

AAPL Newsletter

American Academy of Psychiatry and the Law



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2019 Annual Meeting - AAPL at 50: Teaching and Advocating for Forensic Psychiatry

Susan Hatters Friedman, MD
Program Chair



As President, Richard Frierson's theme for the 50th Anniversary of the American Academy of Psychiatry and the Law is teaching and advocacy, and this year's Annual Meeting will highlight the last 50 years of that theme. We are excited to announce the distinguished speaker series for 2019. The lunch speakers will include Ms. Amanda Knox, Professor Adam Benforado, and Dr. Stephen Young.

Amanda Knox was an American college student studying abroad in Perugia, Italy in 2007. Ms. Knox's roommate Meredith Kercher, a fellow exchange student, was murdered in their apartment. Ms. Knox was incarcerated in an Italian prison for approximately four years following her conviction for the murder. Ms. Knox was in international headlines for approximately a decade, and in these stories she was both shamed and vilified. (Her boyfriend at the

time, Raffaele Sollecito, who was also incarcerated, spoke at a recent International Academy of Law and Mental Health meeting.) Ms. Knox published her memoir in 2013 entitled *Waiting To Be Heard*. After multiple trials, in 2015, Knox was acquitted definitively by the Italian Supreme Court of Cassation, and earlier this year Italy was ordered to pay damages to Ms. Knox after a finding of rights violations by the European Court of Human Rights, because she wasn't allowed access to an appropriate interpreter or a lawyer during her interrogation.

Upon return to America as an exoneree, Ms. Knox became an author and an activist, and has been sharing her story of wrongful incarceration overseas as a university student. *Waiting To Be Heard* was a *New York Times* bestselling memoir. She is currently the host of *The Scarlet Let-*

ter Reports and *The Truth About True Crime*. Her current work seeks to expose issues of wrongful conviction and public shaming, and to promote empathy and truth seeking. She has published in *USA Today*, *The Los Angeles Times*, *The Seattle Times*, *Seattle Magazine*, and *The West Seattle Herald*. Attendees of the AAPL Annual Meeting may benefit from watching the Netflix documentary entitled *Amanda Knox* which was released in 2016, prior to the meeting.

Professor Adam Benforado is Professor of Law at Drexel University. His work applies insights from cognitive psychology to legal theory and law. Professor Benforado was awarded a National Science Foundation grant for his work investigating human intuition about punishment. His op-eds and essays have appeared in *The Washington Post* and *The New York Times*. His book, *Unfair: The New Science of Criminal Injustice*, has been a *New York Times* bestseller, in addition to winning the 2017 American Psychology Law Society Book Award. Professor Benforado has been interviewed by Larry King as well as on National Public Radio. In his book, Professor Benforado uses historical examples, court cases, and scientific studies to demonstrate how judicial processes do not protect the weakest members of society. Further, he describes the scope of this dysfunction and proposes practical reforms to help achieve fairness in the law.

Dr. Stephen Young, US State Department Psychiatrist covering Europe, is our third lunch speaker. He is the Regional Medical Officer for Psychiatry and is currently stationed at the US Embassy in London. He is also the former Director of Mental Health Services, United States Department of State. Dr. Young will talk about forensic psychiatry in the State Department. This would focus

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COVER STORY

2019 Annual Meeting

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on, for example, medical clearance, fitness for duty, suicide, and criminal issues that arise in the State Department. Issues of confidentiality and dual agency must be considered in this role. Mental health services combine local resources, Washington D.C. resources, and the Regional Medical Officer. Dr. Young will share with us what he has clearance to share.

Additionally, the Thursday evening program will be a debate regarding the most influential Landmark Case since the founding of AAPL 50 years ago. Led by past AAPL President Dr. Peter Ash, five forensic psychiatrists will present arguments as to which case is the most influential case in forensic psychiatry in the past half-century in America. These cases include *Wyatt v. Stickney*, *Roy v. Har-togs*, *Tarasoff v. Regents of University of California*, *United States v. John Hinckley*, and *Cruzan v. Director, Missouri Department of Health*. We expect a lively audience discussion, as well as the opportunity to provide feedback using the audience response system, and finally a vote regarding which is the most influential case since the founding of AAPL.

The 50th anniversary is the perfect opportunity to return to Baltimore, Maryland, where AAPL was born. This year is a great time to come to the annual meeting, even if you haven't been to AAPL in years, to help AAPL celebrate. Looking forward to seeing everyone and celebrating with AAPL! 🎉

AAPL Awards Committee Seeks Nominations for 2019

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.

JOIN US IN BALTIMORE!

Forensic Psychiatry Review Course October 21-23, 2019

This intensive three-day course in forensic psychiatry will provide an in-depth review of selected topics and relevant landmark cases. Basic concepts will be reviewed along with the latest case law.

50th Annual Meeting October 24-27, 2019

This meeting will inform attendees about current major issues in forensic psychiatry and afford them opportunities to refresh skills in the fundamentals of the discipline, engage in discussion with peers, and update their present knowledge.

A block of hotel rooms will be reserved at the Marriott Waterfront in Baltimore, Maryland.

Looking to the Future

Joseph Simpson, MD, PhD



In this, AAPL's 50th year, there will be many reflections on the organization's history, its accomplishments, and how much it has

evolved, grown and changed over these past five decades. There is much to be learned in looking back over AAPL's illustrious record and seeing how far the field has come. This milestone anniversary is also an excellent time to think about new areas of forensic psychiatric practice that are little-known or even purely theoretical now, but which may see a great expansion in the next couple of decades.

Although forensic psychiatry might be considered a "small" subspecialty, in terms of the number of fellowship training programs, trainees in those fellowships, and board-certified practitioners, it encompasses a wide variety of disparate areas of specialized knowledge. Attending an AAPL Annual Meeting, or just reading the organization's Journal or Newsletter, one is bound to be struck by the sheer diversity of topics addressed. With the pace of advances in the biosciences today, it is inevitable that psychiatry and forensic psychiatry will experience a great deal of change in the years ahead. As forensic practitioners, we should strive to keep informed about some of the areas likely to see an expansion in the need for forensic expertise in the future. No one can keep current in all areas, so focusing on those areas one finds most interesting will make this challenge more manageable.

For example, new treatment modalities for depression, such as repetitive Transcranial Magnetic Stimulation and ketamine infusions, are being offered by an increasing number of clinical practitioners. In the case of ketamine, many of these physicians are not even psychiatrists.

It seems likely that there will be a growing demand for experts to opine on what the standard of care should be for novel treatments such as these. (Time will tell if the recently-approved esketamine nasal spray reduces or even ends the proliferation of "ketamine clinics.") Another promising area is the use of genetic testing to aid in the selection of psychopharmacological treatments. Will such testing ultimately be done routinely prior to starting medications? At what point will prescribers who are not obtaining such tests expose themselves to liability for adverse effects of the medication they choose – or simply for a delay in identifying an effective treatment?

Looking further into the future, we can imagine a time when forensic psychiatrists are called upon to opine on the mental health implications of gene editing via techniques such as CRISPR, a technology that at some point may offer the possibility of creating so-called "designer babies," among many other potential applications.

Of course, changes in the field's approach to forensic challenges will not be limited to the harnessing of advances in neuroscience. Two growing areas of forensic psychiatry that are not as directly related to brain research include the movement toward delivery of community-based forensic services – which has an AAPL Committee dedicated to it, but is still not as widely known and implemented as it seems certain to be in the future – and the broad topic of threat assessment and management, which until recently was not a common theme of AAPL Annual Meeting presentations, but which has become increasingly visible over the past couple of years.

The final area I will mention is one that in its more speculative incarnations tends to quickly provoke skepticism in some, along with an impression that the discussion is drifting into the realm of science

fiction. This is the very broad and somewhat vaguely defined field of "neurolaw." Over the past several years, grant-funded academic centers and even a combined PhD/ JD degree (at Vanderbilt University) have been established, focusing on potential applications of neuroscience to medico-legal questions of all types. These run the gamut from measuring pain to lie detection to the ethics of cognitive enhancement technologies, among many others.

Will consultants one day subject potential jurors to neuroimaging to identify bias? Can neuroimaging accurately predict future dangerousness?

In the pages of law reviews and bioethics journals, scholars have been examining the possibilities and pitfalls contained in advances in our neuroscientific understanding of brain and behavior since around the turn of the century. The sci-fi flavor this endeavor can take on is indicated by the titles of some of that output, such as, "The Government Can Read Your Mind: Can the Constitution Stop It?" (1) and one of my personal favorite titles, "Fundamental Protections for Non-Biological Intelligences or: How We Learn to Stop Worrying and Love Our Robot Brethren." (2)

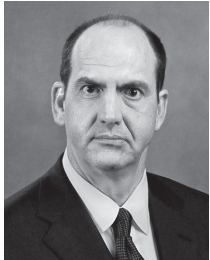
All practicing forensic psychiatrists stand to benefit by keeping current on the state of the art in various aspects of the field. Attending AAPL Annual Meetings exposes us to newly emerging ideas, as does being active in AAPL Committees. Both will also facilitate networking with colleagues. Taken together, they increase your prospects for staying up to date. After all, the future will be here before you know it. ☺

References:

- (1) Boundy M. The Government Can Read Your Mind: Can the Constitution Stop It? *Hastings LJ* 63:1627-1644, 2012.
- (2) Dowell R. Fundamental Protections for Non-Biological Intelligences or: How We Learn to Stop Worrying and Love Our Robot Brethren, 19 *Minn J L Sci & Tech* 305-336, 2018.

Taking our Heads out of the Sand: Manpower Needs in Correctional Psychiatry

Richard L. Frierson, MD



In his President's address at AAPL's 49th Annual Meeting last year, "A Seat at the Table," Christopher ("Kip") Thompson, MD called

for AAPL to begin working towards governmental advocacy and public engagement. This includes educating policymakers and the public on current and future topics related to forensic mental health. (1) Sometimes, however, advocacy regarding forensic issues needs to begin at home – that is, with AAPL's role in the framework of organized psychiatry and AAPL's interaction, or lack thereof, with the various organizations that oversee education and training in psychiatry and forensic psychiatry.

AAPL members are undoubtedly aware of the crisis involving the large numbers of persons with mental illness in US jails and prisons. Although epidemiological methods differ, the prevalence of mental illness among incarcerated individuals is unquestionably high. At least 15-30% of prison and jail inmates have psychiatric disorders that result in significant functional disabilities, and another 15-20% will require some form of psychiatric intervention during their incarceration, with higher rates noted among female prisoners. (2) Perhaps most shocking, there are now more mentally ill persons in jails and prisons in the United States than in hospitals. (3) Clearly, jails and prisons have become the new mental hospitals.

The response of organized psychiatry (i.e., the American Psychiatric Association) to this crisis has primarily been aimed at reducing the number of incarcerated persons with mental illness, as reflected in programs such as the Stepping Up Initiative, devel-

oped in collaboration with county and state governments. (4) Among the facets of this approach is the development of diversion programs (e.g., mental health courts and drug courts) designed to divert persons with mental illness into treatment programs in lieu of incarceration. However, most diversion programs are not available to persons with felony-level charges; furthermore, these programs are typically not available in more rural areas. In fact, some states lack mental health courts altogether.

The APA Board of Trustees approved an updated Position Statement on Psychiatric Services in Adult Correctional Facilities in July of 2018 (currently available by request), and has previously issued a position statement on Segregation of Prisoners with Mental Illness. (5) However, all of these initiatives and position statements fail to address one crucial issue: the training and development of future psychiatrists to meet the growing demands for treatment of incarcerated persons. In regard to this issue, it is time for AAPL and APA to take our heads out of the sand and advocate for this growing manpower need.

The curriculum for forensic psychiatry fellowships and general psychiatry residency training programs is developed on a program-by-program basis, but there are core requirements dictated by the Accreditation Council for Graduate Medical Education (ACGME). The ACGME Program Requirements for Graduate Medical Education in Forensic Psychiatry state that "fellows must have at least six months of longitudinal experience in the management of patients in correctional systems." (6) Currently, the ACGME Program Requirements for Graduate Medical Education in Psychiatry have very minimal requirements for forensic psychiatry: "Resident experience in forensic psychiatry

must include experience evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency". (7) The requirements are silent on the need for general psychiatry residencies to include an educational experience that involves provision of treatment in a correctional or forensic facility.

Should general psychiatry residents be required to have a correctional or forensic hospital experience? Certainly, any well-trained psychiatrist could work in such a setting without specific training. However, correctional systems provide unique treatment challenges including, but not limited to, the following:

- establishing a working relationship with correctional officers who have no medical training
- understanding custody levels
- managing boundaries
- balancing patient confidentiality with the facility's security needs
- providing quality psychiatric care with a limited formulary
- understanding prison culture
- dealing with medication diversion (including medications that are abused in correctional settings but not outside correctional settings)
- advocating for needs of the seriously mental ill in a system that is inherently not designed as a therapeutic milieu.

Exposure to these challenges while in psychiatric training can lay the foundation for a rewarding career in correctional psychiatry, whether practiced full- or part-time.

Many psychiatrists have inaccurate impressions of what it is like to work in corrections (partially because of a fear of the unknown), and therefore do not consider practicing in a correctional setting. Common obstacles include concerns over personal safety and a negative impression of inmate-patients. However, the presence of correctional officers, physical restrictions on inmate movement, and other institutional safety policies can create a personal feeling of safety that is greater than that found in general

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Charles v. Orange County: The Importance of Discharge Planning on Release from Custody

Jeffrey S. Janofsky, MD



AAPL, along with the American Psychiatric Association, the American Medical Association, the American Psychological Association and

three other *amici curiae*, participated in a brief in *Charles v. Orange County, New York*. (1) The brief, primarily authored by APA, explained the importance of discharge planning for detainees with severe mental illness in the correctional setting.

Plaintiffs Charles and Ross were both confined in an Immigration Detention Facility in Orange County, New York. Mr. Charles had been diagnosed with bipolar disorder and schizoaffective disorder prior to his incarceration and had received psychiatric care and psychotropic medications while incarcerated. Ms. Ross had no pre-incarceration psychiatric history, but developed psychotic symptoms while detained. Ross was newly diagnosed with schizophrenia and received medications and psychiatric care while detained. Both were allegedly discharged from custody without medications, a discharge plan or follow-up care. Charles was psychiatrically hospitalized two weeks after discharge. Ross went to an emergency room which she found on her own, and received psychiatric care.

Charles and Ross sued Orange County (which had operated the detention center on contract with US Immigration and Customs Enforcement (ICE) and others) in US District Court alleging their substantive due process rights were violated under the Fourteenth Amendment to the US Constitution. They argued that the failure to provide discharge planning during detention rose to the level of deliberate indifference.

The District Court dismissed the complaint. The court agreed that the defendants may have owed a limited duty of protection beyond their periods of incarceration to the defendants. However, the District Court noted that while the most recent guidance from ICE itself requires discharge planning, the claims asserted were more akin to negligence or malpractice claims than constitutional violations. The District Court found that any alleged failure to provide discharge planning did not “shock the contemporary conscience,” the required threshold for a substantive due process claim under the Fourteenth Amendment. (2)

Plaintiffs appealed to the Second Circuit. Plaintiffs argued that while under *DeShaney v. Winnebago Cty. Dep’t of Soc. Servs.* (3) there is generally no affirmative right to governmental aid including health care, under special circumstances like civil immigration detention, a constitutional right to health care for detainees does exist. Plaintiffs argued that this special relationship includes discharge planning, in part because discharge planning must begin while the detainee is still detained and because the detainee has no immediate access to medication or treatment once released.

Our *amicus* brief attempted to educate the Circuit Court that, “professionals with expertise in correctional mental health care are in uniform agreement that discharge planning is an essential component of mental health care for incarcerated individuals with serious mental illness,” (4) and that continuity of care after release from incarceration is critical to prevent relapse or re-incarceration. Citing the work of AAPL members Alec Buchanan, Ken Hoge, Beatrice Kovaszny, Jeffrey Metzner, Debra Pinals, Erik Roskes, Charles Scott,

Robert Trestman and others, the brief provided data to support the following principles:

- 1) Discharge planning is essential to minimally adequate mental health care for incarcerated persons;
- 2) For individuals with serious mental illness, continuity of care is essential to effective treatment;
- 3) Discharge planning reduces the risk that needed care will be interrupted following release and is critical in ensuring continuity of mental health care for inmates with severe mental illness;
- 4) Discharge planning must include, at a minimum, a discharge plan for an inmate with serious mental illness that accounts for the inmate’s medical needs;
- 5) Failure to provide discharge planning can place individuals with serious mental illness at risk of grave harm;
- 6) Standards for discharge planning for person discharged from correctional facilities exist and are promulgated by professional and standard-setting organizations; and
- 7) Discharge planning enhances post-release outcomes for individuals with serious mental illness.

As is usual practice, the AAPL Council reviewed draft versions of the brief and approved the brief in principle. AAPL members, including members of the AAPL Corrections Committee, were asked to review the brief and to provide additional data and citations. Our members’ comments were forwarded to APA *amicus* counsel, and substantially improved the brief. Some AAPL members who reviewed the brief expressed the concern that AAPL should not sign on to an *amicus* brief in a case that could expand the potential risk of correctional psychiatrists being sued for deliberate indifference. Others felt that it was important to educate the court regarding existing data, and if the courts found a constitutional right to discharge planning, that would lead to improved funding and allow correctional psychiatrists to provide better services. After re-review the AAPL Executive Committee con-

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As the 50th Anniversary Comes Close

Jacquelyn T. Coleman, CAE



As the 50th Anniversary comes close, I am shocked to realize that I have been involved for over half of the AAPL lifespan.

Still, I hesitate to comment. My sense of AAPL's history is so much different from what a member's would be.

When I started working for AAPL in 1992, the Internet and email were novel. AAPL's first email address was execoff@aol.com, and we had to remember to go check email at the one computer that had internet service. Our fax machine was relatively new then also.

The advent of the ABDick machine that would actually print labels for mailings was a blessing.

From the ABDick, we graduated to actual computers with WordPerfect as the software. Then came Access, a relational database program, which along with other Microsoft products handled rudimentary organizational necessities.

As time went on, however, the task became too complicated for Access, and we purchased an association management system. We had easy access to the developer and updates were free. A talented person, which we were lucky to have in Marie Westlake, could discover new ways to manipulate data. We were able to do so many things and people were impressed.

Life was good.

Much to our horror however, the system started showing signs of age. Running old software on new hardware is tricky and eventually the two systems stop communicating with each other. In less than a year our software would be – those dreaded words – “no longer supported.”

Along with database management, other needs arose. Members wanted online abstract submissions, and a Maintenance of Certification test with

some really sophisticated requirements and an online Journal.

Life was no longer good when it came to database management. We had to search for programs that would do exactly what we wanted, or that could be modified to do what we wanted. Anyone who purchases software programs will know what we experienced. When you ask a sales person can your system do “X” they say yes, but yes means I'm pretty sure we can build it if we don't have it. And let's not even have the discussion if the product will work on a network, and if so, is there a charge for EACH station in the network?

Nothing is free anymore. The companies have gotten smart; monthly maintenance fee plus extra fees for development are now the norm, and they decide what is “extra.”

My father said that if you ask a machine to do two things, it will only do one well. In the age of computers, it's a struggle to make sure that everything is done well. We hate patches and quick fixes. Allowing for increases in scale, you were so right, Dad.

The most essential element to AAPL's management is our relational database. It has huge amounts of data, and we have to carefully manage it so that when one function is changed, we don't accidentally cause another one to fail. We also have to assure that our ancillary programs, such as the abstract database and the MOC test don't accidentally mess something else up. Another example: we have four different entities involved in delivering the online Journal to you.

A surprising number of software programs have glitches. I hate that word because “glitch” doesn't begin to describe the magnitude of some of these failures. We all spend a lot of time these days speaking to “customer support.” And we're so relieved to find a person who is fluent in translating computer speak to person speak.

I don't know how many of you use EHRs, but I can tell you that most doctors I see have complaints about the system they are expected to use.

As for generational shifts, I don't need to tell you that there are many approaches to technology. We still have many members who only access email through their home system when they get home from work. Then on the other side, there are many who are very innovative. Our systems of communication have to account for all levels.

So, these days, new technology is not greeted by us with the same enthusiasm it once was. We are no longer in control, and we want to be in control so we can deliver for you. We want to meet your expectations.

Technology has made radical improvements in all aspects of society. In AAPL's case, the efforts of your staff are multiplied dramatically, and members benefit, but everything comes with a price.

I hope to still be alive when all that needs to be done is to THINK it and it happens. And meanwhile, put that chip under my skin! ☯

Medical Director

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firmed that AAPL should sign on to the final brief.

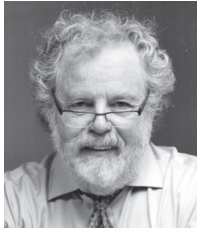
Oral arguments were held on September 25th, 2018. They were recorded and can be heard at: www.courtlistener.com/audio/58403/charles-v-orange-county-new/. At the time I write this article the Circuit Court has not issued a decision in the appeal. ☯

References:

- (1) Charles v. Orange County, New York. Court of Appeals for the Second Circuit. Docket No. 17-3506.
- (2) Charles v. Orange County, New York. United States District Court for the Southern District of New York (White Plains), No. 16-cv-5527-NSR casetext.com/case/charles-v-cnty-of-orange
- (3) *DeShaney v. Winnebago Cty. Dep't of Soc. Servs.* 489 U.S. 189, 195 (1989)
- (4) *Amicus Curiae* Brief of the APA, AAPL, et al., p. 17. Available at www.psychiatry.org/

The Voice(s) of the Children

Stephen P. Herman, MD



Leo Szilard, a well-known physicist and inventor, who was born in Budapest and educated in Berlin, achieved fame in the United States.

He invented the linear accelerator, cyclotron and electron microscope. In 1939, he wrote a historic letter to President Franklin D. Roosevelt which was signed by the pacifist, Albert Einstein. That correspondence led to the Manhattan Project, whose team built the first atom bomb. Einstein wrote FDR:

“...It may become possible to set up a nuclear chain reaction in a large mass of uranium, by which vast amounts of power and large quantities of new radium-like elements would be generated... This new phenomenon would also lead to the construction of bombs, and it is conceivable – though much less certain – that extremely powerful bombs of a new type may thus be constructed...”

Szilard was one of the founders of the Salk Institute for Biological Studies. He died in 1964, at age 66. In 1961, his book of short stories, *The Voice of the Dolphins*, was published. The book was one way of demonstrating his moral outrage about the Cold War and the dangers of nuclear weapons. The fictional story by the same name called for the establishment of a European consortium to study molecular biology. When this became a reality, the association was named after him. Its stamp depicts dolphins.

I read this book when I was 15 years old. I am now 72, but that story has remained close to my heart. In his futuristic tale, Szilard wrote of a marvel:

“...The organization of the brain of the dolphin has a complexity comparable to that of man had been known for a long time. In 1960, Dr. John C. Lilly reported that the dolphins might have a language of their own, that

they were capable of imitating human speech and that the intelligence of the dolphins might be equal to that of humans... Subsequent attempts to learn the language of the dolphins, to communicate with them and to teach them, appeared to be discouraging, however, and it was generally assumed that Dr. Lilly had overrated their intelligence...”

That short story inaugurated my lifelong commitment to working with children: to learn how to communicate with them, respect them and recognize that they possessed an abundance of gifts for those who listened.

Today, everyone takes this for granted. Clinicians and researchers appreciate that developmental stages, genetics, environment, resilience and many other factors – some yet to be discovered – lead to the complexity of the term “child.” And this intricacy is ineluctably experienced in forensic psychiatry.

Legal definitions vary; case law may be confusing; rules are sometimes arbitrary and contradictory; judges may possess or lack the experience, training and ability to speak with children in the mystifying *in camera* interview. Questions confront us: How do you define a law guardian? What are the responsibilities of the lawyer for the child? Do Court-appointed Special Advocates help with or obfuscate issues? What about custody disputes, severance actions, foster care decisions, *Miranda* rights, delinquency dispositions? How much weight should judges give to children of what age? What does “weight” mean, anyway?

A five-year-old girl ensnared in a custody battle offered, unsolicited, that she wanted to live with her mother, a veterinarian. Her mother promised, the child told me, all the while drawing a picture of a kitten, that she and her mother would live in the country and have dogs and cats and maybe even a horse. The law guardian, sometimes called the Best Interests Attorney, related to the court that his investiga-

tion could not support the child’s wishes. On the contrary, he said, she had been programmed by her mother. In this state, however, that child could have her own counsel. Who would prevail? How much “weight” ought the court grant this child’s wishes?

Another state codified the hoary “Age of Reason” doctrine through case law. Any child seven or older could hire counsel and compel the court to consider her desire or explain through findings why the child’s wish did not prevail. What about “weighing” the child’s preference?

A 13-year-old boy, whose single father lost his parental rights, was ordered to live with relatives in another state. He demanded to be returned to his home state, because his friends lived there. His lawyer was ardent; the law guardian informed the court that the child wanted to return because the house rules were lax, and his friends were experimenting with drugs and alcohol. The seasoned judge took the child in chambers and with empathy explained his reasoning and told the teenager he was staying where he was.

A 16-year-old girl was caught up in the vortex of a custody battle. She refused to have any communication with her father. He insisted their daughter had been alienated by his ex-wife. The mother charged that the father had been violent toward her and their daughter. The court followed the teen’s wishes. Another judge might have ordered a therapeutic process with the hopes of helping father and daughter reconnect. A domestic violence finding in most states requires a detailed explanation by the trier of fact if he deviates from the presumption that DV is not in the child’s best interest.

About 20 years ago, I was part of a multidisciplinary team in the New York State First Appellate Division convened to provide firm definitions of the clear boundaries between *guardian ad litem* and a lawyer for the child. What if the child is three and the family has the money to pay for a law guardian *and* an attorney for the child? Do these professionals have different responsibilities? Does the

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Report From the APA Assembly

Danielle B. Kushner, MD

AAPL Representative to APA Assembly

The American Psychiatric Association (APA) Assembly met November 2-4, 2018 in Washington, DC. The meeting opened with a moment of silence recognizing the recent loss of life at the Tree of Life Synagogue in Pittsburgh, Pennsylvania. In the Report of the APA President, Altha Stewart, MD, spoke of the responsibility of psychiatrists to speak up regarding the growing public trauma in our communities caused by violent acts of terror. Together with Dr. Stewart, APA Speaker James Batterson, MD and APA Medical Director/CEO Saul Levin, MD, MPA additionally reflected on the experience of the wreath-laying ceremony at the Vietnam War Memorial the previous day. This event was inspired by an Action Paper passed by the Assembly to commemorate the 50th anniversary of the Vietnam War.

In his report, Dr. Levin discussed the organization's recent political and legislative updates. The APA was one of three awardees of a CMS Quality Measure Development Grant for managing substance use disorders. The grant will forge a partnership between the APA and the National Committee for Quality Assurance (NCQA). APA legislative priorities continue to be Telehealth, CURES state-targeted opioid grants, ChiP parity, Medicaid for jail and prison inmates with substance use disorders, NIH opioid pain management research, establishing best practices for opioid prescribing and pain management, and defense of the Affordable Care Act. Of note, the APA has joined a lawsuit against short-term limited insurance (www.stopjunkinsurance.com).

The APA was one of the first organizations to oppose the Trump administration's immigrant family separation and detention policies. They signed on to a letter to Congress opposing policies of separating refugee children from their parents. The organization also submitted comments opposing proposed modifications to the *Flores*

settlement. To become more involved in such issues, APA members are encouraged to become involved with the APA Political Action Committee (APAPAC) and the APA Congressional Advocacy Network (CAN).

In addition to hearing reports, the APA Assembly voted on approximately thirty motions. One of the more important items on the agenda was the passing of a new Position Statement on Safe Prescribing after a lively discussion. The statement reads: "1) The treatment with medication of patients with mental illness requires a foundation of medical education, training, supervision, and care of patients with a broad range and severity of medical problems. 2) The safety of patients and the public must be the primary consideration of each state's licensing agencies and legislature." The goal of the statement is to provide a foundation for the ongoing fight regarding scope-of-practice issues. In response to recent events, the Assembly also passed a Position Statement on Police Brutality and Black Males and a motion to develop and distribute a tool kit addressing racial discrimination to department chairs and training directors. Other forensic issues of note included approving action papers designed to improve psychiatric treatment in child welfare and juvenile justice programs, promoting access to quality mental health services to forcibly separated immigrant children and families, and advocating for keeping families intact while applying for asylum status in the United States.

Highlights from the Assembly Committees included a discussion regarding a new thinking process for upcoming revisions of the DSM and a possible forensic dilemma as to whether the online or print version of the DSM should be regarded as the authoritative version. The Maintenance of Certification committee continued to explore alternative options for board certification. In addition, a practice guideline on schizophrenia is

nearing a first draft from the Practice Guidelines Committee.

Assembly members were also encouraged to tour the new APA headquarters, which officially moved back to Washington, DC as of January 2nd, 2018 in order to be closer to the US Capitol and other political organizations to more effectively advocate for people with mental illness and to support the professional needs of its members. All APA members have been encouraged to take advantage of the Members' Lounge along with viewing panels that recount APA and psychiatry history. Another highlight is visiting the Rare Book Room where some of APA's treasures are on display.

The APA will be celebrating its 175th Anniversary at the Annual Meeting in San Francisco from May 18-22, 2019. This year's theme will be *Revitalize Psychiatry: Disrupt, Include, Engage, & Innovate*, which is dedicated to the work of addressing the most challenging issues facing psychiatry today. ☯

Child Column

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law guardian in this Division have to be an attorney? (Rules varied across the state.) After a year, we thought we had cleared up the confusion. But some judges still made up their own minds about which professionals did what.

In some areas, Court-appointed Special Advocates have wide latitude in their responsibilities. They might opine that a nine-year-old's wishes should be followed. Or, they may be limited to steering the family through the maze of the court system. There might be no statute or case law that sets the boundaries.

There are no easy answers to these conundrums. We know that cetaceans, e.g. dolphins, porpoises and whales, are intelligent, play, communicate and even pass on what they have learned to their offspring. By 2021, Swedish researchers expect to have compiled a complete dictionary of cetacean language. One hopes these scientists will *listen* as well. ☯

Ask the Experts

Neil S. Kaye, MD, DFAPA

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

Drs. Kaye and Glancy will answer questions from members related to practical issues in the real world of forensic psychiatry. Please send questions to nskaye@aol.com.

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 should I charge for out-of-state work and travel time?



A. Kaye:

Psychiatrists and forensic psychiatrists have always billed for our time. If I have to testify across the country, it takes me a day to

get there, a day to be there, and a day to return. It costs me three full billing days out of my office to appear for the hiring lawyer, and so I charge for three full days. I use a flat day rate but it could just as well be an hourly rate.

In advance of taking a case, I tell the lawyer via my written fee agreement that: “fees for expert testimony and days away from office (traveling on weekdays) are billed for a full calendar day and not for any increments of time thereof. All expenses incurred will be billed after computation, but fees for testimony time will be paid at least three days in advance.”

Incurred expenses include: coach airfare for me (I know AAPL members who charge the *lesser* of first-class air travel or car+ground expenses+the time difference), parking, tolls, car rental if required, hotel, and a reasonable stipend for meals. I make it clear that I’m not expected to fly after hours just to save the lawyer money. I’m too old for red-eye flights and I’m not expected to start a trip after a full workday. Most AAPL members I know

consider an hourly billing day to be 8-12 hours long. It is not appropriate to charge for alcohol or entertainment. If I am able to work on another case or income-producing endeavor, I don’t charge for those hours.

I do feel I can afford to reduce the charges if I am traveling on a Sunday, testify on Monday, and can get home late Monday night or early Tuesday morning and still see some patients. I know some AAPL members charge for only half a day if the flight is after 3 PM or the return flight gets home by noon. That decision is made on a case-by-case basis.

I always require payment of any outstanding charges and for the expected travel expenses in advance of departing my house. If I am driving, I bill mileage at the IRS approved rate [2018: \$0.545/mile (www.irs.gov/tax-professionals/standard-mileage-rates)].

I keep the receipts and send them with a final bill and a thank-you note. If I have been overpaid due to an overestimate of expenses, I send a refund promptly and that always builds good will.



A. Glancy:

I agree that it is essential to establish a fee schedule, usually by way of the written fee agreement, prior to taking on a case.

You should also be fair when sending an invoice. For example, it is often possible, and even expedient, to travel in the evening for a case the next day. In this case, usually after discussion with the lawyer, I may feel I only have to bill for the actual hours spent traveling. In addition, I can often spend some of my traveling hours reading material for the case. Be careful not to double-bill for this time.

When I first started in forensic psychiatry, I had no idea that if I took on cases in different places it would com-

mit me to travel and see the sights. I used to try to look at this as an opportunity to see the country. I quickly realized that is not the case. Generally speaking, because of time constraints, I fly in the night before, get up early, spend the next day assessing the client, rush to the airport for an early evening flight, and often get home late at night. Things are even worse when I have to testify. This often involves arriving the evening before feeling tense and worried, perhaps meeting with the lawyer for an hour or more, and then returning to my hotel room to ruminate over what is in store over the next day or two. This might involve the meager luxury of ordering room service eaten while I continue preparation. Far from seeing the city sights, any recreation is confined to a solo late-night walk around the block to try and clear my mind. Inevitably, the next morning is direct examination and a lonely sandwich for lunch. The afternoon is usually spent being cross-examined by a lawyer who seems to be a disciple of the Marquis de Sade. I keep one eye on the clock, wondering whether I’ll make my 6:00 PM flight, in order to get home at a reasonable time.

Suffice it to say, as peripatetic forensic psychiatrists, we earn our money! You should not feel guilty about charging reasonable rates for your valuable time. Often most of us put in time for which we never bill such as brief phone calls with the lawyer or time spent reading around the subject of the case, doing “research” just because we’re all so obsessive by nature that we need to make sure we know the latest.

Life would be a lot easier just to go to my office or my home hospital and do a routine day’s work. There is no reason why we should not be well-compensated for all of our time. The lawyer who retains you for a case outside your geographic locale is picking you because of your special knowledge, experience, and reputation. Be comfortable and professional about your charges and don’t devalue yourself!

I do realize that the above description, which is partly in jest, may paint a

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Jonas R. Rappeport, MD: Founding Father of the American Academy of Psychiatry and the Law

Jeffrey S. Janofsky, MD and Christiane Tellefsen, MD
Originally appeared in *J Am Acad Psychiatry Law* 35:290-3, 2007



Dr. Jonas Rappeport, first President and first Medical Director of the American Academy of Psychiatry and the Law (AAPL),

retired from forensic practice in 1999. Even during his retirement, he remains active in AAPL and teaches forensic psychiatry at the University of Maryland Fellowship in Forensic Psychiatry. Dr. Rappeport continues as a resource and mentor for us, two of his former fellows, as well as for his colleagues throughout the United States. Recently, we sat down with him over the course of several days and asked him to review his life's story. He was happy to oblige us.

Jonas Rappeport grew up in Baltimore. As a teenager he babysat for Manfred Guttmacher, a noted forensic psychiatrist and chief medical officer at the Court Clinic for Baltimore City's Supreme Bench. (1) He recalled leaving through Dr. Guttmacher's medical library while babysitting, including a copy of Krafft-Ebbings' *Psychopathia Sexualis*. Much later, Dr. Guttmacher invited him, then a newly minted psychiatrist, to sit in on discussions at the legal psychiatry section of the annual meeting of the American Psychiatric Association (APA). Dr. Rappeport recalled being with Colonel Albert Glass, Henry Davidson, Manfred Guttmacher, Karl Menninger, Herbert Modlin, John Ordway, John Torrens, and several others at those meetings. As he recalled the experience, "They'd ask what I thought and I shot my mouth off." After President Kennedy's assassination, Dr. Guttmacher evaluated Jack Ruby, who had killed the assassin Lee Harvey Oswald. Dr. Rappeport recalled Dr. Guttmacher's discussion of Ruby at those meetings.

Dr. Rappeport graduated from the University of Maryland School of

Medicine in 1952. He first became interested in forensic psychiatry when he conducted research on inpatient psychiatric patient violence, after a patient assaulted a staff member. He interned at the Michael Reese Hospital in Chicago and then returned to Maryland for his residency in psychiatry at the University of Maryland Medical School and the Sheppard Pratt Hospital. He remained an extra year at Sheppard Pratt as assistant chief of service (chief resident) in 1956. While a resident at Sheppard, he was asked to testify at civil commitment hearings and worked with psychoanalyst Dr. Samuel Novey, evaluating juveniles for the Baltimore County Circuit Court.

After completing his residency, Dr. Rappeport joined the staff at Maryland's Spring Grove State Hospital. Spring Grove housed Maryland's only forensic psychiatry unit at the time. He recalled that the forensic unit was a primitive place by today's standards, with literally a hole in the floor in which violent patients were housed. Spring Grove Hospital Superintendent Isadore Tuerk, who was interested in forensic psychiatry, supervised Dr. Rappeport's evaluation and treatment of forensic patients. Dr. Rappeport also began psychiatric consulting at the Hagerstown Maryland Reformatory. While at Spring Grove, he worked and socialized with Dr. Saleem Shah, then a psychology intern, who later became branch chief for the Center for Studies of Crime and Delinquency at the National Institute of Mental Health (NIMH). (2)

In 1959, Dr. Rappeport opened a private practice in clinical psychiatry in Baltimore. He continued his outpatient clinical practice until his retirement. He consulted Dr. Novey for supervision in his practice. Dr. Novey recommended him for the new part-time position as court psychiatrist for the Baltimore County Circuit Court. Dr. Rappeport established the office of

Court Psychiatrist for Baltimore County.

After Dr. Guttmacher's death, Dr. Rappeport left Baltimore County and was invited to succeed Dr. Guttmacher as Chief Medical Officer for the Supreme Bench in Baltimore City in 1967. Dr. Shah had obtained funding for teaching fellowships in forensic psychiatry through the NIMH for eight university forensic psychiatry teaching programs across the United States. (3) Dr. Rappeport applied for and obtained funding for his first forensic fellow at the University of Maryland in 1968.

He remained interested in teaching and advancing knowledge of forensic psychiatry and began correspondence to locate other training program directors. This resulted in an initial meeting during the APA Annual Meeting in Boston in May 1968, and a subsequent meeting of forensic psychiatry program directors at the Miami APA in May 1969, which he chaired. At that meeting, a new organization was formed to:

... advance the body of knowledge in the area of psychiatry and law, to act as an agency of exchange of information, knowledge and ideas between members and at the interface between psychiatry and the law, and to indicate and study where contribution to the legal and penal system could be made by the behavioral sciences [Ref. 4, p 1].

The organization, which became AAPL, had its first meeting in Baltimore in November 1969. Dr. Rappeport became the first President that year and the first executive director in 1980. He recalled that AAPL was originally a "mom and pop organization." Administrative support was initially provided by staff at the Baltimore City Court Medical office, then through the Baltimore City Medical Society and the Maryland Medical Society (MedChi). During its early years, members' wives provided all administrative support at meetings (all of the original members were men). Along with Herbert Thomas, Winn Perr, and Robert Sadoff, Dr. Rappeport wrote AAPL's first ethics code.

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Criminal Behavior & Developmental Theories

Kavita Khajuria, MD

Are people truly different or are we essentially the same but shaped by different experiences? Crime is a baffling phenomenon. Criminal careers can be difficult to explain, partly because there are many paths to crime.

In the 1940s and 1950s, research by the Gluecks on the biopsychosocial approach formed the basis of the developmental theory. This was sharply criticized at first. The eventual question posed was: When faced with the same life circumstances, what prompts one person to engage in persistent criminal activity, while another steers clear? Why do some escalate while others don't?

Developmental theories look at the evolution of a criminal career. The *life course theory* suggests criminal behavior to be a dynamic process influenced by individual characteristics and social experiences stimulated by shifts in experience and life events. People begin relationships and engage in behaviors that will determine their entire life course. These transitions are expected to take place in an orderly fashion, disruptions of which could be destructive and ultimately promote criminality.

Suspected causes of childhood offending include inadequate emotional support, distant peer relationships and poor parental discipline and monitoring. While most adolescents age out of crime, the ability to change declines with age as one becomes engrossed in the criminal lifestyle. Those who join gangs are more likely to get involved in antisocial behavior after they leave, rather than before they join. One life course view is that criminality is one of many problems faced by people who live a risky lifestyle. Referred to collectively as *problem behavior syndrome*, this cluster of antisocial behaviors includes family dysfunction, substance abuse, smoking, precocious sexuality, early pregnancy, educational underachievement, suicide attempts, sensation-seeking, unemployment and criminality.

Early entry into adult roles with precocious sexuality, motherhood, independent living and romantic relationships can all pave the path into a substance-abusing lifestyle. By adulthood, vocational achievement and marital relations may be the most critical influences. Love (not sex) is cited as a key to success: it strengthens social bonds and reduces the likelihood of offending. McCarthy and Casey found juveniles involved in sexual activity without the promise of love to actually increase their involvement in criminality.

According to Sampson and Laub's age-graded life course theory (1993), the course of a criminal career can be affected by events and turning points, which can alter the course and trajectory. Acquiring social capital helps some at-risk people disengage from a criminal career. The *propensity theory* holds the view that a stable unchanging feature, characteristic or condition, such as defective intelligence or impulsive personality, makes some people crime-prone.

In a *general theory of crime*, Gottfredson and Hirschi argue the propensity to commit antisocial acts to be tied directly to a person's level of self-control. By integrating socialization and criminality, they help explain why some people who lack self-control can escape criminality, and conversely, why some people with self-control might live conventional lives. In contrast, the concept of the *population heterogeneity* assumes that the propensity of an individual to participate in antisocial and/or criminal behaviors is a relatively stable trait, unchanging over the life course.

The *trajectory theory* suggests multiple trajectories or paths into a criminal career with distinctively different routes, both towards and away from a criminal career. Some may specialize in violence, some in fraud, while others may engage in a variety of criminal acts. Some offenders begin their

careers early in life, others are late starters. Some are frequent offenders, while others travel a more moderate path. Experiences in young adulthood and beyond can redirect criminal trajectories or paths. In some cases people can be turned in a positive direction, while in others, negative life consequences can be harmful and injurious.

How are crime causation theories relevant to correctional and forensic psychiatrists? The same question could be asked as to why we consider stressors, medical history, family history or a social history during an intake evaluation. They all have potential influence on mental health treatment and rehabilitation decisions, and could also have implications for wrongfulness and criminal responsibility. (P)

Reference:

Siegel, L PhD: Developmental Theories: Life Course, Propensity, and Trajectory. In: *Criminology: The Core*. 6th ed., Boston, Massachusetts: Cengage Learning: 2016; 264-300.

Ask The Experts

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grim picture of our work. On the other hand, it is what we do, what we live for, and let's face it, we cannot resist doing it.

Take Home Points:

Written fee agreements and advance payment/retainers and the standard for forensic psychiatry. Make sure the lawyer signs the agreement and returns it with a check. Always get paid in advance when doing work for private lawyers. You will never regret standing by your fee schedule; having it available will make it easier for you and for the lawyers with whom you work.

There are some cases (e.g.: Federal Public Defender, State Medical Board) where you will not be able to be paid in advance. Further, some of these agencies have predetermined fee schedules and when you agree to work for them you are agreeing to their terms and rates, so make sure you read and understand the fine print. But, as long as you have a signed contract with the public/government entity you will be paid, although this will not necessarily be timely. (P)

Financial Arrangements in Forensic Work

William H. Reid, MD, MPH; Brian Crowley, MD;
Ana Natasha Cervantes, MD and James Reynolds, MD
Private Practice Committee

Many forensic practitioners, especially early career psychiatrists, experience difficulty collecting fees. The authors, in the field for decades, having had such experiences ourselves, now collect almost all our fees. Below are practical steps that should lead to financially thriving practices, allowing concentration on service without worry about payment.

Be scrupulously honest. Forensic professionals should be honest about their abilities, intentions, value, and charges. Understand your worth to a client, but don't overestimate it. Never pad bills. Document all time and expenses transparently. Never bill your rate for an assistant's work. When a refund is due, pay it promptly.

Be clear, in writing, from the beginning. Have a written, detailed fee agreement in place before work begins. That agreement should specify fees charged, exactly who is responsible for payment, how and when expenses are billed, consequences of arrears or nonpayment, retainer and deposit requirements, and cancellation and refund procedures, and should state that compensation will not be contingency-based. Be sure the person signing the agreement is authorized to sign by the retaining entity. Keep a signed copy on file.

Some retaining entities, e.g., many government agencies, cannot accept private fee agreements. In those cases, a clear contract is usually sufficient, provided it addresses key subjects in your fee agreement. However, some, particularly small local agencies and rural counties and courts, may not pay reliably. Satisfy yourself in advance that you will be paid promptly. Don't rely on "Don't worry; you'll get paid."

To avoid one's work being undervalued by agencies, consider a non-discrimination clause. This provides that the evaluator is not being paid *less* than any *other* evaluator doing similar work, and that should another evaluator be given a better rate, the expert's rate will be increased to match.

We strongly discourage accepting payment directly from litigants. If a check signed by a litigant arrives, send it, uncashed, to the attorney. Ask that payment be processed through the firm. This reinforces that the law firm is the responsible party, not the litigant.

What and how much to bill for. Forensic psychiatrists set rates at their discretion. Professional services are typically billed hourly. Testimony may be billed hourly, on a half-day, or full-day rate. Experts may bill for research or literature review and include a retainer provision to bill for these tasks. Some charge a fixed hourly rate regardless of the type of work; some charge different rates depending on the task (e.g. travel might be billed at a lower rate than depositions or testimony). There are regional differences in expert charges. Fees may depend on expert supply and demand, expertise, experience, and specific skills (e.g. foreign language fluency).

Experts should initially establish current and anticipated record quantities, whether records are handwritten or electronic, and any unique situations, e.g., interpreter use. One might track the time it takes to review "x" pages or inches of records, to accurately estimate for future cases.

Avoid package deals & flat rates. Local agencies, e.g., jails, often pay flat rates for evaluations, and (usually new) forensic psychiatrists may accept them. Such arrangements are notoriously exploitative, and tempt

the expert toward quick, slipshod work. Don't discount your fees to lawyers or firms on their promise to send you more, better cases. Those cases *never* materialize. These arrangements may mark you as doing cheap, low-quality work.

Get a retainer or, if not possible (e.g., in most government matters), a specific contract. Your retainer, as your fee agreement details, applies against future billings. If the case, or your role in it, ends before the retainer is exhausted, promptly refund; however, your agreement should allow you to keep the retainer if you have submitted a report or your name has been used in legal proceedings.

Require deposits for significant future work (e.g., travel and deposition or trial testimony). Once you release a report or are deposed, your value to the retaining entity decreases; it becomes zero after testimony. Unless you are extremely comfortable relying on the retaining entity for payment, do not release reports or testify until the bill is current. Expert witnesses may usually decline testimony if they haven't been paid. We often tell clients, "Juries doubt the credibility of experts who testify while owed a lot of money. It's much better to say, 'The bill's been paid.'"

Send a deposit letter to the lawyer *several weeks* before deposition or trial. Waiting until later may suggest that you're extorting rather than conducting a routine office procedure. Many government agencies cannot issue deposits, but may provide travel advances.

Explain in the letter that you cannot schedule travel, testimony, etc., without a deposit covering time and expenses. Estimate preparation, travel, attorney conference, testimony, expenses, etc., noting that you will commit the date(s) once the deposit arrives. Clarify that the amounts are estimates only.

Remember that these payments are *deposits*; send refunds promptly when appropriate. You may keep some of the deposit if your testimony

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Financial Arrangements

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is canceled at the last minute, provided your fee agreement allows it.

Be alert for early signs of trouble, especially with new clients, plaintiff's lawyers, criminal defense lawyers, family law attorneys, and small government agencies. Discuss your fees in the first conversation and be cautious if the potential client balks or invokes litigants of limited means. If you wish to work *pro bono* or at a discount, it's best to decide this at the outset, not when the bill has mounted. Note also that a lawyer's working *pro bono* doesn't suggest that the expert work for nothing, any more than it suggests the lawyer need not pay their phone bill.

Be cautious about contracting with lawyers who are being paid by third parties. Make clear from the outset, in writing, that the contracting entity is responsible for your bill regardless of third-party payment.

"Court-appointed" does not usually mean court-paid. If you expect payment from a court, be certain that the court is actually the contracting entity.

Bill early and often. Do not wait until the bill is substantial or the case has progressed or resolved. Any lawyer who wants you to wait until the case is resolved is suggesting a contingency process. Don't do it.

Billing should start within weeks of your initial work and be regular thereafter. Your first bill starts the compensation process and the expectation of payment, and its payment denotes acceptance of your fee agreement. Problems with the first payment are harbingers of future problems. *Deal with them early.* Don't be afraid to suspend work or resign for nonpayment (which should be covered in your fee agreement).

Be certain your bills are submitted to the appropriate person or department and *know whom to call to follow up.* You may choose to wait for

insurer or government payments to flow through the retaining lawyer, but settle this *before* starting work. Payment is often faster, especially with government payers, when you accept direct deposit or electronic funds transfer.

Decline *pro se* cases. Always go through a lawyer, court or contracting agency that understands your forensic role and guarantees your fees and expenses. Don't accept cases that have a court or lawyer overseeing the *pro se* litigant. Decline people requesting fitness-for-duty or other evaluations on themselves. *Pro se* clients (often criminal defendants, civil plaintiffs, or parents in child custody disputes) rarely understand our need for honesty, objectivity and completeness. This creates conflicts of interest *and* payment issues.

Be careful when subcontracting, e.g., for psychological testing. It's usually better for the professional to be separately retained. If you subcontract with additional professionals, ethics require that you compensate them promptly even if you don't get paid. Also, note that you likely must file W-9/1099 forms.

Don't nickel & dime your clients. Treat them as valued customers. Never charge for an initial inquiry or a brief update. Reasonable copying and administrative charges are part of *your* overhead; don't bill for them. If a case settles just before deposition or on the courthouse steps, congratulate the lawyer and consider refunding most or all of the deposit. *Lawyers love to get refunds from experts and remember them fondly!*

Overdue bills & collections. It's business. Be reasonable, but not shy, about collections. Don't sue unless the amount is truly worth it (unpaid bills shouldn't get big in the first place). The authors have successfully sued lawyers, choosing our cases carefully. The experiences were unpleasant. Don't *threaten* suit unless you plan to follow through. Empty

threats of lawsuit are sometimes illegal.

We don't recommend charging interest on overdue bills. It entails lots of recordkeeping and irritates people without real return. Your fee agreement *should* say that costs of collecting overdue bills may be charged to the client.

Finally, don't be cowed by lawyers threatening to spread bad reviews if you insist on full payment. Dissatisfied clients are entitled to spread accurate complaints, not to slander or libel. Such threats are usually empty bullying. Other lawyers probably won't pay attention. Believe in yourself, not the blowhard. ☹

FUTURE AAPL MEETING DATES

Forensic Psychiatry Review Course

October 19-21, 2020

51st Annual Meeting

October 22-25, 2020

Marriott Downtown, Chicago, IL

Forensic Psychiatry Review Course

October 25-27, 2021

52nd Annual Meeting

October 28-31, 2021

Vancouver, BC, Canada

Forensic Psychiatry Review Course

October 23-26, 2022

53rd Annual Meeting

October 27-30, 2022

New Orleans, LA

For more information regarding these meetings please visit our website at www.aapl.org or contact us at 800-331-1389.

Brief review of Gabapentin Abuse Potential

Ryan Hall, MD

Psychopharmacology Committee

Gabapentin has traditionally been thought to be a relatively safe medication with no addictive potential. (1-3) It was considered a good treatment option for many neurologic and psychiatric conditions, both for FDA-approved indications (seizure disorders, certain forms of neuropathies) and for off-label indications (e.g., alcohol withdrawal/dependence, anxiety, mood instability, insomnia, somatoform disorders, and withdrawal symptoms from recreational drugs). (1-6) Given its perceived safety, gabapentin has historically not been listed as a controlled substance, unlike its pharmacologically-related cousin pregabalin, which is a Schedule V drug in the US. Although gabapentin has a similar mechanism of action to pregabalin, it does behave differently, pharmacologically speaking. Gabapentin is absorbed more slowly (3-4 hours to peak absorption with a 6-hour half-life, compared to one hour for pregabalin with a similar 6.3-hour half-life), has a lower bioavailability, especially at higher doses (60% bioavailability for low doses, dropping to 30% for higher doses, compared to 90% bioavailability for pregabalin, unaffected by dose), and has roughly six times less binding affinity for its target (voltage-dependent calcium channels) than pregabalin. (1, 5) However some articles and case studies report that gabapentin abuse results in feelings of euphoria, improved sociability and a “marijuana-like high.” (1)

Gabapentin is a derivative of the neurotransmitter GABA which inhibits $\alpha 2\delta$ -subunit-containing voltage-dependent calcium channels. (1-5) This action reduces exocytosis of synaptic vesicles, affecting primarily glutamate, norepinephrine, and substance P, but not dopamine. (1, 3, 5) Its antiseizure effects are thought to be related to the inhibition of excitatory neurotransmitters such as glutamate.

Gabapentin does not bind to the GABA_A, GABA_B, or glycine/NMDA receptors at relevant clinical concentrations. (1, 3) In addition, there is no indication that gabapentin binds to benzodiazepine, opioid or cannabinoid receptors. (1, 3) To date there have not been any studies showing that gabapentin by itself actually increases the extracellular dopamine activity in the mesolimbic reward system. (5) It has been hypothesized that since dopamine release is not inhibited and other control pathways are, that gabapentin may indirectly affect traditional reward pathways and potentiate the effects of other drugs of abuse. (1, 5)

Over the last 10 years concerns regarding the abuse potential of gabapentin have begun to arise. (2, 4, 6) Gabapentin abuse has been reported in the United Kingdom, Scandinavia, and Germany. (1, 5) Four hundred and ten cases of suspected gabapentin abuse were reported to the European Medicine Agency by means of the EudraVigilance database (peak reporting in 2014). (5) The estimate of lifetime prevalence of gabapentin abuse in the general population was 1.1% in a British study. (3)

In the US, a 2013 study found that 15% of individuals in the Appalachian region in Kentucky being treated for opioid abuse reported using gabapentin “to get high.” (6) With studies such as this it is not surprising that Kentucky in 2017 was the first state to list gabapentin as a Schedule V controlled substance. (7) In addition, Bastiaens *et al.* found 26% of an incarcerated population with an opioid abuse disorder reported abuse of gabapentin, compared to only 4% of those who did not abuse opioids. (2) Although gabapentin has been reported to be helpful in treating some substance abuse populations (e.g. alcohol, cannabis) it appears to have some risk of being abused, often in combi-

nation with opioids. (2, 3, 5)

Mersfelder and Nichols in their review focusing on abuse, dependence and withdrawal of gabapentin found examples of it being abused as a single agent and in conjunction with other compounds such as opioids or sedatives (e.g., benzodiazepines). (4) It appeared that gabapentin often worked as a potentiator, increasing the effects of the primary intoxicant. Individuals abusing gabapentin were on average taking more than 3000 mg a day (range, 600-8000mg). (4) Withdrawal was noted to occur within 12 hours to seven days of last use, with common symptoms being agitation and confusion. (4) Other symptoms of gabapentin withdrawal included diaphoresis, gastrointestinal symptoms, tremor, tachycardia, hypertension and insomnia. (4) When gabapentin was restarted the suspected withdrawal symptoms resolved. One of the case reports reviewed even noted that the subject experienced cravings for gabapentin upon discontinuing the drug.

In a review of both gabapentin and pregabalin (*i.e.* gabapentinoid) abuse Bonnet and Sherbaum noted much stronger literature support for pregabalin addiction (e.g. greater magnitude of behavioral dependence symptoms, more frequent transitions from prescription to self-administration, and greater length of time of self-administration). (5) In addition, there were four cases of pregabalin behavioral dependence symptoms by ICD-10 criteria in individuals who did not already abuse other substances (apart from nicotine) either currently or historically, but none for gabapentin. (5) The review did not find any cases of patients seeking substance abuse treatment for just gabapentinoid abuse and rarely found reports of relapse on gabapentinoids. The review also reported a 15-22% six-month prevalence rate for individuals in opioid substance abuse treatment (either abstinence or opioid maintenance programs) taking gabapentin without a prescription. (5) Primary means of ingestion was oral, but there were reports of ingestion by nasal,

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Prenatal Alcohol Exposure in Forensic Patients – Why Does It Matter?

Mansfield Mela, MBBS

Developmental Disability Committee

Forensic psychiatrists frequently encounter cognitive and adaptive deficits in perpetrators, victims and witnesses in the criminal justice system (CJS). These deficits are responsible for poor decision making, continued victimization and increased risk of recidivism. (1) Deficits in executive function, impulse control, attention and memory abound in offender populations and are the essential brain domains affected in individuals with prenatal alcohol exposure (PAE) or diagnosed with fetal alcohol spectrum disorder (FASD). (2) Those same deficits challenge the basic assumptions of the traditional CJS (e.g., punishment for individuals who fail to make the link between actions and consequences,

presumption of competence and criminal responsibility). (3, 4)

Diagnosis of those affected by the neurocognitive and behavioral consequences of PAE has become more straightforward since the introduction of the DSM-5, which includes criteria for Neurodevelopmental Disorder Associated with Prenatal Alcohol Exposure, (under Other Specified Neurodevelopmental Disorder, 315.8 (F88)), as well as Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE) (in Section III, Conditions for Further Study). (5) Offenders are 5-25 times more likely to have PAE or an FASD diagnosis than the general population. (6) Despite the overrepresentation of ND-PAE in the CJS, many psychia-

trists and other mental health professionals are unaware of the implications of ND-PAE. (7) The important question is: will a forensic psychiatrist encounter individuals with these deficits during assessments (e.g., for competency to stand trial or insanity) and treatment (sorting out comorbid mental disorders, correctional placement and psychotherapy)?

ND-PAE, unlike other neurodevelopmental disorders, has minimal or no physical distinguishing features (invisible disability). Complexity is the norm, with comorbid diagnoses in over 90%. (3, 8) High rates of misdiagnosis have caused many offenders and witnesses to fall through the cracks of the CJS. Given this level of unrecognized psychopathology, forensic mental health systems bear the brunt of the disproportionate overrepresentation of ND-PAE among offenders. Studies estimate that in psychiatric units, 8% of adults and over 20% of youths were diagnosed with ND-PAE. (6, 7) Between 10-36

TABLE 1

Author & Year	Population (age range)	Method	Rate of ND-PAE/FASD (%)	Comments
Rojas & Gretton 2007 (13)	230 youths (12-18)	Retrospective file review	10.9	sexual offender community program
Murphy & Chittenden 2007 (14)	137 youths (14-19)	Adolescent health questionnaire survey	11.7	in custody and only 14% females
Fast et. al 1999 (15)	287 youths (12-18)	Active case ascertainment (Diagnostic)	22.3	in forensic psychiatric facility
McPherson & Grant 2008 (16)	91 adults (19-30)	Active case ascertainment (Diagnostic)	10-18	Only those <30 years old
Stinson & Robbins 2014 (7)	secure forensic psychiatric hospital, n=235	Diagnostic survey	8	Only Fetal Alcohol Syndrome not FASD
McLachlan et. al 2017 (17)	90 adults in prison	Active case ascertainment (Diagnostic)	17	<50 years old, PAE confirmed in 50%
Bower et al. 2018 (9)	Diagnostic in youth prison, n=99	Active case ascertainment (Diagnostic)	36	Predominantly male and aboriginal Australian; majority not previously diagnosed

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Evolving Policy Topics of Interest for Institutions of Higher Learning

Ryan Hall, MD; Susan Hatters Friedman, MD; and Renée Sorrentino, MD

Due to changing societal and political pressures, colleges and universities are facing some unique policy challenges, many of which directly or indirectly implicate forensic psychiatry themes. These challenges range from marijuana on campus to firearms on campus, to policies on investigations of sexual assault. Although some aspects of these issues arise in the primary and secondary school systems as well, on college campuses the majority of students are legally adults, and there is less parental and school-based oversight.

Medical and recreational marijuana is one area where universities are having to make significant policy decisions while trying to navigate conflicting state and federal laws. Historically, institutions of higher learning have not allowed marijuana on campus in order to comply with the Drug-Free Schools and Campuses Act, as well as the Drug-Free Workplace Act. (1, 2) However, Congress passed the 2014 Hinchey-Rohrabacher Amendment (a.k.a. Rohrabacher–Farr or Rohrabacher–Blumenauer), which initially had a time-limited restriction on the US Department of Justice spending federal dollars to enforce federal prohibition laws in states with medical marijuana laws. (3) Although this law has been repeatedly renewed, as of 2018, nine states allow recreational marijuana and 21 states allow medicinal marijuana. Although campuses may still forbid recreational use, the number of legal challenges to the prohibition of medical marijuana is rising. In 2018 there were two court rulings, one in Illinois (4) and the other in California (5) which prevent K-12 school districts from imposing a blanket denial of students' access to medicinal marijuana on school grounds. The California ruling noted that since the federal government was not actively enforcing the Drug-free Schools and Campus Act in regard to medical marijuana, citing such laws

was not a legal justification to prevent medicinal use. Traditionally, courts have allowed colleges to prohibit medical marijuana on campus or in the dorms as part of school policy (6), however whether the new K-12 school rulings will carry over to the college level is yet to be seen. In the K-12 school rulings usually a guardian or healthcare professional is in charge of the medication, not a student, which would be harder to enforce in college and dorm environments.

It needs to be remembered that colleges and universities often have policies which restrict what would be otherwise legal behavior. An example would be firearms on campus and in dorms. One large study found that 4.3% of American university students had a working firearm at college. (7) When lawmakers focus on whether concealed firearms should be allowed on campuses across the US, what students and faculty think about safety related to guns on campus should be considered. Cavanaugh et al., studying undergraduates at public universities in Texas and Washington state, found that approximately one-quarter of students were not comfortable at all with guns on campus. (8) Opponents to guns on campus may cite research finding that college students who carry guns are more likely to be male, engage in binge drinking and drug use, drive under the influence, perpetrate physical and sexual violence, be in trouble with the law, attend college in southern and mountain states, and live off-campus. (7, 8) Proponents for increased access to weapons on campus list concern for the need for self-protection in the wake of rare large-scale events such as shootings or knife attacks, or the more frequent small-scale acts of violence such as sexual assault, estimated to occur at an incidence of 20-25%. (9-11)

In an effort to address campus violence and college sexual assault (CSA), Congress passed such Acts as

the Student Right-to-Know and Campus Security Act (1990) and Clergy Act (1998), which require all Title IX-eligible institutions of higher education to publically disclose crime statistics, crime prevention and security policies and procedures. (11, 12) Unfortunately many institutions have not successfully responded to the mandates outlined in these Acts. As a result many of the reporting procedures, on-campus procedures for investigating, adjudicating, and disciplining perpetrators of sexual assault vary greatly across institutions of higher education.

In an attempt to clarify and standardize the process, new policies on college sexual misconduct were promulgated by first the Obama administration and more recently the Trump Administration. In April 2011 the Obama administration issued what's known as the "Dear Colleague" letter, which was a directive that required Title IX schools to investigate sexual assault allegations and adjudicate them under a "preponderance of the evidence" standard. (13) The proposed Trump administration's approach (public comment closed on January 30th, 2019, with rule finalization pending at time of writing) addresses CSA with a higher legal standard ("clear and convincing") as well as a change in scope of responsibility for institutions. (14) Under this proposal, institutions would be exempt from investigating any assaults that occurred outside the school's own program or activity, as well as from investigating any assaults that were not reported to school officials with authority to take corrective action (such as a Title IX Coordinator).

Although this is just a brief synopsis of some evolving issues facing universities, it is easy to see how forensic psychiatrists could become involved, and thus need to be aware of the background and current legal standards. It should also be noted that any government or college/university policy decisions that are made in one of these areas could potentially have ramifications for the others as well.

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Shrinking Access to State Hospital Beds: A Growing Problem

Joy Stankowski, MD

Forensic Hospital Services Committee

The forensic patient population in state psychiatric hospitals has been steadily rising over the past 20 years, largely due to increased admissions for restoration to competency to stand trial. (1) Since forensic patients, typically defined as those with a history of criminal charges, have longer average lengths of stay than their non-forensic counterparts (2), many hospitals are experiencing a “funnel effect:” the pace and ease of bringing in a forensic referral far exceeds the steps needed to plan and execute a forensic discharge. As demand for forensic admissions to state hospital beds grows, courts have shown little patience for hospital administrators unable to prevent an admission bottleneck and the resulting waitlist. (3) Furthermore, federal courts have ruled that lengthy jail stays waiting for state hospital beds are unconstitutional. (4)

There are two possible approaches to improving bed access: decrease admissions or increase discharges. Regarding the former, some states have sought to reduce hospital referrals for restoration to competency through community- or jail-based programs. (5) These programs, however, present their own challenges. (4-6) Competency restoration in jail offers a secure environment for those with high-level charges or histories of dangerousness, yet there are limitations to what can be provided in terms of treatment or a therapeutic milieu. (4, 5) Community-based programs offer a more recovery-focused environment, but may not be appropriate for persons where there are serious issues of dangerousness (7) or a high risk of alcohol or illicit substance abuse. As a result, most competency restoration is still done in state facilities.

Increasing the rate of forensic discharges presents many challenges. The majority (75-80%) of patients admitted for competency restoration are successfully restored within one

year. (7, 8) At minimum, therefore, a forensic patient is likely to occupy a bed for many months. For patients who do not get restored stays are often much longer. Charges may be dismissed, but not competent and not restorable (NCNR) patients are likely to be found eligible for hospitalization via civil commitment. (2, 9, 10) In fact, such persons are more likely to be civilly committed, and to stay longer than persons without forensic status. (2) Someone found NCNR never stands trial, yet sometimes has a history suggesting dangerousness, making community placement difficult. As suggested by Fisher and Grisso, the result is a population composed of a “class of individuals who seem to not fit anywhere else” (Ref. 11, p. 367). When this population is combined with patients adjudicated not guilty by reason of insanity, the plight of keeping state hospital beds open becomes even more problematic.

What are the barriers to discharge? Theoretically, case law supports the discharge of those who are no longer mentally ill and dangerous (*Jones v. United States; Foucha v. Louisiana*) (12, 13), do not have a substantial probability of being restored to competency (*Jackson v. Indiana*) (14), or can be safely cared for in a less restrictive environment (*Olmstead v. LC and EW*). (15) In practice, however, the perception of dangerousness based on history of criminal charges is a significant hurdle. As Fisher and Grisso note, there is a belief that “persons who have committed a crime, cannot simply be allowed to walk away because of their psychiatric illness” (Ref. 11, p. 367). Discharge of a forensic patient therefore requires demonstration of symptom stability, lack of dangerousness, and frequently consent from proposed community partners. These may include treatment providers, case managers, housing supervisors, forensic monitors,

and criminal courts. Even the most stable psychiatric patient bears a stigma when there is a history of criminal charges, and community providers juggling limited resources may be reluctant to assume this perceived risk.

Forensic patients themselves often have circumstances that are impediments to discharge. Since most admissions for competency restoration are restored, those not restored tend to be more resistant to treatment. Overall, non-restorability has been shown to be related to older age, treatment-resistant psychotic disorders, substance use disorders, and intellectual disability (7, 16), all of which present unique challenges to discharge planning. Furthermore, extended lengths of stay may promote dependence on the institutional setting. As noted by Talbot in his review of deinstitutionalization, expecting people with chronic mental illness “without families and social networks, to suddenly be able to obtain for themselves the professional and custodial services they formerly took for granted in a total institution seems the stuff of sheer fantasy” (17). Although forensic patients typically are not left to fend for themselves, especially in the case of conditional release, few community plans match the breadth and convenience of institutional services. The long lengths of stay most forensic patients experience can contribute to dependence on such services. (18)

So, what to do? With state hospital beds at a premium, research on optimal management is critical. As suggested by Bloom and Novosad, a targeted census of the different populations in state hospitals would help define categories of forensic patients and pinpoint needs. (19) Management of each type of patient could then be guided by data predicting outcomes. For example, there is evidence that persons found either NCNR or not guilty by reason of insanity may be successfully transitioned to the community via step-down programs leading to conditional release, or court-monitored discharge, and both clinical and actuarial data such as the HCR-20

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Female Incarceration – What is Happening in Oklahoma?

Reagan Gill, DO; Susan Hatters Friedman, MD; Jennifer Piel, JD, MD; and Jason Beaman, DO, MS, MPH
Gender Issues Committee

Oklahoma incarcerates more women per capita than anywhere else in the world. Thailand ranks highest when comparing countries at 66.4 women per 100,000. The US is second at 64.6. (1) When comparing states, Rhode Island has the lowest rate of female incarceration at 12 per 100,000, while Oklahoma is highest at 142. (2) Even more concerning is the fact that while male incarceration has increased nationwide by approximately 6% since 1980, female incarceration has increased by closer to 10%. (3)

Over half of Oklahoma's incarcerated women are in prison for drug offenses, and 20% are sentenced for technical violations of probation or parole. (4) A majority are first-time offenders. Oklahoma incarcerates people 80% longer than the national average for drug and property crimes. Incarcerating non-violent offenders increases recidivism rates. (5) Unlike men, for whom longer sentences show a negative correlation with violent recidivism, women with longer sentences for both violent and non-violent crimes actually have a greater risk for violent recidivism. (6)

Only recently has research started to focus on differences between male and female offenders. Women, collectively, are less likely to commit violent crimes against others as compared to men. When they do, it is often in the context of a relationship: they are more likely than men to have committed their offense against someone close to them. (7) Drug offenses account for much of the rise in the number of women incarcerated nationally. In the 1980s, public concern about crime led to a crackdown on drug crimes. Many jurisdictions imposed mandatory minimums and longer sentences for drug-related crimes.

Women in Oklahoma are receiving harsher sentences from gender-biased

laws. In 2004 Tondalao Hall was a 19-year-old mother of three young children with no criminal record. While she was at work, the father of her two youngest children fractured a femur in each child, as well as 12 ribs of their one-year-old son and seven ribs of their three-month-old daughter. He pled guilty and was sentenced to 10 years in prison. After serving two years he was released in 2006. Hall, however, was charged with failure to protect her children and was sentenced to 30 years in prison, where she remains today. (8) Laws like "Failure to Protect" are almost exclusively charged against mothers.

One approach to combat the multifaceted problem of astronomical female incarceration rates is legislative change. Oklahomans for Criminal Justice Reform led the "Yes on 780 and 781" campaign. (9) State Question 780 reclassified drug possession from a felony to a misdemeanor. (10) Since its passage felony charges have dropped 28%. (11) State Question 781 distributed the funds saved by the reclassification into privately-run rehabilitative organizations providing drug and mental health treatment, job training, and education programs. (10)

Another law, State Question 788, legalized medical marijuana. (10) Prior to this legislation, a second marijuana possession charge was a felony requiring between two and 10 years in prison. In 2016 arrests for marijuana possession made up almost half of drug-related arrests in the state. (12) Question 788 should drastically reduce the number of women being sent to prison.

Another type of solution is bolstering a woman's legal defense team. Still She Rises Tulsa was established in February 2017 to reduce incarceration for women, reunite them with their children, and stabilize families. (13) They provide individualized rep-

resentation and assist with many different needs including housing, immigration when applicable, and social support. Similarly, the Women's Justice Team focuses on keeping first-time, nonviolent female offenders out of prison. (14) They work with women without means of assistance to navigate the legal system. They develop individualized treatment plans including mental health services, substance abuse treatment, housing programs, employment, and educational services.

Women who are incarcerated often have complex mental health needs. A history of trauma has been reported in approximately three-quarters of female prisoners. (15) The rate of PTSD among female prisoners is higher than for male prisoners, and much higher than the rate in the general population. "Complex PTSD" from a series of events or prolonged trauma also occurs. Both women and men in prison average about 4% prevalence of psychosis across studies. (16) However, women in prison, like women in the community, have higher rates of mood disorders than men in prison. Substance use disorders are commonly comorbid with mental health concerns.

Oklahoma's Women in Recovery is an intensive outpatient alternative to incarceration for women with drug-related offenses. (17) Its goal is to reduce recidivism, reunite families, and break the cycle of intergenerational incarceration. Since 2009 over 700 women have participated. Approximately 75% are mothers. By the end of the program, 92% reestablished contact with their children, which is an important factor in successful community reintegration. (18) The program has a recidivism rate of 6.7%, less than one-third the overall rate for Oklahoma in 2014. (19)

Unfortunately, Oklahoma's female incarceration rate continues to rise. Most women in the state are incarcerated for non-violent offenses, held in prison for longer periods than men, and suffer from antiquated laws. However, there are solutions giving hope including legislative reform, defense teams, and alternatives to incarceration. (20)

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Physician-Assisted Suicide and Euthanasia for Individuals with Non-terminal or Mental Illness – is Canada Sliding Down the Slippery Slope?

Patricia Westmoreland, MD and Mark Komrad, MD
Suicidology Committee

Physician-assisted suicide (PAS) is legal in several European countries, Canada and eight states/jurisdictions in the US. Other jurisdictions will likely follow. However, it appears that the more experience a country has with PAS, the more the horizon of eligibility has expanded beyond terminal cases. The “Benelux” countries (Belgium, the Netherlands and Luxembourg) have expanded criteria for PAS (by self-administered prescription) and euthanasia (by physician-administered injection) to include patients whose psychiatric conditions cause intense distress and are unresponsive to treatment. (1) Also, they have followed the spirit of parity and removed any distinctions between “physical” and “mental” suffering. Therefore, individuals who suffer from psychiatric illness can request PAS and euthanasia.

In the Benelux countries, where these practices have evolved over 18 years, 4.6% of all deaths are by physicians’ injections (2). They have slid a significant distance down the slippery slope, to include eligibility for people with non-terminal illnesses. In some cases, advanced directives and proxy consent for euthanasia of the incompetent are honored. Two retrospective studies, one from The Netherlands and one from Belgium, uncovered a troubling pattern with regard to the demographics of individuals requesting physician-assisted death. In both studies, roughly half the individuals requesting death for psychiatric concerns had a personality disorder diagnosis. (3, 4) In addition, although treatment-resistant depression was responsible for the majority of death requests by individuals requesting relief from intractable mental suffer-

ing, between 10 and 15% of cases in the Netherlands involved diagnoses of anxiety and PTSD. (4) Approximately 70% were female and under 70 years old. Personality disorders, as well as a propensity for social isolation and loneliness, were pervasive in that sample. (4) These demographics could indicate that female gender, difficulty getting along with others and social isolation could be considered potential indicators of a life not worth living. Moreover, these are endemic issues in those with chronic mental illness. As to the point that applicants for PAS need not try any form of treatment they deem unacceptable, up to 28% of those with personality problems may not have received psychotherapy prior to receiving PAS. (5)

In all US jurisdictions with PAS, it is limited to terminal medical conditions (individuals who are expected to survive less than six months and for whom there is no known cure for their condition) and excludes psychiatric conditions. In addition to standing with the American Medical Association (AMA) against all PAS and euthanasia, the American Psychiatric Association (APA), concerned about practices in Europe, has adopted a position statement opposing PAS for any non-terminal disorder, noting that a psychiatrist should not prescribe or administer medication to a person who is not terminally ill for the purpose of causing death. (6)

In Canada, a federal law (C-14 Medical Aid in Dying - MAID) has permitted PAS and euthanasia since 2016. As in the Benelux countries, the vast majority of the practice is euthanasia. The Canadian terminology for eligibility, not shared by any other country, states that death must

be “in the reasonably foreseeable future,” as opposed to the US notion of “terminal illness”. The Canadian term was not statutorily defined, but is generally believed to imply that patients are somewhere near the end of their lives due to their illness. While this suggests that people with psychiatric disorders would not be eligible, they are not explicitly excluded. In *Carter v. Canada* (2015), the Canadian Supreme Court ruled that PAS could not be prohibited for a competent adult who 1) consents to the termination of life and 2) has a grievous and irremediable medical condition that causes enduring suffering that is intolerable to that individual. In addition, in demonstrating that a condition is irremediable, an individual is *not* required to accept a treatment that he or she finds unacceptable (7), preserving the status quo in medical ethics allowing patients to refuse treatments. For individuals with psychiatric illness, this opens a veritable Pandora’s Box. Those who eschew psychiatric medications and life-saving procedures such as ECT might more easily be assisted in ending their lives than provided treatment that could assist in improving if not saving their lives.

In the first reported Canadian case of MAID in the context of psychiatric illness, in 2016, EF, an individual with conversion disorder, was granted MAID on the basis of her mental disorder which caused intractable muscle spasms resulting in severe pain. She also suffered from digestive dysfunction, resulting in being unable to eat. She had lost significant weight and muscle mass and could not ambulate. EF’s quality of life was described as “non-existent.” (8) Although the government argued that she did not meet criteria for MAID, the court granted her request. When Parliament later passed C-14, it specified that the patient be in “an advanced state of irreversible decline” and that death be reasonably foreseeable. (9) Since the passage of C-14, more than 3,700 Canadians have received PAS, predominantly via euthanasia. (10) Under Canadian law, patients must be

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(Historical-Clinical-Risk Management 20) can help predict readiness. (20, 21) Defining the nature and scope of forensic patients in state hospitals may help guide clinicians towards improved management and discharge strategies, thereby helping fulfill obligations to both patients and the community. (4)

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Jonas R. Rappeport

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The writers concentrated on forensic psychiatrists' relationships with the people they examined and how much information should be shared when writing a report or testifying. Dr. Sadoff recalled that the initial draft was written by a group seated at his kitchen table in Philadelphia during 1980 or 1981 (Sadoff R, personal communication, April 2007). That draft became the basis for AAPL's "Ethics Guidelines for the Practice of Forensic Psychiatry." (5)

Dr. Rappeport became very active in the Maryland Psychiatric Society (MPS), Maryland's APA district branch. He recalled, "I'd go to meetings, and I'd sound off in committees. If you sound off enough they either kick you out or make you President." Indeed, Dr. Rappeport served as MPS President from 1965 to 1966. Before his presidency, he wrote and advocated the passage of a psychiatrist-patient privileged-communications statute in Maryland. (6) An initial attempt to pass the statute failed. The legislature then passed a privileged-communications statute for psychiatrists in 1965, only to have it vetoed by the governor after lobbying by the state bar association and the state psychological association (who claimed they were discriminated against). Thus began the "territorial rift" between psychologists and psychiatrists. During Dr. Rappeport's MPS presidency, a new bill was signed into law only when psychiatrists and psychologists joined to obtain the privilege for both professions. (7) He said, "I can still see myself on the telephone getting people to call their legislators [to gain support for the bill]."

Dr. Rappeport remained active in advocacy and public policy matters, both in Maryland and nationally. After the *Hinckley* verdict, he was appointed in 1983 to the Maryland Governor's Task Force to Review the Insanity Defense. He strongly advocated retaining Maryland's American Law Institute (ALI) insanity test. The Task Force subsequently recommended retaining the ALI Test, but changed the burden of proof and the

form of the verdict. The Task Force specifically rejected any proposal to restrict expert testimony by mental health professionals in cases involving the insanity defense based on "the general excellence the task force found in Maryland's forensic psychiatric examination and evaluation which in turn influences the thoroughness and quality of independent psychiatric evaluation and testimony in criminal cases" (Ref. 8, p 37). In 1984, the Maryland legislature passed parallel bills that retained the ALI Insanity Test based on the recommendations of the Task Force. Dr. Rappeport advocated for the same position when he testified before the U.S. Congress in hearings after the *Hinckley* verdict. (9)

In the early 1980s, along with Nicholas Conti, LCSW-C, his long-time colleague and the administrator of the Supreme Bench of Baltimore Medical Office (the name of the court was changed in 1983 to the Circuit Court for Baltimore City), Dr. Rappeport developed Maryland's pretrial screening program for all defendants who raised questions about their competency to stand trial or about their criminal responsibility. (10) Before the initiation of the program, such defendants were always sent to the hospital. The pretrial screening program reduced unnecessary hospitalizations, saved money, and resulted in more rapid submission of reports to the court. In addition, the program led to quicker hospitalization for those who were found to be acutely mentally ill. Mr. Conti recalled, "Jonas has a good understanding of people. He looked for people who thought outside the box." Dr. Rappeport and Mr. Conti received strong support from Maryland's chief judge and then visited all 23 Maryland counties to explain the program and to obtain the support of county judges and sheriffs.

As Baltimore City's Chief Medical Officer, Dr. Rappeport consulted on virtually all major forensic psychiatry cases in Baltimore City during his career. Nationally, he consulted on the Arthur Bremer (attempted assassination of presidential candidate George Wallace), Sarah Jane Moore (attempted assassination of President Ford), John Hinckley (attempted

assassination of President Reagan), and John DuPont (murder of wrestler David Schultz) cases.

Dr. Rappeport met his wife Joan during his internship at Michael Reese Hospital, where she served as head nurse on the psychiatric unit. Recalling her professionalism, he stated, "She wouldn't date me while I was working on her service." They quickly fell in love and married when both were 29 years of age. In Baltimore, Mrs. Rappeport taught psychiatric nursing and worked as a psychiatric nurse, an outpatient therapist, and then a visiting nurse until 1985 when she retired. She staffed the registration booth at almost every AAPL meeting through October 2006, only a few months before her death in June 2007. The Rappeports have three children and four grandchildren.

By the time he retired, Jonas Rappeport had trained 39 fellows. Twenty of those fellows, along with 130 AAPL members, celebrated Dr. Rappeport's contributions to American forensic psychiatry during a dinner at AAPL's 30th Annual Meeting in Baltimore in 1999. (11) AAPL created the Rappeport Fellowship in 1985 to offer outstanding residents with interests in forensic psychiatry the opportunity to attend AAPL's Annual Meeting to develop their knowledge and skills in forensic psychiatry. Dr. Rappeport received the APA's Isaac Ray Award in 1984 and the MPS Lifetime of Service Award in 2002.

Phillip Resnick, MD, another Past President of AAPL, views Dr. Rappeport as his "primary mentor." When Dr. Resnick began running the court clinic in Cleveland, there were no local forensic psychiatrists to turn to for guidance. He said Dr. Rappeport was "warm, open, and supportive." Over the years, he found that Dr. Rappeport's "most remarkable qualities were his inclusiveness and graciousness to young people." In summing up Dr. Rappeport's contributions to AAPL, Dr. Resnick recalled a famous quote of Ralph Waldo Emerson that "every institution is the lengthened shadow of one man."

Dr. Rappeport has cast a long shadow indeed. ☪

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Prenatal Alcohol

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% of incarcerated offenders were diagnosed with ND-PAE in surveys and active case ascertainment studies. (6, 9) Therefore, forensic systems should accommodate these manifestations of mental or cognitive disorder. (Table I lists rates of ND-PAE and FASD found in published studies over the past two decades.)

Cognitive deficits and disorders affect medico-legal tasks such as competence to stand trial and criminal responsibility. The expert/clinician should be sensitive to these deficits because those with ND-PAE are frequently unrecognized by the police, show higher suggestibility and may falsely confess to crimes. (8, 10) They also receive their first criminal charge earlier in life, display substantial impairments in their ability to appreciate and understand their rights related to arrest, interrogation, and court procedures, and have significantly poorer ability to adequately communicate with counsel. Interestingly, their self-rated assessments of their abilities do not correspond to these objective impairments. (10)

Inconsistent application in insanity proceedings and criminal sentencing was apparent in a systematic review of ND-PAE cases raised in US courts. (11) Not surprisingly, deficits due to ND-PAE typically fail to meet the high threshold for an insanity defense. ND-PAE was mentioned in the defense of diminished capacity and noted as the number one reason in 133 Canadian cases in which neuroscientific evidence was presented in court. (12) Alternative legal approaches should be considered when opining on criminal responsibility in ND-PAE. (3) Linking deficits with capacity for a medico-legal duty (legal nexus) is paramount in comprehensive forensic assessments. Such thorough evaluation may allow recommendation of individualized supports or interventions. Recognition is the first step to identification, responsiveness and appropriate intervention. ND-PAE's importance as a mitigator remains contro-

versial. For nonviolent offenses, diversion programs may allow for assessment and treatment instead of incarceration.

After sentencing, the ingredients necessary to perpetuate high rates of institutional offending align with ND-PAE features such as impulsivity, suggestibility, gullibility, dysregulation and disinhibition. High rates of increased sensitivity to physical touch, risk unawareness and self-harm behaviors characterize ND-PAE and feature prominently in institutional perpetrators. (8) Therefore, institutional psychiatrists have a role in understanding these behavioral deficits in ND-PAE in order to reduce psychological consequences, as well as reducing the impact on staff morale when approaches that work with other offenders fail to have the desired effect.

Misdiagnosis and under-recognition of ND-PAE call for targeted training. Knowledge of maternal alcohol history, multiple childhood placements, academic underachievement and cognitive deficits should prompt comprehensive assessments. Executive dysfunction contributes to a disproportionately higher number of administration of justice offenses (breaches and failures). Obstacles to diagnosis (lack of training, preference for extra specialization using a multidisciplinary team approach) can be overcome by adopting a "red flagging" system combining confirmed maternal alcohol use and evidence of neurocognitive deficits.

Forensic psychiatrists' expertise and comfort with uncertainty and ambiguity are advantageous in separating the effects of PAE in the context of multiple psychiatric diagnoses. PAE's contribution is clarified through reconceptualization of behavior in a hierarchical list of causes. For instance, criminal activities associated with lifelong neurodevelopmental deficits may support ND-PAE as opposed to mental disorders of later onset such as schizophrenia. Compared to other offenders, those with ND-PAE experience an earlier onset of problem behaviors, higher rates of

functional impairment, multiple complex traumas, and parental substance abuse. Supportive interventions that are informed and targeted are beneficial to those with ND-PAE. Strategies, approaches, and adaptations specific to FASD follow the Risk-Need-Responsivity (RNR) model.

Continuing to ignore ND-PAE leads to missed opportunities for prevention, early identification and interventions to reduce recidivism. The path of an ND-PAE offender through the CJS contributes to the disproportionate cost arising from arrest, administration of justice offenses and serious and violent offenses. The cost of being victimized as an individual living with ND-PAE is high.

Only through understanding the behaviors viewed through a developmental lens can customized and targeted interventions be effective and negative consequences reduced. Innovative, comprehensive treatment interventions coupled with diversionary measures signify an FASD-informed approach and are pivotal tools in the hands of the forensic psychiatrist. (3, 6) Details of interventions will be the subject of a future article. ☞

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Gabapentin

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intravenous and rectal routes. There was no indication from this review that gabapentin was a gateway agent for use of opioids or other drugs; it was usually taken/abused after opioid use had already been occurring.

It will be interesting to see if other states or the federal government will follow Kentucky's lead in making gabapentin a controlled substance. There is definitely literature that supports that gabapentin abuse occurs, especially in certain populations, such as the incarcerated and opioid abusers. However, the risk of abuse in patients without a pre-existing substance use disorder using low to moderate doses appears to be relatively low. ☹

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Slippery Slope

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lucid enough to give informed consent twice: at the time the request is made and immediately before they are administered life-ending drugs. For this reason, unlike in Benelux countries, advance directives for euthanasia are not permitted. Critics say this forces patients to make a cruel choice: forgoing the death they want and prolonging their suffering, or ending their lives before they want to. Neither scenario provides the autonomy to end their lives on their own terms.

While the question of MAID for individuals with psychiatric illness in Canada has been in limbo, the overall rate of MAID increased 30% in the last half of 2017. (11) One province declared that it is neither ethical nor legal for a conscientiously objecting physician to refuse to refer a patient to a colleague who is more open to PAS. (12, 13) Apropos psychiatric illness is a case involving two plaintiffs, one with cerebral palsy and the other with post-polio syndrome, before the Quebec courts. These individuals are asking that they not be discriminated against and prevented from accessing euthanasia for their "unbearable" and "untreatable" conditions because their deaths are clearly not going to occur in the "reasonably foreseeable future." There is a similar challenge in British Columbia. If these cases are successful, the door will open far wider to people with indisputably non-terminal illnesses. This raises concerns about all chronically disabled people; there is special concern about allowing people with psychiatric illness to have doctors provide assistance in suicide instead of preventing it, as has happened in the Benelux countries.

An argument against euthanasia in such cases is made by Catherine Ferrier, President of *Collectif des Médecins Contre L'Euthanasia* (Physicians' Alliance Against Euthanasia). Dr. Ferrier raises the concern that if these cases modify the current parameters for euthanasia, all individuals with disabilities could be stripped of the protections to which they are enti-

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Jonas R. Rappeport

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Slippery Slope

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tled. (14) For psychiatric patients, PAS flies in the face of all we have been taught as psychiatric physicians, in evaluating and caring for those whose lives are fraught with struggle so that they may have the opportunity to live meaningful lives despite adversity. ☯

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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 APA and the American Academy of Psychiatry and the Law that honors Isaac Ray, M.D., one of the original founders and the fourth president of the American Psychiatric Association.

Deadline for Nominations: 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:

psychiatry.org/awards



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President's Report

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inpatient settings. Therefore, because the future need for correctional mental health services can only be expected to increase, the requirement of a correctional training experience during residency training could alleviate such fears and help create a mental health workforce that is motivated to work in such systems. (8)

Finally, there are also tremendous benefits for correctional systems to have an affiliation with an academic institution. These include an improvement in the overall standard of care, help for overburdened correctional medical staff, the possibility of academic appointments for correctional psychiatrists, and opportunities for research collaboration and publication. Most importantly, having an academic affiliation provides the opportunity for correctional systems to recruit residents to work after they graduate, thus helping the system meet the increasing demand for correctional psychiatrists.

The development of correctional experiences for psychiatry residency programs is a win-win proposition, and the training of future psychiatrists should take into account the needs of this population of psychiatric patients. Given the fact that persons with serious mental illness are increasingly found in correctional and forensic settings, the need for a mandated training experience has never been greater. For that reason, in regard to an ACGME-mandated correctional experience in psychiatry residency, the time has come. (9)

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JANUARY NEWSLETTER CORRECTION:

In the January 2019 newsletter on page 2, the winner of the Award for Outstanding Teaching in a Forensic Fellowship Program should be listed as Kaustubh G. Joshi, MD.

Medical Transcription

35 years' exp in Psychiatry, Forensic Psychiatry, and Psychology

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MUSE & VIEWS

FLAWED FIRST DATE

A Texas man sued a woman who met him for a first date based on his belief that she was spending too much time on her phone and not paying attention to the movie. The woman declined to pay him the \$17.31 for the movie ticket, so he filed suit. She eventually opted to reimburse him for the ticket in exchange for him leaving her alone.

<http://www.facesoflawsuit-abuse.org/2017/06/omg-man-sues-date-for-texting-during-movie/>

*Submitted by
William Newman MD*

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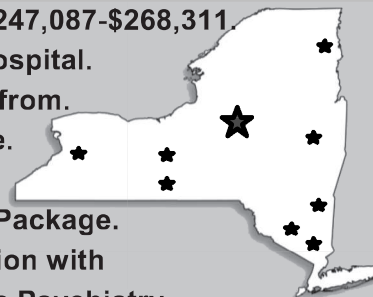
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AAPL NEWSLETTER?**

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

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

Advertising deadlines:
November 15 (January issue)
March 1 (April issue)
July 1 (September issue)

Contact the AAPL Executive Office to obtain the order form.



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

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

We invite your interest in this unique and rewarding opportunity.

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

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

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