on their correspondents dispersed around the world. In similar fashion, the committee restructured its members to provide geographical and topic assignments to each of its members, in order to ensure adequate coverage of international matters. Independent work is strengthened during our collaboration, rather than operating as free-standing islands or rigid cement structures.

Our branches connect and expand, while maintaining a direct link with the hub. In this way, the committee is looking for coalitions with other committees, acknowledging that matters of interest rarely pertain to the realm of international psychiatry exclusively, but almost always do (and should) overlap with matters of Technology, Human Rights, Violence, and other AAPL committee domains. Beyond AAPL, the committee continues to explore ways of hosting or encouraging international scholars in an effort to expand opportunities for our members, as well as to foster international collaborations. Like recent coalitions and mergers, all of our airlines are forming conglomerates that offer better possibilities for all, while maintaining identified, convenient, and reliable airline hubs.

The Paradox of Choice exists when an overwhelming amount of choices stand in the way of goal achievement, happiness, and personal accomplishment. We may be able to maintain the infinitude of options and information, if we focus on streamlining the avenues by which we operate and expand as an institution and as a professional field.

If You Don't Know Where You Are Going, You Might Wind Up Somewhere Else: Tips for Mentoring General Psychiatry Residents into Forensics

R. Scott Johnson MD JD and Jessica Ferranti MD,
Forensic Training in General Psychiatry Committee

Famed New York Yankees three-time MVP (most valuable player) Yogi Berra not only gave us the quote in this article's title but also famously remarked that "baseball is 90% mental, and the other half is physical." Similarly, the process of finding a forensic fellowship that is a good fit involves a mix of mental effort and due diligence, as well as some old-fashioned physical legwork and traveling. However, perhaps the most important ingredient is finding an AAPL MVP (most valuable person), a mentor to serve as a guide. Fortunately, my experience at AAPL has been one brimming with the generosity of mentors eager to take residents under their wing. This perception has been reinforced by my experience on the AAPL Committee on Forensic Training in General Psychiatry, where I have witnessed first-hand AAPL's efforts to foster interest and encourage residents. Thus, this piece reflects both great advice that was shared with me by many wonderful AAPL mentors as well as some tidbits that I wish I had known.

When to Begin: You can never start too early. Encourage residents to talk with current and former fellows at AAPL meetings. This was extremely helpful for me. At the AAPL annual meeting, residents should consider attending the annual ADFPF Reception for fellowship directors and potential applicants, as many fellowship directors will be present. I found that this was a good way to feel out how well you might fit within a particular program's culture.

Applications: I found that there were significant differences between the application materials required at various institutions, with some requiring USMLE scores and medical school transcripts. Forensic writing samples were frequently solicited, if available. Mentors can be helpful in guiding residents to opportunities for early exposure to forensics within their general psychiatry programs. Even at programs that do not have forensic fellowships, a good mentor may be able to highlight forensic aspects of general practice within common residency experiences such as inpatient psychiatry.

Away Rotations: Away rotations are a wonderful opportunity to experience forensic training at an institution other than one's own, albeit at some expense. Given this cost burden, a two-week rotation markedly decreases the cost and may give a potential applicant almost as much exposure to a program as had they stayed a full month. Mentors may have professional connections that can open doors at some programs. They can also provide guidance regarding the timing of the rotation in light of the fellowship application cycle. First and foremost, mentors can provide a valuable sounding board when weighing the relative benefits versus costs of doing an away rotation.

Variety: At least to me, the forensic fellowships that I saw seemed quite different, almost a unique island unto themselves, in a way that general psychiatry residencies perhaps are not. Having attended a few AAPL meetings and discussed various fellowships with those who knew much more than I did, I had come away with the impression that some fellowships were more reliant than others on their fellowship director. My away rotations and interviews lent further weight to that perception. Ultimately, whether applicants prefer a fellowship where one individual looms large versus a program where that is less the case is a matter of personal preference.

Criminal vs Civil: While most forensic fellowships have a predominantly criminal forensics focus due to the difficulty of getting fellows involved in civil litigation, the extent to which criminal work predominates seemed to vary somewhat in the handful of programs that I saw. Furthermore, some fellowships appear to have more opportunities to work with minors, adding an additional wrinkle. As an applicant is likely to have a preference as to what kind of work most interests them, it seems wise to ascertain the mix of criminal, civil and child exposure at each program being considered. Most general residents will be quite familiar with criminal forensics but may be less familiar with the role of the forensic psychiatrist in civil litigation. Offering suggested readings, discussing interesting cases, and guiding the resident to a broader view of forensic psychiatry is an invaluable contribution at the transition between general residency and forensic fellowship.

Rotation Structure: Some fellowships seemed to have a considerable amount of structure in the work week, while others were far more fluid. While choosing between the two is once again a matter of personal preference, the less structured fellowship may fit best with a fellow who is more of a self-starter.

Program Change: Not infrequently, funding for forensic fellowships can be cut or reinitiated, causing fellowships to come and go based on the economics of state funding and university funding, as well as the fluctuating political priorities of state governments. Similarly, fellowship directors leave positions of training or relocate to new fellowships. Therefore, the fellowship landscape is seemingly in a constant state of flux. Mentors may be able to high-

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Life in Prison with the Remote Possibility of Death: Recent trends in Capital Punishment

Chinmoy Gulrajani MD

On July 16, 2014 the United States District Court for the Central District of California (Judge Cormac J. Carney) declared California's Death Penalty system unconstitutional and vacated the death sentence of petitioner Ernest Dewayne Jones[1]. In a scathing 29 page opinion Judge Carney methodically reviewed problems related to inordinate delays at every step of the appeals process from direct appeal to state and federal review. He brought to light that about 40 percent of inmates convicted of capital crimes in California had been on death row longer than Mr. Jones, the petitioner. Approximately a third of these, he gathered, will never face execution as a real possibility due to systemic delays. Yet Mr. Jones was facing execution ahead of them.

Judge Carney noted that since the adoption of the present system in 1978, California has sentenced over 900 individuals to death, though only 13 have actually been executed. He concluded that selection for execution in California is arbitrary and in violation of Eighth Amendment's prohibition against cruel and unusual punishment since it depends on a factor largely outside an inmate's control: how quickly the inmate proceeds through the State's dysfunctional post-conviction review process. This schemata, the Judge opined, is wholly divorced from the penological purposes the State sought to achieve by sentencing an individual to death in the first instance. Expressing his displeasure with California's death penalty system at large, the Judge called this sentencing scheme *"Life in Prison, with the Remote Possibility of Death"*[1].

While in California the state's attorney has already vowed to appeal Judge Carney's decision, on the whole it has not been a good decade for the death penalty in the United States. In 2013 Maryland became the sixth state in the last seven years to have repealed its death penalty laws, bringing the total up to 18. Elsewhere in the country recent high profile exonerations[2,3], some based on DNA evidence[4], have led to furor amongst opponents of capital punishment. Added to this fire was fuel from notable botched executions in Ohio[5] and Oklahoma[6] which have also raised novel methodological problems related to the administration of the punishment itself. In reaction, the courts in these two states have ordered a moratorium on the death penalty until these issues have been resolved[7,8], while the state medical boards[9] and the American Board of Anesthesiology[10] have been forced to refresh their positions regarding the involvement of physicians in capital punishment.

Also, within the last decade, landmark Supreme Court decisions in *Roper v. Simmons*[11] and *Hall v. Florida*[12], expanding on their opinion in *Atkins v. Virginia*[13], have rendered the execution of individuals under 18 and those with intellectual disabilities unconstitutional and in violation of protection afforded under the Eighth Amendment. While the court has explained the drastic shift in its stance on the basis of the *"evolving standard for decency"* test[11, 12], a summation of all these recent developments begs the reader to inquire: Is the death penalty on its way out of the United States?

True, from the public debacle of lynching or hanging to the sterile environ of the lethal injection or electric chair, the practice of capital punishment has come a long way since its inception. And while the execution itself has been hidden from public view, the issue of Capital Punishment has grown extraordinarily visible. Whether phrased in philosophical, political, ethical or economic terms, for the past two centuries the death penalty has been the subject of bitter debate[14], one which is not new to the medicine[15] or for that matter, organized psychiatry[16].

While it is clear that it is unethical for physicians to participate in the actual mechanics of the execution, the official positions of both the AMA and APA (with the efforts of senior members of AAPL[17]) now reflect that the psychiatrist, in his role of consultant to the courts, may assist the court selectively without committing ethical violations[18, 19]. Within AAPL, death penalty has remained a subject of vigorous debate[20], with almost 60% of the members opposed to capital punishment at last count[21]. Of the remaining, psychiatrists who provide consultation in death penalty cases struggle to maintain objectivity due to lack of uniformity of legal standards[22], system wide caveats[23] and absence of definitive guidelines in this arena where the cost of error is a human life. Moreover, with recent developments, new ethical questions have arisen in the absence of a central authority to provide conclusive answers.

With these unanswered questions in mind, four active members of AAPL will be meeting in Vienna in the summer of 2015 at the biennial conference of the International Academy of Law and Mental Health to keep the debate on capital punishment alive and to highlight the legal, ethical and clinical stumbling blocks that remain for psychiatrists practicing in this arena.

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New Potential Hazard For Forensic Evaluators: Using Prescription Drug Data Bases

Henry S. Levine MD Chair, Psychopharmacology Committee

Experienced forensic psychiatrists know well many potential legal hazards they face in completing examinations of evaluees. Legal dangers exist particularly when working outside the state in which one is licensed. A colleague recently discovered a new area of difficulty in completing such evaluations, and wants fellow forensic psychiatrists to be warned to avoid his fate.

49 states and the District of Columbia now collect data on prescriptions written within their jurisdictions for controlled substances (Missouri being the only current exception). Physicians and other prescribers are asked, and in some states are mandated, to review their state's data base before issuing new schedule prescriptions. The number of states compiling these data and allowing prescribers to review them has grown markedly in the past decade.

The Federal Government has put forward a good deal of effort and funding to encourage states to establish these programs. They are part of a nationwide effort to reduce the number of physician prescriptions leading to abuse, injury and death from the prescription of controlled substances.

Such data may be extremely valuable to forensic psychiatrists evaluating persons who might be listed in those data bases. Evaluees frequently use and sometimes overuse or abuse controlled substances, and may withhold such information from evaluators. Prior to the existence of these prescription drug databases, verifying the solicitation and issuance of such prescriptions was difficult at best.

However, physician licensure is now linked to the ability to access this information on one's patients. Forensic evaluators may have assumed that their license also allows them to access data on their evaluees when consent to do so by the evaluee is granted. Be forewarned: this may not be so.

A colleague providing forensic evaluation in a state in which he did not live or practice, but in which he was licensed, obtained information from that state's prescription drug data base and testified, in a civil case, to having done so. A complaint was filed against him. He then learned that while in his home state, an evaluee's consent to access information in the data base was sufficient to allow him to do so, that was not the case in the neighboring state. The data in the neighboring state's repository is held to be used primarily as a police function. The data on the patient is not owned by the patient. The patient cannot consent to its use. Without a specific court order, the data may not be used in a civil matter. It can only be accessed by treating physicians and by those with police authority. Unfortunately for our colleague, that learning came with a $15000 price tag for legal representation to successfully defend the complaint against him.

Prescription drug data bases hold a potential treasure trove of information for those in our subspecialty. It is tempting to use them as part of forensic psychiatric evaluation. While in some states it may be legal to do so with evaluees' informed consent, in other states it is clearly illegal to do so. Some of the state codes governing the prescription drug data bases are ambiguously written. Before accessing a prescription drug data base to gather information concerning an evaluee, it is advisable to read the applicable state code establishing the data base. If, after reading the state code, you think that you may have the right to access the data base in that state, it may be best to request written permission to do so from the applicable State Medical Board.

Do not assume that your license in a particular state gives you access to data on non-patients, or that individual consent allows such access. The penalties for not exercising the above-recommended degree of care may be severe and even career-threatening.

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Asylum and Immigration Issues in the LGBT population

Danielle B. Kushner MD, Human Rights and National Security Committee

Immigration issues in the LGBT population in the United States have evolved significantly through the past decades. Seventy-seven countries criminalize some aspect of being homosexual, bisexual, or transgender[1]. As a result, increasing numbers of LGBT people are applying for asylum in the United States and other countries. The following details a background of current immigration issues in this particular population for the forensic psychiatrist.

Asylum: In order to apply for asylum, an applicant must show a well-founded fear of persecution based on one or more of five grounds, which include: race, religion, nationality, political opinion, or membership in a particular group. The last ground provides the best claim for asylum cases based on sexual orientation and gender identity. The case *Matter of Acosta* (Board of Immigration Appeals 1985) defined a social group as "whatever the common characteristic that defines the group, it must be one that the members of the group either cannot change or should not be required to change because it is fundamental to their individual identities or consciences." Case law has shown that no malignant intent or exact motive is required by the persecutor, but one must establish that the persecution suffered was motivated on account of his or her possession of a protective characteristic and whether a reasonable person would find the suffering or harm to be offensive[2].

In 1994 former Attorney General Janet Reno designated the case of *Toboso-Alfonso* (BIA 1990) as a precedent decision in which a defendant's homosexuality was an immutable characteristic that fit the criteria of membership of a particular social group for purposes of an asylum application. Since then, there have been landmark asylum cases recognizing gender-based violence, such as female genital mutilation and domestic violence, transgender, and HIV positive cases as potential grounds for asylum. Yet, the strongest cases remain those in which the applicant suffers harm in the public sphere and the activity that was targeted by the persecutor was also public in nature, which are more common with homosexual men than other LGBT groups[3].

Research suggests that compared with their heterosexual counterparts, homosexual adults suffer from more mental health problems including substance use disorders, affective disorders, and suicide, due to minority stress[4]. Thus asylum seekers from foreign countries with known persecution or criminalization of such activities would be presumed to have a higher probability of psychiatric symptoms. Thus, the increased amount of LGBT asylum claims along with higher probability of psychiatric symptoms increases the predicted amount of future forensic psychiatric evaluations.

Detention: The Immigration and Nationality Act provides the Immigration and Customs Enforcement agency (ICE) with broad authority to detain aliens believed to be removable while awaiting determination of whether they should be removed. Mandatory detention includes those without documentation or with fraudulent documentation, those who are inadmissible or deportable on criminal or national security grounds, those certified as terror suspects, and those with final orders of removal. Unlike criminal incarceration, immigration detention is not intended to be punitive, but to confine detainees for the administrative purpose of holding, processing, and preparing them for removal[5]. Yet immigration detention, like traditional correctional facilities, has been shown to be particularly problematic for LGBT and HIV positive detainees. For example, commonly transgender women are placed in male facilities, gay men and people with HIV are harassed, and LGBT people are often put in prolonged solitary confinement "for their own protection"[6].

Recently, many US Circuit Courts have found that denial of hormones for transsexual inmates is in violation of the 8th amendment's requirement that the incarcerated receive "adequate medical care." Subsequently in 2011, ICE released national detention standards that included for the first time important safeguards for LGBT immigrants. These protections include recognizing transgender detainees as a vulnerable population, conducting strip searches of transgender detainees in private, basing housing decisions for transgender detainees on the detainee's gender self-identification, and allowing transgender detainees who received hormone therapy before detention to have continued access. Yet, these standards are not mandatory and vary between facilities with no judicial oversight to ensure adherence. The time to obtain medical records to confirm past hormone treatment has been noted to delay treatment initiation[6].

In 2012, ICE created policies and procedures to address sexual assault in immigration detention facilities. Ongoing work is still needed as a November 2013 report shows that there were 215 allegations of sexual abuse and assault in ICE detention facilities from October 2009 through March 2013. It found that 40% of sexual assault allegations were never reported to headquarters and detainees faced barriers of reporting such abuse[5]. As a result of the growing information regarding the treatment of LGBT detainees in ICE detention facilities, ICE created a specialized facility to house LGBT immigrants in the Santa Ana City Jail in Santa Ana, California in April 2012. In addition, The Department of Homeland Security (DHS) also released new rules in September 2013 on use of solitary confinement that explicitly forbid placing detainees in solitary only for sexual orientation or gender identity. The regulation does not set limits on time in solitary, but needs an explanation of why a person is in solitary for

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the child had been born alive and the mother concealed the death of the child, the accused mother was sentenced to death; 3) If the mother concealed the death of the child and it was undetermined whether the child was born alive, then the accused mother was sentenced for up to 2 years in prison. Juries, even in the face of strong evidence against the mother, were much more likely to convict of the lesser charge, and often would find the accused mother not guilty. This example of jury nullification shows that while lawmakers passed laws with the intent of punishing women who killed their child born out of wedlock, individual jurors felt sympathy for these women and refused to punish them. In the context of a long history of jury nullification, British lawmakers passed the Infanticide Act of 1922. The Infanticide Act (later amended in1938 to its modern day version) made the act of a mother killing her child equivalent to committing manslaughter. The accused mother was guilty of infanticide if "at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child." Although the maximum sentence for women convicted of infanticide in Great Britain is up to life in prison, the most common sentence given out since the Infanticide Act was passed has been probation. Many Infanticide laws throughout the world are based on the British model. Canada passed their first Infanticide Law in 1948. Canada's law set the maximum penalty for women convicted of infanticide at 5 years in prison.

For the first two centuries in the USA, the legal system had emphasized the objective of rehabilitation. Judges had a great deal of discretion in determining criminal sentences, and were constrained only by limits on maximum sentencing. Parole boards had a great deal of authority by granting or denying parole. The public became increasingly skeptical of the rehabilitative power of prisons as the crime rates climbed in the 1960s and 1970s. The political climate ripened for sentencing reform which led to the passage of the 1984 Sentencing Reform Act. This Act, which pertained to sentencing of federal crimes, sought to eliminate disparity in sentencing lengths by abolishing parole and creating the commission which was to draft the Federal Sentencing Table. The Federal Sentencing Table is a complex scheme which determines a minimum and maximum sentence for a particular crime based on the criminal history of the defendant and the seriousness of the crime. Although this Table pertains to federal crimes only, states too were individually moving away from the rehabilitative model of sentencing and toward more determinate sentencing with the underlying philosophy of retribution and "just desserts." The net effect of these changes in how we sentence criminals was an increase in the length of sentences and an explosion of the prison population. By 2013, the state prisons housed more than 1.3 million people which represented an overall increase of more than 700%. By 2002, 7% of the U.S.A. population was in the correctional system.

As the great recession hit and state budgets grew tight, the states felt an impetus to reduce the cost of prisons. Adding to the pressures to reduce prison population are court cases such as Plata v. Brown which have ordered states to reduce overcrowding. Thus in the past 10-20 years, we have seen the states moving to reduce their prison population by moving away from mandatory sentencing, changing criminal codes and investing in diversionary programs which have been shown to cost less than incarceration.

In regards to infanticide, there is a great deal of discretion in charges which prosecutors bring and therefore variability in the sentences. Women who commit infanticide are charged with a range of crimes, from a misdemeanor of unlawful disposal of a body to capital murder. The possible sentences range from the death penalty to court mandated therapy and parenting classes. A 2010 study by Shelton et al looked at the legal outcome of 45 neonaticide cases. Of these 45 cases, 64% of the offenders were ultimately incarcerated, and their length of sentences ranged from 9 months to 25 years. Shelton found that offenders who received sentences longer than 5 years were significantly more likely to be of a minority race, to have other living children, and to be married or widowed. Offenders who received sentences less than 5 years in length were likely to be young students living with their parents. Offenders who were sentenced to probation tended to be 20 years of age or younger, living with her parents, had no criminal history, and the victim was the result of her first pregnancy. Shelton compared the average sentence of her 45 neonaticide cases to filicide cases in the FBI database and found that the average length of incarceration increased with the age of the victim. The average length of sentence for neonaticide was 8.8 years as compared to 11.3 years for infanticide and 21.2 years for filicide. In comparison to punishment in a country where there is a specific Infanticide law, we see far greater rates of incarceration in the USA. In England, which does have an Infanticide law in their criminal code, less than 10% of women convicted of Infanticide are incarcerated. This is in contrast to the USA, in which 64% women convicted of neonaticide were sentenced to prison.

Dr. Susan Hatters-Friedman took the position in the debate that the United States should not adopt infanticide laws similar to the one in Canada. Arguments mounted in favor of the US not adopting an Infanticide Act included: fairness of such an act related to both gender bias and age cut-off, the outdated concept of lactational insanity, devaluation of the life of a child, the lack of appreciation in the legislation of the quite significant differences between neonaticide and other cases of infanticide, the importance of consideration of motive for

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the murder, and the alternative defenses available to all perpetrators of child homicide.

An Infanticide Act requires that we as a society believe: 1) the value of the child's life is less than the value of others' lives, and 2) a mother perpetrating the act is, by virtue of her gender, less culpable than a father. Infanticide acts have an inherent gender bias, being available only to mothers who kill. This is despite similar rates of fathers and mothers killing their children. Fathers are more likely to commit suicide along with the filicide, potentially indicating elevated rates of mental illness as well. Research demonstrates that mentally ill mothers are more likely to kill older, rather than younger children, running counter to the law. The age cut-off would allow a mother who kills her 11 month old infant to be charged with infanticide, but if she had also killed her 3 year old in the same desperate act, she would not qualify. Thus, in the most well-known case of Andrea Yates, who killed her 5 children from infancy to age 7, she would still have been charged with murder. The Infanticide Acts spawned from a 1922 British law, from back when lactational insanity was considered a potential medical illness. This has never been shown to exist, and rather demonstrated continuing misunderstandings about maternal mental illness. A woman's balance of the mind is not in general disturbed from delivery. Rather if she is suffering from psychosis, related or unrelated to her postpartum state, the Insanity defense may be appropriate. Further, an Infanticide Act devalues the life of the child, making the penalty for killing one's child less than had the actor killed anyone else.

As described above, neonaticides are different from other infanticide cases, yet under the Act, they are considered the same. In neonaticides, women often kill newborns after a denied or concealed pregnancy, because the child is unwanted, and long before any postpartum mental illness would normally occur. It is unclear why these women who act for rational reasons and usually without mental illness are who the law seeks to exculpate. Finally, alternative defenses that can be used by both genders, which do not devalue the life of the child, nor have illogical age cutoffs are available. Insanity defenses, mitigation of penalty, and diminished capacity may be considered in cases where either parent kills their child.

Dr. Phillip Resnick took the position in the debate that the United States should adopt infanticide laws similar to the one in Canada. He pointed out that women who kill their own infant children constitute a distinct class of offenders and it calls for a distinctive response. Infanticide laws reflect societal attitudes toward women who kill their infants and thus increase respect for the law by allowing a fair apportionment of moral blameworthiness.

Women who commit infanticide with a level of mental illness that falls short of insanity would qualify for a charge of infanticide with a maximum of 5 years in prison. Infanticide laws would reduce the likelihood of unduly harsh punishment by allowing judges more sentencing options. There is now a mandatory penalty of life in prison for a woman convicted of murder for killing her infant. Another argument in favor of a specific infanticide law is that those adolescents who commit infanticide are potentially less culpable given that they have brains that have not fully matured. Lastly, adoption of an infanticide law would not preclude a prosecutor from still charging a woman with murder, but would allow discretion in cases deemed appropriate.

Oliver Wendell Holmes observed, "The life of the law has not been logic. It has been experience." More than 40 countries have passed and retained infanticide laws based on the real life experience of addressing these tragedies.

In conclusion, there are numerous arguments in favor of and against the adoption of Infanticide Laws within the United States. While child murder has occurred throughout human history, it continues to present challenges for those tasked with seeking justice for all involved.

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Elizabeth Ford, M.D., Executive Director of Mental Health at the Bureau of Correctional Health Services, New York City Department of Health and Mental Hygiene presented a talk on *The Evolution of Jail Psychiatry: Should We Really Be striving for the Community Standard of Care?* Dr. Ford began her presentation by providing a historical panoramic perspective on the evolution of psychiatric treatment in incarcerated populations. As the incarcerated population has increased over the years, the mental health needs have also increased. Nevertheless, the availability of mental health services varies significantly due to financial, political, administrative, and local and nationwide legal trends. The number of jail inmates has increased from 160,853 in 1970 to 731,208 in 2013. Dr. Ford pointed out that "jail/prison psychiatry" may be a "different type of psychiatry." Quoting Dorothea Dix, "It is a queer thing, but imaginary troubles are harder to bear than actual ones," Dr. Ford explained how the inmate population is chronically on edge, scared, hyper-vigilant, anxious, and aggressive. This baseline state in many inmates, combined with their cultural and socioeconomic backgrounds, may call for a specialized approach to their needs. Unfortunately, psychiatrists are hard to find, not to mention psychiatrists with specific correctional training. Dr. Ford believes that the "different kind of environment" calls for a "different type of psychiatric services and treatments." There are a significant number of inmates with history of primary and secondary emotional trauma for which the environment may be intimidating and even chaotic. Therefore, inmate psychiatric needs also call for "treatment in a trauma zone," very much like in a war situation. The initial common human response to acute trauma is the activation of sympathetic and parasympathetic mechanisms which prepare human bodies to fight, flight, or freeze. However "fighting is a bad idea in inmates, flight is not possible, and freezing is often also a bad idea for the inmate population." The mental health needs within this population may vary from helping individuals having a "normal" reaction such as demoralization due to their legal issues and incarceration, to having chronic severe psychiatric disorders compounded by being placed in the jail/prison environment. Nevertheless, even for properly trained mental health staff, it is challenging to diagnose some of the inmates due the multiple factors involved. Identifying a "normal" response to the environment versus a legitimate psychiatric disorder such as an Adjustment Disorder, an Acute Stress Disorder, or a chronic and severe disorder while keeping in mind the possibility of malingering, may be a difficult task. To make the mental health task more complicated, Substance use disorders are also prevalent among the incarcerated population, which is often not appropriately addressed. Furthermore, and equally as important, the mental health needs of inmates continue in the post-imprisonment period. Re-introduction of inmates to society carries significant emotional and logistical issues for the ex-inmate that need to be addressed. A multidisciplinary systematic approach addressing issues such as housing, financial needs, addiction relapse prevention, and continuity of psychiatric treatment, among others, should be part of comprehensive mental health services provided for this population to help them readjust to society and decrease risk of criminal recidivism.

> *" ...inmate psychiatric needs also call for 'treatment in a trauma zone,' very much like in a war situation."*

Dr. Ford ended her presentation paralleling the efforts needed in jails and prisons with the inspiring work being done by Doctors Without Borders. She quoted Dr. James Orbinski who said, when accepting the Nobel Peace Prize in 1999 on behalf of *Médecins Sans Frontières*: "Our action is to help people in situations of crisis. And ours is not a contended action. Bringing medical aid to people in distress is an attempt to defend them against what is aggressive to them as human beings. Humanitarian action is more than simple generosity, simple charity. It aims to build spaces of normalcy in the midst of what is profoundly abnormal."

Next was the Annual Abe Halpern Memorial Award lecture delivered by Professor Michael L. Perlin, Director of the International Mental Disability Law Reform Project and Director of the Online Mental Disability Law Program New York Law School. After being honored with the Award for his national and international trajectory advocating for the rights of the mentally ill, Professor Perlin presented his talk on *You That Hide Behind Walls: The Relationship between the Convention on the Rights of Persons with Disabilities and the Convention Against Torture and the Treatment of Institutionalized Forensic Patients, and Its Implications for Forensic Psychiatry*.

Professor Perlin provided a comprehensive view of the lack of proper legal representation, as well as the unfortunate worldwide infringement of human rights of institutionalized psychiatric patients in forensic facilities. He provided examples of gross psychiatric trespasses he has had personal knowledge of, such as Electro Convulsive Therapy (ECT) being administered to individuals without the use of muscle relaxants and without consent in a country outside the US. He also provided examples of infringements occurring within the United States, from State Hospi-

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tals to the US Army. Professor Perlin observed that there is not only lack of public awareness but also a lack of awareness within the professional world; for example, when doing literature searches on the topic, only his own publications come up because "nobody is researching or writing about this in the Western or Eastern hemispheres." Unfortunately not too many lawyers are interested in mental health law. To illustrate the point, he explained that when he started working as an attorney, the cases related to mental health issues were given to him "because those were the cases assigned to the rookies as a form of hazing." Nevertheless, he was the exception and was fascinated by the mental health issues and forensic psychiatry. He also explained that other lawyers did not want mental health cases because only rarely could they be successfully defended, and in addition, they have a high burnout rate. Therefore individuals with mental health legal issues frequently don't get good legal representation. Furthermore, their human rights are frequently disregarded by institutions, and "those who hide behind the walls continue to wrong the mentally ill with impunity. It is time that something is done to change that."

Our next speaker Francisco Pizarro, M.D., who works in his Private Practice as a Child Forensic Psychiatrist, discussed *Child Forensic Psychiatry: Past, Present, and Future*. Dr. Pizarro provided an overview of types of Child & Adolescent Psychiatric Forensic Evaluations, and the historical events that contributed to the development of Family Courts legislation, and other legal venues to protect, evaluate, process, and adjudicate children & adolescents. Dr. Pizarro explained the different types of evaluations commonly requested by the Courts, including child custody and visitation, parenting capacity, child abuse, and issues related to juvenile delinquency. He discussed child competency to provide witness testimony, the evaluation of juvenile sex offenders, and the evaluations for children in need of services. His experience has been mostly focused on child custody cases and he described the intricacies involved in the evaluations including the complexities of the legal procedures, as well as the heightened emotional tension involved. For instance, in custody procedures, forensic experts are typically cross examined by the father's attorney, the mother's attorney, and the child's attorney. In child custody procedures children have a court appointed attorney to represent their wishes. Child custody forensic evaluations are very lengthy and complicated because the forensic expert typically spends over ten hours evaluating each of the parents, several hours observing their interactions with the child, several hours examining the child, several hours examining records and obtaining collateral information, and several more hours writing a forensic report. Nevertheless, Family Courts rely heavily on the experts' opinions when making custody decisions.

Our fifth speaker, Judge Juanita Bing Newton, Dean, The New York State Judicial Institute, presented on *The Growing Importance of Adolescent Brain Science in the Courts or a Little Bit of Knowledge Can Be a Dangerous Thing*. Judge Bing Newton explained that judges and lawyers are not scientifically knowledgeable and that "even lawyers often joke by saying they went into law school because they didn't do well in biology or other sciences." The use of scientific evidence is relatively new to judges and other court officers. Leaving other sciences aside, the understanding of mental disorders and related neurosciences are often foreign to judges, and the diagnostic labels can be particularly confusing. Nevertheless, neuroscience has made its way into the courts; it has important implications in Family Courts because the adolescent brain science has penetrated legal decisions and led to re-thinking of judicial approaches. Judge Bing Newton believes that Judges need to become more knowledgeable about mental health and related sciences to discern better expert opinions. She described the cases of Frye and Daubert and the role of science versus the law. However, in many cases, even when scientific evidence meets Daubert's standards, tension still persists within the Courts; often times Judges are reluctant to accept the evidence. Judge Bing Newton discussed the case of *People v. Donald DD*, in the New York Court of Appeals (the highest Court in NYS) 2014, in which the majority of the Judges agreed that the diagnosis of Paraphilia Not Otherwise Specified amounts to "junk science," and didn't believe it would hold up against the Frye standard. Nevertheless, Judge Bing Newton explained that Judges depend heavily on the psychiatric expert despite the skepticism

There is a significant need to educate Judges with respect to mental disorders and what psychiatry has to offer to the legal system. Psychiatric expert witnesses frequently are unfortunately "sandbagged while testifying mostly due to ignorance." Judges need to be attuned as to what psychiatrists think is important for them to know, and furthermore, they should undergo training that would allow them to become aware of the psychiatric issues at hand and potential implications. Judges need to have some fundamental understanding of mental disorders so that they can become more thoughtful and sophisticated when hearing psychiatric cases.

After the presentations the AAPL Tri-State Chapter held their Annual Business Meeting. Grace Lee, M.D. was recognized for her two years of dedicated service as President of The Tri-State Chapter. New officers were elected: President: Manuel Lopez-Leon, M.D., Vice-President: Bipin Subedi, M.D., Treasurer: Robert Goldstein, M.D., Secretary: Susan Gray, M.D.

Heavy Petting: Bestiality and Zoophilia

Brad Booth MD, Renée Sorrentino MD, Sara Moore MA, and Susan Hatters Friedman MD

At the Hong Kong forensic meeting of the Royal Australia New Zealand College of Psychiatrists, we presented a workshop about bestiality and zoophilia.

Although often used interchangeably, bestiality is defined as sexual contact between a human and a lower animal. Whereas, zoophilia is a paraphilia in which the erotic fixation is on animals - this may lead to bestiality. Zoophiles tend to anthropomorphize animals and describe unconditional love with 'no strings attached.' Parallels can be drawn between zoophilia and pedophilia, and bestiality and offending against children. Similar to pedophiles, zoophiles have a prefered desire for the sexual object of their attention. While some acts of bestiality and offending against children are motivated by the relevant paraphilia, non-paraphilic offenders may act out of other motivations, such as the absence of an adult consenting partner.

Historically, there is evidence of bestiality dating back to the fourth glacial age with ancient carvings depicting sexual acts with animals. While the Ancient Egyptians found bestiality to be punishable by death, it was regularly practiced, and believed to be a cure for nymphomania. More recently, bestiality was against the law in the American colonies. The human (and the animal) may have been executed if found guilty. As of 1997, 25 states had outlawed bestiality, and animal rights groups have lobbied for further legislation citing sex with animals as cruel and inhumane.

The prevalence of bestiality and zoophilia is unknown. Yet, Kinsey found that 8% of men back in the 1940s had engaged in bestiality (compared to 1.5% of women). In the 1970s, Hunt et al found rates of 5% in men and 2% in women. Risks to the human include most commonly tissue trauma, and bites, but also zoonotic diseases (borne by animals) like brucellosis and leptospirosis. Psychiatric comorbidities may include other paraphilias, developmental disabilities, and psychological deficits such as narcissism and poor social skills.

Zoophilia and bestiality are rare, and little is known about what specific treatments are effective and if these are different than for other paraphilias and sexual offending. Consideration of crossing-over to other paraphilias should occur in treatment. Comorbid disorders should be treated, including paraphilia, social deficits, and developmental issues. Case reports that exist about treatment have utilised behavioral therapy or SSRIs. Ethical issues are still being flushed out, such as about mandatory reporting.

Uniquely, we proposed a classification system for human-animal sex that is more pragmatic than previously described classifications. It is the goal of the authors to provide a classification system that can be used in both the clinical and research settings. This would allow for the better understanding of animal-human sex by establishing a common language to discuss such cases and provide the most effective treatment interventions.

"If You Don't Know..."

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light any financial or other factors that may contribute to program instability.

Research Continuity: For residents who have engaged in research, there is a significant benefit to the continuity afforded to those who attend fellowship at the same program where they completed their adult psychiatry residency. Not only are their research mentors still in place, but the fellow will already have familiarity with their program's IRB process and research options.

Significant Others: Obviously, geography, personal preference and one's significant other can and should play a significant role in an applicant's selection process.

For many, fellowship is a great time to make the move to a different part of the country and put down roots, so cost-of-living, weather and the location of family members will naturally play a part. That said, a case can be made that forensic fellowship is just one year, and where possible, the best possible training should be sought out regardless of location. Ultimately, it is a highly personal decision for most, as it was for me.

ERAS Match: Forensic fellowships do not currently use an ERAS "match" process. Fellowship slots fill on a rolling basis and some programs may fill them as early as July of the year preceding fellowship. Therefore, it may be wise for applicants to structure their interviews, where possible, so that they visit programs of greatest interest earlier in the interview season. This was important for me to know as an applicant because I had limited financial resources as well as clinical obligations that made multiple interviews a challenge.

I hope that potential mentors or applicants have found this advice useful as a starting point for fruitful discussions about the important transition between general residency and forensic fellowship.

AAPL has always stood out to me as an organization that nurtures and tries to cultivate interest in forensic psychiatry among residents, and there have been so many AAPL members who have generously offered their time as well as outstanding advice over the years.

I never forgot the kindness of those who invited me to events at the AAPL annual meeting when I was just a PGY-I. If it hadn't been for their kindness and support, I would certainly not have felt as welcomed at AAPL or sought to become involved. Ultimately, the process of finding the best fellowship fit can be daunting, but as Yogi Berra once said, "it ain't over till it's over."

One Head

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with particularly horrendous crimes. In either case, it behooves us to learn how to recognize these feelings and not let them unduly influence our work. This experience was an important lesson during my fellowship that, even when working as forensic psychiatrists, we need to make sure never take off our psychotherapeutic hats.

Tobias Wasser, MD is completing his forensic psychiatric fellowship at Yale University.

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Recovery from Violence

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orary Life President and pioneer in forensic group psychotherapy.

The social side of the conference was enjoyable. There was a reception on the first evening with entertainment from a Yale band of psychiatry department members.

The second evening was the Gala Dinner in a suitable historic building. There was fine dining with pre-dinner entertainment from a Yale student a cappella group.

All in all, we had a very civilized conference as we tossed around themes of mayhem, death, destruction, oppression and sometimes redemption. It was truly international with heavy representation from Europe. The size of less than 150 registrants reminded me of forensic meetings 25 years ago on both sides of the Atlantic.

Next year, the meeting moves to Ghent, Belgium in early April. If you wish a different experience, do come and support Dr. R. Kapoor as she gives her Presidential talk. Well done Reena and colleagues at Yale!

Forensic Hospital Services Committee

The Correctional and Institutional Psychiatry Committee is splitting up and the institutional arm is becoming the forensic hospital services committee. Issues affecting correctional institutions and forensic hospital facilities are similar in some ways, and yet different in many others. For example, by being subject to the Patients Bill of Rights and to regulatory agencies such as The Joint Commission, forensic psychiatric hospitals, even maximum security settings, must abide by the same rules governing general psychiatric hospital facilities, a situation that is distinctly different from correctional institutions and makes working in forensic facilities especially challenging.

In Forensic Hospital Services Committee, members will focus on issues such as:

- Restraints and Seclusion
- Managing aggression
- Admitting civil (non legally involved) patients in forensic facilities; challenges
- Applying recovery principles in forensic hospital facilities; challenges
- Maximum versus medium security services and challenges
- Special treatment; forensic psychotherapy; unique group therapy, virtual reality for social skills training in forensic facilities
- Updates in Competency Restoration statutes and laws
- Managing gangs in forensic facilities
- Patient/inmate transfer between correctional and forensic hospital facilities.
- other issues of interest to members

AAPL members working in forensic psychiatric inpatient facilities, those with knowledge and experience in this area, as well as fellows and new members are encouraged to join the committee. For questions or to become a member of the committee, please contact Charles C Dike at Charles.dike@yale.edu.

A Day at the US Supreme Court

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the 6-3 majority. In a twelve-page opinion, the Court reversed and remanded the case to the Fifth Circuit Court of Appeals, finding that Jennings could rely on his third theory of ineffective assistance of counsel in responding to the state's appeal without filing a cross-appeal or seeking a certificate of appealability. As Justice Scalia explained: "Because Jennings [third ineffective assistance of counsel] theory would neither have enlarged his rights nor diminished the State's rights under the District Court's judgment, he was required neither to take a cross-appeal nor to obtain a certificate of appealability." Justice Thomas, joined by Justices Kennedy and Alito, wrote the dissenting opinion, arguing that habeas corpus jurisprudence requires a defendant to seek a certificate of appealability in this context and that such a requirement is consistent with one of the primary purposes of the AEDPA, namely diminishing the filing of frivolous appeals.

Yearly trips to the Supreme Court are planned in our fellowship as part of the syllabus in practice-based learning. Throughout the year, our didactics cover the major case law that has shaped American mental health law into what it is today.

Many of those cases were heard in the same courtroom we had the opportunity to visit in October. We feel privileged to have been able to experience this process first hand as it has enhanced our learning and appreciation of the law and the legal process and the evolution of our practice today. In the weeks that have passed since October, we have also realized that the shared experience of this Supreme Court visit solidified our camaraderie as colleagues in our fellowship.

http://www.supremecourt.gov/opinions/14pdf/13-7211_8o6a.pdf

Asylum and Immigration Issue

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more than two weeks[6].

Conclusion: Forensic psychiatrists should be aware of the growing area of LGBT immigration and asylum issues. Given the growing LGBT persecution abroad and the development of United States laws and regulations, it will continue to be in the forefront for years to come.

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