

# AAPL Newsletter

American Academy of Psychiatry and the Law



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## Forensic Psychiatry Review Course: October 24-26, 2016 AAPL 47<sup>th</sup> Annual Meeting: October 27-30, 2016 Hilton Portland & Executive Tower Portland, Oregon



## Myths and Realities of Women in Prison

Anna Glezer MD, Susan Hatters Friedman MD, Catherine Lewis MD, Aimee Kaempf MD, Gender Issues Committee

Over past decades, there has been a dramatic rise in the number of incarcerated women in America, fueled in part by the “war on drugs.” This has led to over one million women currently in the criminal justice system, in a combination of jail and prison, probation, and parole. Therefore, it is important to recognize the demographics of this population and learn about the realities of mental illness, substance use, trauma, and issues related to pregnancy and family separation.

The lifetime likelihood of imprisonment for women in the US is 1 in

56 (much higher for black women), and the most common reasons are nonviolent offenses such as drug and drug-related crimes, and prostitution. The reality is that women in prison suffer from physical and mental health problems at rates higher than their male counterparts. They are more likely to have chronic or communicable medical disease, and, almost three fourths of women in state prisons have symptoms of an active mental health problem, according to the Bureau of Justice and The Sentencing Project. Because of the complexity of these inmate-patients,

the staff working in correctional institutions that house primarily women are at risk for burn-out.

### *Mental Illness and PTSD*

Mental illness and PTSD specifically are common in this population. Approximately three-quarters of women entering prison have a history of trauma (Gunter et al, 2012). Female prisoners with serious mental illness are more likely to also have PTSD (Lynch, 2014). Further, a minority of prisoners are victimized whilst in prison. Under-reporting so as not to be seen as weak, as well as over-reporting (malingering for damages or disability) are both potential issues when diagnosing PTSD in this population (Friedman et al, 2015).

### *The Externalizing Endophenotype: Not Just for Men*

Early research on diagnoses in incarcerated populations identified high prevalence of substance use disorders among men and women. The link between Antisocial Personality Disorder and Substance Use Disorder (SUD) is well established in clinical populations

In studying a group of female felons in Connecticut state prison, for example, Dr. Catherine Lewis noted that nearly half the sample met criteria for ASPD. Of those with conduct disorder, more than 75% progressed to ASPD, higher than the one-third reported for general clinical populations. The presence of conduct disorder was associated with heightened prevalence of ADHD (nearly one-third of women), alcohol dependence (nearly two-thirds of women), opiate dependence (half) and PTSD. Furthermore, the age of onset of conduct disorder preceded that of SUD or affective disorder. It was associated with adult aggression when drinking and sober. Overall, the findings supported a link between a childhood

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# American Academy of Psychiatry and the Law

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## CHAPTER NEWS

### Midwest AAPL Annual Meeting

Cathleen Cerny MD

Midwest AAPL gathered in Chicago on April 1-2, 2016 for their 33rd Annual Meeting. This well-attended conference was planned by Drs. Stephen Dinwidie, Philip Pan and Carl Wahlstrom with the invaluable assistance of Sandra Downey. As always, there was a wide range of topics including: impaired professionals, Sovereign Citizens, duty to warn, non-suicidal self-injury, medicolegal issues in prescribing to pregnant patients, false confessions, Hollywood's impact on real legal cases and the Colorado Batman Movie Massacre. Speakers included: Cathleen Cerny, Crystal Clark, Laura Forester, Robert Hanlon, Samuel Libeu, George Parker, Phillip Resnick, Shree Sarathy, Loretta Sonnier, Joshua Tepfer, Jason Washburn and Brian Zachariah.

Several qualified resident submitted applications for the 2016 MWAAPL awards. The Resnick Award honors trainees who've already demonstrated scholarship in forensic psychiatry. The Resnick Scholars this year are: Drew Calhoun, MD (Pittsburgh) and Tanuja Gandhi, MD (Einstein). The aim of the Margolis Travel Scholarship is to help trainees with Midwest connections have financial access to the MWAAPL meeting and to potential forensic mentorship. This year's Margolis Scholars are: Jonathan Dunlop (University of Michigan), Rami Abukamil (Wayne State) and Seth Eappen (Medical College of South Carolina)

Join MWAAPL in Kansas City on March 31-April 1, 2017 for what is sure to be another outstanding meeting! ☺



Pictured is the presentation of the Presidential Plaque by Immediate Past President Cathleen Cerny to New Immediate Past President Sherif Soliman.



Pictured are the officers for the coming year: Treasurer Doug Morris, President Elect Delaney Smith, President Larry Jeckel, Immediate Past President Sherif Soliman, and Immediate Past President Cathleen Cerny.

Photo credit Steve Berger, MD

## “Always in Motion is the Future”

Susan Hatters Friedman MD



I love our AAPL Newsletter. Since joining AAPL as a young resident, I have excitedly read the newsletter, usually the same day it arrived in my

mailbox. So many articles by experts in our field, in easily digestible pieces. I remember avidly reading the summaries of the lunchtime speakers, presidential addresses and the Guttmacher award lecture. It was a great way to become acquainted with the people of AAPL. What pearls would Mike Norko (then editor) have to share? Or the president? Or the medical director? And the fabulous photos from meetings—this was before we were all facile with the internet, seeing what some forensic leaders (whose talks I had heard on borrowed tapes of old meetings) actually looked like. I remember hoping that someday, I’d be experienced enough to write articles for the Newsletter.

As I’ve matured in my career, there are other things I note that stand out about our newsletter. Such a quick turnaround time for publication means that the newsletter represents some of the latest thoughts on a topic, which alternatively might take quite a while to be a fully formed study for publication in a journal. I also love that our newsletter is not an online-only newsletter—but one I can still hold in my hands, and slip in my bag to read on the bus or at the prison.

I’m excited and honored to step into my new role as the newsletter editor. Under Charles Dike, the newsletter has continued to grow and evolve. I’ve leaned on Charles quite a bit for this first newsletter, and have appreciated learning from him over my past couple years on the editorial board. Charles is leaving big shoes to fill.

Members of the newsletter editorial board continue to include Drs. Neil

Kaye and Phil Candilis, both of whom are well known at AAPL and prolific in their newsletter contributions. New editorial board members will include: Joel Watts, Renée Sorrentino, Joseph Simpson, and Ryan Hall.

By way of introduction: Joel Watts, MD is a forensic psychiatrist (psychiatre legiste) on faculty at the University of Ottawa (Canada) where he is clinical lead of the mental health court and of the forensic assessment unit.

Renée Sorrentino, MD, is Director of the Institute for Sexual Wellness specializing in the treatment of sexual offenders, and is on faculty at Harvard.

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*“AAPL is not just a North American organization, but a leader on the world stage as international thinking about forensic topics progresses.”*

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Joe Simpson, MD, PhD has a background in neuroimaging and is a supervising psychiatrist with the Los Angeles County jail system. He also teaches forensic fellows at the University of Southern California.

Ryan C.W. Hall, MD has a private forensic practice, previously served as an AAPL councillor, and is on faculty at the University of South Florida, University of Central Florida, and the Barry Law School.

You just might expect some new occasional columns, based on their specialized knowledge across these vast areas. And I’m eager to work with Kristin at the AAPL office, whose organizational skills are amazing and Jackie, whose editorial skills are top notch. I’ve recently enjoyed looking through the old AAPL photos with Kristin. You just might see your younger self in an upcoming newsletter.

Stephen Herman will continue his much enjoyed Child Column, but in this issue as a one-off has rather reflected on Miranda at 50. Neil Kaye and Graham Glancy will proffer their thoughts and advice in the “Ask the Experts” column. Faces of AAPL continues to be coordinated by Phil Candilis. We are keen to have fellows contribute to the Fellows Corner—about unique experiences of being a fellow or something moving or challenging. We’ll continue to hear about current issues from our President, Medical Director, Executive Director, our rich breadth of committees, APA representatives, and AMA representatives. Reviews of the talks will remain interspersed with “Muse and Views” collected by Will Newman. These take me back to childhood, reading a similar section from the stacks of Reader’s Digests on my grandparents’ coffee table. And many more new photos to come, currently coordinated by Eugene Lee. Special articles of interest will continue to be solicited, including new AAPL voices—such as recent Rapoport fellow Jacob Appel’s piece in this issue about conceptualizing some cases of malingering as theft.

The above Yoda quote about the future is not merely included because I am a Star Wars fan; it is apt as we reflect on the future of our newsletter. AAPL is not just a North American organization, but a leader on the world stage as international thinking about forensic topics progresses. My time working abroad has taught me that other nations face similar struggles in the practice of forensic psychiatry; sometimes we might have a “better” answer, and other times there may be some wheel re-invention going on. Carolina Klein and the international relations committee may be contributing even more in this regard in the future. As well, I’d like to encourage AAPL’s international members to consider writing for the newsletter.

I welcome comments from AAPL members, and invite members to send materials of interest to [AAPLNewsletter@gmail.com](mailto:AAPLNewsletter@gmail.com). Let’s continue to make our newsletter great. Thank you for your support. ☺

## AAPL as a Professional Home

Emily A. Keram MD



I am honored to write my first newsletter column as the President of AAPL. As is true for many of you, our organization is very dear to me. I

deeply appreciate the thoughtful stewardship of our past-presidents, council members, medical directors, and contributing members. I especially want to acknowledge the role our exceptionally talented Executive Director, Jackie Coleman, and her staff play in keeping AAPL strong and vibrant. All involved have created a unique and remarkable institution.

The organization has been my professional home since 1990, the year before I began my forensic fellowship under Sally Johnson, MD at the Federal Correctional Institution at Butner, North Carolina. In my first column, I would like to address the concept of a professional home and the attributes AAPL embodies that make it such a rich anchor for life-long professional development.

Last year I served on selection committees for several AAPL positions. Among those interviewed were a number of early career forensic psychiatrists. At the end of each of their interviews, I found myself encouraging them to make AAPL their professional home, citing my own enrichment through membership. Thinking back on this advice, I recognized that despite having a very firm sense of AAPL as my professional home, I had never taken the time to explore the meaning of the term and how AAPL fulfills it.

Oddly enough, a search of both the National Library of Medicine and Google turned up no reference that dealt directly with the definition and elements of a professional home. Apparently, as with obscenity<sup>1</sup>, we recognize our professional home when we see it. The term is used self-referentially by numerous profession-

al organizations, across disciplines as disparate as ethnology and cardiology. While I found that the cardiologists<sup>2-4</sup> stressed the importance of a professional home, the ethnologists came closest to defining a professional home, on the occasion of the 50<sup>th</sup> anniversary of the Société Internationale d'Ethnologie et de Folklore (SIEF) in 2014. Several authors used the celebration as an opportunity to discuss their discipline and the role SIEF plays within it.<sup>5-7</sup>

Lofgren<sup>7</sup> used the historian EP Thompson's<sup>8</sup> concept of "moral economy" as a lens through which to understand the affective and emotional processes of home. The term moral economy encapsulates a group's shared view of how an economy *ought* to work, and the rights and responsibilities of different market actors in relation to that view. Members of the same moral economy, or socio-economic group, base their actions on the belief that they are defending the rights and customs underpinning a moral consensus in the wider community. In this model, AAPL functions as the arena in which forensic psychiatrists negotiate a shared view of how forensic psychiatry ought to function in society, and the roles and responsibilities of forensic psychiatrists. By extension, AAPL members then act in support of the defense of rights and customs that underpin fundamental moral agreements in the wider arenas of public policy, justice, human rights, national security, and ethics.

Turning toward a discussion of home, Lofgren cites the anthropologist Mary Douglas'<sup>9</sup> view of home as "An internal order with rules, rhythms, and morals. The home is a web of routines, silent agreements, and ingrained reflexes about 'the way we do things here.'" Lofgren<sup>7</sup> argues that Douglas' idea of home describes a moral economy, constantly tackling questions of solidarity, sharing and assistance, as well as the important issues of fairness. He notes, "The

home has to synchronize not only tasks and activities but also needs and longings. It is a moral economy that produces many tensions, for example between individual aspirations and activities and 'the family or household good.' Often there is a diffuse 'we' hovering in the background... The home is a site of negotiation, with constant wheeling and dealing, trying to make different priorities and interests cohabit."

Ethnologist Sánchez-Carretero identifies these attributes of moral economy and home in SIEF, which she calls her "academic home."<sup>6</sup> Similarly, I recognize them in AAPL. Our organization is an immaterial place that still manages to house our shared rules, rhythms, and morals. I view AAPL's practice guidelines as guardrails that describe my approach to evaluations. I find that my calendar is set to an "AAPL year," consisting of the annual meeting; abstract submissions; committee and business meetings in May; readying presentations for the next annual meeting; and coming together again with friends and colleagues in October. I rely on AAPL's ethics guidelines and consultations with colleagues as my lodestars for ethical conduct.

Lofgren is correct in recognizing the home as a moral economy that produces tension between individual aspirations and activities and "the family or household good," with a diffuse "we" hovering in the background. I was particularly struck by Lofgren's description of home as a "site of negotiation with constant wheeling and dealing, trying to make different priorities and interests cohabit." I encourage early career AAPL members to pay particular attention to the process by which AAPL strives to balance the tension between the needs of individual members and the needs of our profession. One of AAPL's (many) sources of strength is its diversity of opinion, civility of discourse, and search for meaningful compromise between and among members of disparate theoretical, political, occupational and geographic backgrounds. This dynamic

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# Hospital Security Officer Weapons Use in Behavioral Emergencies: Is it Ever Appropriate?

Jeffrey S. Janofsky MD



On February 12, 2016, the *New York Times*<sup>1</sup> and *This American Life*<sup>2</sup> reported on an incident where a patient with elevated mood and

delusions was evaluated in a hospital emergency room. He had physically injured himself in an automobile accident prior to the ER visit. Although he told hospital staff, "I'm manic" and clearly presented to the ER with symptoms consistent with psychotic mania, he was not seen in the ER by a psychiatrist and was admitted to a medical floor. There he became verbally and physically agitated. Nursing staff called security for help. Hospital security (who were moonlighting police officers) equipped with Tasers and handguns responded and entered the patient's room without clinical staff. The patient threw a hospital tray at the police officers. The officers first deployed their Tasers, and then shot the patient with their service weapons, causing him serious injury. The patient later recovered from his original physical injuries, his gunshot wounds and his psychiatric illness. He was charged with multiple crimes related to his interactions with the police in the hospital

In a 2010 Sentinel event alert *Preventing Violence in the Health Care Setting*, the Joint Commission noted that health care institutions were confronting increasing rates of violence.<sup>3</sup> The alert addressed only physical assaults, rape or homicide of patients and visitors perpetrated by staff, visitors, other patients, and intruders to the institution. It did not address verbal threats or physical assaults by patients on staff. It made no recommendations on the use of firearms or Tasers by hospital security personnel. On January 2013 JC added as a sen-

tinel event: Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the health care organization."<sup>4</sup>

The FBI divides workplace violence into four separate typologies: Type 1: Violent acts by criminals, who have no other connection with the workplace, but enter to commit robbery or another crime; Type 2: patient or visitor on staff; Type 3: Violence against co-workers by current or former employees; and Type 4: Violence committed in the workplace by someone who doesn't work there, but has a personal relationship with an employee—an abusive spouse or domestic partner.<sup>5</sup> In a 2015 Health Care Crime Survey the International Healthcare Security and Safety Foundation (IHSSF) found that in United States Hospitals 90% of the assaults and 79% of the aggravated assaults were Type 2, patient on staff.<sup>6</sup>

In a study that searched the media to collect data on all hospital based shooting events from 2000 to 2011 Kelen et al. identified 154 hospital related shootings during the study period. In 26 (18%) cases, the perpetrators did not bring their own firearm and in 13 (8%) events, the shooting event was initiated by the perpetrator's taking a security or police officer's gun. In the other cases, security shot the perpetrator for other threats, such as wielding a knife.<sup>7</sup> Kelen found that only 4% of the shooting events were perpetrated by mentally unstable patients.

The TASER company, at its website, notes that: "At TASER we make communities safer with innovative public safety technologies that protect life and truth. Founded in 1993, TASER first transformed law enforcement with our electrical weapons.

Today, we continue to define smarter policing with our growing suite of technology solutions."<sup>8</sup> The TASER website links to a 369 page document, *Brief Outline of Partial Selected CEW<sup>9</sup> Research and Information*. That document has a section linking to research supporting the use of TASERS in hospital settings and on mentally ill subjects.<sup>10</sup>

The Joint Commission does not have a current position on the use of Tasers, pepper spray, or lethal force by hospital personnel responding to behavioral emergencies. The AMA and APA have no current positions on this issue either. However CMS' interpretive guidelines states that, "CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of this regulation, the term "weapon" includes, but is not limited to, pepper spray, mace, nightsticks, tasers [sic], cattle prods, stun guns, and pistols..... CMS does not support the use of weapons by any hospital staff as a means of subduing a patient in order to place that patient in restraint or seclusion." CMS goes on to state that security staff may carry weapons as allowed by hospital policy but that the "use of weapons by security staff is considered a law enforcement action, not a health care intervention." Furthermore CMS states that, "If a weapon is used by security or law enforcement personnel on a person in a hospital (patient, staff, or visitor) to protect people or hospital property from harm, we would expect the situation to be handled as a criminal activity and the perpetrator be placed in the custody of local law enforcement."<sup>11</sup>

Given this data, the APA's Council of Psychiatry and the Law has asked me to chair a workgroup to evaluate whether the APA should write a position statement on the use of handguns or non-lethal force devices in hospital and psychiatric settings. I would appreciate it if AAPL members could share their opinions and experiences with me on this issue. Please e-mail me directly at: [jjanofsky@gmail.com](mailto:jjanofsky@gmail.com) with your thoughts and experiences.

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## AAPL: Ask the Experts-2016

Neil S. Kaye MD,

Graham Glancy MB, ChB, FRC Psych, FRCP

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

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

**Q.** How do I deal with my past record, which includes successful *Daubert* challenges that ruled my testimony inadmissible?



**A. Kaye:** I feel your pain. In today's world, with most experts' testimony readily available with just a few clicks on the Internet, there are

no secrets. Further, most seasoned experts have been through some type of evidentiary hearing process, regardless of whether or not it was a formal *Daubert* hearing. Eventually, most experts should expect to carry some of these battle scars. Do not feel alone, nor should you succumb to the belief that this is some scarlet letter.

The first thing is to let the retaining attorney know of your prior experience and to place it in context. Why you were excluded, at what level court, and if a formal ruling was issued citing the reasons for your exclusion are helpful data. Early in my career, I was in a case where the judge excluded all psychiatric experts and our testimony because he felt it was simply unnecessary, and so I was proud to have been in the company of a renowned expert and past AAPL President. When asked in deposition about this, I tell the story, and somehow that question never gets asked

again in the actual trial.

The second thing is to address this concern on direct examination, so that any opportunity for the opposing counsel to address this on voir dire or on cross-examination can be undermined. This is consistent with my belief that almost always it is best to address any weaknesses in a case on direct examination where control can be maximized.

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*“Almost always it is best to address any weaknesses in a case on direct examination where control can be maximized.”*

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My final advice is to refrain from being overly defensive. If you address this in a matter-of-fact way, with an even tone and a good look directly at the questioner, the sting is greatly mitigated.



**A. Glancy:** Do you ever get that sneaky cognition that comes unbidden and whispers to you “oh this is a good/well-paid case /it will make me famous and I really want it”? But then you get that sickly feeling and think “the last time I did a similar case it was subject to a *Daubert* challenge or I got destroyed in cross-examination.” Well the advice here is to deal with that voice immediately. Pick up the phone and tell the retaining attorney what happened previously and discuss it with him. At this stage you can now try to problem solve and learn from a previously difficult situation. What went wrong, why did it go wrong, and most impor-

tantly how can I correct this? Expertise in any field, and particularly in forensic psychiatry, comes with a continuous investment in dealing with and solving increasingly difficult problems. This is a way that you can learn and improve. If the answer is that this is not salvageable then the situation is that you tell the attorney that you cannot take the case even if he implores you to do so.

If you think that this is something that you can salvage, then consider how you might do it. For instance you might want to do a literature review and find some new literature that supports your position, which you did not have at hand in the previous case. You may want to use adjunctive psychological testing or structured professional judgment, which would support your opinion. Since the time of last case, you may have had extra training in the use of the PCL-R or the HCR 20, for example, which would make the methodology for your opinion peer-reviewed and generally accepted.

The worst thing you can do is hope for the best and not be open about it with the retaining attorney, right from the beginning. There may be other things that you should disclose up front, for instance that you have generally been on the other side of such cases, that you feel that you may be biased in some way, or that the case involves syndromes, science or concepts in which you do not believe. For instance some years ago I saw a case of a man who was charged with murdering prostitutes, who claimed that he had what was then called multiple personality disorder. I told the retaining attorney, who was probably the most well-known criminal lawyer in Canada, that I am skeptical about the concept and referred him to a psychiatrist who I knew believed in the concept. Soon afterwards the lawyer phoned me with another referral and, when I said I had feared I had put you off, he said on the contrary I now know you are somebody I can trust and with whom I can work.

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## MIRANDA AT 50

Stephen P. Herman MD



“You have the right to remain silent. If you give up the right to remain silent, anything you say can and will be used against you in a

court of law. You have the right to an attorney and to have an attorney present during questioning. If you cannot afford an attorney, one will be provided to you at no cost. During any questioning, you may decide at any time to exercise these rights, not answer any questions or make any statements. Do you understand these rights as I have read them to you?”

Perhaps no other outcome of a United States Supreme Court decision is as well known by the general public as *Miranda v. Arizona* (384 U.S. 436 (1966)). In detective procedural books, on television and in film, police read these rights to anyone accused of a crime. The *Miranda Warning*, after half a century, is part of our national culture. It is hard to believe there was a time when these rights were not acknowledged.

The story began in Arizona in 1963, when Ernesto Miranda was arrested for rape, kidnapping and robbery. His truck had been spotted by the brother of the woman victim. She was developmentally delayed but had given a description of the accused and his vehicle.

Miranda was no angel. He dropped out of eighth grade already with a criminal history. He spent a year in reform school after being convicted of burglary. After another crime, he went back to reform school. Later, in Los Angeles Miranda was again arrested for armed robbery and sexual offenses. In Texas, he was jailed for vagrancy; in Nashville he was arrested for driving a stolen car. Eventually, he managed to stay out of trouble and worked for a Phoenix produce business.

When he was arrested for the kidnapping and rape, he signed a written

confession without having been told his rights. The trial court convicted him and he was sentenced to 20 to 30 years. The decision was upheld by the Arizona Supreme Court.

The U.S. Supreme Court granted certiorari along with four similar cases from other states. The issue before the Court was to decide whether the Fifth Amendment's protection against self-incrimination extends to police interrogation of a suspect. Four attorneys, working *pro bono*, represented Miranda and argued that his rights had been violated. The Arizona Assistant Attorney General argued the other side. The case was heard by the Justices for about seven hours over two days.

On June 13, 1966, the decision was announced. The Court voted 5-4 in favor of Miranda. The Majority Opinion was written by Chief Justice Earl Warren, joined by Justices Black, Douglas, Brennan and Fortas. Justice Harlan wrote the Dissent, joined by Justices Stewart and White. Justice Clark wrote a Dissent-in-Part.

Warren wrote that the Fifth Amendment's protection is applicable in all settings. Prosecution cannot use statements from a custodial interrogation of a suspect unless safeguards are met. In *Miranda* and the four other cases, the Court held police interrogation techniques failed to ensure that a defendant's decision to speak or confess was of his own free will.

Justice Tom Clark, in his Dissent, argued the Majority opinion was too strict an interpretation of the Fifth Amendment and would compromise the ability of police to do their jobs. Even if the accused was not informed of his rights, Clark argued, statements by the person should not be automatically excluded.

Justice Harlan argued there was no legal precedent for those accused to be informed of their rights. Justice White, in his Dissent, wrote that the Fifth Amendment protects individuals when they are being compelled to give self-incriminating evidence. He wrote custodial interrogation was not inherently coercive.

*Miranda* was subsequently chal-

lenged by Congress when it passed 18 U. S. C. §3501 in 1999. This bill allowed a defendant to enter a confession without the *Miranda Warning* if it was given voluntarily. There was much negative uproar from legal scholars and the media.

In *Dickerson v. U.S.*, No. 99-5525 (June 26, 2000), the U.S. Supreme Court ruled on the legislation. Charles Dickerson reportedly confessed to a series of bank robberies. (It is disputed as to whether his *Miranda* rights were read to him at all, before, or after his confession.) Dickerson filed a motion to suppress his confession on the grounds that his rights weren't read to him until *after* his confession. The case eventually went to the Court of Appeals, which ruled that although Dickerson was not read his *Miranda Warning*, his confession was voluntary and therefore could be entered. This Court said its decision was in line with §3501: “Congress enacted section §3501 with the express purpose of legislatively overruling *Miranda* and restoring voluntariness as the test for admitting confessions in federal court.”

The question before the United States Supreme Court was whether Congress could overrule *Miranda*. The Court ruled 7-2 that *Miranda* applies in state and federal courts. It is a right protected under the Constitution and therefore could not be overturned by Congress. Chief Justice William H. Rehnquist wrote for the majority: “*Miranda* has become embedded in routine police practice to the point where the warnings have become part of our national culture.” (In a touch of irony, Rehnquist had been appointed by President Nixon to tilt the Court more toward the right.)

The late Justice Antonin Scalia, joined by Justice Clarence Thomas, wrote in his Dissent that the majority gave unnecessary protection to “foolish (but not compelled) confessions.” He wrote, in his characteristically “originalist,” colorful and erudite style, “Today's judgment converts *Miranda* from a milestone of judicial overreaching into the very Cheops' Pyramid (or perhaps the Sphinx

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## From Malingering to Theft of Service

Jacob M. Appel MD, JD

Malingering is an ongoing challenge to psychiatrists practicing both in the emergency and inpatient settings. The financial costs of successfully feigning illness for secondary gain ought not to be underestimated. An ER evaluation in the New York City hospital where I work costs up to \$550; a one night stay on an inpatient unit runs \$4050. Many of the city's finest hotels charge far less for a luxury suite. Malingers also exert a significant drain on more finite resources: emergency service personnel are drawn away from essential duties, increasing response times for urgent cases; patients suffering from legitimate psychiatric illnesses see their waiting times in emergency rooms increase as physicians tend to impostors. A third consequence of malingering, often overlooked, is the psychological drain it places upon providers. Mental health professionals, having entered the field to help those with psychiatric illness, can grow frustrated and jaded expending their energies on sham patients.

Yet all malingers are not created equal. The DSM-V places a uniform label on what is, in fact, a heterogeneous phenomenon. One group of malingers reflect failures of the social service system: the homeless fearful of mistreatment in shelters, the destitute seeking meals and clothing, travelers with physical or cognitive impairments abandoned by family members in strange cities. Many of these individuals suffer from underlying psychiatric illness, even if that is not *why* they have presented to the hospital. Although we should not admit these individuals to inpatient beds at four thousand dollars a night, every reasonable effort should be made to ensure them adequate social and material support. Another population of malingers are individuals in the throes of substance dependence, many of whom arrive at the ER seeking medication. Once again, while we should not supply these patients with non-indicated pills, we

have an ethical obligation to steer them toward treatment for their disease, and to do so with compassion. Although members of both of these groups meet the technical requirements for a diagnosis of malingering, they generally do not exhibit the "presence of antisocial personality disorder" or "medicolegal" goals typically associated with the condition.

A third set of malingers present to hospitals with a diverse set of far more nefarious purposes. These might include evading court dates, process servers, child support payments, and other instruments of the legal system. Sometimes the malingers will be avoiding the consequences of his own illicit conduct—such as hiding from a rival gang or a "drug deal gone bad." Occasionally, his motives rise to the comic. I have encountered a patient in the emergency room seeking an alibi for his extramarital affair and another, a psychology graduate student, who hoped admission might buy him time to turn in his overdue thesis. Unlike those in need of social support or addiction treatment, these individuals are merely engaged in overt criminal behavior—the theft of scarce resources from the healthcare system. I would like to suggest that, in extreme cases, the time has arrived to criminalize formally such behavior.

Criminal sanction for malingers is not without precedent. Article 115 of the Uniform Code of Military Justice provides penalties of up to one year's imprisonment for malingering in peacetime and three years in "time of war." Individuals falsely claiming Social Security Disability Insurance, workers compensation and private insurance payouts are frequently prosecuted. More recently, some hospitals have reportedly engaged in the disturbing tactic of asking courts to impose "body attachments" for the apprehension of patients with legitimate illnesses who have fallen in arrears on their bills. Yet nefarious malingers in the clinical setting

generally face no consequences for their conduct.

Several factors probably account for the reluctance of hospitals to prosecute antisocial malingers and the unwillingness of authorities to charge them. First, since malingering is generally a rule out diagnosis, many providers may fear making an error that leads to both a negative patient outcome and to tort liability. A patient dispatched to the local precinct as a malingers, who later hangs himself in his jail cell, is a nightmare from both perspectives. One might draw an analogy to Type I and Type II errors in epidemiology, with false positives for legitimate illness far less concerning than false negatives. Psychiatric history certainly offers a troublesome history in this regard. In the nineteenth century, for instance, patients with conversion disorder were sometimes mistaken for malingers after examination under ether. The line between factitious disorder patients motivated by a wish to play the sick role and malingers motivated by secondary gain is clear in the DSM, but often blurred in clinical practice. Similarly, some patients with somatic delusions may, on cursory evaluation, be taken for impostors. One should certainly be wary of such misdiagnosis. Yet the solution for that is reasonable caution, which should be exercised in diagnosing malingering anyway, rather than a policy that allows extreme antisocial behavior to pass without consequence.

Second, many psychiatrists are fearful, with justification, of increased entanglement with the criminal justice system. The perception that what begins as a medical encounter may end as a legal one has the potential to deter legitimate patients, particularly those from communities already fearful of law enforcement, from seeking care. Yet there is a distinct trade-off here: time not spent engaged with malingers can be devoted to legitimate patients with idiosyncratic symptoms. From my own ER practice, where a few dozen chronic malingers exhaust a

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# An Overview of The Veterans' Court

R. Scott Johnson MD, JD and Andrea G. Stolar MD,  
Criminal Behavior Committee

The rapid proliferation of veterans' courts in recent years has made them a subject of growing interest. Given their hybrid nature and the fact that they were unknown in most jurisdictions as recently as five years ago, many forensic practitioners may be unfamiliar with this new court entity. Therefore, the purpose of this article is to convey some highlights about veterans' courts and address some of the veterans' court research that is currently being conducted nationally.

Veterans' courts were first established in Buffalo, New York in 2008 as a way to address the needs of veterans suffering from mental illness who had been appearing in drug and county mental health courts with increasing regularity. The needs of these individuals made them a unique subset of these specialty courts' populations inasmuch as these veterans stood to benefit from a close partnership with their local Veterans Affairs (VA) facility and resources. Thus, the idea behind veterans' courts was that for eligible offenses, veterans' courts would allow diversion from incarceration to a specified program of community-based treatment, regular court appearances and veteran-specific interventions including treatment within court-affiliated VA facilities and involvement in VA-based vocational, educational and housing programs. There is considerable variability across jurisdictions with regard to eligibility criteria, with some courts requiring a link between one's service, the illness, and the crime, some allowing for violent felonies, some limited to combat veterans, and some further limited to veterans returning from Iraq and Afghanistan. Some are post-plea, while others allow for pre-trial diversion. (Clark et al, 2011) All require the veteran to have either a substance use disorder or other treatable psychiatric condition. (Smee et al, 2013)

Veterans' courts operate collabora-

tively, similar to other problem-solving courts and as opposed to the more traditional adversarial model. Therefore, the prosecutor, veteran, defense counsel, and the respective VA personnel, such as clinicians and the Veterans Justice Outreach (VJO) coordinator, all work together to enhance rehabilitation. (Clark et al, 2011) Outcomes of successful participation are variable, with the most favorable allowing for dismissal of the criminal charge. Unsuccessful or inadequate participation may result in extension of program obligations, sanctions imposed by the court or even removal from the program, the latter of which would result in a return to the criminal justice system to address the original criminal charge.

Since that first veterans' court in 2008, other jurisdictions have adopted similar programs and growth has been exponential. As an example of this rapid growth, there were 24 veterans' courts in January 2010, (Clark et al, 2011) 97 in April 2012, 168 by December 2012, (Clark et al, 2014) and over 300 courts in more than 35 states as of January 1, 2014. Many VA Medical Centers are linked with the local veterans' court through the VJO Program in order to provide clinical and support services. This VA affiliation provides treatment consistency, integration, and coordination, as opposed to the significant variability in community services that can occur where VA affiliation is lacking.

One example of a veterans' court is the Harris County (Texas) Veterans' Court Program. Harris County created the state's first veterans' court to serve the Houston area in 2009. (Veterans Court Programs, 2010) This court provides an integrated treatment program whose scope encompasses substance abuse treatment, vocational rehabilitation, mental health care and veterans' benefits. In that way, it stands in contrast to non-veteran specialty drug or mental health courts.

Like many others, this program has grown by leaps and bounds in recent years, expanding from one to five courts, spanning surrounding counties and encompassing both felony and misdemeanor charges.

Regarding recidivism rates from veterans' courts, one year into the original Buffalo, New York veterans' court program, record review indicated no criminal recidivism. (Russell, 2009) A subsequent recidivism analysis of 14 courts revealed a one-year criminal recidivism rate of less than 2%. (Holbrook et al, 2011) However, considering the limited follow-up and sparse data due to the novelty of such courts, no firm conclusions can be drawn regarding success as defined by recidivism. In a study examining veterans' court judicial sanctions, an association was found between veterans with substance use relapse and subsequent discharge from the veterans' court program. (Johnson et al, 2015) Further, the veteran infractions of unexcused absence, failure to complete a task, substance use relapse and a missed hearing were all found to be associated with the subsequent court sanction of jail time. Lastly, a considerable body of work has been conducted by the VA VJO Programs and the National Association of Drug Court Professionals (NADCP) to inventory the rapidly changing landscape of veterans' courts, and some of these findings are likely to soon be undergoing peer review. Despite the aforementioned work, the available data is limited and veterans' courts are left with scant guidance as to which court model would result in the greatest efficacy and lowest cost to the taxpayer.

Research is currently ongoing at the Baylor College of Medicine and, no doubt, elsewhere with regard to criminal recidivism and associated predictors. Future research is likely to focus on establishing the most effective veterans' court models by working closely with the VA VJO Programs and the NADCP. This is truly an exciting time for veterans' court research as such courts, despite their rapid proliferation, are still in their

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## Physician-Assisted Dying for Psychiatric Patients

Ariana Nesbit MD, Ethics Committee

Western nations appear to be increasingly open to physician-assisted dying (PAD). Despite the American Medical Association's position against PAD, four US states have legalized some form of the practice over the past 12 years. Although PAD in the US is currently limited to patients with terminal diseases, Belgium, the Netherlands, Luxembourg, and Switzerland now allow physicians to provide assisted death for patients solely diagnosed with psychiatric disorders.<sup>1</sup> In addition, the Canadian government is finalizing legislation to address euthanasia, and they are considering whether to allow it for those exclusively with mental health disorders.<sup>2</sup> At the same time, two studies published in the last year have shed a cautionary light on the controversial practice.

Thienpont and colleagues<sup>3</sup> evaluated 100 consecutive requests made to one Belgian psychiatrist for euthanasia due to mental illness. Most (77%) were women, and more than 90% had multiple psychiatric disorders. The two most common diagnoses were depression (58%) and personality disorder (50%); however, a surprising number (12%) were diagnosed with an autism spectrum disorder. 48 of the 100 requests were accepted, and 35 were carried out. Of the 13 remaining patients, 8 postponed or cancelled on the grounds that "simply having the option gave them enough peace of mind." At time of follow-up, 6 patients had died by suicide (2 after their requests for assisted death were approved, and 4 before a decision had been made), one by palliative sedation, and one of complications of anorexia nervosa.

In the second study, Kim and colleagues<sup>4</sup> reviewed 66 cases of completed euthanasia and assisted suicide in patients with psychiatric disorders in the Netherlands. There were many similarities with the Belgian study: the majority of patients (70%) were

women, most had more than one psychiatric condition (79%), and the most common diagnoses were depressive disorders (55%) and personality disorders (52%). Most (52%) had attempted suicide, 80% had been hospitalized for psychiatric reasons, and 56% percent of patients refused at least some recommended treatment. Social isolation or loneliness was described in 56%. twenty seven percent received euthanasia or assisted suicide by physicians new to them, many of whom were practitioners at an End-of-Life clinic. Although consultation with other physicians was considered "extensive," 11% of cases did not include independent psychiatric consultation, and 24% of cases involved disagreement among consultants. In 12% of cases, the psychiatrist involved did not think that the criteria for assisted death were met, but the procedure was carried out nonetheless.

Advocates of PAD for psychiatric patients argue that physicians are charged with alleviating suffering, and that suffering due to mental distress is just as unbearable as physical pain. With parity as a justification, proponents believe that denying individuals with psychiatric suffering a legal right to assisted death discriminates against them. Other supporters argue that the practice would reduce violent, unassisted suicides that are more traumatic for the patient and family than assisted death.<sup>5</sup> One study, for example, found that family members of patients who died with physician-assistance suffered fewer traumatic grief symptoms and post-traumatic stress reactions than family members of patients who died of natural causes.<sup>6</sup> Finally, requests for physician assistance have been described as therapeutic because they bring patients in for evaluation who would not otherwise seek help for their despair.<sup>7</sup>

The classic rebuttal, of course, is

that it is never acceptable for physicians to help people to end their lives. PAD is particularly problematic for psychiatrists because a core purpose of psychiatry is to prevent suicide. As described by Pols and Oak,<sup>5</sup> "indicating that they are willing to consider a patient's physician-assisted death request after a therapeutic intervention were to fail would undermine the therapeutic process from the beginning." In addition, allowing assisted death for psychiatric patients could reinforce hopelessness among patients with similar disorders.<sup>8</sup> Indeed, as some commentators are now pointing out, allowing PAD into the continuum of "care" would entrench and validate existing biases and stigma.

For forensic practitioners asked to assess PAD-related decision-making, fundamental characteristics of psychiatric disorders will inherently complicate the request. Because suicidality is a symptom of several psychiatric conditions, it is difficult to assess a suicidal patient's decision-making capacity: are the patient's reasons for wanting to end his life a reflection of an accurate appraisal of his condition, or an inaccurate assessment caused by the illness? The assessment is further complicated by the cognitive impairment associated with many psychiatric conditions.<sup>9</sup> Another problem is that suicidality frequently fluctuates, and most patients who attempt suicide do not eventually complete it. This is particularly important for patients with personality disorders: as Appelbaum points out, these disorders are associated with "strong reactivity to environmental and interpersonal stresses, raising questions about the stability of the expressed desires to die."<sup>8</sup>

Critics also point out that it is almost impossible to judge when treatment options have been exhausted for the psychiatric patient. In addition, response to treatment is often less certain than it is for medical conditions.<sup>8</sup> In the study by Kim and colleagues,<sup>4</sup> physicians frequently disagreed about whether the patient met criteria for euthanasia or assisted sui-

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## Rappeport Fellowship Retrospective: Patricia Recupero, JD, MD

Jessica Ferranti MD



In this continuing series exploring the career paths of former AAPL Rappeport fellows, I had the opportunity to speak with Patricia Recupero, JD,

MD. Dr. Recupero was a Rappeport Fellow in 1988, just three years after the inception of the fellowship honouring Jonas R. Rappeport in 1985. Dr. Recupero has been an influential leader both within the AAPL organization and in the field of forensic psychiatry in general. She is a past president of AAPL and is currently a member of the Ethics Committee. On a blustery day at the Annual Meeting of AAPL in Fort Lauderdale, I had the pleasure of sitting down with Dr. Recupero and discussing the role of the Rappeport Fellowship in her professional development.

Dr. Recupero relayed that AAPL played an integral part in introducing her to the field of forensic psychiatry. She attended the meeting for the first time when she was a psychiatry resident. She described that she saw meaningful ways for her to combine her law degree and her medical education. She recalled that she applied for the Rappeport Fellowship when she was a PGY4, and thus began a relationship with the organization that has lasted throughout her career.

Dr. Recupero told me that the Rappeport Fellowship was instrumental in helping her make contacts with mentors early on who would later become colleagues. She said, "...The Rappeport program did align you with a mentor; and when I went to the Rappeport breakfast, the chair of the committee who was Tom Gutheil, gave me the elbow and said, 'Everybody is getting a mentor but you because the one we assigned you died yesterday.'" Dr. Recupero fondly recalled that although she did not

have a formal mentor that year, Dr. Gutheil and others gladly took up the role of mentor for her informally. In particular, Tom Gutheil has been a great guide and an encouraging support throughout her career. She emphasized that as a resident, having the opportunity to meet important leaders in the field of forensic psychiatry was one of the most important benefits of the fellowship. Dr. Recupero said that she was able to recognize through the Rappeport Fellowship that there were no great barriers to approaching the "big names" at AAPL. She found the AAPL leadership to be warmly welcoming, supportive, and accommodating of her.

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*"The first piece of advice I give people is always say "yes" when somebody asks you to do something; and even if it may not always turn out to be something you want to make your career in, you've learned something and you've made a new partner to work with by saying 'yes'."*

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Dr. Recupero discussed how mentorship has played an important role in her career. She said that she now enjoys mentoring others and is informed by her own early experiences as a mentee in the Rappeport program. She said, "...I think it's very hard to have an assigned mentor-mentee relationship because so

much of what makes that relationship work is chemistry... The first thing from the mentee's perspective is to realize that different mentors bring different talents to the table, and you're not limited to having just one. So even using your mentor to find your next mentor is appropriate at early stages in development..." Dr. Recupero stated that she views the primary mission of the Rappeport Fellowship to be one of mentorship. She told me, "When I was president of AAPL, I implored Jeff Janofsky to please take the Chair of the Rappeport Committee. In the recent years, it seemed to both Jeff and me that the awardees were people who were almost at Associate Professor or full Professor level with multiple publications! They were not people who needed to be brought along; and I asked Jeff to try to foster that mentality among the members of the Committee and to give out more awards... So I definitely wanted to change the dynamic to be one that took people who had an interest [in forensics] but perhaps hadn't been able to develop it completely; and, at least, include them among the awardees..." Dr. Recupero commented that she has been extremely pleased and impressed by the recipients of the award in recent years.

I asked Dr. Recupero what advice she would give to the newly appointed Rappeport Fellows and she replied, "...I think the first piece of advice I give people is always say 'yes' when somebody asks you to do something; and even if it may not always turn out to be something you want to make your career in, you've learned something and you've made a new partner to work with by saying 'yes'." Dr. Recupero added that many wonderful people apply for the Rappeport Fellowship; and since all who apply cannot receive the opportunity, perhaps offering mentorship more broadly to all applicants could encourage junior people to stay engaged and active in the AAPL organization. We discussed that this wonderful idea was one that I would take back to the Rappeport Committee for consideration in 2016. ☺

## PHOTO GALLERY - AAPL 2015 ANNUAL MEETING



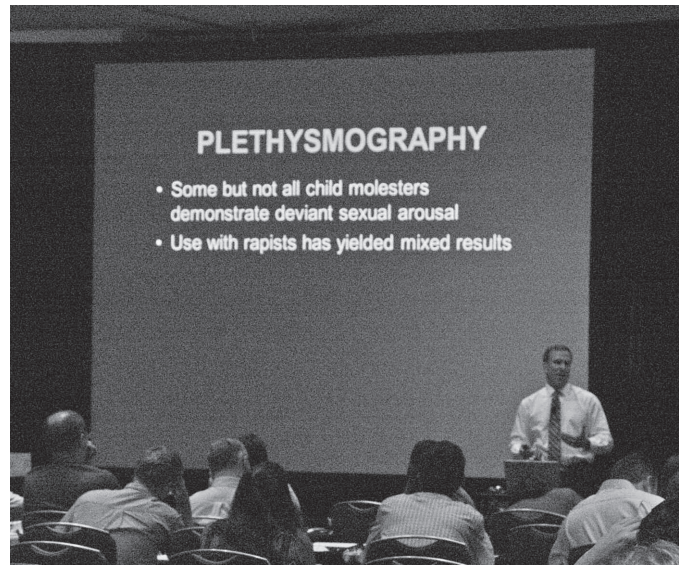
Camille LaCroix, Charles Scott and Jessica Ferranti enjoying the committee dinner.



Liaison with Forensic Sciences Committee pose for a photo.



Christopher Thompson and Greg Sokolov at the committee dinner.



Dr. Scott presents during the Forensic Review Course.

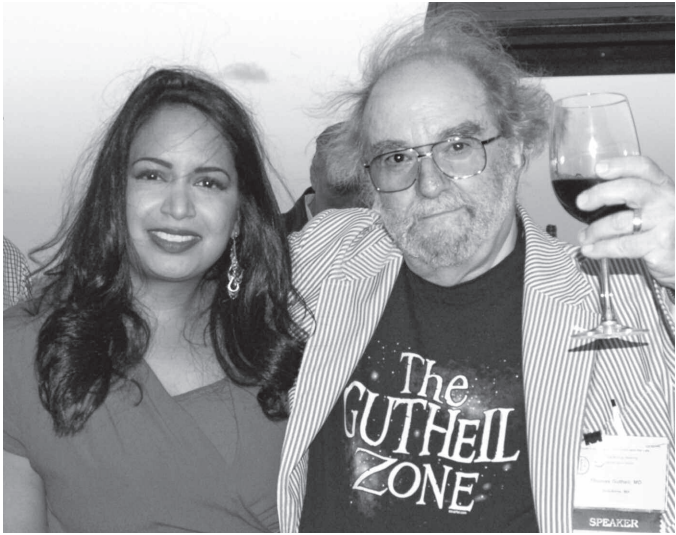


The Ethics Committee gathers for their meeting.



Annette Hanson and Sandy Simpson, 2015 Program Co-Chairs.

# PHOTO GALLERY - AAPL 2015 ANNUAL MEETING



Tom Gutheil and Reena Kapoor catch up at the reception.



Jeff Janofsky mentoring at the ECP breakfast.



Gathering together at the ADFPF Reception.



Official AAPL photographer Eugene Lee on the other side of the camera. Pictured here with Robert Forrest and Raymond Molden.



Mentoring time for the Rapoport Fellows.



Memories of the beautiful Ft. Lauderdale weather.

*Photo Credit: Eugene Lee, MD and Charles Meyer, Jr., MD*

## APA Assembly Report

Cheryl D. Wills MD

AAPL Deputy Representative to APA Assembly



The 169<sup>th</sup> Annual Meeting of the APA will take place in Atlanta, GA from May 14 -18, 2016. APA President Renée L. Binder, who also

is a Past President of AAPL, has selected “Claiming our Future: Psychiatry’s Role in the New Era” as the theme for her presidential year and the Annual Meeting. One of her goals is to focus on psychiatric service delivery to people with serious mental illness and to those who are disenfranchised and marginalized. She accompanied members of the APA Executive Committee to San Quentin Prison to give them firsthand exposure to the problem of criminalizing individuals with serious mental illness.

In November 2015, the APA implemented a structural reorganization plan with guiding principles of inclusivity, diversity, and effectiveness. The plan permits each state, regardless of size, to have two representatives funded to attend the Assembly meeting. Although the plan was introduced, in part, to increase the overall diversity - in terms of gender, ethnicity, age, professional practice interests, regional diversity (e.g. urban, rural), etc. - of the Assembly membership, the extent to which this component of the plan succeeds will depend on how the district branches choose to appoint Assembly delegates. APA member concerns, including fair reimbursement, parity, Maintenance of Certification, and preparing for the changing healthcare environment, have been implemented into the APA Strategic Plan.

APA administrative team members have been working to improve educational and other resources for the members. The new Director of Diversity and the Director of Educa-

tion, both of whom were recruited from the Massachusetts General Hospital, have been described as forward thinking individuals that have a vision for expanding how we learn and how we are perceived in the community. The APA has sponsored several diversity summits, including one in South Dakota, in an effort to embrace cultural diversity and to support psychiatrists who work with patients in underserved regions. Also, a Cultural Competence webpage has been added to the APA Website.

The Mental Health Parity and Equity Act continues to be a topic of discussion. A brochure and poster titled “Fair Insurance Coverage: It’s the Law” is an educational resource for healthcare professionals, patients and others. The brochure, which is available in English and Spanish, is available on the APA website. The U.S. Dept. of Labor is willing to investigate any insurance plan that is not in compliance with the Act. A Confidential Practice Questionnaire has been developed to make it easier for psychiatrists to report unfair reimbursement practices.

Membership numbers continue to improve. 2014 was the 2nd year of increased growth in membership. There was a 4.4% increase in total members, 3.1% increase in dues-paying members, 2.3% in early career psychiatrists, 4.6% increase in Resident and Fellow members, 26.6% increase in international members and a 37.1% increase in medical student members. Membership data for 2015 is not yet available.

APA staff is continuing to work on the website to make it more user friendly. There is a staff directory that members can access after logging onto the website. Also, the American Psychiatric Press, Inc. website has been updated. Eventually all of the APA product line websites will be linked so that they may be accessed from a central point. A ‘find a psychiatrist’ feature that will allow indi-

viduals to identify a psychiatrist in their community is under development. The site, which will provide a timely referral mechanism for patients, will allow APA members to opt in and fine tune the data to which prospective patients will have access.

The APA has been named a permanent member of a U.S. Department of Health and Human Services workgroup that was established to address opioid use disorders. Members have been working on policy initiatives to reduce opioid use and to encourage more physicians to treat substance use disorders. Possibilities under consideration include expanding the buprenorphine prescribing cap, expanding research on opioid use, and reducing obstacles that discourage physicians from treating individuals with substance use disorders.

The American Professional Agency, Inc. (APAI) continues to partner with the APA for endorsed professional liability services. They have created nine risk management courses that are AMA PRA Category 1 credit™ (that can be found at <http://www.psych.org/psychiatrists/practice/risk-management>). The courses, which are free to members, also count towards the three hours of risk management education required to receive a 5% discount on their professional liability policy.

The APA has negotiated with the APAI to increase liability insurance coverage limits for punitive damages increases from \$25,000 to \$250,000. The ‘consent to settle’ clause will be adjusted to provide psychiatrists slightly more flexibility and licensing board defense coverage will increase from \$5,000 to \$50,000. Also, medical payment coverage will increase from \$25,000 to \$50,000.

The Michigan Psychiatric Society (MPS) is considering how best to respond to the water crisis in Flint, including how they may support physicians who are directly dealing with the crisis. The organization intends to serve as a resource to state and local officials who are developing immediate and long term solutions and to the media about related mental health concerns. ☪

## Too dangerous for a forensic hospital?

*Ariana Nesbit MD and Charles C. Dike MD, Forensic Hospital Services Committee*

The dramatic decline in the number of state hospital beds in the past fifty years has led to an evolution of the roles of these facilities. Today, state hospital beds are generally reserved for the most dangerous patients, particularly those involved in the criminal court system.<sup>1,2</sup> The combination of funding cuts and a more heavily concentrated population of forensic patients can lead to dangerous situations and new challenges for the hospitals.

Over the past several years, newspaper articles published in states including Hawaii, California, Washington, and Kansas have brought attention to the escalating violence at state hospitals, including staff murders and sexual assaults.<sup>3-6</sup> Many attribute the mounting violence to hospital overcrowding, lack of funding, and inadequate security. In addition, some argue that state laws and hospital procedures have failed to adjust to meet the needs of the staff and the more dangerous population they now serve. In particular, many consider the regulatory and administrative imperatives to reduce the frequency of seclusion and restraints problematic. Although the intentions of these imperatives are laudable, not infrequently, these pressures are put on the facilities without adequate staffing or training in de-escalation or other violence reduction techniques. This often leads to an increase in violence against patients and staff.<sup>7</sup>

With violence on the rise, states and individual facilities have been forced to develop strategies to deal with the most difficult-to-manage patients. Some hospitals have developed special high-acuity units within the facility. One example of this is an “enhanced treatment” pilot program and separate wing at Napa State Hospital that was created in 2014 for the most violent patients.<sup>8</sup> In contrast, other states have created procedures

by which dangerous forensic patients can be moved from a state hospital to a correctional institution. For example, in 2012, Washington State passed a bill that allowed any hospitalized insanity acquittee to be moved to a correctional facility if they were deemed to be an “unreasonable safety risk.”<sup>9</sup> In an unprecedented judicial decision in Connecticut, in 2014, a superior court judge ordered an insanity acquittee to be placed on a high bond. Because the bond was set so high, he was subsequently transferred to the custody of the Department of Correction (DOC) pending trial for new charges of serious assaults brought by several staff members and patients at the state maximum security psychiatric hospital.<sup>10</sup> The Connecticut Supreme Court later upheld this decision. This year, to address safety and staffing concerns at a state hospital in Maine, the governor revived a proposal to allow a special unit at the Maine State Prison to house the most difficult-to-manage forensic patients.<sup>11</sup>

Proponents of legislation that allows the most violent patients to be held in correctional facilities believe that these laws will address the issue of safety. They also point out that psychiatric treatment can still be delivered in correctional institutions. Representative Deborah Sanderson of Maine says that the administration is simply “trying desperately to do whatever they can” to provide care for those who need it in a safe environment.<sup>11</sup> Advocates also argue that having even one dangerous and disruptive person in a less-secure hospital setting violates the rights of other patients, placing them at risk for assault and treatment disruption.<sup>12</sup>

Disability and patients’ rights advocates believe that it is never ethical to use correctional institutions for the housing of persons found not guilty by reason of insanity (NGRI)

or for persons whose competence to stand trial has been called into question.<sup>9</sup> The Supreme Court has found that insanity acquittees are exempt from criminal responsibility and therefore may not be punished.<sup>13</sup> Based on this, it could be argued that insanity acquittees should never be imprisoned, as this constitutes a punitive measure.<sup>9</sup> This, of course, is a valid argument. It also calls into question other issues that forensic hospitals are grappling with. For example, should civil patients who are so aggressive that they have to be housed in a forensic institution be transferred to prison if their aggressive behaviors overwhelm the capacity of the forensic hospital? In other words, is there any legal means of transferring civil patients to prison solely on account of their unmanageable aggression in the hospital?

Those opposed to housing forensic patients in correctional institutions also raise concerns pertaining to the difference between the missions of the Department of Corrections (DOC) and the Department of Mental Health (DMH): while the DOC emphasizes safety and punishment, the DMH focuses on treatment and recovery.<sup>9</sup> Research by the Human Rights Watch found that no American prison provides the level of treatment recommended by the National Commission on Correctional Health Care.<sup>14</sup> Additionally, inmate-patients under the custody of the DOC are not entitled to the protections of the Patients’ Bill of Rights, the Joint Commission, the Center for Medicare and Medicaid Services (CMS), or other hospital regulatory agencies. As a result, psychiatric patients in DOC facilities can be exposed to more restrictive interventions than the restraints and seclusions that are highly regulated, monitored, and discouraged in hospitals.

Other concerns about housing forensic patients in prison include their increased risk of victimization as well as their difficulty following prison rules; this in turn increases the possibility that they will face disciplinary actions. In addition, there are higher medication refusal rates in

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## Susan Hatters Friedman, MD

Navneet Sidhu MD



It took only a few lectures by her future mentor Phillip Resnick for Dr. Susan Hatters-Friedman to start considering a career in

psychiatry. A native of Pennsylvania, Susan completed her undergraduate studies, medical school, psychiatry residency, and forensic fellowship at Case Western Reserve University in Cleveland.

Susan met her husband when they were students. Susan dreamed of becoming a pediatrician but it was her husband who went on to realize this dream. Susan's career took a different path. The Case Western Law School invited the well-known Phillip Resnick to lecture on the interface of psychiatry and the law. Local medical school students and psychiatry residents were invited to attend these lectures, and Susan registered for the class. She smiles as she recalls how during introductions, she found herself telling Dr. Resnick that she was fascinated with reading mysteries. He replied wryly that she might be better off reading novels by Stephen King. Her curiosity piqued, she signed up for his electives and soon found herself developing her interest in psychiatry. "I didn't know then that I could make a career by combining all these things I loved," she says.

After graduating from residency, Susan's interest in women's mental health led to a fellowship in maternal mental health with another mentor, Mim Rosenthal. This was followed by a forensic psychiatry fellowship with Dr. Resnick. Subsequently, with grant funding, she treated anxiety and depression in mothers with newborns admitted to the Neonatal Intensive Care Unit. Susan combined her interest in pediatrics with forensic psychiatry by focusing her work and research in these areas: perinatal and women's mental health, infanticide, and intimate partner violence.

When discussing her husband's reaction to her career choice, she laughs that he may be the rare spouse who does not require an explanation of what forensic psychiatry entails: his grandfather had been a junior military psychiatrist evaluating war criminals during the Nuremberg trials.

After her forensic fellowship, Dr. Hatters-Friedman ran an NGRI unit at the Northcoast State Hospital, where she stayed for several years. In 2008, her natural spirit of inquiry and desire for a sabbatical led her to seek an international forensic experience. Having a family with school-age children added another layer to the multitude of considerations. With the help of her mentors, she came into contact with Sandy Simpson, a leader of New Zealand psychiatry. After continued discussions with Dr. Simpson and visits to Australia and New Zealand, she became enamored with New Zealand. Initially she spent one year there. She returned to Cleveland enriched and enthused by the experience. In her writings, Susan has highlighted the emphasis placed by the New Zealand health system on reintegrating patients into their communities, and treating patients in settings where cultural advisors are essential team members. She and her husband loved the country; its work-life balance, respect for culture, and the sense of community they found there. It came as no surprise to anyone when she and her husband decided to relocate to New Zealand again.

Currently, Dr. Hatters-Friedman is on faculty at the University of Auckland and works at the regional forensic hospital and the women's prison. She has often spoken about the challenges and biases women face in the legal system. She also co-directs a program that allows American psychiatry residents to spend their electives in Auckland, including focusing on Maori mental health. Susan is excited about her new role as the AAPL Newsletter editor, "I have some ideas," she says, in an obvious

understatement. She also currently serves as vice-president of AAPL, co-chair of Rapoport fellowship committee, member of the sub-committee for writing MOC self-assessment questions, member of the Ethics committee and member of the editorial board for JAAPL. In addition, she was involved in writing AAPL's practice guidelines for forensic assessment. Her past association with AAPL includes being president of the Midwest chapter in 2013, and chair of the Gender Issues committee. She won the best teacher award in a forensic fellowship in 2010 and the Rapoport Fellowship in 2003. She has given numerous presentations at annual meetings and has a long list of publications in JAAPL.

Susan spends a significant time in Unites States, remaining involved in research and mentoring at her alma mater, Case Western. Living on two continents has made Susan adept at staying connected by the Internet. Our Skype call for this interview disconnected a few times, but her patience and sense of humor shone through. In true Renaissance fashion, Susan describes playing clarinet and saxophone in local concerts. I ask how she finds the time to practice. She laughs again that the thin walls in New Zealand homes and her own busy schedule don't allow for much, but she gets by in her rich new environment. ☎

### Book Reviewers Wanted!

The Journal of the American Academy of Psychiatry and the Law is looking for reviewers of texts of interest to forensic psychiatrists.

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# Writing Self-Assessment Question

Co-Chairs Richard L. Frierson MD and Christopher Thompson MD,  
Education Committee

The AAPL Education Committee is now offering a Self-Assessment Examination four times a year: January, April, July and October. The examination is updated yearly and AAPL is building a bank of questions in a variety of topic areas. Examinees who take the examination are given a peer comparison that demonstrates their score compared to the average score of others who have taken the examination. The AAPL Self-Assessment Exam assesses knowledge across several domains of forensic psychiatry and covers the major topic areas that are outlined in the American Board of Psychiatry and Neurology's (ABPN) Maintenance of Certification (MOC) examination. The AAPL Self-Assessment Examination is designed to help AAPL members identify areas of deficiency in their knowledge base, and will guide planning for future CME activities. Additionally, examinees may claim up to 24 Self-Assessment CME credits every three years for taking the examination. The cost of the examination is \$50 for AAPL members.

The AAPL Education Committee has been working diligently to improve the quality of this examination. We greatly appreciate the comments that members have provided regarding their overall experience in taking the exam, as well as feedback on specific exam questions. Building this exam has been a growing experience for our organization, and the learning curve has been somewhat steep. However, as we move forward, we hope to have an increasingly useful exam for AAPL members.

In order to build the question pool for the exam, AAPL has asked committees to submit two questions per year, which are reviewed by a Maintenance of Certification subcommittee chaired by Debra Pinals. The submission of questions by AAPL committees has been crucial in building the item pool from which questions are

selected to build the exam each year. However, the AAPL Education Committee is aware that writing a good test question is much harder than it seems. With that in mind, we offer the following checklist for all AAPL committee members to use when writing questions:

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*“The AAPL Self-Assessment Examination is designed to help AAPL members identify areas of deficiency in their knowledge base, and will guide planning for future CME activities.”*

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1. Questions should be designed to test something most forensic psychiatrists should know, not something that is esoteric or falls in the realm of trivia. Additionally, if possible, the question should be clinically-based. The questions should consist of a stem and four or five possible answers. The answers should not contain “none of the above” or “all of the above” as choices. The correct answer should be keyed (identified) when the question is submitted to the MOC subcommittee. Questions may be submitted to the MOC subcommittee at office@aapl.org and the email should identify the name of the committee that is submitting the question(s).

2. The stem (i.e., the actual question) should be focused. A focused stem addresses a single teaching concept. In order to determine if a stem is focused, decide whether the question could be answered without looking at the options. If so, the question stem is

focused. An example of an unfocused stem would be: “Which of the following is true about sex offenders?” There could be a myriad of correct answers. An example of a focused stem would be: “Which of the following Constitutional Amendments provides protection against cruel and unusual punishment?” Clearly, the 8<sup>th</sup> Amendment is the single answer, and the examinee should merely have to look at the options to find it.

3. Avoid vague frequency terms such as *frequently, usually, often, probably, infrequently, commonly, or rarely* because people do not agree on the meaning of these terms. Conversely, *most likely* is clear because the task is to select one best answer.

4. Avoid negative stems. An example of a negative stem would be “Which of the following is **not** a characteristic of psychopathy?” Another example of a negative stem would be “All of the following instruments are designed to assess violence risk **except**...?”

5. Each question should include a reference. The reference is designed to guide the reader to a specific source for further reading which will cover the concept being tested. Acceptable sources include journal articles, text books (provide name, edition, and page numbers), legal cases, etc. Item references should be authoritative, current, universally available, evidence-based, and accurately cited.

With these five concepts in mind, writing quality self-assessment questions should be much easier. The Education Committee would like the organization to know that we are appreciative of those who have submitted questions in the past, and we look forward to reviewing more submitted questions in the future. We will continue to strive to improve the quality of our self-assessment exam. ☺

## Francis Shen: Neurolaw

Octavio Choi MD, PhD



Dr. Francis X. Shen is a Mc Knight Land-Grant Professor and Associate Professor of Law at the University of Minnesota, where he directs the Shen Neurolaw Lab ([www.fxshen.com](http://www.fxshen.com)). He also serves as Executive Director of Education and Outreach for the MacArthur Foundation Research Network on Law and Neuroscience. Dr. Shen conducts empirical and legal research at the intersection of law and neuroscience, and is one of the world's foremost scholars in this emerging field. He recently co-authored the first *Law and Neuroscience* textbook, and has published on a range of neurolaw topics, including memory, lie detection, mental health, neurolegislation, criminal law, and tort law. I recently had the pleasure of working with Dr. Shen as a co-panelist on "Neuroscience and Criminal Responsibility" at AAPL 2015, and interviewed him shortly afterwards for the AAPL newsletter.

OC: Francis, you are the Executive Director of Education and Outreach for the MacArthur Foundation Research Network on Law and Neuroscience. Could you please explain to our readers what this group does and your role is within that organization?

FS: Sure, the MacArthur Foundation Research Network on Law and Neuroscience is a MacArthur Foundation funded network. I should say as background that the MacArthur Foundation has for many years funded "networks", which are small— say between ten to twentyish— groups of individuals that come together from different fields that they wouldn't otherwise come together from to deal with some problem. These networks have tackled issues such as mental

capacity, aging, things that sometimes have to do with law but things that also just might have to do with policy.

One of the ideas that was floated over a decade ago was to bring together a network at the intersection of neuroscience and law. Its origins actually came from the neuroscientist Robert Sapolsky at Stanford, who didn't end up being a member of the network but got the conversation started. He wrote a provocative article called, "The Frontal Cortex and the Criminal Justice System" and he suggested to the MacArthur group (he was a MacArthur Genius Fellow), that this would be something to really think about. It turned into a network that combined neuroscientists, lawyers, judges, philosophers, and some fellow travelers from related disciplines, psychology and others, to try and tackle these issues.

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*"We try to help judges... by giving them more information by which they can make an educated call on admitting the evidence or keeping it out or asking the right questions of experts."*

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The network focuses specifically on criminal law and criminal justice, though, of course, neurolaw can be more than that and is. Initially the first phase of the network focused on a wide variety of topics, really just trying to envision the scope of the field, and in the process, create the field. Currently the network is in its phase two and has focused on a more tightly knit group of issues surrounding mental states, adolescent development and adolescent brain development, and evidentiary questions; for

instance, the "group to individual" inference problem and a host of related issues at those intersections.

In addition to all of the basic research that the network has done, we run an education and outreach program, which I direct. We see as part of our mission to translate both the research that we've done and the research that others are doing into a more usable end product for ultimate consumers who are lawyers and judges, probation officers, prosecutors, public defenders and the like. So, what we do is run programs and create materials that can facilitate that discussion. They can be as involved as bringing judges to a day and a half or two-day conference introducing them to neuroscience, and building up then to talk about issues such as memory in the courtroom, mental states, and the determination of capacity, what do you do with a brain injured defendant, what do you do with an adolescent, and so forth— specifically trying to answer the question "what, if anything, does neuroscience add" to your judging or to your lawyering and to your assessment of these individuals.

A lot of work, too, has to do with separating wheat from chaff— lawyers do not have to wait until there's scientific consensus, and often don't wait before they proffer the evidence, and that puts judges and the entire legal system in a tough situation because we have to evaluate this new type of evidence, this new type of proffered expert testimony, and so we try to help judges work through that process by giving them more information by which they can make an educated call on admitting the evidence or keeping it out or asking the right questions of experts. We're developing right now a set of judicial kind of bench cards or checklists that we think judges might be able to use as quick reference when confronted with sort of this information.

OC: Like how to evaluate a neuroimage, as an example or...?

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## Juvenile Incompetence and the New Zealand Youth Court: An Introduction

Davin Tan MbChB, Caleb Armstrong MbChB, and Susan Hatters Friedman MD

In New Zealand, the adjudication of youth aged 12 to 16 years of age proceeds by way of the same legislation that governs Child Protective Services with its dual focus on accountability and rehabilitation. (The Children, Young Persons and their Families Act 1989) The New Zealand police have a degree of discretionary power and are able to divert the majority of youth offenders away from the court system, unless their offenses are serious in nature (for example sexual offenses). The majority of youth who offend therefore avoid a criminal record if they agree to the conditions of diversion offered by police; these conditions might include completing an alcohol and drug program for example. Youth offenders who are not diverted proceed through what is called a Family Group Conference (FGC), unless the charge is murder or manslaughter. The FGC is a process unique to New Zealand's youth justice system and involves collaborative planning between the offender, victim (or representative), police, social workers, legal counsel and other relevant stakeholders. An FGC can be convened before formal charges are laid to determine if prosecution should be avoided. An FGC can also be convened after charges are laid to determine how a case is best handled or disposed. The FGC process may result in conditions imposed whereby youth offenders make reparations for their offending and avoid appearing in court. The maximum possible sentence for youth (apart from homicide cases) is 6 months residence in a Youth Justice facility, but less restrictive sentences are typically preferred. Thus the tension between criminal and *parens patriae* approaches is apparent.

There is concern from North American jurisdictions that sentences are becoming increasingly harsh in

the cases of youth waived to adult courts (Grisso, 1997). As a result of these concerns there have been calls for modification and review of juvenile competency standards (Larson & Grisso, 2011) where it has been argued that such standards might be adjusted according to potential punishments that a youth could face if found competent. In New Zealand these concerns may be less apparent because 'care and protection' approaches are employed with differing sentencing implications compared to adults. New Zealand youth charged with murder or manslaughter are brought before the youth court for a preliminary hearing before being transferred to adult court where they could be sentenced to imprisonment or to be detained in a Youth Residence Facility for a term greater than six months.

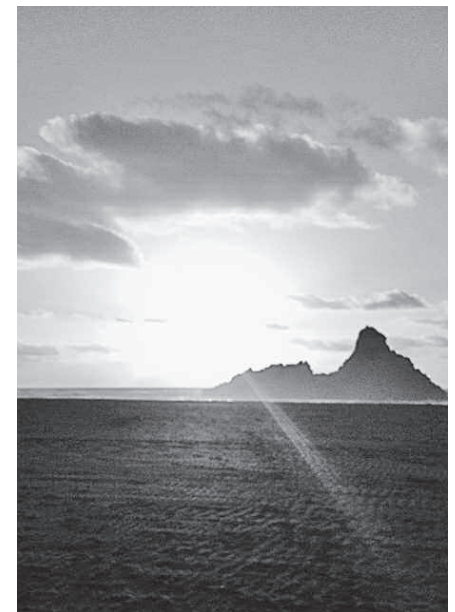
In New Zealand, the threshold for fitness to stand trial is the finding that a defendant's *mental impairment* renders them unable to plead, understand proceedings or instruct counsel meaningfully for the purpose of constructing a defense. Importantly for those working in the field of youth justice in New Zealand, 'mental impairment' is not defined in statute, and can be broadly interpreted. Could developmental immaturity alone be considered mental impairment in this situation? This issue has not yet been resolved by the New Zealand courts. The question of whether same age norms should be established is open for debate. As it stands currently, among younger children, a case could be made for their trial incompetency based on their level of maturity. Therefore, if a young person is unable to participate in the Court process due to their level of immaturity, they may be found unfit to stand trial.

The disposition of persons found unfit to stand trial in New Zealand Courts proceeds either via the Mental

Health Act, or the Intellectual Disability (Compulsory Care and Rehabilitation) Act. This poses unique challenges where there is no specific pathway for the disposition of youth found unfit to stand trial on account of immaturity. Neither of the aforementioned pathways are appropriate courses of action for immature youth without mental illness or intellectual disability, and in practice this can lead to charges being dropped. It should be noted that teaching program to educate youth about court proceedings have no official basis in New Zealand.

Juvenile competency research in New Zealand is limited but recent efforts by local practitioners reveal both similarities and contrast with our North American counterparts. Armstrong and Friedman (2015) found that in cases where developmental immaturity was a relevant factor in determining a recommendation that a youth be considered unfit, it was not a sufficient factor on its own but rather a constellation of difficulties (various cognitive limitations together with immaturity) that undermined the youth's fitness to stand trial. Tan, Neumann, Armstrong and Friedman (unpublished data) have found a third of youth evaluated by forensic services were opined unfit to stand trial.

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### Myths and Realities

*continued from page 1*

conduct disorder and development of more virulent substance dependence and ASPD. The characteristics of women in this sample differed sharply from those of women in clinical populations. Specifically, the high prevalence of ASPD, CD, aggression, substance dependence, and ADHD are more typical of male populations. These findings are important because of the current emphasis on gender-specific programming within the criminal justice system. The women in this sample present with trajectories and symptoms not typical of women in clinical populations. It is important to treat their substance dependence and to consider more “typically male” disorders such as ASPD, CD, and ADHD in this population. An overemphasis of trauma recovery to the exclusion of these other diagnoses (particularly substance dependence) is not likely to serve this population’s needs fully.

#### *Pregnancy and Postpartum Care*

Despite large numbers of women incarcerated in the U.S., data regarding pregnancy and incarceration remain limited due to inconsistencies in pregnancy testing and reporting. A 2008 Bureau of Justice report estimated that 6% of women incarcerated pre-trial are pregnant and that 4% are pregnant at the time of commitment to prison, meaning that anywhere from 5,000 to 10,000 pregnant women are incarcerated at any given time (Maruschak 2008). Approximately 2,000 babies are born to incarcerated women annually (Clarke et al 2013).

Pregnancy during incarceration is a unique challenge. Pregnancies among inmates are often unplanned and complicated by lack of prenatal care, mental illness, substance use, domestic violence, limited social support, and poor nutrition (Clarke et al 2011). Pregnant inmates are entitled to perinatal medical care (*Estelle v. Gamble* 1976), and standards for prenatal care in the general population apply to correctional populations

(ACOG 2011). However, policies regarding pregnancy-related health care vary from state-to-state and across institutions ([www.aclu.org](http://www.aclu.org)). In a 2010 analysis of pregnancy and conditions of confinement, 21 states received failing grades with regard to their policies concerning prenatal care, shackling of pregnant inmates, and the provision of family-based treatment alternatives (National Women’s Law Center 2010). Perinatal care is often shared among correctional medical staff and community providers and requires the transportation of inmates and coordination of care among providers. Pregnant

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*“...most studies show better outcomes for pregnancies managed in correctional settings than for women of similar socioeconomic status whose pregnancies are managed in the community...”*

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inmates have less control over their environment compared to women in the community, and therefore may have special needs with regard to activity restrictions, safety, nutritional requirements, the timing of meals, the provision of prenatal vitamins, and how medications are dispensed. Pregnancy-related education is especially important for this population, however, educational and support needs are often not met due to economic constraints (Ferszt et al 2008). Childbirth education and doula programs have been developed in several states (Schroeder et al 2005, Ferszt et al 2008). Postpartum contraception should be recommended to incarcerated women (ACOG 2011) and has been shown to greatly increase birth control initiation compared to providing contraception after release

(Clarke et al 2006).

Despite the many challenges in the treatment of pregnant inmates, most studies show better outcomes for pregnancies managed in correctional settings than for women of similar socioeconomic status whose pregnancies are managed in the community (Clarke et al 2011), since aspects of the correctional environment including stable housing, prenatal care, and limited substance use, may enhance pregnancy outcomes among high risk women.

#### *Newborn Nurseries and Family Separation*

Research indicates that two-thirds to three-quarters of women in prison are the mother of a child under age 18. Children whose mothers are incarcerated are more likely than children whose fathers are incarcerated to enter into foster care. Communication between mothers and their children during incarceration is important for the relationship after release.

While only approximately 9 states have prison nurseries of some sort, they are present in multiple other countries. Canada allows children to be with their mothers full-time until age 4, or part-time until age 12. (Warner, 2015) England has mother-baby units, with specific entry criteria, including best interest of the child with likely custody after release, drug free, behavior which is safe, and the mother participating in her appropriate programs. (Birmingham et al, 2006) New Zealand’s mother-baby units include children up to 24 months old. Purposes include bonding, feeding, and continuity of care, as well as having a goal of decreasing recidivism. And, costs of prison nurseries are similar to those for foster care. (Warner, 2015)

#### *Concluding Thoughts*

In conclusion, the population of incarcerated women is heterogeneous in terms of illness and violence, and with unique challenges related to pregnancy and postpartum care. It is important for the correctional and

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## President's Report

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arises most often in the development of practice guidelines and evaluation of *amici*. Some of my most enriching experiences in AAPL have occurred when I've discarded previously held positions as a result of hearing the careful considerations and arguments of other members.

AAPL's stated goals are to "promote scientific and educational activities in forensic psychiatry" by facilitating the exchange of ideas and practical clinical experience through publications and regularly scheduled national and regional meetings; developing ethical guidelines for forensic psychiatry; stimulating research in forensic psychiatry, developing guidelines for education and training in forensic psychiatry for residents and fellows; and providing information to the public about forensic psychiatry.<sup>10</sup> As a result of functioning as the center of forensic psychiatry's moral economy, and in addition to its educational and research activities, AAPL has developed additional significant and often unrecognized attributes of a professional home.

A professional home should provide members with opportunities to develop and consolidate their professional identity throughout all of the successive stages of their careers. In addition to promulgating "rules and rites," a professional home should provide both formal and informal contact with role models; more senior colleagues who embody the principles, values, and spirit of the discipline. The organization should create formal contacts by encouraging younger members to become involved in the organization's structure. Informal contacts, though more difficult to establish, are often more enriching. A professional home can create opportunities for these contacts by instilling a culture of mentorship among its members and establishing formal mentorship programs.

I don't think my rich experience of contact with role models and mentors

in AAPL is at all unique. AAPL supports many avenues for contact with senior members. However, it is incumbent on younger members to see them out. I strongly encourage Early Career forensic psychiatrists to join a committee that engages your interest. Ask to meet or speak with a senior member whose work is compelling to you. Volunteer to write a newsletter article. Participate in the business meetings at the semiannual and annual meetings. Become a role model of an Early Career forensic psychiatrist!

A professional home should also encourage contact between career-stage cohorts within the membership. There is a unique value found in these relationships. Peer support provides excellent reality testing during the stressful period of establishing a career. Some of the most helpful experiences I had early in my practice came about through sharing my concerns about reports, testimony, and billing. AAPL excels at this facet of a professional home. Early Career members can join the Early Career committee, and attend the Early Career breakfast and social event for current and prospective fellows.

A professional home should consider establishing a mechanism for formal or informal self-assessment. AAPL provides this by virtue of our Peer Review of Psychiatric Testimony Committee and Maintenance of Certification activities such as the self-assessment examination.

Finally, a professional home should offer opportunities for service throughout a member's career. It is natural to want to give back to an organization that provides so much to its members. AAPL provides these opportunities through continuing committee work, participating in leadership, and encouraging mentorship of younger members. Some mid-career members join the faculty of the board review course. Some senior members enjoy writing editorials for the journal. Others participate in AAPL chapter meetings. I look forward to continuing my service to AAPL for many years to come. ☺

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### Neurolaw

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FS: That's a good example. The checklists we're developing wouldn't give anything in depth but would provide judges with questions to ask and places to go to, resources that are free online that they can take a look at and have their clerks look at just to get up to speed on what is this new information suddenly showing up in my courtroom.

OC: What do you think forensic psychiatrists should know about neuro-law, and what do you see as the forensic psychiatrist's role in this emerging field?

FS: The first thing to say is that neuroscience in the courtroom is just really starting to emerge in its newest form. For instance, fMRI or even the advent of PET in the courtroom is still somewhat new, even though PET has been around for a long time. So I think what the forensic psychiatry community should be aware of more generally the use of neuroimaging in psychiatry. We're unlikely to see much forensic psychiatry engaging with neuroscience until psychiatry, more generally, is engaging meaningfully with neuroscience.

You know, we talked about that and it's something that is also just starting to emerge. Last year's AAPL panel (on "Neuroscience and Criminal Responsibility") was actually really interesting. I followed up and emailed [AAPL member] Nathan Kolla for some sites on the dementia side, which he mentioned is maybe one of the places where we're seeing the most, if still limited use of neuroimaging to perhaps help in assessing the diagnosis or confirming a diagnosis or informing treatment. Neuroscience is increasingly emerging as a potential tool in the psychiatric toolbox, and the law is going to have to evaluate whether the use of that tool is useful in the courtroom. I don't think it's special in many ways but it is new and so what law is going to do is use its tried-and-true techniques, such as the Daubert standard

and the Frye standard and other modes of evaluation to either analogize or distinguish the use of this evidence in assessing mental states in the same way it's evaluated previous types of information that psychiatrists are beginning to use and maybe didn't use before.

I think the dialogue is going to be a lot of forensic psychiatry saying to the law: here's what is a reasonable use of neuroimaging just for clinical purposes and the law will then assess that and figure out if there's some additional concern or if they'll say, okay, add it to your package of stuff that you put in your report in the same way that you use a lot of other tools, you know, actuarial tools or other standardized, MMPI, whatever it might be. You know, tools that you already use that are admissible and that have legal import even though they're not defined by law. We recognize them as being useful to law.

OC: You mentioned that the MacArthur Network on Law and Neuroscience is wrapping up its second phase. What's the future of the project, moving forward?

FS: The network, by design, and this is true for all the MacArthur networks, they run between eight and twelve years or so. We will complete our run at the end of 2016 by design, so this is a capstone year as we wrap up the research and put out sort of the final publications and those sorts of things so we are in our final stage. I think that the network has been tremendously productive without question and tremendously successful in beginning to get this field started but I'll say that there are a lot of opportunities for many in and around this area, very much including forensic psychiatrists. The future is dependent on the interest and willingness of those at the frontline, like forensic psychiatrists, to be open to thinking about new methods for assessment and treatment, and that's a question that your community can answer that I can't, which is: when does a particular area of neuroscience evidence

actually add value to the legal questions being considered?

OC: Just to wrap up, Francis, I wonder if you could point out some online resources that an interested forensic psychiatrist might go to to learn more about the topics we've been discussing in neurolaw.

FS: Sure, so let me give you two. The MacArthur Foundation Research Network on Law and Neuroscience has a webpage at [www.lawneuro.org](http://www.lawneuro.org) and we have many resources there. We have a searchable bibliography that includes over 1200 listings, we have links to all of the education programs that we've run, including over two dozen videos, the full videos from those programs so you can see exactly what we've been up to, and then we have links to a large number, maybe over fifty conferences that have been sponsored by all sorts of groups and panels and the like. It's really one of the hubs for work in this area. A second prominent website is the Center for Law, Brain and Behavior (CLBB) at Harvard Medical School, which partners with the Harvard Law School and with the neuroscience group there.

<http://clbb.mgh.harvard.edu/>

OC: Great, thank you so much for your time Francis.

FS: You're welcome! I'm looking forward to working with you again at AAPL this fall in Portland. ☺

### MUSE & VIEWS

**"If Moses had gone to Harvard Law School and spent three years working on the Hill, he would have written the Ten Commandments with three exceptions and a saving clause."**

Charles Morgan – British Novelist

*Submitted by William Newman MD*

## Juvenile Incompetence

*continued from page 19*

Developmental immaturity formed part of a constellation of difficulties amounting to mental impairment in 10% of those cases opined unfit to stand trial. Of great concern, Armstrong and Friedman found that half of unfit youth were not engaged in education of any kind. The most common diagnosis among those opined Unfit to Stand Trial was Mental Retardation; co-morbid conditions were common. Younger age was not associated with incompetence in the opinion of the assessors, a finding which was surprising in the light of international literature suggesting that younger age places defendants at a relatively high risk of being incompetent (Steinberg, 2009). It is hoped that more jurisdiction-specific research will help contextualize these findings. ④

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## Myths and Realities

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clinical staff to be familiar with these issues, in order to provide targeted and appropriate care and treatment and ensure safety. Over the years, various lawsuits have been filed under the equal protection clause of the 14th amendment to ensure that women's facilities receive the same attention as men's do. We hope that ongoing research and work with the female incarcerated population will continue to move our knowledge base forward and allow more targeted treatment and rehabilitation approaches. ④

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## Malingering

*continued from page 8*

large percentage of clinical effort, even a small reduction in this burden would enable me and my residents to spend considerably more time with the most challenging diagnostic cases.

Third, hospitals themselves have minimal financial incentive to weed out malingerers. Many of these patients are covered by insurers of last resort, such as Medicaid, and so while the taxpayers lose \$4050 per night, the institutions themselves profit by the same amount. Ironically, anti-social malingerers often prove ideal patients: once admitted, they require few healthcare services. At least, that is, until they injure a staff member or file a legal grievance.

Finally, the most likely reason that malingerers are not prosecuted is that providers do not realize this option is open to them. Some may fear compliance with HIPAA. Yet that statute specifically permits the reporting of crimes that occur on hospital premises ((45 CFR 164.512(f)(5)).

Others may not realize that “theft of services” laws in most states easily encompass the behavior of malingerers with medical or social service needs. Some jurisdictions may allow for charges under fraud or trespass statutes as well. Unfortunately, police departments often are also unaware of these options or, viewing the conduct as trivial, prove unwilling to act.

Specific anti-malingering statutes have the power to overcome this impasse. Such laws might serve a powerful deterrent effect as well: in lieu of prosecution, merely raising the possibility of arrest with certain patients, or handing them a copy of the law, might deter their conduct.

I do not mean to suggest that such prosecutions ought to be an everyday occurrence. Rather, they should be one weapon among many in the anti-malingering arsenal. An anecdote from my own practice may clarify the sorts of cases ripe for such a response. Last year, during the course of forty-eight hours, a patient with no history of mental illness pre-

sented to two New York City hospitals under three different names seeking hospitalization. His goal, providers later discovered, was to avoid a relative on a short-term visit to the city whom he owed what he perceived to be a large quantity of money. Ultimately, the costs incurred by the healthcare system vastly exceeded his minor debt—and he walked away from the episode scot-free.

As the final attending to see the patient in the ER setting, I sought to press charges for trespassing and theft of services, but the police were unwilling to take my complaint. ☹

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## Physician Assisted Dying

*continued from page 10*

cide. This may reflect how difficult it is to determine decision-making capacity for these patients, as well as how difficult it is to deem a case “treatment resistant.” In their study, 56% of patients who died by euthanasia or assisted suicide had refused at least some recommended treatment, and 20% had never been psychiatrically hospitalized. These numbers raise serious concerns about whether these cases should have been considered truly intractable.<sup>8</sup>

Opponents also worry that PAD will reduce incentives to improve available, high-quality care. For example, loneliness and social isolation were part of the majority of cases studied by Kim and colleagues.<sup>4</sup> This raises the concern that assisted suicide may replace effective psychosocial interventions.<sup>8</sup> Finally, there is the “slippery-slope” argument: this includes concerns that involuntary psychiatric patients would eventually be eligible for PAD, and that the practice would be applied disproportionately to vulnerable individuals. The predominant number of women in both studies could be evidence of this.

Physician-assisted dying is gaining acceptance in the United States. Although assisted death for non-ter-

minal patients is currently illegal in all states, based on the overall trend, we should expect to hear the arguments for extending legislation to include assisted dying for persons diagnosed with mental illness. For this reason, it is critical for the psychiatric community, especially those at the intersection of psychiatry and the law, to consider carefully these ethically problematic – and now empirically supported – problems. ☹

*I appreciate the input of committee chair, Philip Candilis, MD*

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## Too Dangerous

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prison; this is thought to be due to the stigma of mental illness. Perhaps the most problematic issue is the prison milieu (as opposed to the hospital therapeutic milieu) for these individuals, most of whom have suffered untold trauma. They are also more likely than healthy inmates to be placed in isolation/segregation, which may also exacerbate their mental health issues. Finally, because it is less expensive to house people in prisons than in hospitals, administrative pressure could conceivably lead to unnecessary transfers from hospitals to correctional facilities.<sup>9</sup>

The demographics of state hospitals have changed dramatically. With greater numbers of forensic patients, old models of treatment, particularly in conjunction with shrinking state budgets, are unlikely to keep staff and patients safe. Issues of safety and individual justice can conflict when developing policies for managing these risky patients. Housing forensic patients in correctional settings is ethically problematic; however, in the existing system, it is understandable why some advocate for it in extreme cases. One issue with allowing forensic patients to be housed in correctional facilities is that it absolves the government of their responsibility to develop highly specialized therapeutic spaces with specially trained staff (such as behavioral psychologists) for the most vulnerable patients. Another thing one must consider is whether, if an argument can be made for transferring NGRI patients to DOC custody, can the same argument be made for the transfer of seriously dangerous civil patients who are too aggressive for a maximum security forensic hospital?

In conclusion, in select cases, civil and forensic psychiatric patients who are too dangerous to be treated in a forensic hospital may need to be transferred to correctional facilities. If this is the case, we need to educate and include correctional staff and administrators in conversations about

how to provide mental health care in these unconventional environments; standards of care must be applied not only to hospitals, but to correctional settings, too.<sup>12</sup> 

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## Miranda At 50

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would be a better analogue) of judicial arrogance. In imposing its Court-made code upon the States, the original opinion at least *asserted* that it was demanded by the Constitution. Today's decision does not pretend that it is—and yet *still* asserts the right to impose it against the will of the people's representatives in Congress. Far from believing that *stare decisis* compels this result, I believe we cannot allow to remain on the books even a celebrated decision—*especially* a celebrated decision—that has come to stand for the proposition that the Supreme Court has power to impose extra-constitutional constraints upon Congress and the States. This is not the system that was established by the Framers, or that would be established by any sane supporter of government by the people.”

Now, what happened to the victorious, history-making Ernesto Miranda? He didn't do very well. He was re-tried by the State of Arizona without the introduction of his confession and found guilty. He served 11 years and was paroled in 1972. He continued his criminal career until 1976, when he was stabbed to death in a bar. In a strange twist of fate, a suspect was arrested, but he exercised his *Miranda* right to remain silent. He was released, and no one was ever charged with the murder. ☞

### MUSE & VIEWS

#### The Live Witness

- **Lawyer:** “What happened then?”
- **Witness:** “He told me, he says, ‘I have to kill you because you can identify me.’”
- **Lawyer:** “Did he kill you?”
- **Witness:** “No.”

Source: <http://www.rinkworks.com/said/courtroom.shtml>

Submitted by William Newman MD

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Karl Mobbs, M.D., Assistant Professor of Psychiatry, OHSU  
OHSU Chief Psychiatrist, Oregon State Hospital  
[mobbs@ohsu.edu](mailto:mobbs@ohsu.edu)

## Ask The Experts

*continued from page 6*

### Take Home Points:

The lesson here is to be open and honest with the referring attorney. Any other course of action will be to your detriment, both in the short-term and the long-term. The goal of the opposing attorney is to invoke shame and to thus precipitate the chain reaction that comes from such a powerful emotion. As psychiatrists, we know all about that response and so we know it can be managed. Discussing this with a peer can be of benefit in normalizing your feelings as well, and consultation is always encouraged. And remember, there is always another case and there is no point in taking unnecessary risks. ☯

## Veteran's Court

*continued from page 9*

inception with tremendous variability between jurisdictions, and much to learn about best practices. ☯

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