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2015 AAPL Presidential Address

Graham Glancy, MBChB, FRCPsych, FRCP(C):
Witness Protection Program: A Matter of Training

Tobias Wasser, MD

The 46th Annual Meeting of AAPL opened on Thursday October 22, 2015 at the Marriott Harbor Beach Resort in Fort Lauderdale with the presidential address delivered by Dr. Graham Glancy. This year's presidential address had a distinct warmth and personal touch, as Dr. Glancy was introduced not by a professional colleague, but by his children – Dylan and Kaitlyn, herself a broadcaster and television personality. They described that in their preparation for making the opening remarks, they had interviewed Dr. Glancy's brother, Robert Glancy, a judge in England. They played an audio clip from the interview, in which Robert recounted tales of Dr. Glancy's rugged determination in training to become a swimmer, eventually leading to his becoming the youngest member of the British national swim team and later, to his swimming at the University of Indiana with future Olympian Mark Spitz. They described Dr. Glancy's work in developing forensic psychiatry as a recognized subspecialty in Canada, as well as his work teaching both at the University of Toronto and within AAPL. They described his development within AAPL over the past 27 years, highlighting his focus on building relationships with his colleagues and pulling for their success even more greatly than his own. Finally, they described him as a dedicated father, who coached his children's soccer, rugby and waterpolo teams, as well as taking karate lessons with them. The theme which emerged through all of their stories was their father's relentless commitment to preparation and training, whatever the desired goal.

As Dr. Glancy took the stage, he informed the audience that this was his 26th presentation at an AAPL Annual Meeting since 1989. He began with a video clip of David Beckham playing soccer ("football" to Dr. Glancy) and asked the audience to consider whether the excellent skills he displayed and his ability to "bend it like Beckham" were a matter of "born genius" or the results of tireless effort and training at his craft. He proposed that despite Beckham's extraordinary skillset, that he could not have achieved his greatness without the latter. He then transitioned to describing three of the fundamental competencies of forensic psychiatrists – assessment skills, report writing skills, and presenting of evidence on the witness stand. He described the latter as the "public face of our work", which merited particular focus in the training of future forensic psychiatrists. He proposed the use of mock trials as a vital training tool and a form of simulation learning that could be used to prepare forensic psychiatrists for this aspect of our work. He described mock trials as a "good safe place for learning, to try things out, to make mistakes". He highlighted the advantages of using mock trials as a form of experiential learning and placed particular focus on the importance of debriefing after the exercise so as to maximize the educational opportunities it presented.

He then described how he had recently undertaken a qualitative research project to interview the "greats of forensic psychiatry" to better understand how they achieved their success and expertise. He shared that a prominent theme which resulted from this project were that these individuals were extremely motivated and worked tirelessly, most for 50-70 hours weekly for over 20 years of their career. As a result of their tireless efforts, they accrued tens of thousands of practice hours in the competencies that uniquely character-

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Incoming President Emily Keram receives the President's Medal from Graham Glancy

American Academy of Psychiatry and the Law

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Presidential Address

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ize forensic psychiatry, in particular practice in trial testimony. He used this example to emphasize the importance of practice and in particular the importance of "deliberate practice", which he described as, "the type of practice that hurts…that makes you sweat… that involves someone giving you feedback… that makes you great!" He also described that each expert "had a coach on every case they had" (i.e. the attorney) who provided them feedback on their performance and allowed them to modify and perfect their approach in subsequent cases. He discussed the importance of the period of critical analysis that follows the feedback and helps to motivate the individual and provide the platform for learning and improvement.

Dr. Glancy then moved on to providing specific recommendations for how to utilize mock trials in the education of forensic trainees. He distinguished between their use as either a brief training exercise or in a true simulated learning environment. He described their use in a brief training exercise as a means of providing feedback on specific behaviors, such as eye contact, enunciation, voice projection or posture. In contrast, their use for the purposes of simulation learning allows the learner to become more deeply involved and allows for reflection on the mental models and assumptions underlying testimony, as well as preparing for future practice. In simulated learning, all aspects are designed so as to closely as possible mimic a true lived experience of testimony. For example, the scene is set in an actual courtroom, legal professionals (attorneys and judges) participate in the direct and cross-examination, and trainees are expected to dress the part as they would were they truly testifying. Regardless of the method, it should be repeated as frequently as possible to maximize its learning potential.

Dr. Glancy concluded by underscoring that in whatever manner mock trials are utilized, the significance of debriefing and feedback is critical. He discussed that feedback may take many forms – judgmental, non-judgmental or "good judgment." Regardless of its content, he outlined how there must be careful delineation in advance of the exercise in regards to which faculty participants will be providing the feedback and the manner in which it will be delivered. One novel concept he proposed was the idea of breaking up a mock trial into five minute increments and pausing after each five minute interval so that the designated faculty member could provide specific and focused feedback to the learner on their performance. He highlighted how this allows the learner to receive in the moment instruction and adapt their performance accordingly, as opposed to waiting to the end of a longer session after which specific suggestions may be forgotten and the learner is unable to immediately modify their behavior by putting the feedback into practice.

Dr. Glancy's speech was greeted with a vibrant response from the audience and an active question and answer session regarding educational methods and practices followed.

Kaitlyn Regehr and Dylan Glancy introduce their father to the AAPL audience

A New Era Beckons

Charles C. Dike, MD, MPH, FRCPsych

There is an appointed time for everything. And there is a time for every event under heaven. A time to give birth and a time to die. A time to plant and a time to uproot. A time to kill and a time to heal. A time to tear down and a time to build up. A time to weep and a time to laugh. A time to mourn and a time to dance…A time to search and a time to give up…

I love these verses from the Book of Ecclesiastes 3. It is a humbling reminder that everything comes to an end at some point, even life itself. For me, the "time to give up" the Newsletter editor position is here. It is now a time to move on. But moving on can be hard. Little wonder some teenagers strike up a fight with their beloved staff members on the eve of their departure from a residential placement; being angry at the staff makes it easier to separate from them. Not being a teenager, myself, I will attempt a more adaptive separation by trying to apply humor, if possible, to a couple of topical issues. Humor is, after all, a mature defense mechanism!

While reflecting on my last days as Newsletter editor, a couple of news items kept butting in, forcing me to spend an extra minute on them on my way out, perhaps akin to the so-called door knob phenomenon. Like most people, I could not but be caught up in the drama that is unfolding around the "Affluenza" kid, who is no longer a kid but a young man. At his trial in 2013, his defense team argued that because he was brought up in an environment of considerable wealth and privilege in which his parents did not place limits on his behavior (no supervision and no consequences for bad behavior), he did not know that his actions had consequences. This was subsequently termed the Affluenza defense. The judge was apparently swayed by this argument, and to the consternation of many, sentenced the boy to 10 years of probation only. After killing four people and seriously injuring others for driving while drunk, his sentence was considered outrageous by many.

A debate arose among a couple of my colleagues soon after the verdict. One of them opined that Affluenza was intricately interwoven with "Influenza" (not to be mistaken with the viral disease), which he defined as the influence ridiculously rich people have over our legal system. Another colleague quickly coined the term "Povertenza," arguing that children being raised in extreme poverty, whose parents (or single parent) worked two or more low end jobs, equally lacked supervision and, as a result, could get into trouble with the law. Unfortunately, because they lacked "Influenza," they would suffer the full weight of the law, and then some. The impending return of the Affluenza man from Mexico where he had attempted to escape the law presents an opportunity. There is a time for casual disregard of the injustices of our legal system, and a time for honest discussion by all concerned. The time for the latter is now.

Another issue I could not shake off my consciousness was gun violence and mental illness. If you listened to commentaries from highly educated and respected leaders of our country, you would believe that the solution for gun violence was simple and straightforward; remove guns from the dangerous hands of the mentally ill and all will be well with the country. After all, they argue, "guns don't kill, (mentally ill) people do." These comments are made with confidence by those who should know better. The research is clear. Removing guns from the hands of the mentally ill decreases gun violence in the USA by only 4%! (Swanson, J.) There is a time for manipulating issues of such importance as gun violence around politics, and a time for honest discussion by all concerned. The time for the latter is now.

Now, let me return to the matter at hand. It is with immense pleasure that I announce the incoming editor of the Newsletter. She is Susan Hatters-Friedman. Susan is well known at AAPL having held several important positions. In addition, she has extensive experience as an editor. She has been a member of the editorial board of the AAPL Newsletter since 2011, and of JAAPL since 2012. In addition, she is section editor of the forthcoming third edition of the Principles and Practice of Forensic Psychiatry (Eds. Richard Rosner and Charles Scott); section editor of the Encyclopedia of Immigrant Health, 2012 (Eds. Sana Loue and Martha Sajatovic); and associate editor for mental health, Journal of Immigrant and Minority Health since 2010. Further, Susan is a prolific writer on forensic psychiatric issues in diverse journals and publications. Please join me in welcoming Susan to her new position, and I ask that you kindly extend to her the same warm reception and support you graciously extended to me through the years.

It has been a wonderful run, and I have enjoyed every bit. I have also learned a lot from the incredibly smart and diverse human beings brought together under the umbrella of AAPL. It has been a real pleasure and honor to edit the Newsletter.

New and retiring newsletter editors

Physician Peer Review Privilege in the Federal Courts?

Jeffrey Janofsky, MD

Root cause analysis (RCA) of sentinel events is critical to improve health care and minimize future errors. The Joint Commission has found that the most common root causes of sentinel events are failures relating to human factors, leadership, and communication.[1] The collection of data through RCA requires the candid and honest participation of all health care providers linked to the sentinel event. The purpose of an RCA is not to assess blame to any one individual, but to improve patient care systems to minimize the risk that a human error can adversely affect future patient care. However, the RCA process may uncover errors that could expose individual providers to malpractice liability. Because of this problem, RCAs are generally conducted under a state's medical peer review process. All states have enacted some degree of statutory privilege for materials generated or maintained as part of a medical peer review process,[2] and such materials generally are not discoverable in state court malpractice actions. The AMA expressly advocates confidentiality in the peer review process as integral to promoting "the highest quality of medical care as well as patient safety."[3]

In sharp contrast to state courts, federal courts have shown reluctance to recognize privilege for medical peer review materials. While the Healthcare Quality Improvement Act (HCQIA)[4] extends qualified immunity to persons who participate in the peer review process, the HCQIA does not protect peer review material from discovery in litigation in federal court.

In federal cases where state substantive law controls, such as some diversity cases, a federal court generally will apply the peer review privilege statute of the state in which it sits. However, in federal cases where federal substantive law controls when a federal law is at issue, federal common law applies pursuant to Federal Rule of Evidence 501 (Rule 501).[5] Examples include suits under the Civil Rights of Institutionalized Persons Act (CRIPA)[6], the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI)[7], the False Claims Act (FCA)[8], and claims of federal civil rights and restraint of trade violations in physician credentialing, hiring and firing decisions.

The Supreme Court, citing Rule 501, rejected the notion that there is a nonmedical, academic peer review privilege in *University of Pennsylvania v. Equal Employment Opportunity Commission*,[9] a 1990 case concerning whether there was a privilege applicable to academic tenure decisions. Later, the Supreme Court used Rule 501 to recognize a psychotherapist-patient privilege in *Jaffee v. Redmond*.[10] In determining that the public good of such a privilege outweighed any harm to litigants, the *Jaffee* court relied heavily on the fact that all states had recognized some form of psychotherapist-patient privilege, representing a consensus among the states on the issue.

> *"... all federal appellate courts that have considered the issue have refused to recognize a medical peer review privilege, reasoning that the evidentiary benefit of the denial of privilege outweighed the public good of promoting vigorous physician oversight."*

The Supreme Court never has considered whether to recognize a peer review privilege pursuant to federal common law. However, all four of the U.S. Courts of Appeals that have considered the issue, the Fourth[11], Seventh[12], Ninth[13], and Eleventh[14] Circuits, have declined to recognize a medical peer review privilege. The Fourth, Seventh, and Eleventh Circuit Court cases involved alleged restraint of trade or employment discrimination in peer review decisions. The Ninth Circuit Court case involved alleged errors in the medical treatment of a prisoner.

As the Eleventh Circuit Court of Appeals explained:

> The Supreme Court's decision in *Jaffee v. Redmond* provides us with useful guidance on how to determine whether an evidentiary privilege should be created. In *Jaffee*, the Supreme Court identified some factors as relevant to the inquiry including: 1) the needs of the public good; 2) whether the privilege is rooted in the imperative need for confidence and trust; 3) the evidentiary benefit of the denial of the privilege; and 4) consensus among the states. In deciding whether to recognize a privilege, we must consider that there is "a general duty to give what testimony one is capable of giving, and that any exemptions which may exist are distinctly exceptional, being so many derogations from a positive general rule."[15]

The federal appellate courts that have refused to recognize a medical peer review privilege did so even though, as also was the case with the psychotherapist privilege in *Jaffee*, there is a widespread consensus among the states on the issue. The various state statutes recognizing a medical peer review privilege are not

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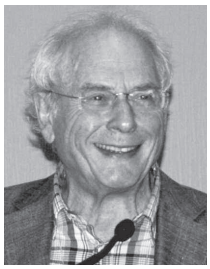
John Kastner:

De-stigmatizing Patients: A Filmmaker's Prescription

Sylvester Smarty, MD



The 46th Annual Meeting of the American Academy of Psychiatry and the Law (AAPL) was held in beautiful Fort Lauderdale, Florida, from October 22 to 25, 2015. As is customary, luncheon talks were given on Thursday, Friday, and Saturday during the meeting. The Saturday luncheon at this year's meeting had a unique guest speaker, John Kastner, a multiple Emmy-award winning, Canadian film maker. Mr. Kastner is renowned for making documentary films aimed at changing public opinion about a wide variety of social issues. He has been nominated for more Emmy awards than anybody else in the history of Canadian Television. In 2007, he was recognized by the Academy of Canadian Cinema and Television with its achievement award. The objective of his luncheon talk was to discuss the challenges involved in producing documentaries aimed at destigmatizing mental health. He was also charged with outlining his "journey into the world of forensic psychiatry."

Following his introduction to the attendees, Mr. Kastner espoused his long record of making documentary films aimed at de-stigmatization, with the purpose of "turning hostile public response to a more empathic one" He stated that everybody has been talking about the stigma of mental health "forever." As a result, because he was a filmmaker, he decided to find a "filmmaker's solution to this ancient wound, the stigma enigma." The results of his search were presented in two documentary films that he has since released and which have been broadcast on Canadian Television. He had presented one of his films, "Out of Sight" at a previous lecture session at this meeting. He planned to present the trailer of his first documentary film during the luncheon talk, as well as discuss the public reception of his approach.

Mr. Kastner told the audience that he aimed from the outset to present an alternative view to common believes about the mentally ill. He was optimistic about success given his past success in changing public opinion about some individuals who have been the "subject of a major public furor." He cited one of his films, titled "Monster Family "as an example of his ability to successfully change public opinion. In that documentary, he presented the human side of Martin Ferrer, an inmate who was released from prison in 1997 against the background of a hostile media report. Mr. Ferrer had been demonized by the police and even his own mother. However, upon interviewing Mr. Ferrer, he found out that he was nothing but "a petty criminal with a big mouth." After his film came out, the media did a major turnaround, which ultimately led to a more positive public opinion about him.

> *"... rather than protect the public, "hiding" forensic psychiatry patients made it more difficult to monitor them which in turn increased future risks to the general public."*

Mr. Kastner admitted that the idea to make documentaries to help destigmatize public opinions about forensic psychiatry patients was not originally his. It was suggested to him in 2010 by Dr. Richard Lamshore, a Canadian forensic psychiatrist who had seen his previous films and who urged him to make a movie about the stigmatization experienced by forensic psychiatry patients. He immediately recognized that there was going to be some difficulty in presenting a documentary focused on this topic because of strong social views about forensic psychiatry patients. To test public response to his proposed work, he wrote an article which was published in the Toronto Globe and Mail titled: *Forensic Psychiatry Patients are ill not evil and we should stop hiding them*. In that article, he argued that forensic psychiatry hospitals were hiding forensic patients from public but that approach has been shown to be ineffective. Furthermore, he opined that rather than protect the public, "hiding" forensic psychiatry patients made it more difficult to monitor them which in turn increased future risks to the general public. Contrary to general belief, "hiding" forensic psychiatry patients has helped to promote stigmatization. As a professional communicator, he did not believe that anybody should be stigmatized by hiding them away. This sends a terrible message to society that "these individuals are such freaks we dare not even let you look at them." He confessed that when his first film on this subject, *NCR (Not Criminally Responsible)*, was about to be released at the Hot Docs Film festival in Toronto in April 2013, rather than celebrating, they were "terrified." because they could not predict media response.

Following his introductory speech, Mr. Kastner proceeded to show the audience clips of the trailer of his documentary film titled: *NRC (Not Criminally Responsible)*, interjecting periodically with commentaries and explanations. He instructed the audience to pay attention and tell him what was missing from the film after they have viewed it. The trailer followed the story of a forensic psychiatry patient at the Brockville forensic psychiatric facility in Toronto, Canada. The patient was Sean Clifton, a

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Physician Peer Review

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uniform (which also was the case with the psychotherapist privilege statutes considered in *Jaffee*). However, they all reflect the common purpose of encouraging health care providers to participate fully and candidly in the peer review process in order to advance the quality of medical care. Despite this consensus among the states, all federal appellate courts that have considered the issue have refused to recognize a medical peer review privilege, reasoning that the evidentiary benefit of the denial of privilege outweighed the public good of promoting vigorous physician oversight.

Federal courts have applied different reasoning in cases involving PAIMI. PAIMI provides federal funds for states that have protection and advocacy (P & A) groups that monitor the care of persons with mental illness in facilities providing for their care and treatment. (42 U.S.C. § 10801). The Second Circuit held that:

> the plain language of PAIMI that grants … [P & A] agencies access to "all records of ... any individual," including "reports prepared by any staff of a facility," encompasses peer review reports.[16]

The Court thus held that in cases involving PAIMI, peer review records were fully discoverable by the P & A agencies. Cases from the Third and Tenth Circuits have reached similar conclusions.[17]

To further address the lack of a medical peer review privilege for patient safety issues, Congress passed the Patient Safety and Quality Improvement Act (PSQIA).[18] The PSQIA does not create a general peer review privilege. However, the PSQIA does create a limited work-product privilege in all tribunals including Federal and State Courts for "any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements that a health care provider assembles or develops and reports to a patient safety organization ("PSO") on a timely basis."[19] Thus, the PSQIA creates a new work-product privilege in federal court for peer review material involving patient safety issues, and it supplements pre-existing peer review privilege laws in state courts.

There are no federal appellate cases interpreting PSQIA. Several federal district courts have upheld the peer review privilege in cases involving alleged errors in medical practice.[20] It will be interesting to observe how federal law governing the peer review privilege in the context of patient safety issues evolves over time, especially in CRIPA and PAIMI cases.

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John Kastner: *De-stigmatizing Patients*

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man who suffered from schizophrenia and obsessive compulsive disorder (OCD). He was found Not Criminally Responsible of attempted murder after he viciously attacked Ms. Julie Bouvier (a 22-year-old at the time) in front of Walmart in Cornwall, Canada sometime in 1999. Prior to the attack, he had been hearing voices telling him to stab the prettiest girl he could find. In an attempt to prevent his actions, he had presented to the emergency room earlier that day but was not taken seriously. Following his actions, he did not flee the scene, as would be expected, rather he asked witnesses if they knew when the police would arrive. The documentary methodically follows his story from the time he was placed at Brockville, to his release back into the community. It also documented his first meeting with his victim's family, as well as his meeting with the victim herself. Highlights of the documentary included the initial resistance of the victim and her family to Mr. Sean Clifton's release, as well as their subsequent acceptance of his request for forgiveness from them.

Mr. Kastner observed that in the beginning of the movie, neither the patient's face nor his name was mentioned. He explained that this was a deliberate omission that was motivated by the public atmosphere at the start of filming in 2010. At that time, there were a number of high profile

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David P. Farrington, O.B.E.:

Risk Factors for Offending and Psychopathy in Two Generations

Abiola Adelaja, MD

Dr. Farrington is a renowned professor of criminology with over 650 publications. He discussed risk factors for psychopathy in two generations based on research conducted in the United Kingdom known as the Cambridge Study in Delinquent Development (CSDD). Key contributions of the CSDD sample included study of development of offending and antisocial behavior of people at different ages, risk and protective factors, life events and transitions and correlation with substance abuse, sexual behavior, employment problems, and educational, mental and physical health.The Study addressed two major questions: 1. to what extent are the risk factors for offending (for convictions up to age 21) similar in two successive generations of males, and, 2. To what extent are risk factors for psychopathic symptoms similar in two successive generations of males?

The study involved 411 South London males known as Generation Two or G2 who were from the traditional British urban lower class. Their parents were referred to as G1, and children, G3.

The G2 males were attending the schools in the working-class area of South London; about 87% of them were of white British origin while others were Irish, African-Caribbean, Cypriot, and other non-British whites. The data was collected at different ages and over a 47-year period (1964 – 2011). There were 56 criminal records.

A follow up of G2 males was conducted at age 48 using social interviews, psychiatric interview, The Hare Psychopathy Checklist-Screening Version PCL: SV, and Structured Clinical Interview for DSM disorders [SCID-II]), Partner Interview and Biological data. A social interview of their children (G3) was done. About 551 of 691 children identified were interviewed, which amounted to about 84.4% of the sample. They were similar in percentage of males and females, from ages 23-27 and the criminal record search was from 1994 to 2012.

The risk factors for G2 males offending at age 8-10 was correlated with their G1-parents looking at the following factors: Parental, family, socio-economic attainment, impulsiveness and behavioral factors. The results showed that the higher the odds ratio (OR), typically >2, the stronger the predictor/relationship.

In the multivariate analysis, there were 5 significant (or near significant) independent predictors of G2 convictions. These were convicted G1 father at 32, high daring, low attainment, disrupted family and large family size.

The risk factors for the G3 males (children of G2 males) offending up to age 21 looking at 344 children included parental risk factors such as, convicted G2 father and mother at age 32; Physical punishment, poor supervision, separation from child, low SES, low income, large family size and poor housing. Early school leaving (dropping out) for G3 was a highly significant risk factor for offending. Other factors significantly correlated include; no A level (i.e., no postgraduate years after high school), risk taking under age 12, suspension from school and truancy.

In the Multivariate Analysis the 6 significant (or near significant) independent predictors of G3 convictions were 1. Convicted father at age 32. 2. Risk taking under age 12. 3. Low income at 32. 4. Physical punishment. 5. Poor supervision and 6. Being separated from parents.

The study also looked at the effect sizes of 20 of the most comparable risk factors, and found that the mean effect sizes were similar for G2 and G3 ($p < .001$) except for parental conflict ($p=.01$).

In conclusion, risk factors for offending in parents-G2 and their children-G3 are mostly similar. Factors like convicted parents, poor supervision, disrupted families, harsh discipline (G2), physical punishment (G3), and parental conflict (raging conflicts for G2 when divorce was rare) were significant. Other factors like low income, large family size, poor housing, low achievement and problematic behaviors were important for both parents and children.

The study also tried to answer the second key question of understanding to what extent risk factors for psychopathic symptoms are similar in two successive generations of males.

To answer this question, the Hare Psychopathy Checklist-Screening Version (PCL: SV) was assessed at age 48 for G2 males and at age 25 for G3 males with analyses more tentative at the time Dr. Farrington made this presentation. He stated that Psychopathic Personality Disorder had 3 main overlapping domains: Arrogant interpersonal style, Deficient affective experience and Impulsive behavioral style. For G2 and G3 males, it was noted that the higher the PCL: SV score for an individual, the higher the conviction rate.

Significant risk factors for G2 PCL: SV scores 10 and higher, looking at 304 cases with Odds Ratio >2, included convicted G1 parents at age 32, nervous G1 mother, uninvolved G1 father, disrupted family, poor supervision and harsh discipline. Also low SES, low family income, poor housing, large family size, low IQ, impulsiveness (high daring, impulsivity and hyperactivity), troublesomeness and dishonesty were significant.

Similarly in G3 with PCL: SV score >10, the risk factors like young G2 parents, physical punishment, poor supervision, separation from child-G3; socioeconomic problems, attainment issues, impulsivity and

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Brian D. Hodges, MD, PhD, FRCPC:

The Question of (Continuing) Competence

Brian Cooke, MD

Brian D. Hodges, MD, PhD, FRCPC is a pioneer in the field of professional competence. AAPL attendees were fortunate to hear this dynamic, distinguished speaker on Friday, October 23, 2015 as he presented, "The Question of (Continuing) Competence." Dr. Hodges is Professor in the Faculty of Medicine and Faculty of Education at the University of Toronto. His accolades, among other things, include the pivotal work he has done with psychiatry OSCEs (objective structured clinical examinations). While at the AAPL annual meeting, he admitted he was thinking of our own collective and individual competence.

Dr. Hodges framed his talk in the metaphor of "the flat earth." Medical training and advances in professional development have been stymied by the collective ignorance of ideas that inhibit the field from seeking the truth. This is evident by several notable changes in perspective. In the 19th century, medicine was largely driven by guilds. In the early 20th century, there were significant changes in science and knowledge after the Flexner reforms but no established concept of continuing competence. In the mid-20th century, there was a rise in the use of standardized patients and OSCE exams in medical education; concepts of simulations, feedback, and performance led to a shift in the beliefs of competence through observable behaviors. The question posed by Dr. Hodges for the 21st century, and for the experts and educators in the audience, was, "Where is education and continuing education going?"

Hodges proposed that in the 21st century, we will move away from focusing on *what we know* to *what we know is evolving*. This will require educators to break down the silos that separate us. The movement will lead us from less emphasis on what the individual professional knows to being able to identify one's gaps in knowledge. For example, while many individuals would self-identify as an above-average practitioner, there are inherent problems with insight, self-preservation of esteem, and ineffectiveness of self-assessment. Hodges recommended that the profession insert self-directed modules into competence monitoring with challenging situations that stretch the limit of one's competence and then provide feedback to the individual.

"... consider the deliberate practice of a forensic psychiatrist seeking to improve his or her performance skills who solicits feedback from the retaining attorney after providing testimony."

Hodges' second proposal involved a change in the domain of performance skills, moving from a question of "Can you do it?" to "Can you still do it?" He believed that the principles espoused in the adage, "See one, do one, teach one," and also reinforced in the physician's "weekend course" (e.g., when a surgeon might spend two days learning and practicing a new operative technique) are inconsistent with the need to reform our understanding of performance skills. More in line with his thinking are the ideas put forth by Anders Ericsson – that deliberate practice is necessary to achieve expert performance, and that this might only be achieved by deliberate practice of 10,000 hours (e.g., 20 hours a week for 50 weeks a year for 10 years). Guided self-directed learning will be needed to implement this change.

Imagine the implications (and possibilities!) for forensic psychiatry training and continued competence. Hodges' ideas appear consistent with some of the ideas already emphasized in this year's Annual Meeting at AAPL, i.e., using mock trials as deliberate practice with providing immediate feedback to learners. Debriefings following significant or critical events, already gaining momentum in clinical medicine and psychiatry, could also be implemented in forensic psychiatry. Lastly, perhaps consider the deliberate practice of a forensic psychiatrist seeking to improve his or her performance skills who solicits feedback from the retaining attorney after providing testimony.

Hodges' third and final proposal for change focused on a transformation from individual competence to collective competence. Hodges admitted this would represent a significant paradigm shift in our system. While team-based learning and group exercises have gained momentum in undergraduate medical education, learners are still assessed on their individual competences of knowledge, professionalism, and communication skills. The need for this, he argued, is that individual competence is not fixed and medical practitioners are often performing in teams with real patients. In order to implement these changes, there will be a need to focus on studying and collecting data

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Renée Binder, MD

Philip Candilis, MD

Renee Binder, MD, is one of two AAPL presidents to serve as President of the APA (the other being Paul Appelbaum). A longtime advocate for patients and access to mental health services, Dr. Binder's current tenure at APA has been marked by numerous initiatives increasing awareness of mental health resources, de-stigmatizing mental illness, and de-criminalizing persons diagnosed with mental illness. In her public statements, Dr. Binder's background at the intersection of psychiatry and the law is clear as she calls for psychiatry to claim its role in the public discussions of gun violence, access to care, community support, and programs to divert individuals with mental illness from the criminal justice system to psychiatric treatment.

Founding director of the Law and Psychiatry Program and the Forensic Psychiatry Fellowship at the University of California, San Francisco (UCSF), Renée has written widely in forensics, including important work on stalking, risk assessment, and dangerousness. Hers is one of the only pieces in the literature on the effects of the California Tarasoff decisions on the use of therapy. A professor of psychiatry at UCSF, Dr. Binder also serves as associate dean in the medical school and was interim Chair of the Department of Psychiatry for over three years.

Dr. Binder's focus on vulnerable populations is most evident in her work to de-criminalize persons diagnosed with mental illness. With mounting evidence that correctional systems provide more mental health treatment than any other sector of society, Dr. Binder emphasized the issue in her Presidential address, and toured San Quentin with the APA Board of Trustees. Symbolic of her mentorship to a generation of forensic psychiatrists, the tour was led by her former fellow, Paul Burton, M.D. who is now Chief Psychiatrist at San Quentin. With over a million persons with mental illness held in jails and prisons – largely on nonviolent nuisance charges – and over 40% interacting with law enforcement, it is a topic of enormous consequence to the profession, and one that holds her close attention.

The Stepping Up Initiative is exemplary of this focus, as Renee and the APA will lead a two-day conference coordinating the American Psychiatric Association Foundation with the National Association of Counties and the Council of State Governments to bolster the national effort decreasing the number of mentally ill persons in jails and prisons.

Under Dr. Binder's leadership, the APA has already initiated the American Psychiatric Excellence Awards (APEX) to honor people who have made a difference in the lives of our patients. The 2016 awards will honor media and entertainment celebrities who have worked to decriminalize patients who live with mental illness.

The Institute for Psychiatric Services this past fall also highlighted Dr. Binder's policy and administrative background. Entitled "When Good Care Confronts Red Tape: Navigating the System for Our Patients and Our Practice," the conference drew heavily on her expertise in public systems of care and the increasing regulatory burden on practitioners.

The Presidential Forum on risk management took particular advantage of her expertise as a past member of each of APA's forensic components: the Council on Psychiatry and the Law, the Committee on Judicial Action, the Committee on Confidentiality, and the Isaac Ray Award Selection Committee.

Clearly influenced by policy work on Capitol Hill during her APA congressional fellowship, Renee has advocated for specific legislation in support of mental health parity and decriminalization. Her October 2015 testimony before the U.S. House of Representatives underscored the critical need for improved staffing, better training, and increased coordination between law enforcement and public health to de-criminalize and de-stigmatize mental illness. The importance of mental health courts, diversion programs, and community outreach teams are all part of the appropriate community response she envisions. Dr. Binder sees the advent of bipartisan bills supporting such general improvements as an encouraging sign that increased attention, resources, and support will reinvigorate the beleaguered mental health system and the patients we serve.

"The Question of..."

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from teams and to employ team-based training.

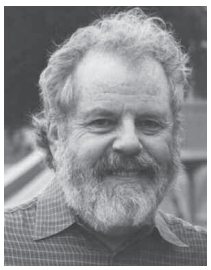
In conclusion, as Hodges reflected on the imminent changes and shifts in medical training and competence, he alerted audience members to some of the important concepts that he predicts will get buzz in the 21st century. Readers of the *Newsletter* should be on the lookout for these watch words: metacognition, adaptive expertise, deliberate practice, and collective competence. Lastly, there will be a growing emphasis on the value of the mentor-supervisor relationship.

Hodges' ideas must have resonated with many, if not all, in the audience. For those involved in medical education and forensic fellowships, he proposed significant changes that force us to examine the core assumptions inherent in how we teach and provide training experiences to our learners. For those not involved in education but continue to practice medicine, then his words also influence the way we think of our continuing competence and maintenance of professional standards.

Tick ... Tock ... Tick ... Tock ... Terrorist?

High Profile Cases and The Role of Forensic Child Psychiatrists

Stephen P. Herman, MD



You have undoubtedly heard about this story: In mid-September 2015, Ahmed Mohamed, a 14-year-old student in Irving Texas, came to school with a clock he had made to impress one of his teachers. The teacher, far from being grateful for the gift, started a chain of events that led to Ahmed being led away from his home in handcuffs. It was thought he might have made a bomb. He was interrogated without a lawyer present.

Social media weighed in, pretty much in favor of Ahmed and castigating the school for overreacting because the boy is a Muslim. What you may not know is the backstory: according to some of the local authorities, as reported by CNN.com, the "clock" was old, from Radio Shack and was enclosed in a case. Ahmed also had a reputation for making projects that, while original, were annoying. For example, one teacher said the teenager made a device that interfered wirelessly with a slide projector. Even celebrities were interested. For example, Bill Maher said on one of his shows, as reported by CNN with an accompanying video:

"He's a science kid and that's great. . . . Ok, and the people at the school thought it might be a bomb, perhaps because it looks exactly like a fing bomb."*** (Audience laughter)

As might be expected, and as is their right, the parents are suing the school district and have retained two prominent Dallas attorneys. Ahmed's mother and father believe he was unjustly arrested and his rights were ignored. Both the plaintiff and the defendant might call forensic psychiatrists to examine Ahmed. There is the possibility the experts will have different opinions. Time will tell.

There is often more than meets the eye in these cases. The media do not have all the information when they first report such a high profile story. We see what we want to see, depending upon our own biases, something all forensic evaluators must guard against. Of course, this is true in *all* forensic matters – whether high profile or not.

What will be asked of the forensic psychiatrist? Does the boy have a diagnosis? Is he capable of violence? Are his parents dangerous? Did they influence Ahmed? What should *not* be asked of the expert is whether the child is or is not a terrorist. That is for the trier of fact.

Here's another story, right out of my home state of Connecticut. Just before Christmas 2012, in the Sandy Hook section of Newtown, CT, 20 elementary school students and 6 staff members were gunned down by a reportedly depressed and paranoid former student from the same school. Our whole state has been put on edge ever since.

According to the *New York* Times (November 5, 2015), during Hallowe'en celebrations in the town of Litchfield, CT, two high school sophomores came dressed as the Columbine killers. They wore trench coats and sunglasses, and allegedly threatened other students "with bodily harm," according to the State Police. A girl told her parents about this and her parents called the police. The students were first sent to a juvenile detention facility and their cellphones and homes were searched. The students attended a hearing the next day, and were released in their parents' custody. They were charged with inciting injury to persons or property, a felony, and breach of peace, a misdemeanor. Soon after they were arrested, the school, it was reported in the *Times*, moved to expel them. Their names were not released because of their ages. (Some thought they were terrorists, this being Connecticut.)

The parents of one of the students immediately hired a prominent criminal defense attorney. He spoke to the media, denying his client meant any harm, although he conceded it was a stupid mistake to dress up the way his client did.

Will the case go to trial? It is doubtful. There will probably be a plea-bargain with neither of the boys serving any prison time. It is likely, though, that the boys will undergo psychiatric evaluations while in their parents' custody. (Full-disclosure: I know the prosecutor for that area of Connecticut and he is fair and quite psychologically-minded. I doubt he wants these boys to have a record. However, he will send a message to them and the community at large that this kind of behavior has to be taken seriously and will not be tolerated.)

As I write this in mid-November 2015, an 8-year-old boy in Birmingham, Alabama has been charged with murder for beating to death a toddler because of her constant crying. Their mothers were out of the house at the time. The media are all over this story as of this writing. Hopefully, one of our colleagues will have been involved in assessing the child by the time this newsletter is published.

In early October 2015 The New York Times reported that an 11-year-old boy from a small town in Tennessee took out his father's shotgun and killed a neighbor – an 8-year-old girl because she would not show him her puppies.

Why does this happen? How does the forensic psychiatrist approach these cases? We can ethically work with either side and provide our knowledge of child or adolescent development, and, from our medical degree, have the big picture. We do everything from administering a com-

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A Careful Dance: How one fellow transitioned into motherhood

Katherine Michaelsen, MD

December 2013: good news! I was pregnant. Bad news… I was pregnant! – and my due date would land in the second month of my forensic fellowship. The fellowship director was the first person outside of my immediate family to learn that I was pregnant, the first steps in a precarious balance of family and work.

Although several male colleagues had had children in fellowship, there were a lot of concerns in my case. My supervisors and I grappled in different ways with concerns about my safety as a pregnant woman in the prison setting, concerns about my ability to manage the challenges of motherhood and a demanding fellowship, concerns about my ability to keep up with my peers. One of my residency supervisors even expressed the concern that I might damage the well-being of my child by spending long hours away from her during her first year of life.

I began with preparation, both to help ease my transition into fellowship and to demonstrate my dedication. I attended landmark case discussions to improve my reading and comprehension of court decisions. I attended forensic case presentations and discussions when my schedule would allow, in order to begin the journey of what Dr. Pinals calls the "transformation" phase (Forensic Psychiatry Fellowship Training: Developmental Stages as an Educational Framework, JAAPL 33(3):17-23, 2005) learning how forensic psychiatrists think about evaluations, and how they organize their time.

In the fellowship, I was mindful of my safety. Once, just before nine months of pregnancy, I walked the long way around the courtroom to avoid passing next to a defendant who I was about to testify did not understand the charges against him and could not assist in his own defense. As my childbearing status was open to public view, I noted evaluees' transference toward me. They would spontaneously bring up their children or mothers. They would be surprisingly gentle or irritable without provocation. I also became adept at deflecting questions about my due date or the gender of the fetus when I preferred not to answer. I became acutely aware of the difficulty of being assigned cases when my maternity leave could start any day.

> *" Through necessity and stubbornness, I learned to pump milk while driving around the state to courts, prisons, and the forensic hospital."*

Once my daughter came, I took six weeks of maternity leave and a couple weeks of vacation. My time away was a short and sweet haze of breastfeeding, diapers, — and trying to keep up with landmark cases. Returning was difficult. I was still breastfeeding and sleep deprived, not to mention anxious about my daughter's development. I felt pressure to perform in the fellowship and lacked confidence in my skills. I worked urgently to catch up with my co-fellows. Through necessity and stubbornness, I learned to pump milk while driving around the state to courts, prisons, and the forensic hospital. I carried around a cooler and pumped in prison parking lots between evaluations. I tried to see my daughter occasionally during lunch breaks. I felt a constant pull between spending time with my family and caring for my daughter, and succeeding in a fellowship and developing a professional identity outside the home. Sometimes I felt oppressed when observers exclaimed over my apparent success at work because I wanted to be able to say, "This is hard" or "I am struggling."

Fortunately, I benefited from steady support from many corners. My husband and family assisted with childcare until my daughter was in daycare. My mother-in-law attended the AAPL conference with me so that I could bring my two and a half month old daughter along. Lecturers politely ignored soft coos and grunts as I breastfed in the back of the room. At work, small gestures, such as providing my hot office with an extra fan when I was pregnant or with a sign that said "do not disturb" for when I was pumping made me feel like a welcomed member in the program. My supervisors patiently answered questions and reviewed my reports. They also taught me a deeper appreciation for the power of expectations: feeling that others expected me to succeed was an immeasurable boost to my confidence.

Gradually, as my daughter began to roll over, sit, and then crawl, I developed as a fellow. My comfort with a diverse caseload grew. I was humbled by the complexities of the forensic field and diversity of perspectives—certain case questions and legal concerns requiring long, thoughtful consideration and debate. I recommitted to continuing my forensic work, even though my position after fellowship would not be a

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Suicide Risk in Transgender Inmates

Dalia N. Balsamo, MD

Last November, Vikki Thompson, a transgender woman, was found dead in a British male prison after threatening suicide[1]. She had warned she would kill herself if she were placed in a male prison. Earlier in December, another transgender woman committed suicide (also in a British male prison) due to her high level of distress[2]. These unfortunate incidents prompted the Ministry of Justice (MoJ) to issue a statement calling to review and revise their current guidelines (Prison Service Instruction 7/2011) pertaining to transgender inmates. The review is expected to conclude early this year[3]. The current MoJ guidelines for transgender prisoners were issued in 2011 and set to expire in March 2015. They recommend that transgender prisoners be considered at-risk for suicide and self-harm and further recommend that proper procedures be utilized to prevent suicide if needed[4].

In the United States, the situation of transgender inmates is not much different. Transgender inmates have historically been at a higher risk for discrimination in the prison system. Their rate of incarceration is higher than the general population, and the rate becomes even higher for transgender people of color[5]. According to the National Transgender Discrimination Survey, transgender people are at a higher risk of committing suicide compared to the general population[6]. Prison environments tend to be unsafe and invalidating places for gender nonconforming people. Recently, Ashley Diamond, a transgender woman who was incarcerated due to a non-violent crime, filed a complaint under §1983 against the Georgia Department of Corrections. As an inmate, she was denied hormone treatments, was sexually assaulted by male inmates on multiple occasions, and was placed into solitary confinement on two occasions (once for reportedly "pretending to be a woman") [7]. Notable in her history were her multiple suicidal and self-castration attempts while under the custody of the Georgia Department of Corrections.

Unfortunately, there have been several other cases of transgender inmates attempting suicide and self-castration while incarcerated[8, 9]. Most of these self-harming behaviors seem to originate in the context of being denied medical treatment for their gender dysphoria[10]. The World Professional Association for Transgender Health (WPATH) mentions in their Standard of Care how either abruptly withdrawing hormones or not initiating hormonal therapy can lead to worsening dysphoria, depression, and/or suicidality. It also cautions against a "freeze frame" approach (which only allows for the continuation of already existing therapy, but does not authorize any initiation or expansion of treatment) [11]. This past October (2015), California became the first state to pay for an inmate's sex reassignment surgery [12].

In addition to lack of access to hormone therapy and sex reassignment surgery, transgender prisoners face the issue of unsafe housing conditions. They are at higher risk of being victims of violence and sexual assault, and experts have attributed this to the current policies surrounding their housing assignments [13]. Currently, the majority of jails and prisons in the United States assign people based on their external genitalia, not their identified gender. In addition, transgender inmates are at higher risk of being put in solitary confinement, which is also referred to as administrative segregation. In many instances, this assignment is not meant to be punitive, but done out of administrative convenience. While some may argue that this may "protect" transgender people against potential physical and sexual abuse, it usually causes emotional distress and has debilitating psychological effects on the individual [14].

In conclusion, transgender inmates face unique challenges and adversities. A major step in preventing future episodes of suicide and self-harm is to create an environment that recognizes and validates their needs while ensuring their safety.

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Ask the Experts

Neil S. Kaye, MD, DFAPA
Graham Glancy, MBChB, FRCPsych, FRCP(C)

Neil S. Kaye, MD, DFAPA and Graham Glancy, MB, ChB, FRC Psych, FRCP (C), 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. Should I ask the referring attorney who else has already evaluated the case?

This is a very challenging question and we are certain there are as many answers as there are AAPL members. Nonetheless, we will not run from an attempt to address such an important and controversial topic. For educational purposes, Neil will address the "pro" side and Graham will address the "con" side.

A. Kaye: There are many reasons why knowing if the case has already been "shopped" around can be helpful. First, it tells you something about the lawyer. While I know some lawyers who routinely do this to help them assess the real value of a case, more often it appears to be an effort to find an expert who will be "helpful" after a prior expert has either turned down the case or reached an opinion that is not helpful or supportive of the lawyer's theory or strategy.

Second, it puts you on notice that there are problems with the case and could lead to an even more thorough review of the materials. While I routinely consider what an expert on the other side might opine, this would make me even more critical as I undergo the process of review.

Third, it helps an expert to learn more about a colleague. One of the rarely talked about parts of expert witness work includes our personal knowledge of a colleague, information that can be helpful when "the battle of the experts" erupts in a more public setting.

The last issue this raises is what I refer to as "personal minimums." I am not only a physician, I am also a helicopter pilot. While the FAA sets certain parameters ("minimums") for flying, each pilot must know her/his own "personal limits" in terms of safety and comfort for any given flight. I believe the same concept can and should be applied to forensic work.

"Most attorneys are ethical and knowledgeable of the law and you can generally accept that there are perhaps things that you do not need to know in a case for good reasons."

My knowledge and experience may rightfully allow me to reach an opinion when a colleague could not. My ability and willingness to reach a conclusion could be greater or less than another equally respected expert. Knowing that another expert (especially if it's a colleague I know, respect, and trust) has declined a case, serves to remind me of where my personal limits are and can help me to be sure that I am not over-reaching.

A. Glancy: This is a difficult situation and thankfully, in my practice, does not arise frequently. There are always two sides to every argument and I will review with you three points on the "con" side.

Firstly, this may be an opportunity to come to a case with a fresh viewpoint using unique forensic skills. Confronted by what is likely a dead end at which your colleague arrived, you may pursue a different avenue altogether, which may result in a helpful forensic opinion. For instance, I was once referred a case of a university student who had stabbed his roommate after being bullied. The defense theory was of an attenuation of battered woman's syndrome. A respected colleague had assessed the client and rejected this argument. When I saw him, I believed that this brilliant computer student met the criteria for a diagnosis of Autism Spectrum disorder and that certain known characteristics of this disorder contributed to his anxiety and paranoia at the material time, thereby mitigating specific intent. If I had simply looked at my colleague's report I may just have been tempted to agree with his reasoning.

Secondly, I believe that most attorneys will usually disclose that another expert has reviewed the case and allow you to read her/his report. If the attorney doesn't do so suggests that there may be specific reasons that they do not want you to see a report. This might involve the fact that the other expert had a serious conflict of interest, or that they made serious errors that could be embarrassing. In other cases sometimes there have been interpersonal problems between two of the parties or the expert himself may have had personal problems. In these types of cases, if the attorney has not revealed the issue to you, it is probably better not to know.

Thirdly, this material may be cov-

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American Medical Association 2015 Interim Meeting Highlights

Barry Wall, MD, Delegate, Linda Gruenberg, DO, Alternate Delegate Jennifer Piel, MD, JD, Young Physician Delegate, Tobias Wasser, MD, Young Physician Delegate

The American Medical Association's (AMA) November 2015 Interim Meeting was held in Atlanta, Georgia and focused on advocacy, education, and public health concerns.

Resolutions specifically pertinent to psychiatry and forensic psychiatry included ethical and appropriate practice in telemedicine; addressing sexual violence and the improvement of American Indian and Alaska Native Women's Health outcomes; research effects of physical or verbal violence between law enforcement officers and public citizens on public health outcomes; and supporting research to better understand models of healthcare delivery, including mental health, for the incarcerated population.

In addition, ensuring mental health care for unaccompanied minors detained by immigration services was discussed. Several resolutions also addressed patient access to mental health services and models to improve psychiatric reimbursement.

The House of Delegates took a principled stand in calling for a ban on direct-to consumer advertising by pharmacuetical companies. The policy shift occurred in response to increasing drug costs impacting patient access to needed medications. The House of Delegates also voted to convene a task force and to launch an advocacy campaign to help make prescription drugs more affordable. Media attention has been given to the passed resolution banning pharmaceutical advertising.

In the face of mergers between major national health insurers, the House of Delegates also voted to stand against health insurance market consolidation that enhances health insurer market power, particularly because it decreases health care access, quality and affordability. Also of note, a resolution to defund Planned Parenthood, which was introduced by a lone House of Delegates member, was swiftly voted down.

A resolution on Principles for Hospital Sponsored Electronic Health Records has potential ethical and legal implications, in particular related to issues of confidentiality and access to and ownership of medical records. It relates to concern for records of children in abuse situations: when can parents get access to these records?; who owns the medical data? Who is the custodian of the information? This was referred to the June 2016 Meeting in Chicago

The AMA continues to work on its project to modernize the Code of Medical Ethics. Adoption of the Code will not occur until the AMA can cohesively integrate House of Delegates' input and editorial suggestions. Problems involving secure access to the Code on the Internet, as well as problems collating various drafts, also hinder progress.

Other general issues discussed at the meeting included positions on prescribing and dispensing of prescription medication samples, ethical parameters for recommending mobile medical applications and the IOM "Dying in America" report. For more information on the resolutions and the actions of the AMA House of Delegates at the 2015 Interim Meeting, please go to http://www.ama-assn.org/sub/meeting/index.html. AMA website (www.ama-assn.org).

The next AMA meeting will occur in Chicago in June 2016. If any AAPL members have topics that they would like the AAPL delegation to consider at the next meeting, please contact the AAPL Council or members of the AAPL AMA Delegation prior to the May 2016 American Psychiatric Association meeting.

Doctor: Is Your Patient At Risk for Gun Violence?

The National Medical Council on Gun Violence (NCGMV) is presenting a CME accredited multidisciplinary conference at the University of Chicago on 4/16/16 and 4/17/16 addressing the public health crisis of gun violence and medical interventions that can reduce risk of suicide, homicide, and injury. Presenters include leaders in clinical practice and research in public health and psychiatry, among other fields. The NMCGV is dedicated to educating physicians from all specialties about the risks our patients face from gun violence and what we can do to reduce their morbidity and mortality due to firearms.

For more information or to register, go to nmcgv.org/conferences/. To learn more about NMCGV, go to NMCGV.org.

Nominations for AAPL Sought

The Nominating Committee of AAPL will be presenting a slate of Officers and Council candidates at the Semiannual Business Meeting in May, 2016.

Any regular AAPL member who would like to be considered for a position should send a letter to the AAPL Office with a statement regarding his/her interest in serving and a brief summary of activities within AAPL.

Open officer positions are: President-elect (one year); Vice-President (one year); Secretary (one year). Councilors serve for three years. Attendance at both the Annual and Semiannual Council Meetings is expected of all officers and councilors.

Please send statements of interest and activity to Emily Keram, MD, Chair, Nominating Committee, AAPL, P.O. Box 30, Bloomfield, CT 06002 by April 1, 2016.

Tick ... Tock ...

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prehensive mental status exam, taking a detailed history of the child and family, noting whether there might be physical and genetic disorders which may present as a primary psychiatric disorder, considering a consultation with a neurologist, ordering an MRI, and if indicated, an EEG, and visiting a child's home. This detailed evaluation, represents the still-viable concept of the biopsychosocial approach to patients and their families.

Forensic psychiatrists evaluating young children who kill or act like terrorists must have some resident-level training in pediatrics. Only then can the physician fully investigate the underlying medical and behavioral components manifest in the child. The psychiatrist should then be a member of a team of lawyers and other professionals to brainstorm about what the child or adolescent needs.

In a world of dramatic discoveries of the brain, we will probably approach such aberrant behavior in children in a new way. Even now, we grapple with the conundrum of whether an as yet unknown brain abnormality and/or a genetic disorder might be responsible for antisocial behavior in children – and adults. This, as we forensic psychiatrists know, raises a myriad of new legal issues. It has already started, with fMRI and PET scans. Many articles in peer-reviewed journals speak of a new age of determining whether a person is lying, when there is frontal lobe damage, subclinical seizures and so on. However, the data are still controversial. (Merikangas J, Commentary: Functional MRI Lie Detection, *J Am Acad Psychiatry Law 36:4:499-501* December 2008). It remains to be seen where courts will go with this.

For now, forensic child psychiatrists evaluating these types of cases need to keep an open mind, learn as much as possible about the *factual* details and not be swayed by the media. And always ask: why is that clock ticking?

A Careful Dance

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primarily forensic one (Pinal's Second and Third Stages).

I write this account aware that I am not the first, the last, nor the most successful mother in fellowship. Many other women struggle with balancing motherhood and career. I think that today this careful dance is still defining for many women, more than the achievements of their professional careers. I aspire to the energetic successes of AAPL leaders but am equally aware of the colleagues who have declined former career aspirations to work part time or to stay at home with their children. We "choose" what makes sense for us and our families, yet our choices are still sometimes constrained by outside factors like lack of time or place to pump breast milk, inflexible work environments and work schedules, or lack of quality, affordable childcare. I have thus far been successful, thanks in large part to supportive supervisors and family, and good daycare. I am also indebted to more senior forensic psychiatrists at AAPL and WAAPL for their personal interest in me and their career advice. I hope that the forensic fellowships and AAPL continue to invest in women and families by encouraging career aspirations while providing tangible support—flexible hours, adequate parenting leave, and quality child care—to a new generation of forensic psychiatrists as we attempt to balance professional and personal demands.

Dr. Michaelson was a 2014-2015 fellow in the Yale University forensic psychiatry fellowship program.

Suicide Risk

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Ask The Experts

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ered by the umbrella of attorney-client privilege; to know it may make you vulnerable to the legal issue as follows: When on the stand if you were asked "doctor, are you aware of anyone else who reviewed this case and what they thought?" you would be put in an invidious situation. This would add a complication to the case, which could have been prevented. In this situation you should trust your retaining attorney to understand both the law and courtroom procedure. Most frequently lawyers are trying to protect their experts, not to trick them.

Sometimes as forensic psychiatrists, when we get together, we get into a mindset that the attorneys as a group cannot be trusted. This myth should be dispelled. Most lawyers are honest, ethical, and knowledgeable of the law. In 30 years of practice of forensic psychiatry I can count on one hand those who have tried to trick me or have been blatantly dishonest or unethical.

Take Home Points:

Knowing your personal limit and biases is important and can influence your decisions in accepting or refusing to take a specific case. While honest experts can in fact disagree, it is important to strive for objectivity

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PHOTO GALLERY

Dr. Metzner presents Dr. Charles Meyer, Jr. with the Red AAPL Award.

The President's Club!

Research Committee Chair, Andrew Kaufman, MD presents the Young Investigator Award to Artha Gills, MD, PhD.

Another Red AAPL award is presented to Dr. Steven Berger.

Dr. Kenneth Weiss is the recipient of the 2015 Golden AAPL award.

Rappeport Fellows pictured with Committee Co-Chairs Britta Ostermeyer and Susan Hatters Friedman.

PHOTO GALLERY

Dr. Metzner presents the Seymour Pollack Award to Dr. William Reid.

New Officers and Council Members.

Research Committee Chair, Andrew Kaufman, MD presents the Poster Award to Nathan Kolla, MD.

AAPL Chief Photographers – past and present!

Dr. Sherif Soliman is presented with the Award for Outstanding Teaching in a Forensic Fellowship Program.

AAPL visits Judge Lerner-Wren's Mental Health Court.

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

Designer Drugs: Legal and Forensic Aspects

Karen B. Rosenbaum, MD, Ryan Wagoner, MD, and Manuel Lopez-Leon, MD
Liaison with Forensic Sciences Committee and Addiction Psychiatry Committee

The Liaison with Forensic Sciences and the Addiction Committees created a joint presentation for the 2015 AAPL Annual Meeting held in Fort Lauderdale, Florida entitled *Designer Drugs: Dangers, Detection, and Defenses*. The panel included a featured guest speaker from the Forensic Toxicology Section of the American Academy of Forensic Sciences (AAFS), Teri Stockham, Ph.D. She discussed the forensic implications of the chemical properties of novel designer drugs including synthetic cannabinoids and cathinones (Bath Salts). The panel was also composed of Ryan Wagoner, M.D., Chief of Forensic Psychiatry at the University of South Florida, and the co-chairs of the Liaison with Forensic Sciences Committee of AAPL, Karen B Rosenbaum, M.D. and Manuel Lopez-Leon, M.D. Gregory Sokolov, M.D., chair of the Addiction Committee monitored the panel.

One of the goals of the Liaison with Forensic Sciences Committee is to facilitate and enhance the collaboration between forensic psychiatrists and forensic scientists from different disciplines. Forensic psychiatrists form a part of a larger group collectively known as forensic scientists, thus our discipline is recognized as such by the American Academy of Forensic Sciences (AAFS). The Forensic Psychiatry and Behavioral Science Section of AAFS is one of the eleven recognized sections, and there are topics that cross psychiatry and most of the other disciplines, including toxicology, which was featured in this panel.

A designer drug is an analog of a controlled substance, meant to mimic the effects of the original substance and avoid detection in commonly used drug tests.[1] While designer drugs are often associated with MDMA (ecstasy) and the rave scene of the 1980s and 1990s, newer designer drugs have exploded onto the scene within the last decade. Synthetic cannabinoids and synthetic cathinones are two designer drugs, which come up in the media time and again due to their effects and the dangers associated with their use. These and other newer substances are also referred to as Novel Psychoactive Substances.

"The decrease in the supply of MDMA and decrease in the purity of ecstasy and cocaine also contributed to an increase in seeking synthetic compounds with similar effects especially in the UK."

Synthetic cannabinoids, often known by the name "spice," are specifically crafted to attach to the cannabinoid receptor of the brain, much like marijuana. However, like many designer drugs, the potency of synthetic cannabinoids can be far greater than the original substance it is meant to mimic. Synthetic cannabinoids are sold under multiple names and brands, including "K2, fake weed, Yucatan Fire, Skunk, and Moon Rocks." When synthetic cannabinoids first became popular, they were often sold at gas stations and "head shops," prior to greater law enforcement intervention into their sale. These substances have also been widely available over the internet. Utilizing bright, cartoonish packaging and liberal use of the word "natural," synthetic cannabinoids were advertised as being a "safe" alternative to marijuana, with the desired effects of elevated mood, relaxation, and altered perceptions. However, multiple cases of "spice use" have shown a darker side to this substance, with side effects including extreme anxiety, paranoia, hallucinations, tachycardia, vomiting, and confusion.[2]

Synthetic cathinones, also referred to as "bath salts," target the dopamine and serotonin receptors of the brain. Cathinones are related to amphetamines and thus have a stimulant activity, however they are also potent hallucinogens due to serotoninergic effects. Through the activation of sympathetic receptors, they cause a broad spectrum of effects; from excitement and euphoria, to paranoia and mood changes, to hallucinations, convulsions, and death. Designed to mimic effects of the khat plant, synthetic cathinones encompass a wide variety of substances with structural similarities meant to produce effects of euphoria, increased sociability, and increased sex drive. Synthetic cathinones are sold online and in drug paraphernalia stores, under names such as "jewelry cleaner, plant food, and phone screen cleaner." Very often, these "bath salts" are labeled as being "not for human consumption" in an effort to avoid regulation of their use. Like synthetic cannabinoids, there are increasing reports of multiple side effects with the use of synthetic cathinones, including paranoia, agitation, hallucinatory delirium, violent behavior, tachycardia, hypertension, and chest pain.[2]

One particular synthetic cathinone, known as "flakka," has gained an increased level of attention from the media due to the dramatic effects it can cause and the extremely cheap price tag it carries on the street. Particularly a problem in south Florida, flakka is also referred to by its chemical structure (alpha-PVP) and the name "gravel." Like many of the synthetic cathinones, flakka can be eaten, snorted, or injected during use. However, a new route of administration, which is gaining popularity is vapor-

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Designer Drugs

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izing flakka through the use of an e-cigarette or personal vaporizer. In addition to the side effects for other synthetic cathinones, flakka has raised concern for reports of deaths from both cardiac issues and suicide while under the influence of this substance.[2]

The chemical composition of this dangerous novel designer drug is alpha-PVP (α-pyrrolidinopentiophenone). This drug has come to the attention of crime labs in several states. In South Florida there were only two cases related to Flakka in 2012 and six cases in 2013, however that jumped to 576 cases in 2014. In 2015 in Broward County, FL, there were 34 confirmed cases. In September 2015 a new variety of Flakka began to appear; alpha-PHP (α-pyrrolidinyl-hexaphenone),

In January of 2012, Murray et al. described a case report of a 40 year-old man with bipolar disorder who had been abusing cocaine but switched to "bath salts." Shortly after he snorted and injected an unknown quantity, he became "aggressive, uncontrollable, and delusional, and removed all of his clothing and ran outside." The police were called. When they arrived, the man struggled with the police, exhibiting strength, violence, and aggression. He was restrained with an electronic control device and was physically restrained in the ambulance. His breathing was labored and he was placed on a non-rebreather mask with 100% oxygen. He was "yelling incomprehensibly," had dilated pupils, and his vitals were unstable. He was given 2 mg of Lorazepam for agitation, but was still not sedated.

When he arrived at the hospital, he was still yelling and aggressive. Medical records showed routine medications of quetiapine, methadone, and temazepam. With medical intervention, his vitals stabilized. However, while being transferred from the ER stretcher to a hospital bed, he suddenly became quiet and withdrawn. Within five minutes of his arrival to hospital, he developed bradycardia and then had a cardiac arrest with pulseless electrical activity. He was resuscitated and admitted to the Medical Intensive Care Unit (MICU). There, he was given IV fluids, and treated for persistent hypotension. He proceeded to develop metabolic acidosis, renal failure, hepatic failure, and anoxic brain injury. Forty-two hours after presenting, he was declared brain dead. During the evaluation, blood and urine toxicology were negative for barbiturates, amphetamines, benzodiazepines, cocaine, marijuana, methadone and opiates. Further specialized testing of the sample in a tertiary care center revealed it was positive for MDPV, and negative for quetiapine.[3]

In April, 2015, Mohsen et al conducted a survey of ER clinicians' experience with Bath Salts. Urine toxicology confirmation of Bath salts in the ER is impractical because the results take several days. Clinicians need to rely on patient's self report. In the survey, 77% of the 25 ER doctor respondents did not specifically ask patients about bath salt use. 60% of them had encountered bath-salt intoxicated individuals. Results also indicated that their patients were mostly male, between 19 and 29 years old and most used other drugs as well. Presentations in the ER included agitation, aggression/violence, and hallucinations. Tranquilization was used with IM and IV medications. Most survived and were discharged home.[4]

Synthetic Marijuana has caused a large increase in Emergency Room visits in New York, causing Governor Cuomo to intervene.[5] There have been many high profile suicides, homicides, and other tragedies related to use of designer drugs, which have increased over the past few years.

Winstock and Wilkins discussed the challenge of policy makers to keep up with the constant and rapid changing of molecular structures of novel psychoactive substances, as well as the wide distribution, which has increased in the last few years. Novel psychoactive substances have been around for decades. What has changed has been their diversity, potency, and the internet, which is a "drug market without borders." The decrease in the supply of MDMA and decrease in the purity of ecstasy and cocaine also contributed to an increase in seeking synthetic compounds with similar effects especially in the UK. They have also been marketed as "safer" alternatives to illicit drugs. The authors discussed advantages and disadvantages to criminalization of novel psychoactive substances and alternatives to criminalization such as wide spread education.[6]·

In conclusion, it is important to assess for the use of Bath Salts and Synthetic Marijuana in clinical and forensic work. Another role for forensic psychiatrists could be facilitating policy to educate the public regarding these harmful substances.

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Evaluating the Neuropsychiatric Risks of Youth Contact Sports

Christopher Fischer MD, Child and Adolescent Committee

In February 2015, the mother of a 25-year-old man who committed suicide in 2012 filed a wrongful death lawsuit against Pop Warner, the largest organization of youth football. The lawsuit claimed that cognitive damage, allegedly incurred during his years playing in youth football, contributed to his death.[1] On autopsy, the young man's brain revealed striking evidence of chronic traumatic encephalopathy (CTE), a progressive neurodegenerative condition associated with repeated head trauma. The young man had played contact football for four years in the Pop Warner league, followed by four years in high school.

Over the past decade, significant media attention has been directed toward concussions, or mild Traumatic Brain Injuries (mTBIs), in contact sports.[2] CTE reached national headlines when autopsies of the brains of a number of ex-NFL players, including Pro Football Hall of Famer Junior Seau, revealed evidence of CTE. Several studies have associated CTE with a variety of neuropsychiatric symptoms, including mood (depression, irritability, hopelessness), behavior (impulsivity, explosivity, aggression), cognition (memory impairment, executive dysfunction, dementia), and motor symptoms (parkinsonism, dysarthria, ataxia).[3] The mood and behavior symptoms are speculated to begin 8-10 years after experiencing repeated concussions, followed by more severe cognitive and motor symptoms later in the course of the disease.[4]

Currently, CTE can only be diagnosed post-mortem by pathological findings. A clinical diagnosis of CTE is difficult to make because there are no consensus diagnostic criteria, large-scale longitudinal clinical studies, or randomized pathological studies.[5] It is not known how many or what severity of head injuries place a person at risk for developing CTE. There have been cases of CTE after a single severe TBI, after multiple concussions, and even after only repeated sub-concussive hits to the head (and no documented history of concussion).[6] There is evidence that repeated sub-concussive hits, a common occurrence in contact sports, can disrupt neuronal integrity and is associated with white matter damage.[6]

Recent media reports have focused on concussions sustained during youth sports as a possible risk factor for later development of CTE and other neuropsychiatric symptoms. This is an important issue, given that millions of youth participate in contact sports annually.[7] Concussions occur in males and females of all ages and in all sports but are most common in contact sports. Of all the contact sports, the risk of concussion is highest in football. There are nearly 67,000 diagnosed concussions in high school football each year.[8] However, high school students are not the only youth that are at risk for sustaining concussions; 70% of all football players are actually under the age of 14.[7] One study found that the incidence of football-related concussions per football game or practice in children ages 8-12 years is at least double that of high school or college players.[9]

"The mood and behavior symptoms are speculated to begin 8-10 years after experiencing repeated concussions, followed by more severe cognitive and motor symptoms later in the course of the disease."

Younger brains may be more vulnerable to injury and the age at which an athlete suffers a head trauma may influence the risk of later developing CTE.[5] There is growing evidence of long-term neurodegenerative changes following TBI of all levels of severity in youth. One review found decreased brain volume in specific regions, increased CSF and ventricular space, and decreased axonal integrity, particularly in the corpus callosum, following TBIs of all levels of severity in youth.[10] The hippocampus and deep limbic structures appear to be particularly sensitive to atrophy following TBIs in youth – regions of the brain that have been notably atrophied in diagnosed cases of CTE in adults.[10]

Although CTE has been linked with depression and suicide, little is known about the actual neuropsychiatric implications of the head trauma, especially in youth. There are only a few studies that have explored this topic thoroughly – none of which included cases of CTE in youth. Of note, the earliest documented evidence of CTE ever recorded was in an 18-year-old multi-sport athlete who suffered multiple concussions in high school.[11] Because symptoms of CTE generally do not present until years or even decades after exposure to head trauma, causal relationships are often difficult to establish. One study did find that a history of concussion was associated with a higher prevalence of diagnosed depression (3.3-fold greater risk of depression diagnosis) in adolescents, after controlling for age, sex, parental mental health, and socioeconomic status.[12] Similarly, an adult study found that retired professional football players with a self-reported history of three or more concussions were three times more likely to be diagnosed with depression than their peers with no reported history of concussions.[13] Another study in a group of former NFL players found an association between participation in tackle football prior to age 12 and greater later-life impairment in executive function,

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Developing Forensic Clinical Experiences for General Psychiatry Residents: Navigating the Obstacles

Tobias Wasser, MD; Katherine Michaelsen, MD; Jessica Ferranti, MD, Forensic Training Committee

For all medical disciplines, one of the core educational missions is developing interest and curiosity amongst students and residents as a step toward fostering robust fellowship programs and excited and engaged professionals. Early experiences in a particular field may stimulate trainees' interest in a specialty. In forensic psychiatry, such experiences prepare medical students and residents to pursue additional forensic work to enhance their general practice or to prepare for a forensic fellowship. Thus, it is incumbent upon the field of forensic psychiatry to develop opportunities for students and general psychiatry residents to gain early experiences in forensics. However, there are a number of obstacles to developing and sustaining such clinical experiences in forensic psychiatry. Here we highlight these challenges in order to identify potential stumbling blocks for designing forensic experiences for residents and medical students. Our hope is that this will serve as an aid for educators developing forensic experiences.

Vague ACGME Guidelines

The ACGME guidelines for a forensic psychiatry experience for general psychiatry residents lack clarity. The guidelines state, "This experience must expose residents to the evaluation of forensic issues such as patients facing criminal charges, establishing competency to stand trial, criminal responsibility, commitment, and an assessment of their potential to harm themselves or others."[1] Unlike our counterparts in addiction, geriatrics, child and adolescent, and consult liaison psychiatry, the requirements for an "experience" in forensic psychiatry lack any guidance about the amount of time one should be engaged in this activity (in comparison, for example, to requiring a one month clinical experience in addiction psychiatry). Also, some of the experiential examples listed can, and likely often are, met via residents' clinical experiences on a consult or otherwise non-forensic service. Further, the newly developed Psychiatry Milestones for general psychiatry residents make no mention of forensic competencies beyond a brief mention of violence risk assessment and consulting to non-mental health systems (in which "forensic" is listed among a long list of options).[2]

> *"... security clearance and safety concerns may inhibit or pose barriers to residents and students accessing forensic or correctional settings for either care or evaluations, and may make forensic hospitals and prisons more reluctant to accept trainees."*

Although the vague language allows residency programs without an affiliated forensic fellowship, forensic clinical service, or forensic faculty to more easily meet these requirements, the lack of requirements for a defined period of time or forensic setting make it difficult to engage residency program administration or our colleagues in other subspecialties to create space for forensic opportunities as a core component of the residents' training experiences.

Forensics-Specific Obstacles

There are a number of factors related to the nature of forensic psychiatry work that can present challenges to easily incorporating general psychiatry residents into these experiences. First, should the priority be forensic consultative evaluations for legal purposes or clinical practice in forensic settings? While there are likely benefits to both, each also comes with its own complications.

Forensic consultative evaluations do not necessarily fit neatly into a two to four week or once-a-week resident rotation schedules. Forensic evaluations often take place over several sessions which may be spaced out in time by weeks or months. Similarly, when courtroom testimony is required, it may take several days and scheduling is often unpredictable and rarely close in time to the original evaluation. These scheduling issues present challenges for both residents and program administrators who need rotations to occur in a regular and predictable fashion. Also, forensic evaluations sometimes involve very sensitive or highly publicized events and referring parties may be hesitant to consent to having a resident present during the examination. Further, for evaluations occurring in a correctional setting, the physical space may be limited, particularly if the evaluation already involves a team of clinicians. Record review may be more accessible for residents' participation, though without the direct contact with the evaluee, it may lack context, leading to a less stimulating experience.

Providing care in forensic and correctional settings may also pose unique challenges for residents. In many states, forensic hospitals and correctional institutions are geographically separated from other hospitals or academic centers. As such, those residents and medical students without a means of transportation will be disadvantaged. Further, security

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New York SAFE Act: Unintended Limitations?

Ana Natasha Cervantes, MD

On January 15, 2013, New York State passed the Secure Ammunition and Firearms Enforcement (SAFE) Act. The law has been the subject of much debate and commentary, most of it occurring after it was signed into law. The law includes a new section in Mental Hygiene Law 9.46 (MHL 9.46) that imposes a duty on mental health professionals (physicians, nurses, psychologists and social workers) to report patients "likely to engage in conduct that would result in serious harm to self or others." However, it does not specify whether the risk is short term or long term. Additionally, a physician filing a report must be a *current treating* physician, and must have evaluated the person within 30 days of filing a report.

Most forensic psychiatrists, particularly those with interest in criminal cases, have evaluated individuals whose past history would lead to an elevation of their risk of harming themselves or others if they owned a firearm.

Consider the case, for example, of a worker who is referred to a forensic psychiatrist for a fitness for duty evaluation because of increasing irritability at work. The evaluee is not currently receiving psychiatric treatment. During the course of the evaluation, the forensic psychiatrist concludes the evaluee meets criteria for delusional disorder but does not meet criteria for civil commitment. For the purposes of this example, let us assume that numerous historical risk factors that increase the evaluee's risk for future violence are identified, for example, a history of reacting violently when fired from a prior job, and a history of serious fights while intoxicated. If the forensic psychiatrist believed the risk factors remained, and were likely to contribute to future violence, the psychiatrist could not make a SAFE Act report that would bar the evaluee from legally purchasing a firearm.

Another important issue with the SAFE Act reporting has to do with the period within which the reports must be made. In the scenario described above, let us assume the employee becomes upset about being required to have a psychiatric evaluation, subsequently "harasses" the employer, and then gets arrested by the police and remanded in jail. The jail psychiatrist concludes the employee has psychotic symptoms and presents long-term but not immediate risk of violence, starts an antipsychotic medication and considers filing a SAFE Act report. However, the psychiatrist believes it would serve no useful purpose to do so immediately, as the patient has no ability to purchase a weapon while incarcerated. The law states that the report should be made "as soon as practicable," and allows for up to 30 days.

"It is perhaps more disconcerting that a forensic evaluator is unable to file a SAFE Act report because the evaluator is not a current treating psychiatrist."

The patient refuses to engage in treatment with the psychiatrist or take medications, but remains in good behavioral control. After two months, the patient is released from jail without the knowledge of the psychiatrist. Upon being made aware of the patient's discharge, the psychiatrist concludes that the same risk factors that were identified on arrival to the jail (increased potential for violence when not taking medications or when in a stressful relationship, complicated by substance use problems) likely remained, and decides to file a SAFE Act report. However, he is unable to do so because the treater must have personally evaluated the patient within the 30 days prior to making the report.

In the different scenarios presented earlier, each psychiatrist assessed the issue as one where "likely to engage in conduct that would result in serious harm to self or others" would apply. However, both were precluded from making a SAFE Act report.

It is understandable that a reasonable time frame be set for SAFE Act reports to be made in order to be relevant. However, there should also be exceptions in cases of persons whose long- term risk of causing serious harm to themselves or others is chronically elevated and likely to remain unchanged well beyond the required 30 days. A SAFE Act report restricts gun purchases for 5 years from the date of the report, which could be reset for another 5 years if a subsequent report is made on the same individual. It seems clear the intention of MHL 9.46 is to consider not just short-term, but also long-term risk of dangerousness. To limit risk assessments to those made within 30 days with no exceptions, appears overly restrictive.

It is perhaps more disconcerting that a forensic evaluator is unable to file a SAFE Act report because the evaluator is not a *current treating* psychiatrist. This is problematic as forensic evaluators may not be in a position to release information about an evaluee's dangerousness to treatment providers (assuming there is a treatment provider) that could cause the providers to consider making a SAFE Act report. Perhaps consideration will be given in the future to extend the reporting period and allow forensic evaluators who could have the most accurate and complete data

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An Update on Stalkers and Their Victims

Renee Sorrentino, MD; Susan Hatters Friedman, MD; Britta Ostermeyer, MD; Brad Booth, MD

At the 2015 International Congress of Law and Mental Health in Vienna, we presented a workshop entitled "An Update on Stalkers and Their Victims." The workshop provided a review of the classification systems described in the stalking literature and a discussion about female stalkers, juvenile stalkers and stalkers of psychiatrists.

Stalker Classifications

The goal of stalker classification is to identify the differences between the otherwise heterogeneous groups of stalkers and provide guidance for treatment and violence risk prediction. The classifications focused on the stalker's relationship with victim and the degree to which violence was an issue. While there is no consensus on a single classification system, there are three widely recognized stalker classifications: The Zona's Stalker-Victim Types, 1993; the Mullen's Stalker Typology, 1999; and the RECON (RElationship and CONtext-Based) Stalker Typology, 2006. Studies showed that stalking behaviors provide insight about stalkers, and prior sexual intimacy between stalkers and victims placed victims at substantially higher risk of violence.

Based on violence risk prediction, the Zona's Stalker-Victim Types came up with three types of stalkers: Simple Obsessionals; Love Obsessionals; and Erotomanics. The Mullen's Stalker Typology expanded the prior classification to include motivation for the stalking in the context of stalking behavior, and stipulated five stalker types that are not mutually exclusive: The Rejected; the Intimacy Seekers; the Incompetent; the Resentful; and the Predatory. Lastly, the RECON Stalker Typology is based on the nature and the context of the stalker-victim relationship and its violence risk prediction. This latest typology, derived from a large study of 1005 North American stalkers, separated stalkers into two main types based on whether or not the stalker and victim had a prior relationship (RE). Then, each type is further subdivided into two subtypes of stalkers based on the context (CON) of the stalker-victim relationship: Type I, prior relationship: A. Intimate Stalker and B. Acquaintance Stalker; Type II, no prior relationship: 1. Public Figure Stalker and 2. Private Stranger.

> *"However, unlike adult stalking, stalking in adolescence is more likely to be motivated by romantic emotions, more likely to involve physical approaches, and adolescent stalkers more frequently change victims."*

Female Stalkers

When we are asked to think of female stalkers in Hollywood films, Fatal Attraction, and Single White Female may quickly come to mind. While we see them in popular culture, they are often disregarded in real life or their risk minimized. When men report being stalked by women, they may be called "lucky", told they should be "flattered" or disbelieved. Yet, their female stalkers, like male stalkers, are capable of violence. Women may have similar motivations for stalking as men (West & Friedman, 2008). Borderline personality or erotomania may be found. Women are more likely than men to stalk both same-gender and opposite gender victims, or professional contacts (like psychiatrists). Like male stalkers, they are more likely to be violent toward their former intimates than other stalking victims. Female stalkers and their potential for violence should not be underestimated.

Juvenile Stalkers

Most of us don't consider juveniles as stalkers or victims of stalking. Stalking by juveniles has been considered rare or uncommon despite extensive study in this area. Research on college populations suggests that stalking behavior in late adolescence is not uncommon. Higher rates of intrusive contact have been found among undergraduates, although these vary substantially between studies.

The variability between these findings may be largely attributable to variations in the ways that stalking has been operationalized. The prevalence of juvenile stalking is somewhere between 11-30% (Logan et al 2000, Mustaine & Tewksbury 1999). There are some similarities between adult and adolescent stalking. For example, adolescent stalking tends to be male on female, just as adult stalking. However, unlike adult stalking, stalking in adolescence is more likely to be motivated by romantic emotions, more likely to involve physical approaches, and adolescent stalkers more frequently change victims. The risk for violence in juvenile stalkers is not well known, studies vary from 3-47% of stalkers (McCann et al, 2001; Purcell et al 2008)

A classification system for juvenile stalkers has been described by both McCann et al and Purcell et al. However the application of a classification system in juvenile stalkers has not sufficiently been studied. The risk assessment of juvenile stalkers largely relies on research extrapolated from adult stalking studies. However, it is clear that there are unique features of juvenile stalking that should be considered distinct from the adult stalking literature, in order to competently evaluate risk.

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Risk Factors

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behavioral problems were significant.

The conclusions about psychopathy are as follows: Parental factors like young father and young mother were only important for children (G3). Family factors like uninvolved father was important for G2-males not their children-G3. Harsh discipline was significant for G2 (includes cold attitude) and physical punishment was important for G3. Parental conflict was not important. Socioeconomic risk factors and individual risk factors like low attainment, impulsivity, and behavioral problems were important for both G2 and G3. Even though there were similarities between the two generations, the strength of the risk factors for psychopathy for G2 was not correlated with the strength of risk factors for G3. Dr. Farrington said the reasons are unknown at this time and further research was needed as these were very recent findings.

In comparing the main differences between risk factors for G2 (males) offending and psychopathy, the following were discovered:

1 An uninvolved G1 father was a strong predictor of psychopathy (OR-6.51) but not offending (OR 1.44).
2. Parental conflict was a strong predictor of offending but not psychopathy.
3. Low SES was a strong risk factor for psychopathy but not offending.
4. Low attainment was strong for offending not psychopathy.

Similarly, the main difference between risk factors for G3 (children) offending and psychopathy included the following:

1. Young G2 father and young G2 mother strongly predicted psychopathy but not offending.
2. Large family size was a stronger predictor of psychopathy than offending.
3. No Advanced (A) level or college level education was a stronger predictor of psychopathy than offending.

Overall, Dr. Farrington discussed the need for more research in this area to challenge questions regarding replicability of risk factors across regions and time periods.

Summary of results can be found in Farrington, D.P. (2003) Key results from the first 40 years of the CSDD; Farrington D.P. et al (2006) - New findings from the CSDD and Farrington D.P et al (2009): Recent results from the CSDD

Evaluating

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impairment in memory, and lower estimated verbal IQ.[14]

Although several case series of CTE have included individuals who completed suicide, published reviews of the literature have concluded that there is insufficient evidence to support a causal relationship between CTE and suicide.[3,15,16,17] Individuals who were diagnosed with CTE posthumously often have risk factors for depression, in addition to well-established risk factors for suicide. These include decline in cognitive functioning, decline in socioeconomic status, divorce, chronic pain, substance abuse, and gender.[15] One large-scale retrospective epidemiologic study of retired NFL players found that former NFL players were actually less likely to die by suicide than males in the general population.[16,18] Between 1960 and 2007, only nine former NFL players were known to have completed suicide, as opposed to the 21.8 individuals in the general population that would have been expected, based on the total number of players in the NFL during that time period, to have completed suicide.[18] Future research may establish a causal relationship between CTE and suicide. However, no cross-sectional, epidemiological, or prospective studies have been conducted yet to arrive at such a conclusion.[16]

The results of the Pop Warner lawsuit could have significant implications for participation in youth football, as well as other contact sports. The National Hockey League (NHL), the National Collegiate Athletic Association (NCAA), and the Fédération Internationale de Football Association (FIFA) also currently are involved in head injury litigation. It is likely that, within the next few years, the number of sports-related concussion lawsuits will increase significantly. However, more research at the youth level is

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APA Medical Director, Saul Levin, and President, Renée Binder, pose with Graham Glancy and Tom Gutheil.

John Kastner: *De-stigmatizing Patients*

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homicide cases in Canada and "the continent" which were causing the public to view forensic psychiatry defendants with negativity. In response to this negative public opinion, Stephen Harper, the Canadian Prime Minister at the time, introduced a "punitive" new piece of legislation named the Not Criminally Responsible Reform Act.

This new law was aimed at making mentally ill defendants responsible for their actions, and fueled negative public opinion about forensic psychiatry patients. There were some concerns among members of his crew about what will happen to Mr. Clifton should his identity become public after the film was released. Prior to the film being made, none of Mr. Clifton's neighbors knew who he was or what he had done, because he had been stabilized prior to his release back to the community. They were worried that the victim's family, who were on a crusade to try to get Mr. Clifton back to the hospital, could use the film as basis for their campaign. It would have been possible because the Not Criminally Responsible Reform Act could be applied retroactively. They were also worried that proponents of harsh punishments for forensic psychiatry patients could use the film as propaganda to further their agenda.

He realized that to take the risk of exposing Mr. Clifton's identify, he first had to turn public opinion to a favorable one. He had an inclination that tackling that task would involve demystifying the common belief, especially among women, that forensic psychiatry patients could not be successfully treated.

After spending so much time in the hospital, he was struck by how much improvement could be achieved with adequate treatment. The question for him and his team then was "could we capture this remarkable metamorphosis on film." This was not the only element in their strategy but it was the most important.

Mr. Kastner's documentary is a powerful tool not only for destigmatizing mental illness, but also for demystifying severe psychosis. The message was presented with sensitivity and expertise. It was received by the AAPL audience of experienced forensic psychiatrists with wide and sustained applause.

Evaluating

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needed for the legal system and the public to be able to draw meaningful conclusions about the long-term neuropsychiatric risks that youth face when stepping out on to the playing field.

Dr. Fischer is a first-year Child & Adolescent Psychiatry fellow at Keck School of Medicine at University of Southern California.

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Developing Forensic

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clearance and safety concerns may inhibit or pose barriers to residents and students accessing forensic or correctional settings for either care or evaluations, and may make forensic hospitals and prisons more reluctant to accept trainees. The requirements for background check and security clearance to enter many correctional facilities may make the administrative process for bringing residents too complicated and time-consuming to be practically feasible.

Residency Program-Related Obstacles

Finally, residency programs themselves may impede the implementation of forensic clinical experiences. Non-forensic psychiatrists within the programs may have a limited understanding of forensic work, its relevance to the practice of general psychiatry, and the importance of basic forensic exposure for all residents. Lack of familiarity with the subspecialty may contribute to views of forensic psychiatrists as "hired guns" to whom residents should not be exposed, anxiety about interacting with the legal/criminal justice system, or ambivalence about devoting time and energy to create or maintain specific forensic rotations when ACGME requirements are already met through other non-forensic clinical rotations. Given these attitudes and the lack of a specific ACGME time requirement for a forensic clinical experience, it may be particularly challenging to make room for forensic rotations among the already packed schedule of residency training. Lack of forensic faculty available to advocate for the rotation and to supervise trainees may present an additional barrier.

Conclusion

While we have highlighted impediments to developing forensic experiences for trainees, our intention is not to be pessimistic. Rather, our hope is that by identifying potential obstacles, we can contribute to thoughtful strategizing for how to overcome

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The American Academy of Psychiatry and the Law is pleased to announce the **29th Annual Rappeport Fellowship competition**. Named in honor of AAPL's founding president, Jonas R. Rappeport, MD, the fellowships offer an opportunity for outstanding residents with interests in psychiatry and the law to develop their knowledge and skills.

Winners must attend the Annual Meeting and Forensic Psychiatry Review Course, in order to win the award.

The meeting will be held in Portland, OR from October 27-30, 2016. Immediately prior to the Annual Meeting, Fellows will also attend AAPL's Forensic Psychiatry Review Course, an intensive, comprehensive overview of psychiatry and law. Travel, lodging, and educational expenses are included in the fellowship award, and a per diem will be paid to cover meals and other expenses.

Residents who are currently PGY-3 in a general program, or PGY-4 in a child or geriatric subspecialty training program and who will begin their final year of training in July 2016, are eligible. Canadian PGY-5 general psychiatry residents and Canadian PGY-6 child residents are eligible. Deadline for applications is April 1, 2016. Please contact the AAPL Office at 800-331-1389 or office@aapl.org for more information.

An Update on Stalkers

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Stalking of Psychiatrists

While stalking can take many forms and motivations, and involve numerous victim typologies, psychiatrists and mental health workers may be at heightened risk of becoming a victim of stalking. Forensic psychiatrists, who at times have greater notoriety and work with individuals who may have greater risk of criminal behaviors, may be at risk for stalking. Studies of psychiatrists suggest that up to 25% have been stalked, primarily by patients (Whyte, Penny et al. (2011)), (Nwachukwu, Agyapong et al. 2012).

Being stalked as a psychiatrist can cause particular difficulties. The term, "stalking by proxy" was coined to describe a special form of stalking often used against psychiatrists. In this form of stalking, patients may initially start by using traditional stalking methods of calls, letters, and emails. However, they may then start to sequentially enlist unbiased third parties with complaints against the psychiatrist. This may include the psychiatrist's hospital administration, licensing body, police, media, human rights tribunals, colleagues and others. These third parties are unaware of the stalker's history, and thus naively take up the cause of the stalker – acting as a proxy for the stalker. They embark on repeated contact with the psychiatrist under the assumption that the stalker's complaints may have merit. While ultimately the complaints are found to be frivolous and vexatious, the emotional toll on the psychiatrist is the same. Pathé and Malloy (2013) noted that the approach with colleagues being harassed should be to support, not to censure – good advice.

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New York SAFE Act

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upon which to render an opinion on dangerousness, to make a report against those deemed to be at risk for future violence.

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Ask The Experts

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and impartiality in reaching an expert opinion. In forensic pathology, while the manner of death is usually classified as natural, accidental, suicide, or homicide, there is also a category called "undetermined," to be used when the evidence isn't clear enough or strong enough to support a more precise answer. Perhaps it's time for forensic psychiatrists to get more comfortable with saying "I'm not able to reach an opinion to a reasonable degree of medical/psychiatric/scientific" certainty.

Secondly, in general you can trust that attorneys may have a good reason not to reveal information to you. Most attorneys are ethical and knowledgeable of the law and you can generally accept that there are perhaps things that you do not need to know in a case for good reasons. Unless there is something about the attorney that makes you suspect something nefarious, you should accept the conditions of the retainer in good faith.

Developing ...

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them. Creating such opportunities for residents may not be easy, but this does not mean it is any less worthwhile. For the future of forensic psychiatry, it is vital for our field to continue to engender interest and curiosity from young trainees, whether they decide to pursue specialization or not. However, this will require creative thinking on the part of motivated and energetic educators, collaboration with program administration, and collection and incorporation of feedback from trainees.

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2016 Guttmacher Award Announced

Kenneth L. Appelbaum, Jeffrey L. Metzner, and Robert L. Trestman to receive the prestigious Manfred S. Guttmacher Award at the Annual Meeting of the American Psychiatric Association and the Semiannual Meeting of the American Academy of Psychiatry and the Law in Atlanta, GA in May 2016.

The award, which was established in 1967 and first awarded in 1972, is co-presented by the American Psychiatric Association and AAPL, and honors outstanding contributions to the literature of forensic psychiatry in the form of a book, monograph, paper or any other work presented at a professional meeting or published between May 1, 2014 and April 30, 2015.

The book for which they are being honored is:

Oxford Textbook of Correctional Psychiatry, the first comprehensive correctional psychiatric textbook. New York, Oxford University Press, 2015

AAPL FUTURE MEETINGS

October 24-26, 2016
Forensic Review Course
October 27-30, 2016
47th Annual Meeting
Hilton Portland
& Executive Tower
Portland, OR

October 23-25, 2017
Forensic Review Course
October 26-29, 2017
48th Annual Meeting
Hyatt Regency
Denver, CO

October 22-24, 2018
Forensic Review Course
October 25-28, 2018
49th Annual Meeting
JW Marriott
Austin, TX

October 21-23, 2019
Forensic Review Course
October 24-27, 2019
50th Annual Meeting
Marriott Waterfront
Baltimore, MD

October 19-21, 2020
Forensic Review Course
October 22-25, 2020
51st Annual Meeting
Marriott Downtown
Chicago, IL

AAPL Awards Committee Seeks Nominations for 2016

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.

AAPL Semi-Annual Meeting

Committee Meetings

Saturday, May 14, 2016
1:00 p.m. – 6:00 p.m.
Hilton, Atlanta, GA

Committee reception to follow.

More information coming soon.

National Commission on Correctional Health Care

News Release
January 19, 2016
Contact: Barbara Granner
773-880-1460, ext. 284
barbaragranner@ncchc.org

Correctional Health Care Conference Focuses on Quality

(Chicago) – Quality health care in the nation's prisons and jails takes center stage at the National Commission on Correctional Health Care's Spring Conference, to be held April 9-12, 2016, in Nashville, Tenn. The conference will feature more than 50 educational sessions on clinical, administrative and legal aspects of health care behind bars. In-depth preconference seminars will explore suicide prevention, gender dysphoria, continuous quality improvement, the manufacturing of drugs and alcohol by inmates and NCCHC's *Standards* for managing medical and mental health care delivery in prisons, jails and juvenile facilities. The *Standards* help facilities use resources efficiently while improving quality of care; they are the basis for NCCHC's facility accreditation program as well as its certification program for correctional health professionals.

The conference is recommended for all correctional health professionals, clinicians, administrators and others who are interested in learning more about health care for the incarcerated population – currently more than 2 million adults and juveniles – and its implications for public health and safety.

Professionals can earn up to 26.75 hours of continuing education credit by attending the conference and preconference seminars. Other highlights include networking opportunities, breakfast roundtable discussions, educational lunches and an exhibit hall featuring valuable products and services.

All conference activities take place at the Gaylord Opryland Resort in Nashville.
For more information or to register, visit www.ncchc.org/spring-conference.

About the National Commission on Correctional Health Care

NCCHC is a not-for-profit 501(c)(3) organization working to improve the quality of care in our nation's jails, prisons, and juvenile detention and confinement facilities. NCCHC establishes standards for health services in correctional facilities; operates a voluntary accreditation program for institutions that meet these standards; produces and disseminates resource publications; conducts educational trainings and conferences; and offers a certification program for correctional health professionals. NCCHC is supported by the major national organizations representing the fields of health, law and corrections. Each of these organizations has named a liaison to the NCCHC Board of Directors.

Nominations Requested:

Manfred S. Guttmacher Award

In 1975, the APA established the Guttmacher Award to honor the legacy and great scholarly work of Manfred S. Guttmacher, MD. In the name of this distinguished contributor, the American Psychiatric Association confers this award to authors and editors who have made an outstanding contribution to the literature of forensic psychiatry. The award is supported by a grant from Professional Risk Management Services Inc.

Prize: The Awardee will receive a $1,000 honorarium, an engraved plaque, and present an Award lecture at the APA Annual Meeting

Eligibility: Candidates must submit original work in the field of forensic psychiatry presented and/or published between May 1 and April 30 of the award review year

Submission Requirements: Nominations must be accompanied with six copies of the original work and a statement of the nature and importance of its contribution to the literature

Deadline: May 15

Contact: Advocacy@psych.org

AMERICAN PSYCHIATRIC ASSOCIATION

Director, Whiting Forensic Division,
Connecticut Valley Hospital
Yale University School of Medicine,
Department of Psychiatry

The CT Department of Mental Health & Addiction Services (DMHAS) and Yale University are currently recruiting for the Director of the Whiting Forensic Division (WFD) of Connecticut Valley Hospital, Middletown, CT.

The WFD provides quality forensic inpatient mental health services to forensic and civil populations. It serves a diverse patient population of over 200 patients in a number of specialized forensic treatment programs on 11 units in maximum and enhanced security environments.

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The successful candidate may be appointed as a Yale faculty member whose primary service location will be WFD, or as a state employee. Academic rank would be dependent upon review of the candidate's academic achievements, which must meet Yale University School of Medicine criteria for faculty appointments.

We are also recruiting treating psychiatrists on our competency restoration units. For more info contact: jaime.sanz@ct.gov or 860-262-6745

DMHAS and Yale are Equal Opportunity/ Affirmative Action Employers and welcome applications from women, members of minority groups, persons with disabilities, and protected veterans.

OREGON HEALTH & SCIENCE UNIVERSITY

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

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OHSU is Oregon's only academic medical center and is highly ranked nationally. Here at OHSU, we highly value a diverse and culturally competent workforce. When you join us, you join a dedicated team of caregivers, educators, researchers, and administrative professionals who diligently pursue the advancement and application of knowledge to directly benefit the individuals and communities we serve.

We sincerely invite your interest in this very unique and rewarding opportunity. If you would like more information, please contact Octavio Choi, MD, PhD. We look forward to hearing from you.

Octavio Choi, M.D., Ph.D., Assistant Professor of Psychiatry, OHSU
OHSU Chief Psychiatrist, Oregon State Hospital
choio@ohsu.edu

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December 16, 2015

American Academy of Psychiatry and the Law (APPL)
Attn: Jeffrey S. Janofsky, M.D.
Medical Director
Jacquelyn T. Coleman, C.A.E.
Executive Director
One Regency Drive
P.O. Box 30
Bloomfield, CT 06002

Dear Dr. Janofsky and Ms. Coleman:

It gives the APA great pleasure to inform you that the American Academy of Psychiatry and the Law has been selected to receive the **American Psychiatric Association's 2016 Distinguished Service Award**.

The DSA is given in recognition of significant contributions to the APA and the field of American psychiatry. Your dedication and commitment to the APA and psychiatry have made an immeasurable contribution to the profession and the association.

The DSA will be presented during the **Convocation Ceremony** at the **2016 APA Annual Meeting** (Georgia World Congress Center) in **Atlanta, Georgia** on **May 16, 2016**. Further details regarding the ceremony will be provided at a later date.

We look forward to presenting you with this illustrious award and offer the warmest congratulations on this well-deserved honor.

Sincerely,

Renée Binder M.D. Saul Levin, MD, MPA

Renee Binder, M.D.
President

Saul Levin, M.D., M.P.A.
Chief Executive Officer and Medical Director

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