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American Academy of Psychiatry and the Law

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AAPL 49th Annual Meeting: October 25-28, 2018
JW Marriott, Austin, Texas

2018 Annual Meeting - Expanding AAPL's Mission: Better Educating Policymakers and the Public

William Newman MD, and Jessica Ferranti MD, Program Co-Chairs

When Christopher Thompson, MD was named President of AAPL , he was clear in his vision of AAPL's future: taking on a greater role in educating policymakers and the public. Dr. Thompson acknowledged the important contributions AAPL has made through consultation and organizational initiatives such as signing on to amicus curiae briefs. However, he recognized a capacity to share our expertise more broadly and with honed purpose. To that end, the 2018 Annual Meeting program will highlight the intersection of public policy, legislation, and forensic psychiatry. There will be a multidisciplinary feel to the meeting, with speakers joining us from the world of law enforcement, the law, psychology, and forensic psychiatry. We are pleased to introduce some of our distinguished speakers and events of the upcoming meeting.

We will kick off our series of lunchtime distinguished speaker talks on Thursday with Richard Rogers, Ph.D. He is Professor of Psychology at the University of North Texas and is perhaps most renowned for his development of four validated psychological measures, including the Structured Interview of Reported Symptoms (SIRS) and the Structured Interview of Reported Symptoms - 2 (SIRS-2). Dr. Rogers will speak about the evolution of structured malingering assessments, starting with a historical perspective and taking us through to our most state of the art assessments today. He will share with us his current research and his insights on malingering based on his accumulation of knowledge and expertise in this area.

For our Friday lunchtime talk, Anna Lembke, MD will be our speaker. Dr. Lembke is an Associate Clinical Professor at Stanford University, where she serves as Medical Director of the Stanford Addiction Medicine Program. Dr. Lembke is a leading expert on the opioid crisis and has served as a consultant at the state and federal level, testifying before congress in 2015. In 2016, she published her best-selling book on the prescription drug epidemic: *Drug Dealer, MD – How Doctors Were Duped, Patients Got Hooked, and Why It's So Hard to Stop*. The book combines public policy, cultural anthropology, neuroscience, and case reports to explore the complex relationship between doctors and patients around prescribing controlled drugs. She will comment on the science of addiction and the barriers to successfully addressing prescription drug misuse and addiction. The success of *Drug Dealer, MD* has had an impact on public policy makers and legislators across the nation in the wake of the ongoing opioid epidemic. Attendees of this talk will receive a complimentary copy of the book.

On Saturday, we are pleased to welcome Mr. Ramiro "Ray" Martinez. Mr. Martinez is a retired Texas Ranger who was elected to the Texas Ranger Hall of Fame for his role in disarming and shooting Charles Whitman, the University of Texas Tower Shooter, on August 1, 1966.

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2018 Annual Meeting

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A local hero, Mr. Martinez will describe his experiences on that day and lend insight into the challenges faced by law enforcement officers in active shooter situations. Of note, the 2016 documentary named *Tower*, which commemorated the 50th Anniversary of the University of Texas shooting, featured Mr. Martinez's role in ending the attack. Mr. Martinez will walk us through that day, providing his historical account as a window to the past that can inform our current approach to campus safety and management of mass shooting situations.

There are few more pressing public health priorities than the opioid epidemic. On Thursday evening, we will highlight this problem with a multidisciplinary panel discussing the opioid crisis in America. We are bringing together an exciting group of discussants from law enforcement, medicine, psychiatry, and the law to engage the topic of the opioid epidemic from different perspectives. Anna Lembke, MD will join us to discuss her experience treating patients with addiction and her role as an advocate for a holistic, harm-reduction approach to caring for these vulnerable patients. We will have a representative from the Drug Enforcement Agency to discuss the prosecution of physicians with problematic over-prescribing patterns. We will also have Donna Vanderpool, MBA, JD to speak about her role in defending physicians against malpractice allegations involving scheduled drugs. We expect this will be a lively panel, with plenty of time for an interactive discussion with the audience.

We are also introducing a new type of presentation for the 2018 meeting. "Flash Talks" will be brief, focused presentations on pertinent topics in forensic psychiatry. Delivery time will be only 10 minutes, with 5 minutes for questions, which will allow for several topics to be discussed during a single session. These presentations are available only to first-time presenters at AAPL (excluding poster presentations), with priority given to junior AAPL members who submit abstracts. The purpose is to encourage new and/or junior AAPL members to submit abstracts and present at the meeting.

Austin, Texas is a vibrant city with a youthful feel. With great restaurants, a music scene, and a bustling nightlife, there will be plenty to explore during your free time. The weather promises to be good ... we hope to see you there!

AAPL Awards Committee Seeks Nominations for 2018

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

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

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

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

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

Best Teacher in Forensic Fellowship Award – For outstanding faculty member in fellowship program.

Please send your nominations to Jeffrey Metzner, MD, Chair of the Awards committee at **jeffrey.metzner@ucdenver.edu.**

"Travel makes one modest. You see what a tiny place you occupy in the world."*

Susan Hatters Friedman MD

I've been fortunate to recently spend an amazing couple months visiting forensic services in various parts of the English speaking world. I've also gotten the chance to catch up with lovely colleagues, and see the services that I've heard about for years, but never had a chance to visit. I've been so impressed with more creatively and thoughtfully designed services than I could do any justice to in a column. Personally, I found myself reinvigorated in conceptualizing forensic services.

I visited with many colleagues and friends down under as well as across North America. I spent some time visiting with Dr. Short and her colleagues at the Arohata women's prison in Wellington, New Zealand. (Wellington has been called "the world's coolest little capital" by Lonely Planet.) Forensic psychiatry in New Zealand faces many of the same challenges as in North America, but somehow responsivity feels more possible—because of the smaller scale and national investment in the local district health boards. Guillermo del Toro has been quoted as calling Wellington "Hollywood the way God intended it." (As a side note, *Heavenly Creatures* is an early Peter Jackson New Zealand film about the Parker-Hulme matricide case, an excellent forensic movie to watch.) While in Wellywood (a mash-up of Hollywood and Wellington and the city's nickname related to *Lord of the Rings* and other films by Weta workshops), I also was able to visit the national youth forensic inpatient unit which opened in 2016. Also in Wellington, I attended the international Service User in Academia conference—a remarkable meeting about co-produced or service-user led mental health programs.

Visiting Melbourne, I was fortunate to spend time with Dr. Sullivan and others across the vast reaches of ForensiCare. I got to meet some outstanding forensic psychiatrist counterparts there. ForensiCare includes not only the specialized services at the forensic hospital, but also a highly organized network of outpatient forensic programs and assessment units, as well as specialized services across the prison system. There has long been writing about a "brain drain" from New Zealand to Australia—and I took advantage of my trip by meeting up with kiwi friends who had crossed "the ditch" to Oz.

I also had the opportunity to visit Sydney and reconnect with friends and colleagues there. I was able to visit with Drs. Riordan, Singh and Kasinathan at the NSW forensic hospital and the youth forensic unit. I had amazing opportunities to meet with many forensic and perinatal folks and consider the differences in mental health systems.

I also learned about consideration of culture in forensic psychiatric practice in various locations. Culture plays a prominent role in forensic psychiatry in New Zealand, and I also learned a lot about culture and healing while in Hawai'i. Dr. Champion and his network of colleagues demonstrated an amazing breadth of inclusion of culture in healing. I was fortunate to have the opportunity to meet with many folks involved in different aspects of culture and mental health. One of my favorite experiences was sitting in on the hula class at the women's prison. The most adrenalin-inducing part of my travels was receiving the text message that there was a ballistic missile headed for Honolulu (and also clearly stating it was not a drill).

I was excited to learn about the forensic mental health system in Toronto with Dr. Simpson and colleagues—and to see their mental health court with a psychiatrist and nurse on site. I was able to spend time at St. Elizabeths' and specifically on their women's unit with Dr. Candilis. One of the highlights there was their small museum of the history of St Elizabeths'. Then, I was on to Boston where I was able to learn about the specialized sex offender work by Dr Sorrentino and colleagues, and excitedly attend Dr. Gutheil and colleagues' PIPATL meeting (which I'd heard about for years). My final treat was a visit to Riker's Island's jails with Dr. Ford. Before the trip, I thought I knew something about Riker's Island from the newspaper and from watching *Law and Order*. But the visit gave me a chance to learn about the multiple jails and their mental health programs, as well as to realize how very close to LaGuardia the island is. I learned about the jail boat across the river for the first time.

As I've previously written, during a sabbatical one can further explore the field and oneself. These trips were an amazing opportunity for me to experience forensic psychiatry within different cultures and health care systems, and reflect on my practice. And I'm hoping that this column has perhaps encouraged you to think of doing the same.

We're pleased to share this issue of the AAPL newsletter with you. In addition to learning about the exciting Annual Meeting planned for Austin, it is full of information about topics across our field. Dr. Thompson writes about juveniles and their understanding of their rights; Dr. Janofsky about a current class action challenging mental health coverage decisions by managed care companies; and our Ask the Experts columnists focus on the ethical issue of how much family history to include in a report. From this issue's Fellow's Corner, you'll learn more about the recent case in which a teenage girl was found guilty of involuntary manslaughter for the suicide of

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Juveniles' Waiver of Miranda Rights: A Minor Misunderstanding?

Christopher Thompson MD

Over the past fifteen years, forensic psychiatrists arguably have had no greater impact on policy and law than in the arena of juvenile criminal responsibility. Decisions limiting minors' potential criminal culpability (and subsequent punishment) in cases such as *Roper v. Simmons (2005)*, *Graham v. Florida (2010)*, and *Miller v. Alabama (2012)* were shaped at least in part by forensic psychiatrists' and other forensic mental health professionals' input to the United States Supreme Court (USSC). Similarly, forensic psychiatrists have had significant influence on case law and multiple state statutes related to juvenile competence to stand trial. However, until quite recently, one domain of the juvenile adjudicative process had not received the same significant scrutiny by courts, legislatures, or the media, and the opportunity for expert input had been more limited: juveniles' waiver of Miranda rights, particularly the right to consult with legal counsel prior to or during interrogation.

Most societies recognize that children and adolescents display worse judgment than adults, are more impulsive than adults, and that children and younger adolescents are less able than adults to fully appreciate abstract concepts (such as "rights"). Such recognition is the primary rationale for establishing a minimum age for driving, voting, entering into contracts, drinking, and now (in some states) using marijuana. These transient developmental shortcomings also often negatively impact juveniles' approach to waiver of their Miranda rights. For example, youth are much more likely than adults to view their "rights" (e.g., the "right to have an attorney present during questioning") as discretionary and/or conditional as opposed to inalienable and innate; this is due in no small measure to both their developmental immaturity and lack of experience. Unsurprisingly, youth also are far more likely than adults to trust and obey authority figures, such as police officers. Children's and younger adolescents' ability to think abstractly is likely not yet fully developed. They may be unable to conceptualize what a "right" is. Additionally, many children are taught to both "tell the truth" and "trust the police." This unvarnished honesty and complete trust may serve those youth well in most circumstances. However, these same generally positive traits can become liabilities during a police interrogation, particularly if the youth is a suspect rather than a witness.

Over the past 30-40 years, the evolving scientific literature has corroborated these common-sense notions and observations about youth. More recent studies have raised specific, serious doubts about many juvenile defendants' general abilities to understand pre-trial events and proceedings and to participate meaningfully in their defense (which includes invoking one's Miranda rights appropriately). These deficits are particularly pronounced in children and younger adolescents with lower IQs. In the 2003 MacArthur study, when participants were asked questions about a hypothetical police interrogation scenario, approximately half of 11- to 13-year-olds thought that talking to the police and "admitting everything" was the best choice ("Talk/Admit" rather than "Talk/Deny" or "Remain Silent")[1]. Comparatively, only 15% of 18- to 24-year-olds believed that "Talk/Deny" was the best option. Similarly, Grisso found that 60% of adolescents believed they were required to make statements about their alleged offense if ordered to do so by a judge[2].

More specifically, developmental immaturity can impair a youth's understanding and appreciation of Miranda rights, with children and younger adolescents being the most susceptible to such impairment[3]. Rates of impairment in understanding and appreciating of Miranda rights (assessed using hypothetical criminal scenarios) were especially high among those younger than age 15. Seventy-eight percent of those aged 11-13 and 63% of those aged 14-15 were found to be impaired on one or more measures[3]. Such impairments, particularly when coupled with subtle cognitive deficits and mental disorders, also can make youth quite susceptible to adult coercion. This may contribute to their confessing to a crime, either truthfully or falsely, despite Miranda warnings.

Though false confessions are not unique to youth, they do occur more frequently in this population than in adults. The Innocence Project found that defendants 16 years of age or younger and/or developmentally disabled accounted for 35% of false confession or admission cases. Sadly, false confessions and false incriminating statements resulted in wrongful convictions in 25% of the cases.

Factors intrinsic to children and adolescents are not the only contributors to false confessions. "Extrinsic" factors also increase the rate of false confessions in youth. For example, most police officers/detectives are not trained to interrogate children and adolescents differently than adults. Typically, officers do not consider the youth's developmental level or the impact that certain tactics (such as claiming to possess non-existent evidence), coupled with that developmental level, might have on the truthfulness of a youth's confession and, subsequently, the integrity of the adjudicative process itself[4].

Unfortunately, juveniles' questionably-informed waiver of Miranda rights, coercive police interrogations, and subsequent confessions (be they true or false) are still fairly commonplace, despite ample and growing evidence of their deleterious consequences on defendants' rights and the probative value of the police investigative process. However, over the past five to seven years, often with forensic

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Class Action Challenging Overly Restrictive Managed Care Mental Health Coverage Decisions

Jeffrey S. Janofsky MD

It has been extremely difficult for an individual patient to litigate against insurance carrier coverage decisions because ERISA generally preempts state law actions (including malpractice actions) challenging the handling of benefits determinations. Furthermore, under ERISA, plaintiffs may only recover money not paid for coverage under their insurance contract and may not recover compensatory damages. But a case now pending in northern California may change that for psychiatric patients.

United Behavioral Health (UBH) administers behavioral health plans throughout the United States and is one of the nation's largest managed healthcare organizations. UBH earns money by charging fees for its services as the behavioral health administrator for various health plans. It does so either as a fully insured risk plan, or as an administrator only where USB charges only an administrative fee and the underlying plan pays the benefits USB approves.

In *David Wit, et al. v. United Behavioral Health* and its companion case *Gary Alexander, et al. v. United Behavioral Health*, filed in the U.S. District Court Northern District of California, (Case No. 14-cv-02346 JCS and Related Case No. 14-cv-05337 JCS), plaintiffs alleged that they were improperly denied coverage for residential, intensive outpatient and outpatient mental health and substance use disorder treatment. Plaintiffs were granted class action status in September 2016. The class includes patients whose UBH health plans were governed by both ERISA and the state laws of Connecticut, Illinois, Rhode Island, or Texas, whose request for coverage was denied by UBH, on or after May 22, 2011. Trial in the US district court has concluded, and post-trial motions have been filed.

Based on electronic data produced by UBH, coverage had been denied to class members under as many as 3,000 different health insurance plans. Because of the large number of claims that UBH denied during the relevant class period for the types of treatment that are at issue, the parties stipulated to a sampling methodology under which health insurance plan documents, as well as other information, were produced for 106 class members. Although there were multiple variations, all of the class members in the sample's plans required as one (though not the only) condition of coverage that the mental health or substance use disorder treatment at issue *must be consistent with generally accepted standards of care.*

In making coverage determination decisions, UBH peer reviewers apply criteria contained in various internal coverage decision documents. Plaintiffs alleged that UBH coverage decision documents do not follow accepted standards of care found in generally accepted guidelines produced by professional organizations or the US government. At trial, both sides agreed that appropriate guidelines for determining the standard of care included the American Psychiatric Association Practice Guidelines, the American Society of Addiction Medicine (ASAM) criteria, the Level of Care Utilization System developed by the American Academy of Community Psychiatrists (LOCUS), the Center for Medicare and Medicaid (CMS) Manual, and the Child and Adolescent Psychiatry Level of Care Utilization System (CALOCUS) and the Child and Adolescent Services Intensity Instrument (CASII) — both developed by the American Academy of Child and Adolescent Psychiatry (AACAP).

In its complaint, plaintiffs asserted two claims: breach of fiduciary duty; and arbitrary and capricious denial of benefits. The breach of fiduciary duty claim was based on the theory that UBH is an ERISA fiduciary and therefore owes a duty to discharge its duties solely in the interest of the participants and beneficiaries. According to plaintiffs, UBH violated this duty by developing internal coverage decision documents that were more restrictive than generally accepted standard of care, even though plaintiffs' health insurance plans provide for coverage of treatment that is consistent with generally accepted standards of care, and by prioritizing cost savings over members' recovery of benefits. The arbitrary and capricious denial of benefits claim was based on the theory that UBH improperly denied plaintiffs' requests for coverage by relying on the overly restrictive internal coverage decision documents. Plaintiffs asserted that reliance on the UBH internal coverage decision documents was arbitrary and capricious, because plaintiffs' underlying health insurance plans provided for coverage consistent with generally accepted standards of care, and because some of the plaintiffs' health insurance plans were subject to state laws that explicitly mandated the use of clinical criteria.

As relief plaintiffs sought a declaration that the UBH coverage decision documents at issue were developed in violation of UBH's fiduciary duties, and an injunction ordering UBH to stop utilizing the UBH coverage decision documents, and instead to develop guidelines that are consistent with generally accepted practice standards and with the requirements of state law. They also asked the Court to declare that UBH's denial of benefits had been improper, to order UBH to reprocess claims for treatment that were denied pursuant to the UBH coverage documents using new guidelines, and to order UBH to apply the new guidelines in processing all future claims.

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Ask the Experts 2018

Neil S. Kaye, MD, DFAPA
Graham Glancy, MB, ChB, FRC Psych, FRCP

Drs. Kay 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. 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 much family history should I include in a report?

A. Kaye: While on the surface this seems like a rather simple and straightforward question, it turns out that the answer is remarkably complex. Often, a forensic examiner learns information that is personal and not particularly relevant to the questions of the case. Every "standard" psychiatric evaluation acquires information that may have no relevance to the medical-legal question posed. However, since forensic reports are not confidential, I try to shield examinees when reasonable and I am sure that such information is not really relevant to the basis of the opinions rendered. I tend to be especially sensitive to family history and social history of the examinee; the more distant the relation, the less likely I am to include this information.

However, AAPL members need to familiarize themselves with Title II of the Genetic Information Nondiscrimination Act of 2008 (GINA) which is excerpted below for our American readers:

Under Title II of GINA, it is illegal to discriminate against employees or applicants because of genetic information. Title II of GINA prohibits the use of genetic information in making employment decisions, restricts employers and other entities covered by Title II (employment agencies, labor organizations and joint labor-management training and apprenticeship programs - referred to as "covered entities") from requesting, requiring or purchasing genetic information, and strictly limits the disclosure of genetic information.

Definition of "Genetic Information" under GINA

Genetic information includes information about an individual's genetic tests and the genetic tests of an individual's family members, as well as information about the manifestation of a disease or disorder in an individual's family members (i.e. family medical history). Family medical history is included in the definition of genetic information because it is often used to determine whether someone has an increased risk of getting a disease, disorder, or condition in the future. Genetic information also includes an individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual, and the genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

Discrimination Because of Genetic Information

The law forbids discrimination on the basis of genetic information when it comes to any aspect of employment, including hiring, firing, pay, job assignments, promotions, layoffs, training, fringe benefits, or any other term or condition of employment. An employer may never use genetic information to make an employment decision because genetic information is not relevant to an individual's current ability to work.

Rules Against Acquiring Genetic Information

It will usually be unlawful for a covered entity to get genetic information. There are six narrow exceptions to this prohibition:

- Inadvertent acquisitions of genetic information do not violate GINA, such as in situations where a manager or supervisor overhears someone talking about a family member's illness.
- Genetic information (such as family medical history) may be obtained as part of health or genetic services, including wellness programs, offered by the employer on a voluntary basis, if certain specific requirements are met.
- Family medical history may be acquired as part of the certification process for FMLA leave (or leave under similar state or local laws or pursuant to an employer policy), where an employee is asking for leave to care for a family member with a serious health condition.
- Genetic information may be acquired through commercially and publicly available documents like newspapers, as long as the employer is not searching those sources with the intent of finding genetic information or accessing sources from which they are likely to acquire genetic information (such as websites and on-line discussion groups that focus on issues such as genetic testing of individuals and genetic discrimination).
- Genetic information may be acquired through a genetic monitoring program that monitors the biological effects of toxic substances in the workplace where the monitoring is required by law or, under carefully defined conditions, where the program is voluntary.
- Acquisition of genetic information of employees by employers who engage in DNA testing for law enforcement purposes as a forensic lab or for purposes of

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Manslaughter by Text

Shahrzad Sims DO

Death and life [are] in the power of the tongue: and they that love it shall eat the fruit thereof (Proverbs 18:21)

After encouraging her long-distance boyfriend Conrad Roy III to commit suicide via dozens of texts and one phone call immediately prior to his death, Michelle Carter was found guilty of involuntary manslaughter in June 2017 in Taunton, Massachusetts. This ruling represents a novel terrain, the digital commission of a crime. Previously, cases of involuntary manslaughter required the defendant to have had some physical presence. The 2017 ruling came after the Massachusetts Supreme Judicial Court struck down a motion for dismissal citing that someone could be "virtually present" and words could be enough to establish causation (*Commonwealth v. Michelle Carter,* 2017).

Many argued that Carter's texts were protected by free speech and that Carter, who was 17 at the time of the crime, was consequently protected by the First Amendment. Words, however, have a long history of being used to commit crimes such as threats, harassment, treason, and extortion. Others argued that suicide by definition is an independent choice, and although she encouraged the victim to commit suicide, Carter was not liable. After all, Carter was 30 miles away from Roy when he died via carbon monoxide poisoning in a Kmart parking lot, and thus it was hard to argue she was a quasi-Dr. Kevorkian. Roy died in his own truck, at the age of 18, after obtaining a gasoline-powered water pump from his grandfather's shed to facilitate his suicide. Massachusetts law, unlike 39 states, does not a have a prohibition against assisted suicide (Tucker 2013). But in the eyes of the law, the situation transformed when Roy had a change of heart, exited the truck, and had a critical phone call with Carter in which she directed him to finish. According to the Honorable Judge Lawrence Moniz, who decided the verdict, this satisfied "wanton and reckless behavior" of manslaughter in the eyes of Massachusetts law as Carter knew her directives could cause Roy "substantial harm." Judge Moniz pointed to the fact that Carter "did not issue one simple instruction: Get out of the truck." Carter also showed mens rea by sending text messages the next day to a friend stating, "I helped ease him into it and told him it was okay. I was talking to him on the phone when he did it ... I could have easily stopped him or called the police but I didn't."

What are the legal repercussions? While this is not a United States District Court or Supreme Court decision, it does set precedent for other courts to criminalize similar behavior and broaden the concept of being "present" in a digital world. There was little precedent prior to *Commonwealth v. Michelle Carter*, but many legal scholars point to the 2009 case of *United States v. Drew*, in which Lori Drew, the mother of a teenage girl, suspected 13 year-old Megan Meier was spreading rumors about her daughter. Drew created a false Myspace account under "Josh Evans" and after alleged cyberbullying, Meier hung herself. Drew was never tried for Meier's suicide, although she was later convicted of a misdemeanor violation of the Computer Fraud and Abuse Act. The verdict was later vacated upon appeal (*United States v. Drew*, 2009). The casual relationship to Meier's suicide was not as clear as Carter's diligent directives for Roy. Drew also had no prospective knowledge of Meir's plans, while Carter had at one point even suggested various methods: "Hang yourself, jump off a building, stab yourself idk there's a lot of ways."

Parallels can also be drawn to the case of William Melchert-Dinkel, a Minnesotan married father of two who posed as a depressed woman in her 20s (*State v. Melchert-Dinkel*, 2012). Melchert-Dinkel entered suicide forums under aliases and encouraged others to commit suicide, even entering into several suicide pacts. He was convicted in 2011 of aiding a suicide, but his case was appealed. The Minnesota Supreme Court did reverse and remand the case citing that speech advising or encouraging suicide was constitutionally protected. However, speech that actually assists in suicide is not. In a similar vein, the Massachusetts Chapter of the American Civil Liberties Union issued a statement prior to Carter's sentencing advocating First Amendment rights and even going as far as to say, "Ms. Carter's conviction could chill important and worthwhile end-of-life discussions between loved ones across the Commonwealth." (American Civil Liberties Union 2017).

Regardless, a decade after *United States v. Drew* and seven years since *State v. Melchert-Dinkel*, our lives have become emmeshed and sometimes indistinguishable from our online presence, and Carter's case will likely be one of several to follow of the "virtually present."

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American Psychiatric Association Report: News and Updates

Cheryl Wills MD

The APA headquarters has relocated to Washington, D.C. The new building is large enough to accommodate APA meetings and will reduce the organization's hotel expenses. The facility contains a library, conference rooms, and various other accommodations. There are open house events in November 2018 that members are welcome to attend.

The APA Annual Meeting will be held in NYC from May 5 – 9, 2018, at the Javits Convention Center and the Marriott Marquis. In 2014, the NYC Transit Authority expanded the subway network. A new train stop, which is located two blocks from the Marriott Marquis, will reduce transportation time to the Convention Center to seven minutes.

The theme for the Meeting will be "Enhancing Access and Effective Care." APA President Anita Everett, whose background is in community psychiatry, has made identifying and addressing physician burnout a priority for the organization. She appointed a Workgroup on Physician Well-Being and Burnout that has developed a self-assessment tool which is informed by standardized rating scales. The tool may be accessed at https://psychiatry.org/wellbeing. Individuals who complete the scale will have access to real-time data that compares their results to those of other physicians. The website eventually will include short videos and other resources about physician burnout and rehabilitation. Eventually, screening tools will be accessible by the APA web portal.

Membership in the organization will likely surpass 37,000 by the end of 2017. There has been a 17% increase in female members, 13% in African American members and 5% in Asian members. Also, Latino/Hispanic and International Medical Graduates increased their membership by 2%.

The APA continues to advocate on Capitol Hill against efforts to repeal and replace the Affordable Care Act. The APA Communications Office receives media inquiries about other topics, including the opioid crisis, the immigration ban, Deferred Action for Childhood Arrivals (DACA) and the Goldwater rule. The Office disseminates information regarding these and other topics to the media and key stake holders.

> *"APA President Anita Everett, whose background is in community psychiatry, has made identifying and addressing physician burnout a priority for the organization."*

The APA Division of Education is working to develop a question bank that should meet the needs of those who are preparing for initial psychiatry board certification. The project eventually will be expanded to include self-assessment activities, question-a-day learning programs and an online board review-type program.

The Psychiatry Online website, which is being redesigned, is expected to launch in summer 2018. The APA is developing a podcast for authors to discuss their books and a buprenorphine training manual to accompany the online buprenorphine course. The Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder was released in January 2018.

In September 2017 the APA hosted a successful briefing on Capitol Hill titled "Telemedicine in America: Increasing Patient Access to Care and the Physician Perspective." Topics included an overview of telemedicine, workforce issues and psychiatry and the need for telemedicine legislation. Senator Thad Cochran's (R-MS) office, which sponsored the CONNECT for Health Act of 2017, sent staff member Elizabeth Joseph to speak about the proposed legislation that would reduce restrictions on Medicare reimbursement for healthcare providers who use digital health programs, including telepsychiatry.

The APA Payment Reform Toolkit contains a new document, titled "Take Action Now to Avoid Medicare Penalties," that contains stepwise instructions and a checklist to help psychiatrists avoid penalties under Medicare's new Merit Based Incentive Payment System, MIPS. The document includes suggestions regarding performance improvement, including activities that can help psychiatrists earn performance credits.

The American Psychiatric Excellence (APEX) Awards were presented at a ceremony in November 2017. There were five honorees this year. Kathryn Farinholt, Executive Director of NAMI Maryland, was honored. She developed the book titled *Beyond Punishment: Helping Individuals with Mental Illness Navigate Maryland's Criminal Justice System*. Ms. Farinholt also has been a national trainer for NAMI Programs and the national NAMI Leadership Institute.

Hon. Jennifer González-Cólon (R-PR), Resident Commissioner, who is Puerto Rico's sole and first woman Representative to the US Congress was also honored. She helped secure $36.5 billion in disaster aid for Puerto Rico and other areas that have been affected by last summer's natural disasters.

U.S. Senator Brian Schatz (D-HI), serves on four Senate Committees. The honoree is working to create new clean energy jobs for Hawaii, enhance Social Security and Medicare, support Native Hawaiian Programs and ensure that veterans receive the benefits to which they are entitled. Senator Schatz co-sponsored the Expanding Capacity for Health Outcomes (ECHO) Act which

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Publishing: Some Thoughts on Getting Started

Joseph Simpson MD, PhD

Many psychiatrists feel intimidated by the prospect of writing for publication. The whole process can seem arcane and mysterious. This is quite natural if, like many of us, your exposure to publishing consists of (a) getting your name added to an article for something you worked on as an undergraduate, or (b) none whatsoever.

A key step towards seeing your name in print is overcoming the fear of rejection and the doubt that *you* can contribute something an editor will want to publish. In reality it is not that difficult. Every psychiatrist has a wealth of knowledge, often including training or experience that many others in the field do not have.

Here are a few suggestions for those who have yet to publish. First, do more reading – at least a few journal articles per month. For this purpose, you must do more than what many busy professionals do – if they open journals at all: Glance at the Abstract, and if it seems interesting, flip to and skim the Discussion. Instead, try reading the entire piece word-for-word. Read the Introduction and look closely at the Methods. Try to identify flaws or weaknesses in the research design or analysis, before you get to the Discussion where the authors point out the ones they thought of (it's good practice to try to spot them, and there may be others they neglect to mention). As a simple example, if a treatment intervention study enrolled 100 people, but presents data on 35 because 65 dropped out early, that can say a lot about various aspects of the study, including their recruitment protocol, the design of their intervention, and how relevant the findings on the subjects who completed the study may be for the wider population.

Look at the References section to see what research the authors relied on. You might pull up a few of the most interesting articles, many of which are available free on the Internet. You are not trying to become an expert, but if you do this for a few months you will develop an appreciation of the way authors think when designing a study or putting together a case report.

The other benefit to reading studies this way is that you will start to absorb the scientific style of writing. This differs greatly from other forms of writing and has many rules that are fairly rigidly followed. These are not necessarily listed anywhere, but by reading for a few months you will get a better sense of the conventions.

> *"The other benefit to reading studies this way is that you will start to absorb the scientific style of writing."*

Once you have immersed yourself in the literature for a while, it's time to start writing. It is a cliché that you should "write what you know." But it's good advice, so pick a topic you have knowledge about. Deciding to learn about something new and writing a comprehensive review is extremely daunting and likely to lead to quitting, so that idea is best avoided.

It is important to start putting the ideas to paper, and not imagine that you are going to create a perfect manuscript at one sitting. Get a bunch of the ideas down, without agonizing over every sentence, and then revise. Multiple drafts are the norm. The basic ideas will usually remain the same, but their expression and conciseness can be refined dramatically.

When you begin you might consider a publication that is more "friendly." The reviewers for peer-reviewed journals can be fairly unforgiving. So when you are just getting your feet wet, you could try a publication that doesn't use peer review, but has in-house editors make sure the piece is up to snuff. The Newsletter you are reading now is a good example. You could also try your local APA District Branch publication. For many newsletters that don't have national circulation, you can submit a book or movie review or any type of editorial or reflection. This is not necessarily impossible with the *American Journal of Psychiatry* or the *Journal of the American Academy of Psychiatry and the Law*, but will likely be much more difficult for a newcomer. There are a number of other publications that are not peer-reviewed or have some peer-reviewed and some single-editor sections. For example, *Current Psychiatry* is seen by many residents and early career psychiatrists, and its "Pearls" section is a good place to offer a brief summary of some clinical wisdom with a catchy mnemonic that you can devise. *The Journal of Psychiatric Practice* has sections on forensic psychiatry, psychotherapy and others which would be good for a guest column, working with the section editor.

If this still seems like too much, consider finding a mentor or a coauthor. There are many mental health professionals at universities who would be happy to work with an enthusiastic doctor who lacks experience writing for publication. The collaboration could take the form of advice on your first venture into writing, or an arrangement where each party agrees to write a portion of the paper, with both (or all if there's more than two) editing the others' sections as well.

After the first accepted manuscript, the process becomes easier. You may even find it habit-forming. So fire up those laptops!

This article is adapted with permission from the Southern California Psychiatric Society. The full article was originally was printed in the November (Volume 66, Number 3) Edition of their Newsletter.

Stories v. Studies: The Case of Forensic Psychiatry

Abhishek Jain MD, Research Committee

Forensic psychiatry is a field of "stories" and "studies" – of individual cases as well as of research and scientific evidence. Many of us were probably first drawn to the field after working on a complex clinical case with important legal and ethical nuances, or after seeing a presentation on the role of expert testimony in a famous trial like that of Andrea Yates. These individual cases undoubtedly bring important topics to light, and help transform theory into practice. Diving deeply into an insanity defense case, for example, provides fodder for a range of practical discussions, such as about criminal responsibility laws, malingering, dual agency, and testifying. Similarly, appreciating AAPL's landmark cases, a core component of fellowship training, helps us grasp the evolution of case law and the current state of clinical and forensic practice.

However, it's the "studies," and trying to realistically incorporate research into a forensic psychiatry career, that have often been challenging.[1] We certainly have no shortage of interesting questions in our field. Examining how to improve aspects of mental healthcare delivery in correctional settings; investigating the possibilities of applying neuroscience to the assessment of malingering; studying how to bridge structured professional judgments in violence risk management with routine clinical care; or assessing the impact of laws on our patient populations, are just a few of the abundant areas of intrigue. Yet, some of the obstacles, as well as opportunities, of diving into an academic inquiry stem from how we view our identity and goals as forensic psychiatrists.

Fortunately we are well positioned to think about an array of questions that can contribute to unique aspects of psychiatric care, educate legal systems and policymakers, or even guide our own forensic psychiatric colleagues. Just looking through an AAPL Newsletter (like this one) or an issue of *JAAPL*, and attending AAPL meetings, reveals the refreshing breadth of our field. At the same time, we also ought to try and critically appraise how best to focus and delve into a scientific inquiry that is commensurate with the specified aims. Additionally, simply asking an interesting question may not be sufficient, but being mindful of asking a question that is answerable within available parameters (e.g., sample size, sound methodology, validated measures, access to data, etc.) is clearly important.

> *"...individual cases undoubtedly bring important topics to light, and help transform theory into practice."*

Admittedly, empirical evidence alone does not provide answers for many of our "real life" situations. Well described, for example, is the controversy of applying group-level (i.e., nomothetic) data to an individual person's (i.e., idiographic) risk for violence.[2] And of course the debates regarding scientific evidence in issues such as the standard of care in psychiatry, have famously been chronicled through scholars and thought leaders like Gerald Klerman and Alan Stone.[3,4] Thus, discussions about the limits of science in epistemology are not new, especially in a complex field as forensic psychiatry, but scientific value in furthering our knowledge and our field is also obviously not dismissible. By understanding and appreciating methodology and statistics, we can better determine how to weigh each study and appropriately incorporate and challenge findings that may or may not relate to our specific objectives and tasks (e.g., as expert witnesses, as clinical providers, as administrators, etc.).[5]

So, how do we include research skills in our training and our careers as forensic psychiatrists? As a former program director of a forensic psychiatry fellowship, I grappled with this, as have other program directors. The fellowship year is packed with learning about patient care in correctional settings, conducting criminal and civil evaluations, report writing and testifying, gaining knowledge about law and ethics, and a host of other activities. Trying to also design a meaningful study, seek approval from an Institutional Review Board, collect data, and analyze and publish the findings, on top of the other responsibilities during a fellowship year, is daunting, if not impossible. One solution is linking with existing studies or with other colleagues, such as forensic psychologists, criminologists, and other subspecialty psychiatrists, on relevant ongoing projects. Trainees and even experienced forensic psychiatrists may also consider courses on statistics and research methodologies. The goal is not necessarily to become principal investigators or statisticians, but to become well-informed "consumers" of, and in turn conveyors of, scientific studies – maybe akin to the "see one, do one, teach one" model.

For those considering more traditional academic careers as forensic psychiatrists, pursuing courses on funding and grantsmanship may be useful. These might give ideas about finding federal government funding opportunities, such as through the National Institute of Health (NIH). For instance, an NIH K Award, after a rigorous application process and depending on the specific program, could provide up to 75% salary support for five years towards a post-training research career development track. Courses or grant experts in an academic setting may also offer suggestions about research funding for specific projects from non-governmental sources, including foundations or professional organizations. The

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RISE: Restoring Individuals Safely and Effectively

Bethany Hughes MD, and Carolina Klein MD, International Relations Commitee

During the 2017 AAPL conference, a diverse group of forensic psychiatrists from around the world, including places such as Norway, the United Kingdom, Canada, Puerto Rico and across the United States, gathered together for the annual site visit to tour a unique facility outside of Denver, Colorado, at Arapahoe County Detention Center, called RISE (Restoring Individuals Safely and Effectively): home to a newly developing jail based competency restoration unit.

This facility initially started as one unit housing 22 male patients in a space located in the county jail, and has since expanded to two units housing 56 male patients, with plans for further expansion in the future. The current stay in this facility, as in the time to competency restoration, averages 60 days. Of note, the units are made up entirely of patients who are incompetent to stand trial due to mental illness, and patients do not have any contact with other inmates in the jail.

Each patient in this program is chosen by the state, and is transported to RISE by their individual county jail facility where they were originally located, or occasionally, from Colorado's civil state hospital where they originated. Most patients selected for this program are already in the criminal system and are waiting for a state hospital bed for competency restoration.

While in this program, patients are able to take part in four daily group therapy sessions, as well as individual therapy. Patients are able to participate in educational activities to learn about the court/judicial system, such as role playing and mock court room procedures. Patients also have some amount of recreational time in small outdoor courtyards. The smaller unit has individual rooms with doors, and the larger unit has open style rooms with bunk beds. Both units have open day rooms, and patients have the ability to move about the day rooms freely during daytime hours.

Regarding staffing, RISE has a private contract to provide medical and psychiatric care for its patients. The county jail staffs the guards who work with the RISE patients, but the guards are required to go through extensive training on caring for patients with mental illness, to be able to work on the two RISE units.

Of note, the guards have to request to be placed on the RISE units, and have to pass testing before they are allowed to take the training. In speaking with various guards on the units during the site visit, they seemed to be very compassionate and dedicated to the field of mental health, but at the same time, alert and attentive, stating it was best to respond to issues on the front end, before they escalated to physical aggression. Per RISE staff, they have an extremely low rate of physical aggression at their facility.

As one who is just beginning her career at this baffling time when hospital beds are becoming less available when it seems that the need is merely increasing, jail based competency restoration has become an option many states are beginning to consider. While there are many pros, cons and difficulties to maneuver with this type of patient care, it appears that at this point, hundreds have been restored to competency in a significantly reduced time using the RISE program, who would otherwise have spent weeks, if not months, sitting in a county jail waiting for a state hospital bed due to overcrowding and long wait lists. Hopefully, other states will be able to create more innovate ways to reach more of our patients in need in the future, as the number of state hospital beds continues to decline, as in the end, excellent patient care is always our primary goal as physicians, no matter the location.

Class Action

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At trial plaintiffs provided evidence that generally accepted standards of care for making patient placement decisions were well established, and that UBH failed to meet these standards in a variety of ways including:

- UBH coverage decision documents restricted coverage for mental health or substance abuse treatment to only address specific crises. As soon as the crisis precipitating admission has passed, coverage was no longer available. In contrast, generally accepted standards of care required focus on chronic symptoms and the underlying condition;
- UBH coverage documents emphasize whether co-occurring conditions can be safely managed at a particular level of care, rather than whether the co-occurring condition can be more effectively treated at the requested level of care;
- UBH coverage decision documents seek to move patients to the least intensive level of care at which they could be safely treated, even if the lower level of care might not be effective at all. The standard of care requires treatment at the level it would be most effective;
- Under generally accepted standards of care a higher showing in one dimension should suffice to entitle a patient to a higher level of care, even in the absence of any showing in another dimension. Mandatory prerequisites for treatment at a particular level violate the standard of care;
- UBH coverage decision documents require patients to improve, focusing on improvement of acute symptoms. However, generally accepted standards of care require treatment to maintain functioning or to

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Forensic Training in Policy Development

Jeffrey Guina MD, Kimberly D. Kulp MD, David S. Im MD, Todd E. Moore MD, J. Travis Hendryx MD, Debra A. Pinals MD

On November 6-7, 2017, Michigan Mental Health Diversion Council hosted a stakeholder forum entitled, "Mental Health and Criminal Justice Strategic Planning Summit: Using National Stepping Up and Sequential Mapping Initiatives to Inform Efforts in Michigan." The Mental Health Diversion Council was established in 2013 by Executive Order of Governor Rick Snyder (R), and is chaired by Lieutenant Governor Brian Calley (R). Organized by Michigan Department of Health and Human Services (MDHHS), Diversion Administrator Steven Mays, Behavioral Health and Developmental Disabilities Deputy Director Lynda Zeller, and Behavioral Health and Forensic Programs Medical Director Debra A. Pinals MD, the Summit aimed at bringing stakeholders together to take stock of what had been accomplished since the Council's establishment and to use national strategies to address the number of persons with mental illness and developmental disabilities in the correctional system. The goal of diversion in its broadest sense is to prevent entrance and to refer those who would be better served elsewhere towards treatment rather than incarceration. Through community mental health treatment, police training, and providing courts with alternative options to incarceration, diversion can be highly successful.

The Summit was notable for being the first time that two leading initiatives were spotlighted in the same venue related to reducing the penetration of individuals with mental illness from the justice system. Specifically, Fred Osher MD represented the "Stepping Up" initiative and the Council of State Governments Justice Center, and Hank Steadman PhD and Dan Abreu MS CRC LMHC represented Policy Research Associates and the concepts behind the Sequential Intercept Model. The event was also notable because of the strong support across all stakeholders. Leaders and rank-and-file representatives from community mental health, state psychiatric hospitals, law enforcement, lawyers, judges, and state and local governments were all in attendance. The presence of Michigan Governor Snyder, Michigan Lieutenant Governor Calley, and Michigan Speaker of the House Tom Leonard (R-DeWitt Township) were just a few of the indicators of the high level of support for the initiative in the state.

Michigan has been on the forefront of diversion. In 2013, Gov. Snyder created the Mental Health Diversion Council via Executive Order 2013-7. The Council is chaired by Lt. Gov. Calley and includes members from across the mental health, law enforcement and criminal justice systems. In 2015, the Mental Health Diversion Council launched the Jail Diversion Pilot Program in multiple counties across the state with funding from the MDHHS, in addition to several other initiatives to help with its diversion goals.

Academic and state partnerships were highlighted during the Summit, and were inspiring to participants to think about potential research collaborations. Sheryl Kubiak PhD is the principal investigator of the Jail Diversion Pilot Program. Dr. Osher commented on what a "huge step forward" it is to have the ability to discuss data and real numbers for communities working to reduce the percentage of individuals with mental illness in their local jails.

In addition, the Summit provided an opportunity for collaboration and sharing of ideas in several group break-out sessions. These sessions included (and were facilitated by) fellows and faculty from the state's Center for Forensic Psychiatry including from its forensic psychiatry fellowship training program through University of Michigan. The breakout groups offered a unique opportunity for stakeholders to provide input and become involved in multidisciplinary discussions of how resources might best be utilized to provide a correctional system with a program that seeks to intervene at several levels to provide treatment to those in need, rather than just punishment. Two forensic psychiatry fellows and an early career forensic psychiatrist served in roles as facilitators of these breakout sessions that were organized along the Sequential Intercept Model. In this capacity, the psychiatrists took on active leadership roles in which they promoted and directed meaningful discussions between the participants. The participants included local and statewide experts in their respective systems: Judges and lawyers, corrections officials and administrators, community services and behavioral health care providers and administrators. The facilitators kept the participants focused as they collaborated to identify resources, highlight successful strategies, and identify gaps that hinder their work across the intercepts and systems. In their roles as participants in the Summit and as workshop facilitators, the forensic psychiatry fellows strengthened their facilitation skills and increased the depth and extent of their familiarity in this complex area intersecting justice, behavioral health, community supports, and public policy. The fellows worked with mentors to research, plan, and collaborate with participants to shape new ideas and concepts that will develop into future statewide policies and practices.

Speaker Leonard noted that diversion is one of the few policy issues in which he sees wide agreement across political spectra. Governor Snyder remarked on Michigan's bipartisan accomplishments developing diversionary strategies and a sustainable roadmap to decrease the number of people with mental illness in our state's jails and prisons, and direct them toward appropriate treatment. Lt. Gov. Calley emphasized preven-

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Tuesday Afternoon

Sandy Simpson MBChB, FRANZCP

It had been a hard first week in the dystopian world of Trump's presidency, immigration bans and the mass shooting at a Mosque in Quebec. On my way to the prison for my afternoon clinic, I hear the accounts of the distress people are feeling in the wake of these events, and the attitudes towards each other that they betray. The radio plays a cover version of Simon and Garfunkel's Sounds of Silence, delivered with near operatic intensity.

People talking without speaking
People hearing without listening.

I feel a deep unease and tearfulness about the world and the distress that people are suffering. A political junkie all my life, perhaps absorbing and thinking too much about all of this is getting to me too. Music has a way of getting to the emotions that lie under cognitive barriers.

I visit a remand prison every week, to try and reach people who have a serious mental illness who our care systems may have missed, and who need our help. We have established the system to make sure we reach all the people who might need us. While we see some people only once, we try to connect with everyone in some way. Today, I have three people to see in Segregation, and a fourth young man from the mental health unit.

In Segregation, the men cannot be let out of their cells to talk with me. One man manages to communicate succinctly that he wants me to go away. Which I respect.

The second is a young man, first time in prison, now facing very serious charges. We shake hands through the hatch – the opening in the middle of the cell door that food trays and hands can pass through. He sits on his side, I kneel on the other. We talk. He knows there is little I can do for him, he is not unwell he assures me. He feels the tragedy of his situation, tries to normalize it, but not shirk. He speaks without a cover story, he doesn't pretend things are other than they are. He faces a tough reality, we both know it. He doesn't seek platitudes or reassurance, but responds to my acknowledgement of his situation. No anger or negotiation with me, I am a person, as is he. We shake hands as I rise stiffly from my kneeling position on the concrete. I sensed we had met as people, even if briefly, and so constrained by the context.

The next man is a little older than my 57 years. He has spent his morning communicating anger at anyone that came in range, including slinging a wet T-shirt from the toilet at the officers. He had been abusive to some of my team when they came to see him. By the time I arrived, he had cleaned up his cell, greeted me respectfully and warmly, and so the officers risked opening the hatch for us to talk. We both found a way to get comfortable, a mattress on his side, a chair this time on mine. He talked of himself and his life. Residential schools, graduating high school, university briefly and semi-professional hockey, movies he had been an extra in, too much alcohol, the games played in the many detention centres he had spent time in. All this he did with a jovial account of a storyteller, desiring acceptance of the richness of his life, and his mistakes. But without self-pity or needing anything from me, simply wanting to share the stories, to be heard. He would accept any short-term support I might offer. But he was off to 'native court' as he put it in a week, he would be fine. He gave me a fist bump as I departed.

Finally, with an interpreter, I spoke with a young man with a serious mental illness, on serious charges. Today he is doing much better than he was when he arrived in custody. The voices that were tormenting are now all positive, the medication is working. He gets how lucky he is that his voices are not tormenting him, he has seen so many other people with voices being very troubled. He is in the Mental Health unit and has friends he relates to positively. Indeed he has a knack for finding everyone helpful, has joined the therapeutic groups we run there. Everyone, he says, are like family.

The thoughts that disturbed me three hours earlier have passed. I had made simple connection with these people, on different sides of steel doors. Fleeting, respectful, human connections helped me feel grounded in what matters.

Briefly, at least, people were talking and listening.

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APA Report

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was ratified in 2016. ECHO requires the US Department of Health and Human Services to examine a report on technology-enabled collaborative learning. He also is a lead sponsor of the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act, which the APA has endorsed. If ratified, CONNECT will promote telemedicine use as a vehicle for cost savings and quality care.

Eric Eyre is a statehouse reporter for West Virginia's *Charleston, Gazette Mail.* His investigative reporting focuses on concerns in rural West Virginia communities. He is the recipient of many awards and honors, including the 2017 Pulitzer Prize for his reporting on how millions of opioid pills were distributed in West Virginia.

U.S. Senator Debbie Stabenow (D-MI), ensured that the Affordable Care Act supported comprehensive coverage, including maternity care for women and cost reductions for prescription medication for senior citizens. She also supported legislation that includes language from her Excellence in Mental Health Act, which funds an expansion of mental health services and supports parity for funding of physical and mental health services.

Mental Illness, Criminality and "Social" Disease

Merrill Rotter MD, Community Forensics Committee

Over two hundred years ago, Dr. Edward Jarvis wrote in the American Journal of Insanity (the early iteration of the today's "Green Journal"),

> The insane criminal has nowhere any home: no age or nation has provided a place for him. He is everywhere unwelcome and objectionable. The prisons thrust him out; the hospitals are unwilling to receive him…And yet humanity and justice, the sense of common danger, and a tender regard for a deeply degraded brother-man, all agree that something should be done for him—that some plan must be devised different from, and better than any that has yet been tried, by which he may be properly cared for, by which his malady may be healed, and his criminal propensity overcome.[1]

The dual goals of maximizing recovery and public safety continue to challenge, vex, inspire and drive clinicians who seek to provide treatment to individuals with mental illness who have justice involvement. The Community Forensics Committee is pleased to be part of a wave of activity at AAPL that has begun to focus on this interesting and critical aspect of forensic practice. Success in achieving recovery and public safety requires understanding and addressing the risk of criminal recidivism for offenders with mental illness, is a critical area of knowledge for the forensic clinician, and one which prescribes a holistic approach that incorporates both traditional treatment and recidivism-focused psychosocial interventions.

The role for traditional treatment, (i.e. management of symptoms of major mental illness), in addressing criminal recidivism is complicated because the explanation for the overrepresentation of individuals with mental illness in the criminal justice system is more complicated than merely the criminalization of symptoms of serious mental illness. While some individuals are arrested for behavior associated with psychosis or affective dysregulation, offenders with mental illness often commit crimes associated with the same risk factors as those without mental illness. By the same token, many of these risk factors are ones to which individuals with mental illness may be particularly vulnerable: substance abuse, family support, vocational and educational issues, housing instability and trauma. These areas of vulnerability, however, track equally well with societal problems, also known as social determinants, that are associated with poverty and dislocation. What is the role of the forensic psychiatrist in addressing these challenges? When is the "social" issue a "clinical" problem? Models of general health improvement, mental health recovery, trauma-informed care and recidivism reduction suggest that the answer to that question is "always." Geographical maps demonstrate that similarly troubled communities have disproportionate rates of illness, trauma and arrest. The social determinant lens suggests that at least some of the overrepresentation of individuals with mental illness in the criminal justice system is related to the shared social determinants of health, mental illness, and criminality. These social determinants include:

- Neighborhood access to health, mental health, substance use and social services
- Social dislocation and stigma
- Economic uncertainty
- Housing instability
- Employment insecurity

Difficulties in one or more of these areas have been associated with poorer health outcomes (diabetes, heart disease, cancer), increase in mental health diagnoses (particularly depression and anxiety), substance use, as well as delinquency and arrest. The "bad" news is that these determinants are themselves determined by longstanding, seemingly intractable social, political and fiscal forces - well beyond the control of an individual clinician or provider agency. The "good" news, however, is that to the extent that these challenges can be ameliorated for an individual client, both recovery and recidivism goals can be addressed at the same time.

Two models presented at the Annual Meeting this past year provide a road map for addressing these issues at a system and individual level, respectively. The first, Sequential Intercept Mapping ("SIM"), is a description of the sequence of events from arrest through re-entry from prison or jail which can be applied within a jurisdiction to identify opportunities for interrupting the criminal recidivism cycle, by identifying clients caught in the justice system; and, consistent with the social determinant concern, the model works to identify the availability - or lack - of community resources, that may address their recovery and recidivism challenges.[2]

The second, Risk-Needs-Responsivity ("RNR") is a structured approach to the assessment of the risk of recidivism that provides a risk level determination as well as a delineation of potentially changeable considerations that are associated with increased re-arrest – either directly associated with increased risk ("criminogenic Needs," such as antisocial thinking and substance use) or, again consistent with social determinant literature, indirectly associated with increased risk ("Responsivity factors," such as housing instability and economic insecurity).[3]

Several additional AAPL Committees, including Correctional Psychiatry, Criminal Behavior and the newly formed Recovery Committee have overlapping, if distinguishable perspectives that are clearly relevant to this area of inquiry. The Community Forensics Committee looks forward

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Nature or Nurture? Crime and the Trait Theory

Kavita Khajuria MD

An inmate at work recently demanded better food and more sunlight. He was well aware of his rights, but also the effects of diet and the environment on his health. Despite his charges, he was focused on this, and insisted it would affect his mood. This article attempts to review the relationship between the three: environment, biology, and personality.

In 1978, the biology of crime began to receive national attention during Dan White's Twinkie defense[1]. Today, trait theorists believe biochemical conditions influence antisocial behavior, and that biological and psychological traits interact with environmental factors to influence crime[1].

Diet: An improper diet[1] or severe food allergies i.e. MSG, aspartame and xanthines[3] can cause chemical and mineral imbalances associated with antisocial behaviors. A significant drop in aggression and fewer disciplinary actions occurred when unhealthy diets in a group of inmates were replaced with fresh fruit and vegetables[3].

Hormones: Abnormal levels of androgens and testosterone have been associated with antisocial behavior, criminality and violence. Hormonal change in adolescence partly explains the high violence rates which level out during the aging process[1]. Females may be biologically protected in some regards. Fishbein argues that a significant number of incarcerated females committed their crimes during the pre-menstrual phase, while a small percentage of women appear vulnerable to cyclical hormonal changes that make them more prone to anxiety and hostility[1]. More recently, critics have challenged the associations between menstrual distress and female crime[3].

The Environment: Blood mercury levels of children diagnosed with ADHD tend to be significantly higher. Lead exposure has been found to be irreversible and linked to both emotional and behavioral disorders[1]. Long-term worldwide trends in crime levels correlate significantly with changes in environmental levels of lead.

Neurophysiology: Brain imaging studies demonstrate impairments in select areas of the brain in violent criminals and substance abusers. These have been implicated in a range of developmental disorders and may lead to personality traits linked to antisocial behaviors[1]. Those with low arousal levels seek stimulating activities which may include aggressive, violent behavior patterns. Low levels of MAO are related to defiance of punishment, sensation seeking and risk taking behaviors, with high levels of violence and property crime[1]. Females have a naturally higher level of MAO, which may contribute to gender differences in crime[1].

Genetics and Crime: Troubled parents with antisocial behaviors exert a powerful influence, especially on the never ending cycle of schoolyard bullying. The biological father's criminality can strongly predict his son's criminality, despite his son having a non-criminal adoptive parent[1]. Monozygotic twins raised separately have similar behavior in criminal activities[1]. Genetic influence appears strongest for chronic offenders with severe behavior, and callous, unemotional (C/U) traits. A study on adjudicated youth found a strong association between C/U factors and deficits in cognitive and emotional empathy[2]. To date, no direct link between genes and violence has been found, however[3].

Evolution and Crime: Some believe that those who engaged in certain actions ensured survival. Impulsive, reckless risktakers, who utilized an aggressive mating effort strategy possessed a reduced ability to form strong emotional bonds. This resulted in a lack of conscience with violent antisocial tendencies, and produced offspring prone to criminal behaviors[1].

Psychological Trait View: The psychodynamic perspective depicts the offender as aggressive and frustrated, dominated by early childhood events, resulting in a weak or damaged ego. Immature psychological defenses and rationales to keep feelings under control subsequently invite susceptibility into crime[1]. Cognitive theorists cite crime prone persons as having cognitive deficits.

Personality and Crime: Sociopathic parents, improper socialization, parental rejection, maternal cigarette smoking and inconsistent discipline are factors believed to contribute[1].

IQ and Criminality: The Nature theory argues the genetic determination of intelligence and the greater link of low IQ to criminal behavior, as opposed to children with higher IQ, protected by their superior ability to succeed in school and social relationships[1]. Studies have concluded an IQ to be a more important factor in predicting crime than either race or social class[3].

Criticisms: Critics argue the trait theory to be racist and divisive, i.e divides people into criminals and non-criminals[1]. If biology and psychology explain street crimes, then the poor and minority groups commit more antisocial acts, suggesting these groups to be flawed[1]. Behavioral and social learning perspectives argue that people are not born with violence. Rather, they learn through life experience, i.e mass media or watching others behave aggressively[1]. Mental or physical traits may predispose a person to violence, but violent tendencies are activated by factors in the environment. Contemporary trait theorists maintain however, that some carry the potential to be violent or antisocial, and antisocial behavior occurs with pre-existing tendencies triggered by environmental conditions[1].

In the end, the Trait theory tends to lean towards both nature *and* nurture. Criminology scholars explain

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Ronald Schouten MD, JD

Renée Sorrentino MD

In this continuing series, we are speaking with AAPL's former Rappeport fellows and exploring their career paths. Ronald Schouten, MD, JD received the Rappeport Fellowship in 1987. A well known forensic leader in the area of workplace violence and a sought after colleague and mentor at Massachusetts General Hospital, it was an honor to catch up with Dr. Schouten and learn about his early career and the formative role of AAPL.

Dr. Schouten first learned about the Rappeport Fellowship from Dr. Gutheil who would become his Rappeport Mentor and lifelong mentor. Dr. Schouten described the Rappeport Fellowship as "very helpful for me, as someone who had not had a formal fellowship. It was a great way to get emerged in the culture of the forensic psychiatrist…to learn the language, how people think, and who is in the organization." Dr. Schouten recalled his first AAPL meeting, as a Rappeport Fellow in Ottawa, "meeting the leaders in the field including Dr. Rappeport. Everyone was so generous with their time."

Dr. Schouten received his JD from Boston University School of Law and his MD from the University of Illinois College of Medicine. He practiced employment law in Chicago before attending medical school. Following medical school he began an orthopedic surgery residency. During his orthopedic residency he noted he "didn't really click with the residents" and left the program to pursue psychiatry. He graduated from the Mass Mental Psychiatry residency program in 1989.

Dr. Schouten started the Law and Psychiatry Program at Massachusetts General Hospital in 1997. The mission of the program was to be an academic center for a fellowship program. Dr. Schouten's introduction to AAPL including the development of mentorship relationships with members such as Drs. Gutheil and Strasberger was instrumental in executing the mission of the Law and Psychiatry Program. Dr. Schouten referenced the academic scholarship of the review course and the AAPL Journal as inspirational.

Over the span of his career, Dr. Schouten has continued to view AAPL as a professional home. He noted, "AAPL continues to be important. My hope is for the organization to continue to apply the principles of forensic psychiatry in a wide variety of areas." When asked how AAPL influenced his career, Dr. Schouten stated, "from an advancement standpoint, being able to go hear presidents and past presidents and other people talk about their work. AAPL leaders have such an enthusiasm for teaching-it was really remarkable."

Dr. Schouten has been active in AAPL committees, reviewing articles for the journal, and presenting at annual meetings. He maintains that AAPL has been most influential in providing mentorship, both locally and nationally. It is clear when reflecting on Dr. Schouten's successful career that he continues to embody the key features of what he admired in the Rappeport Fellowship, inspiration, mentorship, and academic scholarship.

Juveniles' Waiver

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psychiatric/mental health input, courts, state legislatures, and even Hollywood (e.g., in "Making a Murderer") have started to identify and attempt to rectify these problems.

1. In *J.D.B v. North Carolina* (2011), the USSC ruled that age be considered with respect to Miranda waivers, reasoning that younger age affects youths' perceptions and decision making. In this case, the justices drew on similar evidence to that presented in *Graham v. Florida* and *Miller v. Alabama*, noting that due to their immaturity, adolescents are less capable of understanding and appreciating their rights as defendants.
2. In early 2017, Illinois enacted a statute (SB 2370) that provided that:
   a. "a minor who was under 18 at the time of the commission of an offense must be represented by counsel throughout the entire custodial interrogation"
   b. "an oral, written, or sign language statement of minor made without counsel present throughout the entire custodial interrogation of the minor shall be inadmissible as evidence in any juvenile court proceeding or criminal proceeding against the minor."
3. Similarly, in October 2017, California Governor Jerry Brown signed into law SB 395, which required that:
   a. "a youth 15 years of age or younger consult with counsel in person, by telephone, or by video conference prior to a custodial interrogation and before waiving any of the above-specified [Miranda] rights."
   b. "[T]he bill would prohibit a waiver of the consultation."

Obviously, policy and legal changes in this area are just beginning, and forensic psychiatrists as individuals and AAPL as an organization will continue to have opportunities to weigh in on and inform policymakers' approach to this issue. As I mentioned in my last Newsletter article, AAPL and its members "are uniquely qualified to shape public policy and opinion as they relate to the interface of psychiatry and the law."

Interestingly, and perhaps not coincidentally, one of the 2018 Annual Meeting lunch speakers, Richard Rogers, PhD, has published extensively on this topic and was instrumental in

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Substance Use in Pretrial Defendants

Cristina M. Secarea MD, Addiction Committee

Substance use has a high prevalence among forensic populations, with more than 80% of jail inmates reporting drug use and 53% meeting the criteria for drug abuse and dependence.[1] Drug use is similarly associated with high rates of recidivism, with 68% of drug offenders rearrested within three years of release from prison.[2] Even with such a high prevalence of substance use and recidivism, there are only few studies on the influence of substance use on forensic populations assessed for competence to stand trial (CST).

Nicholson reported that alcohol use around the time of the offense increased the likelihood of restoration.[3] In a more recent study, however, Mossman reported that substance use reduces the likelihood of restoration.[4] Despite its pervasiveness in forensic populations, substance use's effect on CST appears to run into power problems in more recent efforts.[5,6]

Forensic hospitals providing competence restoration treat acute symptoms of substance use, ranging from withdrawal to agitation and aggression to acute psychosis. Substances, like phencyclidine, cocaine, crack, methamphetamines and synthetic cannabis, are therefore a necessary focus of acute treatment. But once acute symptoms stabilize and restoration starts, defendants may find themselves struggling with impairment caused by chronic substance use, including cravings, insomnia, mood disturbances, lingering paranoia, and cognitive impairment.

What seems to be missing is a more systematic approach to the chronic manifestation of substance use. Because of the resources required, motivational interviewing (MI), individual counseling, cognitive behavioral therapy, substance abuse groups, opioid replacement treatment, and naltrexone treatment appear to be less well represented in institutional programming. State facilities maintain their focus on providing appropriate competence education, especially in states where defendants are not accompanied by a court order mandating substance treatment. This can be a problem, because defendants relapse after discharge, commit crimes, and return for assessment.

Treating acute symptoms is a critical start in addressing relapse and recidivism, but it is not enough without the chronic focus. The benefits are clear. Multiple studies have shown that defendants receiving drug treatment have a longer time to re-arrest as well as fewer arrests.[7] One systematic review of drug treatment programs reported that methadone maintenance and naltrexone reduce reoffending and relapse.[8] In addition, use of naltrexone with alcohol-dependent defendants has a lower likelihood of re-arrest than matched controls (8% versus 26%).[9] MI, a well-established technique that involves empathic listening, developing “discrepancy,” rolling with resistance, and supporting self-efficacy has strong empirical support in trials with substance use. A British systematic review, including ten randomized controlled trials found MI used with offenders leads to higher retention in treatment, enhanced motivation to change, and reduced offending.[10]

Appropriate substance treatment for pretrial defendants that focuses on relapse prevention will likely contribute to shorter length of time to restoration – a view supported by a literature that already connects more intense substance treatment with decreased recidivism.[7-10] A tighter focus on chronic illness should have a measurable effect on time to restoration of competence, on re-offense, and re-hospitalization alike.

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Class Action

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prevent deterioration;

- Using lack of a patient's motivation as grounds for denying coverage, even when the patient has the capacity to recover;
- An overbroad definition of custodial care with a corresponding overly narrow view of improvement and active treatment; and
- Failure to address the unique needs of children and adolescents.

Class action litigation such as this case allows class plaintiffs to band together to seek redress. We should all watch for the outcome of this important case closely.

Updating the Marijuana Use History: "Doc, I treat my depression with Incredible Hulk."

Ryan C. W. Hall MD, and Henry Levine MD, Psychopharmacology Committee

Currently, 29 states and the District of Columbia allow the use of marijuana, either recreationally or medicinally. [1,2] In several of these states, marijuana sellers have started to advertise and publicly proclaim the purported properties and virtues of their products. Unlike its treatment of other herbal products, the federal government via the FDA historically has not regulated claims made about marijuana, since the drug is still listed as a Schedule I Controlled Substance. This prevents legal sale or medical use of marijuana.[3] However, since 2015 the FDA has started to send warning letters to companies regarding egregious marijuana advertising claims, with the most recent warnings in November 2017 relating to claims that medical marijuana shrinks/kills cancer cells.[4] On the FDA website, the agency notes that "[It] considers many factors in deciding whether or not to initiate an enforcement action-include[ing], among other things, agency resources and the threat to the public health."[5]

To date, the federal government has continued to follow the Obama administration's policies as set forth in Deputy Attorney General James Cole's 2013 memorandum.[6] That document stated that the federal government would not prosecute marijuana distributors as long as certain procedures were followed. States are required to prohibit access to recreational marijuana by minors and to prevent diversion of marijuana outside the regulated system, particularly to states where marijuana is illegal. They are required to track revenues from marijuana sales and to prevent diversion of those profits to large cartels and criminal enterprises. The states also must prevent the growth and production of marijuana products on federal and public lands. Nothing in the memorandum, however, addresses how marijuana is to be marketed or advertised for treating illness.

Legalization of marijuana has led to an explosion in the number of strains and varieties of marijuana products offered, and in the means individuals use to consume those products. Products can be smoked (bud, stem and leaf), vaporized, ingested as edibles, sprays and tinctures, and rubbed on the skin in topical preparations. Thus, the traditional way in which a physician obtains a history of substance use (e.g. learning the amount, frequency, route of administration, and mixing) may be insufficient to adequately address the effects of marijuana on today's patient or evaluee due to varying potencies even when taken by similar routes.

Psychiatrists generally may be unaware of the differences between the extent and rate of absorption of different products. For example, one might puzzle over how many "Gummy Bears" it takes to equal the effects of one joint, or how the "Incredible Hulk" strain may affect one differently than the "Fruity Pebbles" strain. While psychiatrists may be familiar with the differential effects of drinking 12 ounces of beer vs. 12 ounces of wine vs. 12 ounces of 100 proof liquor, many may not appreciate that similar degrees of difference in effect occur between smoking 5% THC joint, 29% THC joint, and "dabbing" (vaporizing) 80% THC Butane Honey Oil.

Some websites endeavor to list comparisons of commercially available cannabis products. Medicalmarijuanastrains.com lists over 200 strains of "medicinal marijuana." Many of these strains have colorful names, such as "AK-47" and "91 Chem Dog." Many strains are described similarly to the ways fine wines and cigars are characterized. For example, on Medicalmarijuanastrains.com, "Incredible Hulk" is described as having a "fruity smell [with] lemon undertone taste, [and] vibrant orange hairs." It is additionally presented as having effects of a "good head high [with] no crazy thoughts, [resulting in] just a focused chill." Its medicinal qualities are said to include a "strong potency" for relieving anxiety and depression.

Another website, Cannasos.com, describes "Incredible Hulk" thusly: "[It] induces long lasting cerebral euphoria, energy, and creativity boost [which] uplifts spirits [and] increases social interaction and focus."[8] Cannasos.com implies that the name "Incredible Hulk" derives from the plant's physical and psychedelic properties, stating, "This bud [being] true to its name, with big nugs and high THC content, [but d]on't worry, this giant will not harm you." That same website attempts a more objective comparison by providing average concentrations of various substances found in the strains, such as, for "Incredible Hulk," listing THC content at 15.78-19%, CBD (cannabidiol) 0.10-0.41%, and CBN (cannabinol) 0.10-0.15%.

Contrary to the claims on many commercial marijuana websites, a 2013 APA resource document notes marijuana does have potentially harmful effects: "Several studies have shown that cannabis may in fact exacerbate or hasten the onset of psychiatric illness…including…mood disorders, anxiety, and psychosis, particularly in young adulthood. Cannabis use is associated with the emergence of mood disorders, particularly symptoms of bipolar disorder, among those with a family history of mood disorder. Among those with major depressive disorder, co-morbid cannabis use is associated with increased rates of both suicidal ideation and attempts, raising grave safety concerns. Among those with a predisposition to psychotic disorders, cannabis may hasten the emergence

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Correctional Officer Suicide: An Overlooked Problem

Ariana Nesbit MD, MBE and Hal S. Wortzel MD, Suicidology Committee

Forensic psychiatrists know that prisoners are at high risk for suicide and actively endeavor to mitigate this risk. The issue of police officer suicide has recently gained national attention, and police agencies are increasingly taking steps to improve police officer mental health. For example, agencies are encouraging officers to ask for help, they require officers to seek counseling after traumatic events, they are beginning to emphasize confidentiality, and they are instituting no-punishment policies for obtaining mental health care[1]. Correctional officers are at even higher risk for suicide than police officers[2]. However, the issue of correctional officer suicide has not engendered the same degree of attention.

Few studies have quantified correctional officer suicide. In 1997, Stack and Tsoudis reviewed suicide data from 21 states. After controlling for variables known to be predictive of suicide, the authors found that 7.14% of correctional officers died by suicide compared to 4.51% of the general working-age population[2]. In 2009, the New Jersey Police Suicide Task Force reported that New Jersey corrections officers died by suicide at more than twice the rate for the general working-class population in that state[3]. A review of data from the 2013 California Correctional Peace Officers Association found that the suicide rate for its members was 19.4 deaths per 100,000, compared to 12.6 deaths for the general United States population[4]. Last year, Violanti et al. reported that correctional officers were 41% more likely to die by suicide than the general working population. Female correctional officers died by suicide at nearly twice the rate of other US female workers, though this finding did not reach statistical significance[5].

Researchers have proposed various explanations as to why correctional officers are at high risk for suicide; however, there is little research to support their hypotheses. Correctional officers have low rates of job satisfaction, and the work of a correctional officer is stressful. Correctional officers must be constantly on guard against inmate attacks and other unpredictable behaviors, they work long and rotating shifts, often with mandatory overtime, and many report low social support in the workplace[5,6]. Correctional officers have also identified strict administrative oversight and "seemingly contradictory rigid policies and procedures" as sources of stress[7]. These stressful conditions have been linked to psychological distress. Bezerra et al. reviewed the literature on psychological distress and stress in the work of correctional officers, and identified the following risk factors for psychological distress: work overload, lack of material and human resources, frequent contact with the inmates, overcrowding, perceptions of fear or danger, and the paradox of punish/reeducate[8].

Perhaps unsurprisingly, correctional officers are at increased risk of developing several mental health disorders. For example, they have high rates of alcohol misuse. This is likely in part due to the fact that law enforcement subcultures may normalize the use of alcohol as a way to cope with workplace stress[9]. In addition, Denhof and Spinaris found that 25.7% of US correctional officers report symptoms of at least moderate depression, and 27% report symptoms consistent with a diagnosis of post-traumatic stress disorder[10]. Despite these figures, little attention has been paid to the issue of correctional officer mental health. Pittaro describes how, throughout his 20-year career in corrections, "discussion of suicide within the profession was a taboo topic because corrections employees were not supposed to appear emotionally vulnerable or fragile. After all, emotional vulnerability often equates to emotional instability, which is perceived to be a weakness within the profession." However, some leaders within the profession are now paying attention. As Stephen Walker, the director of governmental affairs for the California Correctional Peace Officers Association, says, "We are finally saying, there is something wrong and we need to fix this"[4].

More research is needed to examine the relationship between job stressors and suicide risk in order to identify target areas. However, as Henning points out, regardless of what the research shows, it will be impossible to eliminate all stressors[7]. That being said, some protective factors against correctional officer psychiatric distress have been identified, and these may be good initial targets: social support within the prison environment, participatory and flexible leadership, officer training on healthy coping strategies, and easily accessible psychological care[8]. Bezerra et al. also recommend training officers to "reflect on the life conditions of prisoners" so that the officers no longer view the inmates as "the enemy"[8].

Many correctional settings do have Employee Assistant Programs (EAPs); however, the quality of these programs varies[7]. Pittaro recommends that EAPs hire mental health clinicians who have experience working in corrections because they will better understand the environment's unique policies and stressors[1]. In order to empower the workers to advocate for their needs, Henning also suggests that administrators engage correctional officers in the development of policies and practices intended to address stress, health, and safety concerns[7]. In addition to offering routine mental health and substance use treatment, correctional institutions should also develop critical incident response teams to support officers who have been involved in traumatic events[1]. Some have advocated for the creation of formal mentoring programs between new and veteran correctional officers in order

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Gender Dysphoria in Juvenile Corrections

Matthew E. Hirschtritt MD, MPH, Child and Adolescent Committee

Gender identity and gender expression can be conceptualized on multiple spectra, including sex assigned at birth (ranging from prototypically male to female physiology and genetic composition), gender identity (a psychological identification with "male" or "female" characteristics), gender expression (one's communication of gender), and sexual orientation (erotic attraction). The term "transgender or gender non-conforming" (TGNC) is used to refer to individuals whose sex assigned at birth does not match their gender identity or expression, or those whose gender identity or expression does not conform to the male/female binary (e.g., genderfluid, genderqueer). The *DSM-5* defines gender dysphoria (GD) among adults and adolescents as a mismatch between an individual's sex assigned at birth and gender identity or expression, lasting at least 6 months, and leading to significant impairment or distress[1].

Researchers, policy makers, and clinicians have drawn attention to the prevalence and unique needs of adults with TGNC in correctional settings[2]. However, much less is known about the prevalence, characteristics, and needs of detained TGNC youth with and without GD, despite evidence suggesting these youth may be increasingly represented in correctional settings[3,4]. A recent study based on youth self-report revealed that 5-8% of adolescents detained in correctional settings may identify as gender non-conforming[5]. In this context, correctional staff and clinicians in many jurisdictions are grappling with ways to balance the psychological, social, and medical needs of these youth with other considerations, such as limited resources, non-standardized assessment techniques, safety concerns, and caregiver involvement.

TGNC youth, regardless of GD diagnosis, are at higher risk of suicidal behavior, mental health issues, substance use disorders, and assault and harassment than their gender-conforming peers[4,6]. Societal stigmatization and rejection places TGNC youth at higher risk for court involvement; for instance, peer victimization in school may lead to truancy, which is considered a status offense, leading to police and juvenile court involvement. Similarly, family rejection, high rates of homelessness and mental health issues (including depression and suicidality), and disproportionate representation with inadequate treatment in the foster care system all place TGNC youth at higher risk of detention than their gender-conforming peers[4].

Once detained, TGNC youth face new challenges; similar to other sexual minority youth (e.g., those who identify or are perceived to be gay, lesbian, or bisexual), TGNC youth in detention centers report experiencing high rates of physical, sexual, or verbal assault[4]. TGNC youth are at higher risk of prolonged "protective" isolation, often enacted to address victimization of sexual minority youth or conflicts that arise because of unconventional gender expression or sexual behavior, as well as rates of sexual abuse nearly 10 times higher than among heterosexual, gender-conforming youth[3]. Incarcerated youth with GD may face barriers in access to medical and mental health professionals with expertise in the evaluation, diagnosis, and treatment of GD (e.g., psychotherapy, puberty-suppressing agents and other hormonal treatments). Parents or legal guardians may not be aware of a youth's desire for GD treatment. This factor raises the need for additional communication between family members, the youth, and the treatment team. Youth assent and consent by the parent, legal guardian, or another decision maker should also be clarified. Custody and administrative staff may struggle with issues regarding pronoun usage, preferred names, housing (e.g., whether to house a TGNC youth in a male- versus female-specific facility or unit), and access to gender-affirming clothing, hair length and style, make-up, hair removal products, and other personal items. Little to no data exists on the complex issue of gender affirming surgery for incarcerated youths with TGNC, which leaves healthcare professionals with minimal guidance on the appropriate use of this potentially beneficial—but irreversible—treatment in juvenile justice settings. Additional research is needed in order to establish evidence-based guidelines for surgery in TGNC youth offenders.

The Prison Rape Elimination Act of 2003 (PREA)[7] was enacted to address the high rates of sexual assault and rape in US prisons and juvenile detention centers; it correspondingly brought increased attention to the presence and needs of sexual minority youth, especially regarding issues of appropriate housing among TGNC youth to prevent sexual assault. Three years later, the first published opinion regarding sexual minority youth in detention centers was issued by the Hawaii US District Court. In *R.G. v. Koller*[8], the court granted preliminary injunction against the Hawaii Youth Correction Facility (HYCF) based on the facility's failure to provide the plaintiffs, who were or were perceived to be sexual minorities, with their due process rights. Specifically, the court ruled that the HYCF demonstrated "deliberate indifference" by failing to provide: (1) policies and training for sexual minority youth, (2) appropriate staffing and supervision, (3) a functioning grievance system, and (4) a classification system designed to protect sexual minority youth. This and subsequent cases have served as signals to juvenile detention centers that they need to proactively consider how to identify and address the needs of TGNC youth.

Concurrent with the increased visibility of TGNC adults and youth in

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Gender Dysphoria

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the justice system, prominent organizations have released position statements and guidelines to address sexual minority (including TGNC) youth. Among national guidelines, the World Professional Association for Transgender Health's Standards of Care (WPATH SOC), 7th Version, provides best-practices for identification and treatment (medical and psychological) of transgender individuals, as well as guidance in correctional settings[9]. Further, the National Commission on Correctional Health Care (NCCHC) issued a position statement regarding transgender health care in correctional settings[10]. Notably, the NCCHC statement includes provisions for facilities to adhere to the WPATH SOC, treat individuals on a case-by-case basis, housing in the least-restrictive environment that ensures safety, providing therapy for GD when appropriate, offering hormonal therapy initiated prior to incarceration, and offering to initiate hormonal therapy or SRS when "medically necessary." Furthermore, the NCCHC statement recommends against offering "reparative" or "conversion" therapy to change gender identity, and isolation or segregation "exclusively […] to ensure safety" unless alternative means have been exhausted, and should not exceed 30 days if enacted.

In addition to national guidelines, various jurisdictions have generated policy statements designed to address the identification and treatment of sexual minority youth in correctional facilities. An up-to-date list of such policies are available from The Equity Project. Although diverse in their scope and mandates, most of these policies share common attributes, including: prohibiting discrimination (e.g., ensuring confidentiality, providing sensitive screening and intake, reporting and responding to victimization), collecting and protecting sexual minority status information, providing ongoing staff training, engaging families, and collaborating with clinicians. Many policies also address specific means to provide respectful treatment (e.g., conducting professional physical searches of TGNC youth when necessary), ensuring safety (e.g., making housing decisions on a case-by-case basis), ensuring privacy (including from caregivers), and appropriate medical care.

Many juvenile detention facilities face hurdles in seeking to adhere to these guidelines and policies. Namely, staff may harbor discriminatory or inaccurate perceptions of TGNC youth or they may lack adequate knowledge about how to identify and address the day-to-day needs of TGNC youth within a custodial setting where most decisions are made based on custody, control, and security concerns. In addition, there may be logistic or resource-specific limitations, such as lack of housing to accommodate genderfluid youth or medical or mental health providers who are well versed in TGNC care. Even with appropriate staff training and resources, detention staff and clinicians may struggle with ways to protect TGNC youth privacy while securing consent from caregivers (e.g., to initiate hormonal treatment). Also, given the increased visibility and societal acceptance of TGNC identities, and the real and perceived privileges of TGNC status in correctional settings, some detained youth may feign TGNC status for secondary gain. Staff and clinicians will increasingly have to find means by which to distinguish "real" from "malingered" TGNC identities.

Identifying and meeting the needs of TGNC youth in correctional settings is a growing issue. Most relevant guidelines are directed toward TGNC and other sexual minority adults; although many provisions of these documents are useful, those working with detained minors must contend with additional challenges (e.g., caregiver consent, the fluidity of gender identity in youth versus the irreversibility of SRS). Future research and policy should address the unique needs of TGNC youth in correctional facilities.

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Gender Issues in Corrections

Tara Collins MD, MPH, Anna Glezer MD, Susan Hatters Friedman MD, Brian Holoyda MD, MPH, MBA, Aimee Kaempf MD, Gender Issues Committee

Women represent the fastest-growing segment of correctional populations, and transgender individuals are found at a higher rate in the penal system than in the general population. Correctional systems must contend with a variety of gender-specific issues involving the provision of appropriate medical and mental health treatment.

The War on Drugs led to the criminalization of illicit substance use, combined with de-emphasis on rehabilitation for substance use disorders. Women, especially impoverished women of color, were disproportionately affected by the change in policies. Women enter the criminal justice system for different reasons than men – mostly for drug use or drug-connected criminal activity. The majority of incarcerated women, up to 78% in some studies, have experienced victimization and/or trauma prior to incarceration. Incarcerated women have a higher lifetime prevalence and severity of psychopathology, particularly substance use disorders, trauma- and stressor-related disorders, major depression, and generalized anxiety disorder. In addition, compared to men, incarcerated women have a higher prevalence and severity of chronic medical conditions which also affects their mental state and functioning (1, 2).

Typically, programming and treatment for women in correctional settings has been inadequate and not suited to women's unique needs. There has been increasing research looking at gender-responsive treatment (GRT) or gender-specific treatment (GST), which takes into account the complex interactions among substance use, trauma, mental illness, and relationships for women. Examples of GRT/GST include Seeking Safety; Addiction and Trauma Recovery Integration Model (ATRIUM); Trauma, Addiction, Mental Health, and Recovery (TAMAR); and Trauma Recovery and Empowerment Model – TREM for women and M-TREM for men; and Path to Freedom (3, 4).

It is challenging to estimate how many incarcerated inmates identify as transgender, as there is a lack of acceptance and a fear of harm with identification. One study from San Francisco found that 14% of transgendered individuals had been incarcerated at least once. Several landmark cases illustrate the challenges transgender inmates have while incarcerated. Most cases are founded on 8th and 14th Amendment rights, including the equal protection clause, the right to due process, and protection from cruel and unusual punishment, including deliberate indifference. Recent cases have used these foundations to answer questions regarding the medical necessity of gender affirming surgery, administration of hormonal medication, and the use or misuse of administrative segregation to house transgender inmates. Last January, an inmate in California was the first to receive gender affirming surgery based on a judge's ruling that it is medically necessary (5). Additionally, the National Commission on Correctional Health Care (NCCHC) released a position statement (which is not binding on courts) that states "Because inmate-patients may be under different stages of care prior to incarceration, there should be no blanket administrative or other policies that restrict specific medical treatments for transgender people" (6).

Despite legislative efforts such as the Prison Rape Elimination Act (PREA), sexual assault and other safety issues remain a significant problem for incarcerated women. Studies estimate that over half of women entering correctional settings within the US have a history of physical and sexual abuse, which places them at greater risk for re-victimization and becoming traumatized while incarcerated. According to the National Former Prisoner Survey of 2008, the rate of inmate-on-inmate sexual victimization during female former prisoners' last episode of incarceration was three times higher than that for male former prisoners (13.7% versus 4.2%). In addition, the rate of unwilling sexual activity with staff was more than twice as high for women (2.5%) as compared to men (1.1%) (7). Some factors that potentially increase female inmates' risk for sexual victimization include inappropriate staffing practices that isolate women with male correctional staff members, as well as work assignments that keep women out of their cells at odd hours.

Cross-gender supervision activities, though meant to be curtailed by PREA standard 115.15, continue to occur in correctional settings around the country. Inmates have attempted to challenge cross-gender supervision activities on Fourth, Eight; and Fourteenth Amendment grounds. Case law indicates that some jurisdictions have recognized inmates' limited bodily privacy right against unreasonable search, though frisks and body cavity searches are not *per se* unconstitutional (8). Cross-gender supervision activities are likely to become an area of increasing concern and scrutiny in coming years due to increased litigation, their presentation in the media, and the associated increased risk for sexual assault of female inmates.

Pregnancy during incarceration is becoming more common. Anywhere from 5,000 to 12,000 pregnant women are incarcerated in the U.S. at any given time. Data on pregnancy and incarceration are limited because of variable reporting requirements and inconsistent testing upon entry into correctional facilities (9). Provision of prenatal care varies across institutions. Though the same standards of obstetrical care apply to women whether they are living in correctional facilities or in the community, the needs of incarcerated pregnant women often conflict with institutional needs. The American College of Obstetrics and Gynecolo-

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Gender Issues

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gy standards for perinatal care in correctional settings include pregnancy testing at intake, access to pregnancy counselling and abortion services, assessing and treating for substance abuse, HIV, and depression, providing vitamins and dietary supplements, delivery in a licensed hospital with facilities for high risk pregnancies, and the provision of postpartum contraception (10). Special challenges arise involving shared care among correctional medical staff and community providers, transportation, dietary needs, reduced access to psychosocial supports, childbirth education, the use of restraints, postpartum care and breastfeeding. Despite such challenges, overall pregnancy outcomes are positive for incarcerated women with more days incarcerated associated with higher birth weights, likely reflecting the impact of regular prenatal care, stable housing and meals, relative physical security, and a reduction is substance use (11).

According to a recent American study, up to three-quarters of women in prison have minor children (12). Yet, because there are fewer female offenders than male offenders, women's prisons are farther between, and the prison may be quite a distance from the woman's home. A large minority of these mothers were single mothers prior to their incarceration. When a man goes to prison, most often his children are looked after by their mother. However, when a woman goes to prison, under a third are cared for by their father. The child of an incarcerated mother may visit the mother in prison during family visit days, and often finds an environment which is not child-friendly.

An alternative to outside caregivers, Mother-Baby Units (MBU) are found in various nations, including the United Kingdom, Germany, Holland, Australia, New Zealand, Canada, and parts of Latin America. As well, 9 states offer MBUs. Estimates are that the cost per infant in a prison nursery are similar to the cost per infant in foster care. Infants and young children may stay with mothers in specialized prison units, for variable lengths of time, if mothers meet criteria for the program. The goals of MBUs are that by keeping the infant and mother together, bonding and parenting skills will be improved, and reoffending will be reduced. There has been some success in both realms.

Mental health professionals working in correctional settings should be familiar with the gender-related issues described in order to provide appropriate, targeted care to female and transgender inmates.

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Editor's Column

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a friend who she encouraged by text and phone. Dr Wills updates us on the work going on at the APA.

You'll read suggestions for getting started in publishing and also a discussion of the importance of research in our field. We will learn about the RISE program in Denver, and the international relations committee trip. You'll learn about Michigan's mental health and criminal justice planning summit—and also how it offered an innovative opportunity for forensic trainees in policy development. We'll spend a Tuesday afternoon with Dr Sandy Simpson in a Canadian remand prison.

Then, we will turn our thinking to 'social disease'. We'll also read about the trait theory. The Rappeport retrospective series (interviewing former Rappeport fellows about their careers) continues in this issue. Further committee articles discuss substance use and competency to stand trial, and thoughtful assessment of the marijuana use history—now that many states have a variety of edible marijuana products available (which you may recall includes the states with the two most recent AAPL meetings).

We next turn to suicide among correctional officers, which as the authors write, is an often overlooked issue. We read about gender in corrections—both the complex issue of gender dysphoria in juvenile correctional facilities, and the multiplicity of gender issues in adult corrections—ranging from the need for gender responsive

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Marijuana Use

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of both positive and negative psychotic symptoms. The use of higher potency cannabis, for longer periods of time and with more frequency, is also associated with increased risk of psychosis."[9]

While high-THC marijuana branded strains such as the "Incredible Hulk" report that it is "good for anxiety," there is more scientifically-based evidence to support the use of cannabidiol, which is not intoxicating, for anxiety. However, even with cannabidiol products, concerns have been expressed regarding accuracy of the labeling. Only 1/3 of cannabidiol (CBD) products (e.g., oils, tinctures, and vaporizer products), when tested independently, contained the percentage of CBD reported.[10] The plurality of the 84 products tested had less CBD than was reported (~42% under label, 26% over label, 30% correctly labeled). In addition, approximately 21% contained THC in concentrations up to 6.43 mg/ml despite their being marketed as CBD products. Therefore, the advertising accompanying such products may do little to enlighten the user or the physician taking a substance use history of what is actually being consumed. This state of affairs has resulted from the historic federal prohibition/limitations to scientific research on medical marijuana, and by the aforementioned lack of regulatory enforcement of the marijuana industry's advertising by the federal and state governments. A potentially useful medical reference discussing various aspects of marijuana physiology and pharmacology is edited by Roger Pertwee, Handbook of Cannabis (Oxford University Press, 2014).

In summary, it may be important for psychiatrists and other practitioners to re-evaluate how they take a marijuana use history and be aware of potential limitations of the answers they receive (e.g. use but do not know strain or real concentrations in an advertised product). As always, it is critical to learn about amount used and means of delivery. However, it is increasingly important to inquire about the particular strains used and the names of the products in order to determine the relative potencies and the nature of the psychoactive compounds to which a user is exposed. It is also useful to ask about the reasons for which the marijuana is being used. Although often use may be presented as medicinal, individuals selecting high potency, high THC strains such as "Incredible Hulk" and "AK-47" may use for other reasons or may be deceived about the product they choose. Websites offering comparative marijuana descriptions may not contain the most accurate information on products they evaluate. However, they may be a place to start trying to gain understanding of the various strains and products to which our patients and evaluees are being exposed. It may be useful as well to contrast that understanding with the users' stated goals for their marijuana use. In addition, knowledge of the varying forms and strains of marijuana in forensic practice is helpful in educating judges and juries as to potential cannabis effects and dangers. As noted at the 2016 Critical Issues in [University] Campus Public Safety Forum, *"courts don't view the gummy bear the same as a pile of raw marijuana."*[11]

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Officer Suicide

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to create a space for the new officer to discuss the stress of the job and to receive support. Such programs might have benefits not only for the new correctional officer, but also for the veteran officer, who may find meaning in their role as a mentor[7]. In fact, Farnese et al. found that a formal mentoring program helped newcomers to adjust to the stressors of the work, "which in turn exerts a protective influence against burnout onset by reducing cynicism and interpersonal stress and enhancing the sense of personal accomplishment"[11].

In conclusion, the job of the correctional officer is stressful, and correctional officers die at disproportionate rates from suicide. Correctional officer suicide has received little attention, and more research is needed to examine the risk factors for suicide in this population, and to develop strategies to mitigate suicide risk. Moreover, an improvement in the mental health of correctional officers may have a positive impact not only on prison workers themselves, but also on inmates, correctional environments, and our greater community[8].

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Becoming the Medical Director of a Forensic Hospital

Tobias Wasser MD, Forensic Hospital Services Committee

In July 2017 I took on a new professional role as the medical director of the forensic division of our state psychiatric hospital. I went from working on a 20-bed inpatient psychiatric unit in a community based civil setting to overseeing two assistant medical directors and 12 attending psychiatrists caring for approximately 200 forensic patients, most of whom have been found not competent to stand trial (CST) or not guilty by reason of insanity (NGRI). While I felt that I had received incredible training in forensic psychiatry during my fellowship and had some clinical and forensic experience under my belt before I embarked on this new adventure, I certainly wondered how well my training would prepare me for the new role I was undertaking.

As many of us know, forensic psychiatry fellowship is a wonderful, enriching and sometimes challenging educational experience in which one learns a great deal about the ways in which mental health issues intersect with the legal and criminal justice systems. Though all fellowships have rigorous guidelines set forth by the Accreditation Council of Graduate Medical Education (ACGME) for shared experiences and developmental expectations for fellows, there is still some room for variability in these experiences.[1] While some fellowships are more heavily weighted toward providing fellows experiences in courtroom settings and writing reports, others focus more so on correctional and forensic hospital settings.

However, given the vast amount of knowledge and experiences which need to be fit into the tightly packed one-year fellowship, there is rarely enough time available to sufficiently prepare fellows for what most "forensic" jobs look like in the world. Much of forensic fellowship focuses on preparing for the courtroom, but most "forensic" jobs entail working in a forensic hospital or correctional setting. And whether one takes a position working in a correctional or forensic hospital setting, there are elements of the work which one cannot anticipate until you are really there. For example, simply treating criminally involved patients with severe mental illness, substance use disorders and/or personality disorders at high risk for violence is a sufficient challenge in and of itself. This task becomes even more complex when one mixes in the additional tasks of overseeing a multidisciplinary clinical team and navigating the needs and differing priorities of correctional staff, particularly when those needs do not align with the goals of treatment.

> *"Much of forensic fellowship focuses on preparing for the courtroom, but most forensic jobs entail working in a forensic hospital or correctional setting."*

I have found that becoming the medical director of a forensic hospital adds yet another layer of complexity to this mix. The medical director of a forensic hospital is typically responsible for overseeing the clinical and psychiatric care provided within the institution. Depending on the particular institution's clinical and administrative framework, this role might involve a variety of tasks, including direct clinical care, supervision of staff, overseeing critical incident reviews, functioning as part of the hospital's leadership team, overseeing compliance with documentation and regulatory requirements and performing audits to monitor adherence to such requirements. Though some of these skills and capacities may be addressed through other training opportunities, such as non-ACGME public/community psychiatry fellowships[2], few if any are thoroughly addressed during the course of a forensic fellowship. Despite this hypothetical mismatch between training experience and job description, it is not uncommon for forensically trained psychiatrists to end up in such roles. This is often due to forensically trained psychiatrists' experience with and understanding of the law's impact on various aspects of mental illness and mental health treatment. For example, in order to oversee the care and management of a large group of legally involved patients (or mentally ill inmates depending on the hospital/jurisdiction), I have found it to be extremely helpful to have experience with and a thorough appreciation of processes such as competence evaluation and restoration, criminal responsibility determinations, violence risk assessment, and the like.

In spite of the challenges, since taking on this new role I have found that serving as the medical director for a forensic hospital has been a uniquely rewarding experience that allows me to make use of my forensic training and experience in new and exciting ways. First, although the staff working in such settings may be quite experienced and capable in a variety of ways, they may not have had significant training in the law or the ways in which the law impacts the patients served in the forensic hospital. The forensic psychiatrist's familiarity with the legal system, particularly as it pertains to issues relevant to the patients treated in that setting (e.g. CST and NGRI patients) allows the forensically trained psychiatrist to teach staff about these issues to help inform their understanding of the patients' circumstances. Also, given the legal oversight of patients in forensic hospitals, typically there are a number of reports being generated on a regular basis to inform the court or appropriate legal body of the patients' clinical status. As medical director one may be directly writing these reports or supervising/reviewing the reports of

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Ask the Experts

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human remains identification is permitted, but the genetic information may only be used for analysis of DNA markers for quality control to detect sample contamination.

Confidentiality of Genetic Information

It is also unlawful for a covered entity to disclose genetic information about applicants, employees or members. Covered entities must keep genetic information confidential and in a separate medical file. (Genetic information may be kept in the same file as other medical information in compliance with the Americans with Disabilities Act.) There are limited exceptions to this non-disclosure rule, such as exceptions that provide for the disclosure of relevant genetic information to government officials investigating compliance with Title II of GINA and for disclosures made pursuant to a court order.

A. Glancy: First and foremost, forensic psychiatrists must be very good general psychiatrist. In a forensic assessment, it is important to take a full psychiatric history, which of course includes a family history. Forensic assessment includes the inquiry into whether there is any family history of a mental disorder that potentially contributes to the formulation whereby genetic or familial influences are factors in a biopsychosocial understanding of the evaluee. It is normal to ask about each parent in turn including their current age, past or present occupation, and mental and physical health. This is followed by an inquiry about the relationship with the evaluees and other family members. A similar sequence of questions will be applicable to each sibling in turn, and any other members of the new family such as grandparents, if this is thought to be relevant to the topic.

In particular, a history of mental disorder or substance use disorder in a family member may be of relevance. It is also essential to ask about medical illnesses as a family history of endocrinological disorder or a neurological disorder such as Huntington's disease may be helpful in directing the examiner towards a diagnosis. The presence of a severe mental disorder in a parent may be relevant to the physical or mental absence of a parent during the evaluee's family life. This may have affected the evaluee's development. In some evaluations the family values and beliefs about illness and treatment may be of relevance and contribute to the formulation.

A family history of suicide or attempted suicide is of particular importance. In a medical malpractice case it may be vital to ensure that the treating psychiatrist asked about a family history of suicide in a suicide risk assessment.

In addition to questions about family history, collateral information may give additional information of which the evaluee was not aware. It may be helpful to speak to the parents and siblings, or close family friends for this purpose.

Take Home Points:

A forensic evaluation includes the family history as an essential component. American forensic psychiatrists should be aware of GINA, which may limit any information in a final report. While GINA doesn't apply to all forensic evaluations, it will be an issue in many employment related evaluations and can clearly govern what may be included in a forensic report. The Federal Government equates family history with genetic information, which is not how most physician-scientists tend to think about these issues. The protections of GINA are quite similar to those of HIPPA but less known or litigated. GINA has only been in effect since 2009 so there is no real case law specific to our work to guide us, but undoubtedly this will be an important topic for a future AAPL presentation.

Medical Director

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others, and thus training in and experience with report writing allows one to utilize these skills to ensure the reports are capturing the patient's progress appropriately and professionally.

It is not uncommon for forensic hospitals to wrestle with the tension of their existence at the uncomfortable intersection of a psychiatric treatment facility combined with a correctional institution. As medical director, one's clear focus should be on providing the best possible clinical care within the facility for the patients. This focus allows one to help steer the ship back toward recovery oriented treatment goals. Fortunately, many of our colleagues have written thoughtfully about ways in which recovery oriented principles[3] and compassion[4] can be woven into forensic treatment. This work can be quite helpful to the medical director in such settings hoping to infuse ideas of hope into a challenging and sometimes conflicted environment.

I should also conclude by noting that I have been blessed in my role to work with a wonderful interdisciplinary staff of mental health professionals truly dedicated to caring for these challenging patients. Further, I have been very fortunate to receive incredible supervision from experienced forensic administrators who are national leaders in the field. While this work may not be for everyone, for me it has proven to be a rewarding and intellectually stimulating challenge. I look forward to having the opportunity to continue to learn along the way.

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Nature or Nurture?

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predatory crime as the interaction of psychological, biological *and* social factors[3]. Eventually, we can understand crime in a society only if criminality is viewed from more than one level of analysis, as a single theory can't explain why when faced with the same life situation, one person commits crime, while another obeys the law.

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Juveniles' Waiver

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getting Illinois SB 2370 enacted. If you see him (or me) at the Annual Meeting, please feel free to ask us about this topic. Given the friendly milieu, I doubt either of us will ask to have our attorney present during questioning!

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Gender Dysphoria

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Stories vs. Studies

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AAPL Institute for Education and Research (AIER), as an example, encourages applications for one-year grants of up to $25,000 to develop innovative educational products or to conduct research in forensic psychiatry. Moreover, simply staying abreast of literature (e.g., *JAAPL, Behavioral Sciences and the Law*, etc.) and networking during poster sessions or after "Research In Progress" presentations at Annual AAPL and regional Chapter Meetings, can be invaluable in gaining ideas and exploring cross-collaboration opportunities.

We have "stories" and "studies" in our field. While we have to be careful about overgeneralizing from one case, as well as dismissing unique aspects of an individual by virtue of group data, each should inform the other. In many ways, assimilating these moving parts is what excites us about forensic psychiatry, and it is also reassuringly not so alien from the challenges experienced by other medical and scientific disciplines.[6] As our field naturally evolves, we continue to examine how we got here and can opportunely contribute in diverse ways to where we are going.

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Mental Illness

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to continuing to collaborate with our colleagues, as we did last year as part of President Norko's Correctional Psychiatrist outreach initiative, in identifying novel solutions to this centuries-old problem.

Sixty years ago, Steven Sondheim penned the following words for Riff, the leader of the Jets gang in West Side Story, "Hey! I'm depraved on account of I'm deprived." Clearly, the work continues.

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Forensic Training

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tion through early intervention, and the importance of working to keep people out of jail in the first place. Dr. Pinals stated, "Treatment and support for these individuals is necessary and best when offered within our community service system. We know that we need our partners in the justice system and the courts to make this happen in order to balance appropriate public safety factors as needed." Gov. Rick Snyder envisioned persons with mental illness, police, clinical professionals, and court officers all as a "family," proposing we all have to work together as such to improve outcomes.

In summary, the Summit brought together national pioneers as well as clinical, administrative, academic researchers, law enforcement, executive and judicial stakeholders, all of whom voiced strong support for diversion in helping individuals with mental illness avoid, exit, and/or stay out of the criminal justice system. This was an opportunity for forensic psychiatry fellows and faculty to participate in policy, and serves as a model for fellowship opportunities. The Summit inspired forensic colleagues to work together to serve the state and train in the important topic of diversion, while providing an opportunity for meaningful mentoring in the area of community forensics and public policy.

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Editor's Column

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treatment for the growing incarcerated population, to pregnancy and mothering while incarcerated, to the needs of transgender adult inmates. Finally, we'll learn about experiences whilst becoming medical director of a forensic hospital. It is a remarkably diverse field in which we work.

Looking forward to seeing everyone at the APA in New York City—and at the semi-annual AAPL meetings which begin on Saturday the 5th of May.

* Gustave Flaubert

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October 22-25, 2020
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MUSE & VIEWS

Finding Bigfoot
If you happen to come across a Bigfoot or Sasquatch while visiting Washington state, be sure not to harass it. It remains a felony to harass a Bigfoot, a Sasquatch, or any other undiscovered species. This crime is punishable by a fine up to $100,000 and/or 10 years in prison

https://medium.com/@CarsonKing/outrageous-laws-you-may-have-broken-in-washington-90eae2934a6d

Submitted by William Newman MD

CALL FOR AWARD NOMINATIONS

Isaac Ray Award
The Isaac Ray Award, established in 1951, recognizes a person who has made outstanding contributions to forensic psychiatry or to the psychiatric aspects of jurisprudence. It is a joint award of the American Psychiatric Association and the American Academy of Psychiatry and the Law that honors Isaac Ray, MD, one of the original founders and the fourth president of the American Psychiatric Association.
Deadline for Nomination: June 1

Manfred S. Guttmacher Award
The Manfred S. Guttmacher Award, established in 1975, recognizes an outstanding contribution to the literature of forensic psychiatry in the form of a book, monograph, paper, or other work published or presented at a professional meeting between May 1 and April 30 of the award year cycle.
Deadline for Nominations: June 1

Learn more about how to make a nomination at **www.psychiatry.org/awards**.

Oregon Health & Science University (OHSU) has an outstanding opportunity for a BC/BE forensic psychiatrist for clinical work at Oregon State Hospital. We offer a unique 80/20 schedule which, upon approval, allows faculty one day per week to pursue academic projects. Opportunities include competency and insanity evaluations, court testimony, medical student and resident supervision, and patient care.

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

We sincerely invite your interest in this very unique and rewarding opportunity.

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

Maya Lopez, M.D., Administrative Chief, Oregon State Hospital
lopezst@ohsu.edu

On behalf of the Department of Psychiatry & Behavioral Neuroscience and the Division of Forensic Psychiatry:

The untimely death of our mentor, teacher, colleague and friend, Dr. Douglas Mossman, has left us with feelings of great sadness and loss. His wisdom, profound intellect, and good humor are sorely missed. Many of you have asked if there is something we may do to keep his legacy alive. The University of Cincinnati Foundation has established the Dr. Douglas Mossman Award, a monetary prize awarded to the selected psychiatry resident from across the country that writes a research paper in the field of forensic psychiatry or composes a well-articulated position (i.e., philosophical argument) regarding current legal or ethical issues in psychiatry.

Donations for the Dr. Douglas Mossman Award are now being accepted and are tax deductible (documentation will be provided upon request). Checks should be made to: University of Cincinnati Foundation. Please write "Dr. Douglas Mossman Award" on the check.

To make a donation via check:
The University of Cincinnati Foundation
ATTN: Allen Chapa, PO Box 19970
Cincinnati, OH 45219-0970

To make a donation via credit card:
1. **Go to: https://foundation.uc.edu/give**
2. **Select a gift amount**
3. **Click on the box right below gift amount that says" "Choose an area for this gift to support"**
4. **In the box that says "Other: Please specify – type in "Dr. Douglas Mossman Memorial Award"**
5. **Click on the red box that says add to cart**
6. **Click on red box that says continue and follow steps from there (filling in name, address, etc.) before going to next page that asks for the credit card information**

If you have further questions, Allen Chapa can be reached by phone (513-556-6374) and by email @ a.chapa@uc.edu.

MUSE & VIEWS

"An example of the comedic spin given to bestiality in the legal literature and among lawyers is the possibly apocryphal examination-in-chief in the English case of R. v. Cozins (1834), repeated in Parker (1986: 96). George Gilbert had been charged with bestiality with a sheep. The act had been witnessed by a farm laborer, Albert Harris, who had been called as a witness for the Crown.

Prosecutor: Mr. Harris, on the day in question, were you proceeding along a line adjacent to the farm of Mr. Clarke?

A.H.: I was.

Prosecutor: Would you describe for His Lordship what you saw?

A.H.: Well, George Gilbert was standing in the doorway of the barn with a sheep.

Prosecutor: Yes, and what was he doing?

A.H.: Well, he was messing around with the sheep.

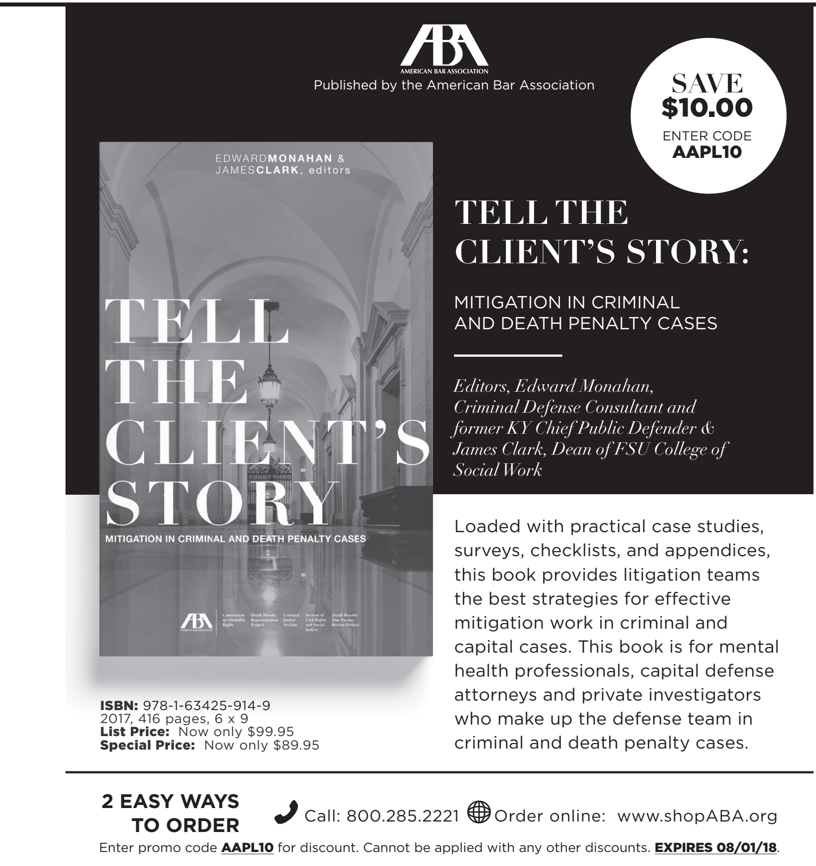
Prosecutor: By that statement, are we to understand that the accused was having sexual intercourse with the sheep?

A.H.: Er, yes.

Prosecutor: Mr. Harris, what did you do when you observed this shocking spectacle?

A.H.: I said, "Morning, George"."

Beirne P. Rethinking bestiality: towards a concept of interspecies sexual assault. Theoretical Criminology. 1997, p. 333.



A MESSAGE FROM THE ISAAC RAY CENTER, INC.

As you may know, the Isaac Ray Center was founded in 1979 and during the next 40 years, in association with Rush University Medical Center and Rush's Department of Psychiatry, developed a forensic fellowship program which trained over 40 of our current colleagues, and engaged in numerous forensic and correctional psychiatric service delivery contracts totally over $75 million, working with such diverse entities as the U.S. Secret Service, the FBI, the Illinois State Police, the Chicago Police Department, the Archdiocese of Chicago, Cook County Jail and the Cook County Juvenile Temporary Detention Center. Through its research division over hundreds of articles and book chapters were published and over 500 scientific presentations were made at local, national and international venues.

Starting approximately two years ago, after struggling with how to keep the Center going as leadership efforts began to wane, James L. Cavanaugh, Jr., MD began developing a relationship with the Chairman of the Department of Psychiatry and Behavioral Sciences at Northwestern, John Csernansky, MD, and with his increasing interest in expanding forensic psychiatric efforts in his department, they fashioned the "new" Isaac Ray Center for Forensic Psychiatry, Behavioral Sciences and Law at Northwestern.

With its dissolution, the assets of Isaac Ray Center, Inc. are being donated to the Northwestern Memorial Foundation to support the creation of the "new" Isaac Ray Center as a dedicated research center, focused on research initiatives at the interface of behavioral sciences and the law, which address current relevant societal concerns. The mission statement of this new IRC is: "advancing justice through the multidisciplinary study of the interface between human behavior and the legal systems to develop interventions and inform public policy." This new Center will be housed within the Department of Psychiatry at Northwestern Medicine.

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WHO WE ARE

CCRS is a national public healthcare leader caring for underserved patients in correctional settings, psychiatric hospitals and residential treatment facilities.

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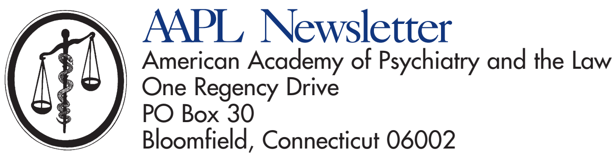
UCDAVIS UC DAVIS SCHOOL OF MEDICINE DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Health Sciences Assistant/Associate Clinical Professor – Correctional Behavioral Health The Department of Psychiatry & Behavioral Sciences is recruiting for two Health Sciences Assistant/Associate Clinical Professors in the clinician teaching series to serve as teaching attending physicians in its jail psychiatric program to which forensic fellows, residents, and medical students are assigned. The applicant(s) will evaluate and treat patients who are in custody at the jail. The applicant(s) will supervise general psychiatry residents and medical students with their adult cases on the inpatient unit and in the general population. Requirements for position include: a medical degree, board certification in general psychiatry, a California Medical license in addition to teaching and supervisory experience for residents, fellows, and medical students. Completion of ACGME Forensic Psychiatry Fellowship and Forensic Psychiatry Board Certification is preferred. Experience supervising child psychiatry residents/fellows, general psychiatry residents, and medical students is preferred. This position is open effective August 28, 2017. The posting will remain open until filled or June 30, 2018.

Qualified applicants should upload a Letter of interest, Curriculum Vitae, Statement of Teaching, and Statement of Contributions to Diversity along with contact information for 3 to 5 references online at: https://recruit.ucdavis.edu/apply/JPF01792.



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