

AAPL Newsletter

American Academy of Psychiatry and the Law



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Guttmacher Award:

William H. Reid MD, MPH: Developing a Forensic Practice: Operations and Ethics for Experts

Eugene Lee MD



From L-R: William H. Reid, MD, MPH and David A. Lowenthal, MD, JD

At the 2014 APA Annual Meeting in New York City, David A. Lowenthal, MD, JD, on behalf of the Committee presented the 2014 APA/AAPL Manfred S. Guttmacher Award to William H. Reid, MD, MPH.

Dr. Lowenthal started with the introduction of Dr. Guttmacher as one of the pioneers in the field of forensic psychiatry, exemplifying characteristics and values both as a forensic evaluator and as an outstanding clinician. Dr. Guttmacher did not shy away from controversy. He testified in the Jack Ruby murder trial of Lee Harvey Oswald. He enjoyed a prolific career until he passed away in 1966. In 1967, friends and family established and funded this Award to acknowledge outstanding contributions to the literature in forensic psychiatry. The Award was first given in 1972 to an attorney, Mr. David

Wexler. Subsequent contributors included AAPL and Professional Risk Management Services, the manager of The Psychiatrists' Program, a medical professional liability insurance specifically designed for psychiatrists.

Dr. Reid is a forensic and clinical psychiatrist practicing in Horseshoe Bay, Texas, and a past president of AAPL. He has practiced forensic psychiatry for over 35 years in private and academic settings, as well as in the public sector. He is Board-certified in general and forensic psychiatry, and served as an examiner for the American Board of Psychiatry and Neurology and the American Board of Forensic Psychiatry. Dr. Reid has held numerous academic appointments and is a Distinguished Life Fellow of the APA as well as a Fellow of the American College of Psy-

chiatrists and the Royal College of Physicians in Edinburgh. Finally, he is widely published with over 300 publications and abstracts, and he has authored or edited 17 professional books. His most recent book, *Developing a Forensic Practice: Operations and Ethics for Experts*, won the 2014 Guttmacher Award.

As part of the Award presentation, Dr. Reid delivered a lecture on the "Top 10 Things to Remember About Private Forensic Work," which I found to be a delightful refresher course, with generous helpings of sage perspectives and copious pearls of wisdom. Here they are—Dr. Reid's Top 10, which he kindly gave permission to re-print in the AAPL Newsletter:

1. Know what lawyers and courts need from an expert. The forensic psychiatrist endeavors to be "accurate and articulate;" it is the attorney's role to be "wise" with respect to the legal issue. The lawyer almost always already knows the answer to the questions he or she is asking.

2. It's an adversarial system, so get used to it. Most of what the law does in litigation is make sure the fight is fair. Give honest, competent, ethical assistance to the side that retains you.

3. Don't mix treatment and forensic work in the same case. The litigant, victim, etc., must not be your patient/client.

4. Know your duty, and to whom it is owed. Your main duties are not to the litigant. You should not have any substantial or direct relationship with the litigant. Advocate for your opinions, but not for the litigant.

5. Stay within your expertise.

6. Give lawyers what they need and they'll appreciate you. Be cautious when a lawyer calls wanting a "rush" job, "just a simple IME," or "a quick report." Stick to your standard procedures. Be available. Be clear. Keep your promises. Don't be arro-

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ALL ABOUT AAPL

AAPL Tri-State Chapter to Celebrate its 45th Anniversary

Stephen Billick, MD

The Tri-State Chapter was conceived at the 1975 Boston AAPL meeting. Although there was significant skepticism among some of the senior AAPL members about the probability of success because a previous NY forensic psychiatry educational group (The Isaac Ray Society) had failed to thrive, the chapter was nonetheless organized. There was also concern that the Chapter might become a competitor for national AAPL for members and dues. A poll of the AAPL membership in NY State found significant enthusiasm and support. The Chapter's initial name was the New York State Membership Group of AAPL because the AAPL Bylaws did not permit chapter creation. It was decided that there would be no dues and that all AAPL members in NY State would automatically become members.

The interest in New Jersey and Connecticut AAPL members in participating led to the expansion of the group to include the Tri-State area.

AAPL members from NJ and CT were included in the elective officers of the chapter annually. Because of the chapter's success, national AAPL modified the Bylaws to include chapters. Tri-State became a model for other chapters around the country to be formed.

Educationally, the chapter sponsored an annual symposium with an annual meeting. Tri-State published several books: *Critical Issues in American Psychiatry and the Law* (1982), a volume 2 (1985), then *Geriatric Psychiatry and the Law* (1987), *Juvenile Psychiatry and the Law* (1989), *Criminal Court Consultation* (1989), *Ethical Practice in Psychiatry and the Law* (1990) and finally the first edition of the *Principles and Practice of Forensic Psychiatry* (1994), its 2nd edition (1998), and is currently developing the 3rd edition.

Tri-State Chapter expanded its educational programming in 1999 to include a three-day conference in San

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Developing a Forensic Practice:

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gant. Don't hesitate to give "bad news." Lawyers appreciate "bad" news almost as much as good news.

7. Write stellar reports. Expert reports are the backbone of your value in many forensic cases. Reports are permanent representations of your opinions, style, and professionalism. You must be good at writing them. Discuss the report with the lawyer (a) before you draft it, and (b) before it is finalized. Do not send drafts of your reports to anyone, including the attorney, unless the lawyer approves.

8. Understand testifying. The lawyer may assess your appearance, demeanor, and communication abilities. Insist that the lawyer prepare you for testimony. Answer questions simply and directly unless asked to explain. (Then explain simply and directly.)

9. Charging, Billing, and Collecting. With respect to retainer payments, it's okay to take the position that "I trust you [the retaining party], but I'm more comfortable holding your money." One might even explicitly specify that "I may stop work on a case if a bill is in arrears." It is not unreasonable to inform an attorney that testimony might not happen until the bill is paid, as expert testimony is voluntary.

10. Stay ethical, and recognize "slippery slopes" such as:

- Bias, or unusual vulnerability to bias.
- Allowing the lawyer to express "your" opinions without your approval.
- Misrepresentation, or failure to disclose relevant things. Ⓢ

The Fear of Suicide...

Charles C. Dike MD, MPH, FRCPsych



A friend and colleague called me at 12:00 midnight for support and advice; he had just received a call from one of his patients'

therapist informing him of the completed suicide of his patient, a teenager whom he had met just three times for medication management. The therapist had called at about 11:30pm, and he knew immediately that it was not good news. Apparently, his patient had had an argument with her boyfriend and he had subsequently broken up with her minutes before her suicide.

He tried to remember her – he had last seen her approximately three weeks earlier and was scheduled to see her again next week. She was an intelligent girl with a pleasant disposition (smiled easily) and she had been with her therapist for approximately 6 months. Different emotions ran through the psychiatrist, first sorrow and sadness for the loss of a young person with so much promise. This transitioned quickly into dread: did he fail to identify the warning signs?; was there anything else he could have done to prevent the suicide?; was his documentation adequate (were there enough descriptions of protective factors against suicide)?; did he document his earlier discussions with her therapist?; did he document his meeting and discussion with her parents?; was she on adequate doses of prescribed medication?; did he fully explore her psychosocial vulnerabilities?; had he ordered routine labs? On and on he went, with each new question tormenting him further. The therapist's off-the-cuff comment suggesting that perhaps the patient's medications made her more impulsive did not help matters.

I tried to reassure him to no avail. The fact that the act was an impul-

sive, spur-of-the-moment response to a break up was not reassuring. The fact that her therapist had seen her earlier that day and she had not expressed suicidal ideation or exhibited signs suggestive of worsening depression or hopelessness had also not re-assured the psychiatrist. Nothing, at that point was re-assuring. This was his first suicide case and he was distraught. Needless to say, he had a sleepless night and many difficult days thereafter. Some doctors never fully recover from the trauma of a patient suicide. I am aware of an inpatient psychiatry attending whose patient's suicide 5 years ago continues to influence his practice to date. The psychiatrist is quick to place his patients on special observation and slow to take them off; every unusual comment from his patients leads to placement on continuous observation for several days or weeks. Discharge planning is slow, and the tenets of the recovery movement have not taken hold on his unit. In addition, he still talks about his patient's suicide as if it occurred yesterday and not 5 years ago.

A psychiatrist in private practice once told me, somewhat tongue-in-cheek, that "the fear of suicide is the beginning of wisdom," an adaptation from "the fear of the Lord is the beginning of wisdom" – Proverbs 9:10. As a result, the psychiatrist is very selective about whom he accepts for treatment. Exclusion criteria during the intake process include recent admission to a psychiatric hospital (in the past 6 months), past history of suicide attempts, history suggestive of Borderline Personality Disorder, history of self-harming behavior, and history of completed suicide in patient's close relatives. Another psychiatrist laughed derisively when asked her thoughts regarding these exclusion criteria, and accused the psychiatrist of suffering from the "Ostrich syndrome" – just because you can't see it at the outset does not mean it is not there or will not occur.

Any seasoned psychiatrist will tell you of patients who did not disclose (lied about) crucial elements of their history until years later; no exclusion criteria at the outset can predict how patients will turn out in the future.

In May 2013, the World Health Organization (WHO) proposed the first ever Mental Health Action Plan, and subsequently identified suicide prevention as an integral component of the Action Plan (Preventing Suicide, A Global Imperative). The WHO observed that over 800,000 people die due to suicide every year and it is the second leading cause of death in 15-29 year-olds. There are indications that for each adult who died of suicide, more than 20 others attempted suicide. Suicide accounted for 1.4% of all deaths worldwide, making it the 15th leading cause of death in 2012.

Most psychiatrists will experience the loss of a patient by suicide at some point in their career - as we were warned in residency, it is a matter of when, not if. After the dust settles following a suicide, the question of whether or not the family of the decedent will bring suit against the psychiatrist causes many a psychiatrist sleepless nights. The focus often shifts to adequacy of the documentation in the patient's chart. In these days of 15 minute appointments and pressure to see as many patients as possible in a day, finding the time to patiently and fully explore pertinent issues related to suicide prevention with a patient and to subsequently demonstrate in a comprehensive documentation that all risk factors have been addressed can be quite a challenge. In my opinion, it is better to be yelled at for decreased productivity on a given clinic day when attending to a potentially suicidal patient than to face an angry and grieving family in court with scanty documentation to back your claims of adequate psychiatric treatment and attention to risks. ☹

Confronting the Ethics Challenges of Forensic Psychiatry

Robert Weinstock MD



This is my last column as your AAPL President. It has been an honor and a pleasure for me to serve as your president this year. We are in

the process of developing new projects to help our members and improving our website and its features. We are in excellent financial shape. In October I will be turning over the reins to the very capable Graham Glancy MD who will be the first Canadian president in a number of years.

Ethics challenges

In this issue I will focus further on the importance of ethical considerations in forensic psychiatry. I initiated this discussion in the last Newsletter issue. We practice at the interface of two very different disciplines, e.g. psychiatry and law. Unlike psychiatry and medicine whose primary goal is to help patients, the primary goal of the law is to settle disputes. When we function in the legal system it can be all too easy to drift into the legal perspective and function as if we are lawyers who should make a one-sided psychiatric argument to help the client. But unlike attorneys, we take an oath to tell the whole truth. It is natural for us to want to focus on the facts that help "our" side. But unlike attorneys for whom leaving a misleading partially truthful impression to help their client might be considered clever lawyering, for us that is not appropriate. Unlike attorneys who are hired guns we must avoid the perception that we are "hired guns."

We bring to the legal system all the trappings of a physician and psychiatrist. We are asked about our credentials and accomplishments. Physicians are expected by society to want to help. That usually means helping patients, but can be extended to help-

ing society at large. Especially after taking an oath, the expectation is not that we will make the best possible case for the side who hired us. Unlike attorneys we are expected to tell the whole truth.

When we assess an individual for a legal purpose the risks in the interview process itself are greater than court testimony. We introduce ourselves as doctor. We are expected to say who hired us and the purpose of the examination. That can of course include being hired by the side opposing the person we are evaluating. We are expected to explain the limits of confidentiality. But that may not be enough. If we are dealing with a psychopath familiar with the legal system, there are no further problems. The psychopath will not trust us no matter what we say and will be on his guard.

"Since there are few second order rules telling us how to balance conflicting ethical guidelines, other rules, societal expectations, and our own values challenge us to determine the best thing to do."

But potential problems arise with those who are not psychopaths and have grown up trusting physicians as people there to try to help. Such an individual might interpret our explanations of our role and how things told to us can be used in court as evidence of how honest and trustworthy we are insofar as we are protecting their rights. That may become especially evident as the interview pro-

gresses as we use our clinical skills to be empathic. If we hear comments like "I know you are trying to help me doctor," we should know something is wrong and there has been slippage of our original warning or the original warning was not understood. Our role is different from that of police who often go through the motions of giving a Miranda warning but then hope despite the warning it will not be understood and the person will give incriminating evidence nonetheless.

So what are we supposed to do? We may not always know how the person is interpreting our warning. But if we get evidence it was misinterpreted or misunderstood, we should clarify it again to the degree we can. Even that may be insufficient. Society expects the physician to be a healer and so may the person we are assessing, but in our forensic role our primary duty is to answer the legal question. An honest answer to that question might well be harmful to the person we evaluate. It would not be helpful to the court if our answers always were spun to help the person we evaluated even if within the bounds of truth.

As I will discuss at length in my presidential address, in my opinion in our forensic role we have additional secondary duties to those we evaluate. Those duties usually are outweighed by our primary duty to answer the legal question truthfully and as objectively as possible. In extreme situations the secondary duty might preclude our taking certain types of roles and cases. Having potentially conflicting duties is common to all psychiatric practice. Even in clinical work, the primary duty to a patient can be overcome by other secondary duties where we are expected or required to report suspected child abuse or protect a potential victim even if that results in harm to our patient. In all practice these days, we need to balance conflicting duties. In my view, forensic practice is and should be no exception, but the secondary considerations should override only in the most extreme and rare sit-

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Intellectual Disability and the Death Penalty: the Profound Effect of Amici on the Supreme Court

Jeffrey Janofsky MD



In 2002 in *Atkins v. Virginia*¹ the United States Supreme Court held that it was a violation of the Eighth Amendment to execute persons who suf-

fered from Mental Retardation, now termed Intellectual Disability (ID). The decision turned in part on an evolving national consensus amongst the states against executing persons with intellectual disability. In *Atkins* the Court found that persons with intellectual disability have impairments in multiple domains including “diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others.” The Court cited both the American Association of Mental Retardation (AAMR)² and The American Psychiatric Association’s DSM-IV-TR definition of Mental Retardation. Both definitions required significant limitations in general intellectual functioning, significant limitations in adaptive skills, and onset before adulthood for the diagnosis. The Court in *Atkins*, however, left it to the states to develop “appropriate ways to enforce the constitutional restriction” in this area. In other words, it was left to the states to decide how Intellectual Disability would be defined as a legal rather than a clinical matter.

On May 27, 2014, in a 5 to 4 decision the United States Supreme Court decided *Hall v. Florida*. Florida statutory law, as interpreted by Florida’s Supreme Court had held that, “If, from test scores, a prisoner is deemed to have an IQ above 70, all further exploration of intellectual disability is foreclosed,”³ in a death penalty case.

The defendants challenged this rigid rule as unconstitutional.

The American Psychological Association, The American Psychiatric Association, AAPL and others filed an amicus brief in *Hall* “to present relevant scientific knowledge that can provide context for the Court’s review of whether Florida’s system for identifying defendants with intellectual disability in capital cases violates the Eighth Amendment and this Court’s decision in *Atkins v. Virginia*, 536 U.S. 304 (2002).”⁴ The APA’s brief emphasized two major issues.

First, APA argued that the clinical

“Now, however, the Court strikes down a state law based on the evolving standards of professional societies, most notably the American Psychiatric Association (APA).”

diagnosis of Intellectual Disability requires clinical judgment in the assessment of general intellectual functioning and adaptive functioning. Citing both the DSM-5 and the AAIDD Manual the brief emphasized that “limitations in general intellectual functioning and adaptive functioning must be evaluated in conjunction and by a mental health professional exercising his or her clinical judgment — judgment rooted in a high level of clinical expertise and experience. This evaluation cannot be limited to a review of IQ test scores because without further clinical assessment, it cannot be known what

impairments in adaptive functioning the person experiences or what other clinical indicators of impaired general intellectual functioning exist.”⁵ Thus both intellectual functioning and adaptive functioning must be evaluated concurrently to make an accurate clinical diagnosis of ID. The brief cited the change in diagnostic criteria for ID in the DSM-5, which makes it clear that an accurate diagnosis must be “based on both clinical assessment and standardized testing of intellectual and adaptive functions,” and that exclusive reliance on standardized tests is inappropriate.⁶ The brief also points out that the DSM-5 is the first edition of the DSM that rejects classification of ID severity by IQ scores, and instead requires an assessment of adaptive functioning impairment severity because “it is adaptive functioning that determines the level of supports required.”

Second, the APA’s brief attempted to educate the Court on the psychometric properties of IQ tests and their limitations. The brief reviewed IQ tests’ standard error of measurement (SEM), how confidence intervals are calculated from SEM data, and how “the use of a fixed IQ cutoff score fails to account for the associated confidence interval of a given test score.” The brief emphasized that good clinical practice requires that a range of IQ score be reported and that failure to do so “is to apply a false precision to the assessment of IQ and presents a significant risk that individuals with intellectual disability will be executed in violation of the Eighth Amendment.”⁷

The underpinnings of Justice Kennedy’s opinion, which held that Florida’s firm IQ threshold requirement was unconstitutional under the Eighth Amendment, drew significantly from the APA’s brief. Kennedy wrote that, “to determine if Florida’s cutoff rule is valid, it is proper to consider the psychiatric and professional studies that elaborate on the purpose and meaning of IQ scores to determine how the scores relate to the holding of *Atkins*.” Kennedy then went on to cite the data and theory in

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Asperger Syndrome Gets a Bad Rap

Stephen P. Herman MD



Hans Asperger might be surprised by the trajectory of the disorder that bears his name. (Or, perhaps, *bore* his name, as it would now be called

Autism Spectrum Disorder – Level 1, far less mellifluous nomenclature.) The term is used and misused today to describe children or adults who may lack empathy, have difficulty forming relationships and trouble with social interactions, seem odd, become self-absorbed with computers and especially these days, gaming, have problems with nonverbal communication and tend to be socially isolated.

To wit: On December 14, 2012, Adam Lanza, of Newtown, CT, shot his mother to death in their home, and then went to a local elementary school and shot to death 20 young children and six of the staff. He then killed himself.

Authorities learned there were guns in his home and that his mother would often take him to a local shooting range. By all accounts, he was very strange and kept to himself. For example, he taped up the windows of his room and communicated with his mother – in the same house – only by email.

The media carried the news that Adam probably had Asperger Syndrome and that would explain his violence. He was described as a ticking time bomb that had finally exploded. It was yet another example, it was said, of a mass shooting in which the person was described as odd, socially inept, absorbed in his computer and a writer of journals filled with frightening drawings and words about killing. While this is a familiar profile of those who engage in mass killings – at schools or the workplace – there are those who look for Asperger Syndrome as an explanation of the horrendous criminal behavior.

Some of the behavioral literature supports the association of Asperger Syndrome and crime. For example, Schwartz-Watts (J Am Acad Psychiatry Law 33:390-3, 2005) extensively reviewed the literature linking AS with violence. She presented three cases of AS defendants charged with murder.

Haskins and Silva (J Am Acad Psychiatry Law 34:374, 2006) reported three cases in which the perpetrator was thought to have AS: a volunteer fireman charged with capital murder, a substitute teacher accused of touching adolescent girls, and a man who “fixated on black males” and “compulsively propositioned male strangers for sex, especially in public rest rooms.” He was eventually arrested.

“The literature I reviewed and, at times, the media, have erroneously led people to believe that AS equals violence.”

The authors went on to review the literature connecting AS and criminal behavior. They concluded these papers draw a connection between AS and criminal activity ranging from serial murder to arson to other forms of violence. Quoting two papers, Haskins and Silva wrote, “Because persons with [AS] have difficulties appreciating the subjective experiences of other persons, there may be a lack of intersubjective resonance, or empathy.” They conclude, “Preliminary findings indicate that [those with AS] are over-represented in criminal populations relative to their presence in the general population.”

Browning and Caulfield (Criminology and Criminal Justice, April 2011,

vol. 11, 2;PP. 165-180) indicated more research suggesting this association needs to be conducted. Thus, they took a more neutral position.

Newman and Ghazluddin (J Autism Dev Disorder (2008) 38:1848-1852) suggested there is co-morbidity between individuals with AS, psychiatric disorders and violent crimes. They did a limited literature review to support their position.

I had a case recently involving a 17-year-old boy from the Midwest with AS. (Some details have been altered for reasons of privacy.) He was on a bus heading home from his specialized high school. He was watching an erotic site on his computer and put his hands inside his pants. A woman and her 7-year-old granddaughter noticed this and immediately informed the bus driver. He stopped the bus and radioed the police. The teenager was taken off the bus, arrested and charged with public lewdness and endangering the welfare of a minor.

In meeting with the family, I found myself asking whether there were any guns at home (no) and whether the parents had found any journals (no). They said their son, while socially delayed, was close to his family. However, he had not made any friends in school and regularly immersed himself in video games with one friend at home.

Why did I ask about guns and journals? Mainly because I wanted to assure the prosecutor and the court that the likelihood this boy would commit a violent act was nil. I wrote in my report to the court that he did not fit the profile of a mass murderer. I described his struggles throughout his life and the fact that he described remorse for what he had done on the bus and empathy for the witnesses to his behavior. There was nothing in the evaluation that would suggest sociopathy.

The literature I reviewed and, at times, the media, have erroneously led people to believe that AS equals violence. The studies concluding this have been conducted in a psychiatric and/or prison population. They do not

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Ask The Experts

Robert Sadoff MD
Neil S. Kaye MD

Neil S. Kaye, MD, and Bob Sadoff, MD will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send 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. Is suicide predictable?



Sadoff: The answer depends on the definition of the word “predictable.” If the symptoms are severe and the risk assessment technique is conducted properly, one may predict in the short term whether a person so evaluated is a high, medium or low risk of suicide (or violence if one is assessing that risk as well). However, generally, psychiatrists are not able to predict behavior in the long term. Prior suicidal attempts may be helpful in making a risk assessment judgment but the frequency of prior suicide attempts may be viewed either as a high risk predictive factor or low risk depending on the frequency of unsuccessful attempts at suicide.

In order to fully answer the question, a forensic psychiatrist should ask the proper questions in a risk assessment technique. For example, one should ask whether that patient is thinking about suicide and if so, has he ever tried it in the past. If so, how many times, by what means and how successful or unsuccessful has he been? If one has tried frequently for attention but without serious intent on dying, the past history may be a predictor of low risk of suicide rather

than one or two serious attempts at suicide that landed the person in the hospital for several days or weeks of treatment. One needs to get a comprehensive history of prior violent or self-destructive behaviors.

Once the person admits that he has suicidal thoughts and intent, then one asks the means by which the person plans to kill himself or herself. If there are five or six different ways, such as stabbing, shooting, burning, hanging or poisoning, one is not as concerned about a high risk of suicide as if one has only one method and has also acquired the implements to carry out his intent. For example, if the person said he was going to shoot himself then one has to ask if he has a gun. If he has no gun, he can’t shoot himself. If he does have a gun, the question is when did he acquire it? If he says he has had it for several years, since it is his grandfather’s old relic and he is not even sure where it is or if it has bullets, there is low risk. If, however he bought it yesterday with bullets in order to accomplish his intent, his risk rises. Finally, the proper question to ask is whether the patient has practiced the act by putting the barrel of the gun in his mouth to see if he could pull the trigger or putting the barrel of the empty gun to his forehead and pulling the trigger. Practice with the implement he chooses to use as a means of his self-destruction is a high risk factor and in my opinion a suicide becomes more predictable and the patient should be hospitalized to prevent the foreseeable act.

That brings us to the difference between preventable and predictable. Most acts of suicide (or violence) if recognized in time are preventable by several means: restraint, seclusion, effective treatment. However, such acts are not readily foreseeable or predictable. Utilizing a combination of clinical risk assessment techniques and actuarial or structured risk assessment instruments, called structured professional judgment, may aid in determining if the suicidal act is foreseeable or predictable.

The law will find the doctor liable if the act is foreseeable, i.e., it is a high

risk and more likely than not to occur, than if it is just preventable. The proper question becomes: is it predictable, and if so, under what conditions, and for how long is the prediction accurate? It is better to err on the side of caution when suicide is a concern, or as I teach my students: “We’d rather bury our mistakes in the hospital than in the cemetery.”



Kaye: Suicide stands alone as a most powerful, indelible event. Despite years of training and research, the thought of a patient success-

fully committing suicide continues to strike fear in the hearts of every physician. Yet, if a psychiatrist is in practice long enough, it is reasonably likely that the practitioner will have a patient commit suicide. Patients with an affective disorder have a suicide rate of at least 15% and those with schizophrenia have a suicide rate of at least 10%.

Suicide has also long been the number one reason for medical-malpractice lawsuits against psychiatrists. The simplistic plaintiff rationale is that if a psychiatrist is treating someone for depression or who presents with suicidal ideation, plan, or intent, and the doctor doesn’t prevent the death, that she has failed and must be guilty of malpractice. This is the common scenario of a bad outcome and must mean that something wrong was done. This is known as one of the most common errors in logic, *post hoc, ergo propter hoc*. The reality is that if the doctor has met the standard of care in assessing and documenting her work, over 90% verdicts are for the defense. Unfortunately, many of these cases take at least two years to be tried and the emotional toll on the doctor can be severe and even disabling. Insisting on good legal counsel and the best experts possible is necessary.

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The Role of The Art of War in Psychiatry and the Law

Danielle Kushner MD, Megan M. Mroczkowski MD,
Christopher W. Racine MD, MPH, Frank Tedeschi MD

On the first day of our Forensic Psychiatry Fellowship at NYU, a member of our faculty handed each of us four books – a law textbook, a textbook on administrative psychiatry, Peter Drucker’s book *Managing the Nonprofit Organization*, and Sun Tzu’s *The Art of War*. The first three made perfect sense as part of a well-rounded curriculum. But why were we given *The Art of War*? While a few of us had heard of this book, none of us had read it. Opening to the table of contents was not reassuring, as we were met with chapters with arcane titles such as “Strategic Assessment,” “Doing Battle,” “Planning A Siege,” “Formation,” “Force,” “Emptiness and Fullness,” “Armed Struggle,” “Adaptations,” “Maneuvering Armies,” “Terrain,” “Nine Grounds,” “Fire Attack,” and lastly - “On The Use of Spies?!”

We soon learned that *The Art of War*, despite being written more than 2,000 years ago, has served as the basis of more than two hundred and fifty books sold by Amazon, with titles like; *The Art of War for Executive: Ancient Knowledge for Today’s Business Professional*, *The Art of War for Writers: Fiction Writing Strategies, Tactics, and Exercises*, even *The Art of War versus The Art of Pool: How Sun Tzu would play pocket billiards*, and, of course, *The Art of War for Lovers*(!). After a few weeks of discussion, the purpose of studying this text crystallized: *The Art of War* can be best understood as a book that teaches planning, an essential element in so many different fields. Yet, no one had yet connected the lessons of *The Art of War* to the field of Psychiatry and the Law. We asked ourselves, “What could Sun Tzu and millennia-old Chinese military practices teach us about the practice of forensic psychiatry?” As a fellowship class, under the guidance of previous chairman of the AAPL Ethics

Committee, Henry Weinstein, MD, we sought to answer this question. The following details our findings on the topic.

We started by analyzing the original purpose of *The Art of War* and the reasons for its broad appeal over the course of more than two thousand years. We learned that the author, Sun Tzu, was a high-ranking military general and strategist whose work is considered to be a seminal work on military strategy and tactics, still used as required reading at the United States Military Academy, West Point. The book contains lessons and ideas that have influenced military leaders throughout the ages – from Mao Zedong to Napoleon Bonaparte to Douglas MacArthur. In 1910, Lionel Giles produced the first English language edition of *The Art of War*. Subsequently, throughout the 20th and 21st centuries, the applicability of *The Art of War* to other fields was realized, which has led it to be applied to an ever-increasing number of disciplines outside of the military.

“...at its core The Art of War is a manual for preparation, planning, and execution. As with military engagement, these characteristics are essential in the field of forensic psychiatry.”

As students of forensic psychiatry, we endeavored to discover how *The Art of War* could teach us about the practice of Psychiatry and the Law. As we all know, the word “art” can have many possible meanings. As it

relates to *The Art of War*, artistry is a skill that is attained by study and practice. And so, in our studies we sought to plumb the depths of the wisdom of *The Art of War* in order to think about and discuss how these ancient precepts (used as metaphors) can be applied to the practice and principles of forensic psychiatry, to further our skills in and expand our appreciation of this unique medical subspecialty. As a result of our study, we concluded that the lessons of *The Art of War* had a particular application to forensic psychiatry, including but not limited to: (1) planning and strategy, (2) tactics, (3) communications, and (4) professionalism.

On Planning and Strategy:

“Those who render others’ armies helpless without fighting are best of all” [page 90]. Facts on each side of a forensic case must be evaluated fully. A skilled forensic psychiatrist understands the case, its nuances, and the position of the opposing side.

On Tactics:

“Attack where there is no defense, defend where there is no attack” [page 136]. Forensic psychiatrists should identify both the weaknesses in the opposition’s case as well as the gaps in one’s own case.

On Communication:

“When the generals are weak and lack authority, instructions are not clear, officers and soldiers lack consistency, and they form battle lines every which way, this is riot” [page 188]. Without clear, concise communication, both written and verbal, the message of a forensic report is lost.

On Professionalism:

“Armies must know there are adaptations of the five kinds of fire attack, and adhere to them scientifically” [page 213]. The psychiatric expert witness must be prepared to defend their testimony from the attacks of the opposing side, and supplant that testimony with knowledge of standard clinical practice and the most up to date psychiatric research.

We realized that at its core *The Art of War* is a manual for preparation, planning, and execution. As with

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Sense and Sensibilities

Willie Mae Jackson MD, MA



It is 6:00 am on July 1st, 2014. The streetlights begin to struggle with maintaining illumination as it competes with the sunrise. My mind is racing with

thoughts of my first day as a forensic psychiatry fellow. The intensity of my curiosity, eagerness, and impatience overshadows the fact that it was orientation day – no reports or keys to an office at a forensic unit or hospital. I sat momentarily, and returned to the reality that I had to pace myself and start with the basics. I will have to learn the medical knowledge, guidelines, and applications of forensic psychiatry before immersing myself in the practice, but what can I say, I was excited!

This was a feeling all too clear to me as I reminisced about my first days of residency. But there are differences. The transition from a treating clinician to an evaluating psychiatrist in the legal system has been the most challenging, to say the least. I find myself more introspective of my own vulnerabilities and ideals as I read landmark cases that have marred the legal system and psychiatry. The statement, “you must know and answer the question being asked,” is becoming the most important phrase in my mental acumen. I envision the temperament of a forensic expert left tense and diaphoretic at the end of court testimony following direct and cross-examinations; luckily, this has not happened to me as yet. Although I must admit, the media and hear-say has romanticized my views of forensics in criminal proceedings, I understand that the psychological underpinning of each case in the legal system is unique. Needless to say, one of my goals is to learn the legal culture and acclimate myself to it in hopes of optimizing this experience.

To some degree, I feel like a law

student. The excitement of new books and becoming versed in another intellectual language has helped to reduce the emotional angst of balancing my time with being a good fellow. Transitioning between adult psychiatry to forensics continues to be both stimulating and intimidating. Reviewing chapters, working with other clinicians, reading legal reports, writing forensic reports, and collecting collateral information are improving my thoroughness at becoming a better clinician. In forensic psychiatry, the dichotomy between medicine and the law is not, from my perspective, as clear as it seems. As I continue to move forward in my fellowship experience, I realize some perspectives will be revised but the fundamentals will remain constant. ☯

Dr. Willie Mae Jackson is a forensic psychiatry fellow at Northwestern University.

MUSE & VIEWS

The “Affluenza” Defense

In Texas, a defense expert testified about the implications of “affluenza” in the case of a 16-year-old boy charged with killing four pedestrians while driving drunk. The term has been used to describe children (typically from rich families) who have a sense of entitlement, are irresponsible, make excuses for bad behavior, and sometimes dabble in substance use. The prosecutor argued in court that if the boy continues to be cushioned by his family’s wealth, another tragedy is inevitable. Ultimately the judge chose not to give the boy a potential 20-year prison sentence, instead giving him 10 years of probation.

Submitted by William Newman, MD

The Art of War

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military engagement, these characteristics are essential in the field of forensic psychiatry. In order to maximize our potential for successful outcomes in our practice of forensic psychiatry, we learned that we needed to understand each case in a comprehensive manner. We learned to examine our opinions for bias and weakness, and similarly to look for ways to highlight flaws in the opposing opinion. We learned the importance of engineering a well-thought out strategy and deploying legal tactics at the right opportunity, such as how to persuasively talk to a judge or jury. As novices studying the intersection of psychiatric practice and our justice system, we learned that the teachings of *The Art of War* will continue to have applications to our future careers. Most importantly of all, we learned to have a tremendous amount of fun along the way.

After nearly a year of discussions, each of us agreed that the teachings of Sun Tzu were integral to a mastery of forensic psychiatry. We each felt a sense of accomplishment in bridging what had seemed to be an insurmountable gap between ancient Chinese military strategy and 21st century forensic psychiatry. In the end however, the masterful prose of Sun Tzu had done most of the hard work for us – it was just a matter of interpreting it. No matter what new challenges we will face in our careers, we will always be able to fall back on the timeless lessons of planning in *The Art of War*. And what is the most valuable lesson that we learned?

“The greatest victory is that which required no battle” [page 90]. ☯

With special gratitude to our mentor, teacher and friend, Henry C. Weinstein, MD without whose guidance this would not have been possible. We will miss spending Friday mornings with you.

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Gary Chaimowitz, MB, ChB

Philip Candilis MD



Born in Cape Town, South Africa, recently installed AAPL councilor Gary Chaimowitz moved to Hamilton, Ontario in his

late twenties. Dr. Chaimowitz appreciated the blend of British traditionalism and American entrepreneurship he found in the Canadian community. Like many ex-patriate South Africans his heart remained in South Africa for many years although he has identified himself strongly as Canadian for some time now. Influenced by a strong family pedigree to enter Internal Medicine, he made the switch to Psychiatry during his internal medicine residency to pursue his long-time interest. He completed his psychiatry residency at McMaster University and remained on faculty there for the next twenty-five years.

On arrival in Canada Dr. Chaimowitz pursued an interest in First Nations Mental Health (Native Canadians), and for almost twenty years conducted monthly fly-in general psychiatric clinics to remote Cree communities on the coast of James Bay, Northern Ontario. Other interests have included improving services for persons with mental health needs in the correctional system, and writing several position papers on related topics for the Canadian Psychiatric Association.

Responsible for a forensic fellowship and the broader forensic service at St Joseph's Hospital and the Forensic Psychiatry Division at McMaster University, Gary oversees inpatient units, outpatient clinics, teaching, and research at his program within the busy Ontario provincial system. He is a Professor in the Department of Psychiatry and Behavioral Neurosciences at McMaster. Committed strongly to organizational medicine, he serves as President of the Ontario Psychiatric Association and Chair of the Royal College of

Forensic Psychiatry Specialty Committee (akin to the US accreditation council). He is particularly proud of having been part of the group that ushered forensic psychiatry into formal specialty status, earning him the honorific of "Founder" at the Royal College.

For many years, Dr. Chaimowitz chaired the Professional Standards and Practice Committee of the Canadian Psychiatric Association and served as President of the Canadian Academy of Psychiatry and the Law between 2008 and 2012. He is Past President of the Medical Staff Association of St. Joseph's Healthcare Hamilton. He is Vice-Chair of the Psychiatry Section of the Ontario Medical Association and on the

"Dr. Chaimowitz's recent efforts center on the development of two risk assessment tools, the Aggression Incidence Scale (AIS) and the Hamilton Anatomy of Risk Management tool (HARM)."

Board of the International Association of Forensic Mental Health Services. As a long-time member of the Ontario (Criminal Code) Review Board and Vice Chair of the Ontario Consent and Capacity Board he is an active member of the tribunals that deal with persons found Not Criminally Responsible/Unfit To Stand Trial, and who appeal their detention/incapacity under the Mental Health Act.

Dr. Chaimowitz's recent efforts center on the development of two risk

assessment tools, the Aggression Incidence Scale (AIS) and the Hamilton Anatomy of Risk Management tool (HARM). These tools were formally recognized by Accreditation Canada as Best Practices. Initially focused on the risk of violence in the inpatient setting, the AIS is now used in a variety of settings while the HARM can be conducted within 5-10 minutes and is finding increased use in the community. The AIS is an easy-to-use aggressive incident measure with some unique risk-management attributes. It not only serves to record easily all aggressive acts, but also triggers a staff response to the aggressive act. It has been automated for use on handheld tablets, yielding easily accessible reports. Both tools have been widely used in Canada. The HARM's structured clinical judgment is now also being applied to juvenile, correctional, general, outpatient and community populations and can identify potential victims of violence as well. Both are being translated into several languages.

Dr. Chaimowitz is an avid, if late career, golfer (friends say "hacker") and opportunistic traveler who enjoys organizing educational programs for the broader psychiatric community and even aboard cruise ships – the latest Canadian Psychiatric Association's International Continuing Professional Development conference occurring aboard an ocean liner to Tahiti. The next few years' cruise conferences in the Mediterranean, South America, and then South Africa will likely keep him closely involved. Tongue firmly in cheek, Gary describes a midlife crisis that brought him a little Boxster convertible which he enjoys in the warmer months, especially on getaways to Blue Mountain, a few hours north of Toronto. His daughter recently completed medical school in Israel and has returned to Hamilton/McMaster to undertake Emergency Medicine training, making world travel a concerted family venture. ☺

Royal College of Psychiatrists Forensic Faculty Annual Residential Meeting, Europa Hotel, Belfast March 5-7, 2014

Professor Jennifer Shaw, Mary Whittle, MB, MRCPsych, Carolina Klein, MD and John Baird, MD

The city of Chicago will host the 2014 meeting of the American Academy of Psychiatry and the Law, and even nowadays for some reason the city is still associated with the prohibition era and gangsters, and in particular with the name of Al Capone. Despite the fact that President Barack Obama lived and prospered in the city much more recently than the long dead gangster, it is the gangster's name which still sells more souvenirs.

Similar comments can be made about Belfast, the city which in March 2014 hosted this year's meeting of the Forensic Faculty of the Royal College of Psychiatrists. In the later years of the twentieth century the city was the scene of considerable civil unrest and the Europa Hotel, which hosted the conference, suffered bomb damage on a number of occasions.

Since those days, however, life in Belfast has returned to normal and President Clinton and his party stayed in the hotel while he was in office. Over 300 delegates attended the Faculty meeting and found Belfast to be a friendly, welcoming city with the hotel ideally situated in the heart of the downtown area.

The first session of the conference began with Professor Dame Sue Bailey, President of the Royal College of Psychiatrists, followed by Professor Louis Appleby, Chair of the Care Quality Commission, who considered the reasons why things go wrong and patients are mistreated, the dangers of allowing an organization to be led by financial targets and the problems of 'whistle-blowers' being ignored, or even worse, ostracized. In examining inquiries which followed a scandal or a serious untoward incident, he concluded that, with the benefit of hindsight, many of the problems could have been anticipated. Professor Appleby noted how the concept of "Positive risk taking," common in

forensic psychiatry, would not be considered acceptable in other areas such as the airline industry. The presentations prompted lively discussion around the need for psychologically healthy and collaborative services and the requirement that managers and senior clinicians carry the responsibility to ensure that this culture is developed and maintained. The perspectives of North American colleagues, working in different healthcare systems, on these principles would be welcome.

"No profession, particularly a relatively young sub specialty such as forensic psychiatry, can stand still. Progress can only be enhanced by challenging "accepted" norms, principles and beliefs and by expanding our thinking, informed by robust research and discussion in our own and other disciplines."

The second session covered controversial and challenging topics. Dr Ed Silva, from maximum security Ashworth Hospital, gave a persuasive presentation about the benefits of administering clozapine via nasogastric tube to severely ill patients who would not accept oral medication. Professor Tom Burns presented research on the benefits of using a financial incentive to

encourage patients to take depot antipsychotic medication. These strategies are potentially controversial and raise ethical concerns, but both were effective in the groups studied, and the audience were generally persuaded that the ethical misgivings were more apparent than real.

Professor Burns went on to discuss a study comparing long-term, voluntary treatment of general psychiatry patients who are suffering from severe and enduring mental illness in the community with patients under Community Treatment Orders, i.e. subject to legislation enacted in the UK within the last few years which requires patients to comply with treatment outside hospital settings. The results were unexpected and counter intuitive in that outcome measures, based upon re-admission rates, were identical after a one year follow up. From the discussion which followed it seemed that forensic psychiatrists in the audience felt that one of the core principles of their practice had been challenged fundamentally.

Professors Amy Watson of the University of Illinois, Chicago and Michael Compton, Professor of Psychiatry, George Washington School of Medicine, Washington DC, spoke about mental health courts and diversion from police and prison custody. The similarities and challenges of working between healthcare, criminal justice and law enforcement on both sides of the Atlantic were very apparent.

The tradition of successful debates at the Annual Conference continues. This year's motion that 'We should abandon the current classification of personality disorder' covered classification in DSM-V, which was contrasted with the changes expected in ICD-11, and the differing emphasis on the various types of personality disorder with an evaluation of the severity of the condition. The difficulty of fitting the different personality types to the patients we encounter, particularly in forensic practice, the increasing attribution of several personality disorders to the same individual, and the lack of any measure of severity, featured

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RAPPEPORT FELLOWSHIP AWARDS 2014-2015

*Britta Ostermeyer, MD, MBA and Susan Hatters Friedman, MD
Co-Chairs, Rappeport Fellowship Committee*

AAPL's Rappeport fellowship was named in honor of AAPL's founding president, Jonas Rappeport, MD and offers the opportunity for outstanding senior residents with a dedicated interest in psychiatry and the law to develop their knowledge and skills. This year, fellows will receive scholarships to attend the AAPL forensic psychiatry review course and annual AAPL meeting in Chicago. Each fellow is also assigned a senior AAPL forensic psychiatry preceptor to help guide their training during their fellowship year. The Rappeport fellowship committee is pleased to announce the six Rappeport Fellows for 2014-15. The Fellows are Drs. Subhash Chandra, Mark Chapman, Cory Jaques, R. Scott Johnson, Kristi Sikes and Georgia Walton.

This year again, we received a high number of wonderful applicants who competed for the six Rappeport Fellowship Awards. The committee noted that there are many excellent residents with an interest in forensic psychiatry, which is wonderful for our field of Forensic Psychiatry. We would like to thank the members of the Rappeport Committee, all Rappeport preceptors, as well as our AAPL Council for their continuing support of this outstanding training opportunity!



Subhash Chandra, MD

Subhash Chandra, MD, is currently a psychiatry resident at SUNY Downstate Medical Center. He also holds an MD degree in Forensic Medicine and law, and Post Graduate Diploma in Clinical Trial Management. He is RFS representative to AMA – IMG Section, New York State Psychiatric Association Area II Resident Fellow Member Deputy Representative to APA Assembly, MSSNY delegate to AMA, and has been active in several committees at AMA. He taught Forensic

Medicine and Psychiatry to medical students across major states in India and abroad and was recognized by the associate dean of medical students at SUNY Downstate for his teaching skills. He served as a panelist at AMA IMG Research symposium. He has been involved in many researches including proton magnetic resonance spectroscopy based in vivo assessment of brain neurochemistry, and suicide-specific forensic linguistic text analysis software based study of suicide notes. His mentor is Ryan Hall, MD



Robert Scott Johnson, MD, JD, LL.M

Dr. Johnson is a resident at Baylor College of Medicine in Houston. After an internship on the Texas Supreme Court, he practiced law for six years in Chicago and New York. He has had three articles accepted for publication in JAAPL. Regarding awards, he has received the APA Leadership Fellowship, the Janssen Research Fellowship, the Resnick Scholar Award, and the Baylor Resident Teaching Award for two consecutive years. There is no forensic fellowship at

his institution. His mentor is Catherine Lewis, MD



Mark A. Chapman, MD

Dr. Chapman is a resident at McGaw Medical Center of Northwestern University. He is originally from West Virginia, where he attended medical school. He developed an interest in forensic psychiatry after studying the John Hinckley trial, as an undergraduate psychology student. Dr. Chapman has a special interest in the teaching of forensic psychiatry as well as issues of diagnosis and classification of mental illness. His mentor is Britta Ostermeyer, MD, MBA.



Kristi Sikes, MD

Dr. Sikes is a resident at Baylor College of Medicine in Houston, Texas. She first became interested in forensic psychiatry while studying abroad in Copenhagen during undergrad, where she studied psychology and criminal justice. She completed medical school at the University of Texas at Houston, prior to residency at Baylor College of Medicine. While at Baylor, she has been active in AAPL, attending the national conference each year and presenting multiple

posters on various forensic research projects. Additionally, she has served on two committees for AAPL and was awarded the Resnick Scholar Award at the MWAAPL meeting in 2012. Her interests in forensic psychiatry are specifically on the subjects of criminal forensic psychiatry, malingering, and public policy. She is honored to receive the Rappeport Fellowship for 2013-2014 and looks forward to a career in forensic psychiatry. Her mentor is Renee Sorrentino, MD



Cory D. Jaques, MD

Dr. Jaques is a Child and Adolescent fellow at UCLA Semel Institute. He completed his adult psychiatry residency training at UCLA Semel Institute. He served as the Psychiatry Emergency Room Chief Resident during his 3rd year of adult training, and is currently the Chief Fellow in the Child program at UCLA. He has published articles on bullying in schools, and is currently writing a book chapter on psychotropic prescribing in youth in state custody. He is an

active member of AAPL, serving on the Child and Adolescent Committee and the Program Committee for the 2014 Annual Meeting. He received the APA Child and Adolescent Fellowship award and recently presented a workshop at the 2014 APA Annual Meeting, increasing awareness of the unique needs of LGBT youth in the child welfare and juvenile justice systems. His mentor is Joseph Penn, MD



Georgia Walton, MD

Dr. Walton is a fifth year psychiatry resident at the University of Toronto. She completed her undergraduate science and medical degrees at the University of British Columbia. With an interest in women's mental health, Dr. Walton presented her research in perinatal psychiatry at the Canadian Psychiatry Association annual meeting in Ottawa and won the award for best oral presentation at Women's College Hospital. Over the course of her residency, Dr. Walton

developed a keen interest in forensic psychiatry. She participated in several forensic psychiatry outreach trips to communities in rural Ontario, taught the medical student seminar on antisocial personality disorder and presented grand rounds on the evolution of the Ontario Review Board. Dr. Walton is looking forward to a career in forensic psychiatry where she can combine her desire for clinical excellence with research in the area of public policy and social justice. Her mentor is Susan Hatters Friedman, MD

PHOTO GALLERY - AAPL AT APA



Javits at the Javits Center



Organized chaos at the registration center



AAPL Business Meeting at the APA



AAPL Council Meeting at the APA



Ever busy Broadway!



Quiet before the storm on Broadway

American Medical Association 2014 Annual Meeting Highlights

Barry Wall MD, Delegate, Ryan Hall MD, Alternate Delegate, Jennifer Piel MD, JD, Young Physician Delegate

The American Medical Association's (AMA) June 2014 Annual Meeting focused on policy, medical education, health initiatives, and elections for leadership positions. Dr. Robert Wah, a reproductive endocrinologist with a military background from Washington D.C., was installed as President of the AMA and Dr. Steven Stack, an emergency medicine physician from Kentucky, was elected to the President-Elect position.

Resolutions specifically pertinent to psychiatry and forensic psychiatry included passage of items promoting mental health services for school-aged children; participation in physician health programs not resulting in delisting from insurance carriers panels; a call for study of competency and the aging physician; and modernization of HIV-specific criminal laws. A report on the development and promotion of a National Prescription Drug Monitoring program is also being developed.

The AMA Council on Ethical and Judicial Affairs (CEJA) presented reports on physician exercise of conscience, ethically sound innovation in medical practice, restrictive covenants, and health promotion and preventive care. Reports on restrictive covenants and health promotion were adopted by the House of Delegates. The restrictive covenants opinion declared that these covenants can disrupt continuity of care and may limit access to care, which is detrimental to patients; therefore, physicians should not enter into covenants that unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area and do not make reasonable accommodations for patients' choice of physician. In addition, physicians in training should not be asked to sign non-compete covenants as a condition of entry into any residency or fellowship programs. A report on the exercise of conscience and innovation was referred back to CEJA for further study and revision.

Other general highlights of the meeting were the AMA supporting a resolution that cheerleading should be considered a "sport" to decrease health disparities for these high school and collegiate athletes; approval of resolutions encouraging better access to care for veterans served by the VA medical system; and encouragement for Medicare to cover lung cancer screening in high-risk patients. Resolutions addressing policy aspects of the practice of medicine in the current regulatory environment were also brought,

"...physicians should not enter into covenants that unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area and do not make reasonable accommodations for patients' choice of physician."

such as alternatives to the implementation of ICD 10, expanding access to networks of care, and debate on the future of Maintenance of Certification/Maintenance of Licensure. Many of these issues were either referred for additional study or already covered by existing AMA policy. For more information on the resolutions and the actions of the AMA House of Delegates at the 2014 Annual Meeting, please go to <http://www.ama-assn.org/sub/meeting/index.html>.

AAPL delegate Dr. Barry Wall served as Co-vice-chair for the psychiatric caucus, as well as a member of

Reference Committee E (Science and Technology), where he and the rest of the committee were responsible for editing and making initial recommendations on the resolutions before they were brought before the full house of delegates. Some of the topics which he was able to weigh in on included resolutions related to education about and risk of methadone use, need for E-cigarette regulation and national drug shortages. In addition, Dr. Wall provided testimony regarding the "medicalization" of the death penalty to represent AAPL's view that physicians should not participate in executions, but that it is important to have psychiatrist involved in treatment and competency evaluations up until the time of execution to ensure appropriate care, as well as due process, for death row inmates. The end result was that AMA reaffirmed exiting policy that physicians should not participate in the actual execution event, with the term "medicalization" not being endorsed.

Alternate delegate Dr. Ryan Hall served as a teller for the AMA election process and also provided testimony regarding resolutions addressing firearm violence. A final resolution addressing firearm violence will be developed by the AMA Board of Trustees in the near future.

Young physician delegate Dr. Jennifer Piel provided testimony regarding the use of Tasers and the need for evaluation and treatment standards post use. Her testimony was referenced in a Psychiatric News article covering the topic.

Past AAPL President and incoming APA President Dr. Renee Binder also attended the meeting as an APA alternate delegate and was a welcome addition to the Psychiatric Section Caucus for the meeting.

There was also a special memorial resolution to honor former AAPL President and AAPL AMA delegate Dr. Robert Phillips. This was our first meeting without him, and many members of the House of Delegates fondly recalled his sharp intellect, his warm personality and compassion, and his valuable contributions in psychiatry, forensic psychiatry and ethics to the AMA. ☹

APA Assembly Highlights

Debra Pinals MD APA Assembly Rep., Cheryl Wills MD, Alternate Rep

The American Psychiatric Association (APA) Assembly met from May 2-4, 2014 during the Annual Meeting of the APA in New York City. A summary of the highlights is presented below.

DSM-5: sales of DSM-5 texts continue to be brisk. Although DSM-5 is being used for diagnostic purposes, the Center for Medicare and Medicaid Services has changed the implementation date for ICD-10 diagnostic codes (for billing) from October 1, 2014 to October 1, 2015 for all providers who are covered by the Health Insurance Affordability and Accountability Act (HIPAA).

Treatment guidelines: The APA Assembly did not ratify proposed treatment guidelines for psychiatric assessment but instead recommended further revision and a later return to the Assembly. Several factors contributed to this, including the need for revisions that would make the document more palatable in forensic settings. The APA's Treatment Guidelines Writing Group has been revising the draft which will be disseminated

to APA District Branches for review by and feedback from APA members before the Assembly votes on it. AAPL members who are interested in reviewing the draft should alert their district branches.

Communication issues: The APA's CEO and Medical Director Saul Levin, M.D., M.P.A. has been working to make the APA more user friendly for members. One of his goals is to diminish the redundancy of information that APA members receive via e-mail by fostering collaboration among APA staff and by integrating and incorporating this goal into their performance reviews. The APA also has tasked their computer experts with making the website more user friendly. The search engine is being reworked so that information will be more easily accessed.

Prescribing by psychologists: This remains a matter of concern in several states. The Clinical Prescribing Licensing Act was signed into law in Illinois on June 25, 2014. The law permits psychologists who complete an extensive training program to pre-

scribe certain psychotropic medication to healthy adults under age 65 years who have less complicated mental disorders. Prescribing psychologists must practice under the supervision of a physician. The law prohibits psychologists from treating children, prescribing controlled substances and prescribing to individuals who have serious medical conditions. The restrictive language of the law was drafted with input from physicians, including general and forensic psychiatrists in Illinois who were opposed to the legislation.

Research funding: The APA has been educating the public about the need for more funding for research to aid in understanding the underpinnings of depression.

ABPN examinations: The APA Assembly supported the recommendation that the ABPN be clear about which text, DSM-IV-TR or DSM-5 will be used during the 2015 and 2016 cognitive examinations. The language is unclear to many members. ☹

Ask the Experts

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Many of these cases hinge on the plaintiff's contention that suicide is predictable. The plaintiff lawyer will list a host of "risk factors" for suicide including depression, prior suicidal ideation, hopelessness, helplessness, family history, anxiety, impaired sleep, marital problems, job problems, etc. and try to get the defense expert to agree that each of these alone is a risk factor and that it was present.

The wise scientist-expert should know that even with all of the "known" risk factors present, fewer than 25% of these people actually commit suicide. Further, the real expert knows that suicide is NOT predictable. Risk stratification is not synonymous with prediction. The risk

stratification approach to suicide prediction results in an unacceptably high number of both false positives and false negatives, and our limitations as scientists should be acknowledged.

The critical nuance is that while something may be foreseeable, it is not the same as predictable. It is challenging to get this across to a jury, but imperative to do so. Predictability includes a temporal element; foreseeability does not. E.g.: A 68-year old man with coronary artery disease, hyperlipidemia, hypertension, diabetes, and obesity, who has a heart attack, would not be a surprise. It would be a foreseeable event, but not predictable, because no cardiologist could tell you when the heart attack was going to happen. Similarly, the ability to predict future behavior in psychiatry is extremely limited, and

the further out in time, the less accurate are such predictions.

Sadoff/Kaye: Take home point: Proper suicide evaluations include assessing the known risk factors as well as the known protective factors. Actuarial modeling or statistical approaches can be part of such an assessment but rarely are used and don't necessarily improve predictive accuracy. Decisions about admission, involuntary commitment, and appropriateness for discharge are discretionary and the sole purview of the treating doctor. The risk of using the "retrospectoscope" by an expert witness, to gauge if the physician's conduct met or breached the standard of care, carries the inherent risk of bias, as the outcome is known. ☹

Ethics Challenges

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uations. If that happens we may need to turn down such cases since we should not distort our opinion. Pathologists and some other forensic scientists also are physicians who in their forensic roles usually do not consider how their testimony will be used. But since we deal with the people themselves and not solely laboratory specimens, our roles are more likely to be confused with clinical work and require more caution.

Aspirational ethics

The AAPL ethics guidelines reflect areas of relative consensus and give us meaningful guidance in most situations as to what is minimally acceptable.¹ Since there are few second order rules telling us how to balance conflicting ethical guidelines, other rules, societal expectations, and our own values challenge us to determine the best thing to do. Of course nobody should get into trouble for their individualized balance so long as we stay faithful to some basic ethics principles. But in my opinion, we should all do the ethics analysis for ourselves to help us decide what we think best. We should identify the relevant issues for us.

What I am suggesting falls under the category of aspirational ethics that require us to go beyond the minimum reflected in the AAPL ethics guidelines. Ethics guidelines reflect a significant consensus in the field, but as such they do not address major controversial areas. Following them is the way to stay out of trouble and suffices for most purposes. They are the start of an ethics analysis and not the end.

Similarly in the citizen context, following the law is the beginning and not the end of trying to be a good ethical person. An ethical person needs to go beyond not breaking the law in order to be a good person and citizen. In the forensic context we should not stop with following guidelines. That means addressing some of the more controversial aspects of our field and balancing conflicting values and rules in an effort to determine the best

course of action. The fundamental values behind our ethics need to be appreciated. Such balancing is true with all psychiatric practice these days.

Some examples

I will illustrate what I mean by ethical issues requiring going beyond our guidelines. Our commentary section of the qualifications section reads, "As a correlate of the AAPL guideline that expertise may be appropriately claimed only in areas of actual knowledge, skill, training and experience, there are areas of special expertise, such as the evaluation of children, persons of foreign cultures, or prisoners, that may require special training or expertise." Does that imply those with no correctional experience should not evaluate prisoners? Most of us, I think, would say it depends on the case. In a case where prison expertise is important, it would be consistent with aspirational ethics and doing the right thing to not take such a case or at least to discuss the limits of your expertise with the hiring attorney so he can determine the relevance of that expertise. The same might be true of those from foreign cultures. Though it might help, it is not usually necessary to be from that foreign culture to evaluate such a person.

Another area is geriatric assessments. Few would recommend only geriatric psychiatrists examine such people in part because there are so few geriatric forensic psychiatrists. But in some cases, special expertise can be important. In areas such as psychopharmacology, all psychiatrists have expertise, but there may be some cases in which special expertise is relevant. Although not usually unethical to take a case despite no special expertise, it might be most ethical not to do so in cases in which such expertise is central to the case. An example might be cases involving questions of adequate treatment including medication management for an elderly person.

AAPL ethics guideline sometimes can conflict with each other. AAPL specifically requires obtaining consent as well as striving to reach an

objective opinion. Arguably, in some instances not getting informed consent might lead to the most valid data and most objective opinion, but not explaining the purpose of the examination specifically violates a number of specific AAPL ethics requirements. They are consent, confidentiality, and honesty. Failure to do so would show no respect for the person. Although there might be some loss of significant information by obtaining informed consent with an honest explanation, the clear violation of specific guidelines should be overriding. In contrast, it is not a direct violation of our requirement to strive to reach an objective opinion if some information is lost. The resolution of this one seems clear.

Forensic work in the death penalty context can raise special concerns. Even the law recognizes death is different. In my opinion, the competing duties and some secondary duties to a person evaluated need consideration in these cases. That cannot influence the opinion itself or permit distortions. But it may be that the most ethical practice is to avoid certain death penalty roles. In instances of participating in the execution process itself, both the APA and AMA preclude such participation and consider it unethical to do this. The APA through its local district branch has the power to sanction people who participate in the execution process itself. If some choose to ignore this prohibition, it is a clear violation of an ethical requirement even if the law permits or in some states requires medical participation in giving lethal injections.

Summary

In conclusion, I want to remind you that there are ethical dilemmas in all of psychiatry. Forensic psychiatry is no exception. It is part of the challenge of all psychiatric practice. But that should not discourage anybody. In most cases our guidelines suffice and there are no ethics dilemmas. However, when they do arise they are part of the excitement and challenge of our field with high stakes for those we evaluate. In an ethics dilemma

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Forensic Psychiatry and Globalization: Ancient Concepts and Current Challenges

Carolina A. Klein MD, Chair - International Relations Committee

Without a doubt, I am what you would call a hybrid. I was born in Chile, but half of my upbringing occurred in Puerto Rico. My Chilean father met my American mother in Spain—her parents came from the UK and the Dominican Republic, his parents came from Chile and Romania. I carry a Jewish last name, but was raised Catholic, and currently ascribe to neither of those denominations. One of my best friends is from India, and lives in Connecticut; the other is from Portugal, and lives in the Netherlands. The last time I was consulted on a case, it pertained to an American living in Japan. On a regular day, I might talk to my sister via Skype, text my friends in Chile, Googlechat with colleagues in Spain, email a coauthor of a research article in Australia, get a phone call from my contact in Japan, and review the online materials of an American training program in Kenya. I could go on like this with an infinite amount of examples that define my life and explain why certain apps and Internet services make it possible to have close relationships and experiences across the world. But my story is not unique: more and more, this is the landscape around us, with undefined borders and an increasing focus on true globalization.

I've had the opportunity to travel extensively, and these trips have enabled me to reach and attain an enormous amount of deep cultural understanding, alternative wisdom, and lifelong learning experiences. I realize that social organizations differ, that certain value systems are granted more predominance in certain countries, and that the circumstances people face, or their ways of coping with them, are very much determined by the vicissitudes of their position. The insights gained through these diverse travel experiences have paved the way to the realization and decision that I wanted to incorporate the global viewpoint I had learned into everything I did henceforward, bringing it into my

practice and development as a forensic psychiatrist. Immersion experiences have long been established among the most effective learning methodologies, and they are the highways we should continue to build and transit through. This can be made possible by enhancing opportunities for international careers as forensic consultants, or as academic pioneers in the development of education and training programs abroad.

“Every unknown land we visit, including that of psychiatry, forensics, and research, and each individual, proves to me that there is much left to be learned, but also, that it is a privilege to be able to make the journey”

Lines of communication and exchange between forensic psychiatrists continue to broaden. As with previous years, the 2013 AAPL Annual Meeting in San Diego provided a wonderful opportunity for collegial relationships to be forged and strengthened, for projects to be designed and developed, and for matters to be collaboratively discussed and explored. The committee met and arranged the annual site visit. Areas of research and topics of interest were prioritized, especially for the AAPL constituency through the AAPL Journal and for the upcoming Annual Meeting in Chicago, 2014. In the upcoming years, professional collaboration will be expanded to include international conferences and peer reviewed journals, such as

the World Psychiatric Association, the International Association of Forensic Mental Health Services, the International Journal of Law and Psychiatry, and the International Conference on Current Trends in Forensic Sciences of the American Academy of Forensic Sciences. Needless to say, the International Relations Committee will continue to make an invitation to current and prospective members of the American Psychiatric Association, and AAPL.

To a large extent, the foundations for future international development of our subspecialty are vested upon our incoming generations and the millennial language of technology. Technology may offer the tools necessary to transcend regional networks and enter global connectivity. It may also represent models to aspire to, as we learn about educational, research, or practice initiatives undertaken by colleagues in locations that years ago seemed remote, but are no longer so.

I uphold my practice as one of exploration, advancement, and respect, much like the attitudes I have learned while visiting foreign countries. Every unknown land we visit, including that of psychiatry, forensics, and research, and each individual, proves to me that there is much left to be learned, but also, that it is a privilege to be able to make the journey. I am deeply honored to be given this opportunity to continue to move the International Relations Committee forward, and I'd like to extend my infinite gratitude to Dr. Kenneth Busch for inviting me to participate in this endeavor. As a guide and mentor, it is difficult to imagine making this trek without such experienced counsel at every step. I am also extremely grateful to all of our committee members, who continuously contribute their ideas, effort, and knowledge from cross-cultural contexts for the betterment of our field and our professional home of AAPL, to all who collaborate year after year and see the value behind reaching beyond national frontiers, and to the institutions who support and host us so graciously.

We look forward to crossing the next frontier in forensic psychiatry. ☺

Prescription Drug Monitoring Programs and New Roles for Psychiatrists

Christopher Horne MD, and Henry S. Levine MD,
Psychopharmacology Committee

The Centers for Disease Control and Prevention has classified prescription drug abuse as an epidemic. As discussed in the President's 2011 report on prescription drug abuse, data from the National Survey on Drug Use and Health (NSDUH) indicate that nearly one-third of people aged 12 and over who used drugs for the first time in 2009 began with a prescription drug. NSDUH also found that the majority (70%) of those who abuse prescription pain relievers accessed them via friends or relatives. Among young people, prescription drugs are the second most-abused category of drugs after cannabis. The milligram per person use of prescription opioids increased from 74 milligrams to 369 milligrams in the 10 years from 1997 to 2007. Though heroin use was once the largest contributor to opiate overdoses, these are now increasingly due to abuse of prescription painkillers. In the May 28, 2014 issue of JAMA Psychiatry, Cicero et al., reported that "more recent [heroin] users were older (mean age 22.9 years) men and women living in less urban areas (75.2%) who were introduced to opioids through prescription drugs (75.0%)."

In order to combat this epidemic, federal and state agencies have implemented a multi-pronged approach. First, funding has been funneled into education for both healthcare providers and consumers. Additionally, more emphasis has been placed on research including work on abuse-deterrent formulations. Law enforcement and proper medication disposal are also parts of the proposed solution. Finally, prescription drug monitoring programs (PDMPs) have been authorized and implemented. As of 2011, 43 states had authorized PDMPs with the aim of detecting and preventing the diversion and abuse of prescription drugs. These

programs are funded by a combination of federal and state dollars. Established program goals include "assisting in patient care, providing early warning of drug abuse epidemics (especially when combined with other data), evaluating interventions, and investigating drug diversion and insurance fraud." Yet there remains no standardization of PDMPs. The National Alliance for Model State Drug Laws reports that only Wyoming and New York collect dispensing data in real time, while six other states require dispensing data be reported to the PDMP within 24 hours.

Limited evidence thus far about the effects of PDMPs has yielded some positive results. Several early studies have been performed on the results of implementing PDMPs. An analysis in 2009 found that PDMPs were associated with lower rates of substance abuse practices. PDMPs have also been associated with slower rates of increase in abuse/misuse over time. More recently, a study found no association between existing PDMPs and lower rates of overdose mortality. Many PDMPs are still in their infancy, and it remains difficult to assess their positive effects this early. Multiple government agencies continue to support PDMPs, including SAMHSA, CDC, and several executive branch departments, including DOJ, VA, and DOD. AMA has continued to support the authorization and implementation of PDMPs whose "primary purpose and mission is health care quality and safety."

One of the most robust PDMPs has been authorized in New York, effective August 2013. The New York PDMP, as mentioned above, updates dispensing data in real-time. Patient reports include all controlled substances dispensed in New York and reported by pharmacies for a preced-

ing six-month period. One of the unique aspects of the New York law is that prescribers are *required* to consult the PDMP registry when writing prescriptions for Schedule II, III and IV controlled substances. Prescribers are required to have an individual Health Commerce System account to gain access to the PDMP, and can designate others including unlicensed office and ward staff, residents, and interns as individuals who can check the database prior to prescribing. Penalties for prescribers not reviewing the PDMP prior to prescribing include fines in the amounts of \$500, \$1000, and \$5000 for the first, second, and each subsequent violation respectively. Pharmacists who dispense medications are under the same requirements as prescribers, and are subject to the same penalties for violations of their duty.

The agency tasked with facilitating, maintaining and enforcing the PDMP in New York is the New York Bureau of Narcotic Enforcement. Its Narcotic Investigators, working with local, state, and federal law enforcement officials, are also tasked with investigating suspected drug diversion or illegal sales. The Commissioner of that Bureau, *without necessity of subpoena*, can disclose data collected from the PDMP to Director of the State Medical Board, the Deputy Attorney General for Medicaid Fraud Control, the Medicaid Inspector General, and any judge, probation or parole officer administering a diversion or probation program. The Commissioner also has broad new powers to disclose previously confidential information from the PDMP in response to requests from practitioners or pharmacists providing medical care. The program even allows for prescribers or dispensers to report prescription discrepancies in the case of *suspected* diversions, on the bottom of the Confidential Drug Utilization Reports. Prescribers and dispensers are also encouraged to contact the Bureau of Narcotic Enforcement or a Narcotic Investigator with any questions or concerns.

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PTSD: Misdiagnosed, Underdiagnosed, Unrecognized in Juvenile Detainees

Rosa Negron MD and Andrew Levin MD, Trauma and Stress Committee

Although interest in Posttraumatic Stress Disorder (PTSD) continues to be centered on civilian and military populations, recent research has highlighted the importance of trauma and PTSD for individuals involved in the criminal justice system. Donley, et al. found a strong association between arrest and/or incarceration for violent charges and a history of childhood trauma.¹ Given this association, juvenile delinquent populations are of particular interest because many are exposed to traumatic childhood experiences. Identification of trauma and PTSD in youth when they first come into contact with the juvenile justice system is critical. With early identification, courts can appropriately divert juveniles to programs that can address and treat their specific needs. In the detention setting, proper identification of these issues can guide mental health treatment and decisions about housing. On the other hand, unrecognized trauma and PTSD can result in continued dysfunction, problems with adjustment to incarceration, and increased risk of reoffending. In addition, trauma and PTSD confer significant risk for suicidal behavior in incarcerated youth, emphasizing the need to identify these issues to address the safety of the individual.²

At present, the prevalence of PTSD in juvenile populations is unknown. In our experience, a large number of the affected youth in detention go undiagnosed and untreated. Among the assessment tools utilized for youth in detention, the Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2),³ may provide an initial indication of the presence of trauma and its impact. The MAYSI-2 screens multiple areas including alcohol/drug abuse, anger/irritability, depression/anxiety, somatic complaints, suicide ideation, thought disturbance, and traumatic experiences.

The scales measuring substance use, anger/irritability, depression/anxiety, and traumatic experiences all contribute to the prediction of PTSD symptoms in boys, whereas only depression/anxiety contribute to the prediction of associated symptoms for girls. The traumatic experiences scale itself has only moderate accuracy in predicting full or partial PTSD. Use of this scale can alert the clinician to explore issues of trauma and PTSD in greater depth.

“PTSD symptoms in youth may emerge as aggression and irritability and not the classic symptoms of re-experiencing and avoidance.”

Clinically, professionals evaluating detained youth for the presence of trauma and PTSD face several challenges. First, youth are often reticent to share traumatic material and may require multiple interviews to feel sufficiently comfortable describing these experiences to the clinician. Second, eliciting trauma may be complicated by the definition of trauma itself. Simply inquiring about “trauma” may yield little or no information because victims do not define their experiences as traumatic, or even out of the ordinary. As noted by Donley,¹ a large percentage of their inner city sample had experienced trauma, indicating that trauma itself is relatively normative in this segment of American society. Investigations of PTSD in children and adolescents have traditionally focused on maltreatment (neglect and/or verbal, physical and sexual abuse), war, nat-

ural disasters, community disasters and single traumatic events.⁴ When evaluating youth in detention, the clinician must review a wider range of traumatic experiences including unstable and dangerous living conditions, cohabitation with a severely mentally ill or substance abusing person, witnessing violence, threats from strangers as well as intimates, and gang violence. The clinician should also be alert to the increased prevalence of substance abuse and self destructive behavior in adolescents who have been victims of trauma. These behaviors often mask PTSD symptoms. In addition, youth who are victims of severe and protracted trauma may present with so-called “complex-PTSD.”⁵ Individuals with this presentation demonstrate a combination of affective and dissociative symptoms along with more traditional PTSD symptoms, and frequently engage in self defeating behaviors such as chaotic relationships, self injury, and substance abuse. Given their affective presentation and dissociative symptoms, juveniles with complex PTSD may be misdiagnosed as having bipolar disorder or a psychotic condition.

Alternately, PTSD symptoms in youth may emerge as aggression and irritability and not the classic symptoms of re-experiencing and avoidance. As a result, courts and correctional professionals may not recognize the link between trauma and aggressive behavior prior to, during, and following detention. Given that females consistently endorse higher levels of posttraumatic symptoms than males even when controlling for the type of trauma experienced,⁶ the clinician must have a high index of suspicion that a female detainee has been the victim of trauma. Compared with males, females are also more likely to engage in self injury as a manifestation of the impact of trauma.

Case Illustration

A 16 year old male treated by one of us (RNM) illustrates several of

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PTSD

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these points. This youth entered the juvenile justice system at age 9, failed multiple programs, and continued to offend. His offenses involved both substance abuse and violence.

Despite the administration of the MAYSI-2 in several programs and repeated psychiatric assessments, this juvenile had no identifiable history of trauma and was not diagnosed with PTSD. Instead, he was assigned diagnoses such as bipolar disorder and conduct disorder. Multiple psychotropic medication trials and several different treatment modalities were unsuccessful.

Over several sessions the therapist was able to develop rapport with this teenager, permitting the uncovering of his extensive trauma history. Following the death of his mother when he was age 9, this boy was the victim of verbal and emotional abuse as well as severe neglect by his father. Given that these experiences began at an early age, the teen did not recognize them as traumatic, or even unusual. Further, history elicited from the father was inaccurate, with the father taking a blaming stance (typical of abusers) toward the child.

After adequate identification of the trauma, the teen was enrolled in services that addressed his trauma, resulting in diminished acting out. His aggression and substance abuse were understood to be manifestations of PTSD. He successfully completed the mental health program in the detention facility, enabling him to return to the community and enroll in an appropriate community program.

This case illustrates that despite negative findings on the MAYSI-2, a standardized instrument designed to elicit a trauma history, clinicians working with youth in detention must maintain a high index of suspicion of trauma. Uncovering and exploring trauma requires clinician sensitivity, and at times, an extended evaluation period. Clinicians working with juveniles in detention need to undertake routine trauma evaluations for all offenders, regardless of available

reports or psychiatric history. More sensitive tools are needed to identify trauma in juvenile populations and further define the relationship between trauma, offending, and adjustment to detention. 

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Asperger Syndrome

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reflect society as a whole. This has often been an error in other behavioral studies.

The Asperger's Association of New England reports the prevalence of AS in the general population to be approximately 0.2% with a male-to-female ratio of 4:1. Estimates are that one in 500 people has AS. The population of the United States is now over three hundred million. It is clear that the vast majority of those with AS are not committing crimes, are not violent (despite playing Grand Theft Auto) and are not a danger to society. They are struggling in ways that someone without the disorder can only understand intellectually.

Let's erase that rap sheet on Asperger Syndrome. 

Ethics Challenges

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there is not usually one right answer. Nobody should get into trouble for resolving an ethics dilemma differently from the way you or I would. But we should not avoid looking at the implications of what we do. We all should try to arrive at what we consider the best and most ethical solution for ourselves and sometimes our profession. All of these factors are part of a "robust professionalism" approach.² We do not function in a vacuum. In the aspirational area we may come up with differing conclusions. That is to be expected since we do not all have the same values and prioritize them in the same way. In my opinion, we should ask the questions and consider them important, legitimate, and necessary. They are part of aspirational ethics, and part of what to me, and I hope most others, make forensic work so interesting and meaningful. 

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MUSE & VIEWS

Here are some of the reported most ridiculous lawsuits of 2013!

- Man sued Apple for his pornography addiction due to them not blocking adult websites
- Teacher sued school district after resigning due to pedophobia, an extreme fear or anxiety around young children
- 32-year-old New York man sued parents for being "indifferent" to his problems
- New Jersey father sued son's high school for \$40 million over son's dismissal from track team due to unexcused absences

Submitted by William Newman, MD

Getting Off? Sex Offenders and NGRI

Renée Sorrentino MD and Susan Hatters Friedman MD

Societal perceptions of sexual offenders as predatory recidivists who are impermeable to treatment and willful in their conduct, rather than mentally ill, have resulted in a rarity of Not Guilty by Reason of Insanity (NGRI) defenses raised in sexual offenses. Despite the inclusion of paraphilias in the DSM, there still exists widespread debate in the field about what type of sexual behavior constitutes a mental illness. We presented a workshop at the New York APA meeting on this topic. In the 1992 Jeffrey Dahmer case, Dahmer had been charged with the murders of 15 young men, whose mutilated, cannibalized bodies were found in his Milwaukee apartment. His defense team entered an insanity defense. The jury was tasked with determining whether Dahmer's paraphilias impaired his ability to appreciate the criminality of his conduct; or to conform his conduct to the requirements of the law. The jury rejected the insanity plea and found Dahmer guilty.

In order to be considered for an insanity defense, the defendant must suffer from a mental illness at the time of the offense. Studies suggest that many sexual offenders meet the criteria for a paraphilia. Dunsieith et al found that 58% of a sample of 113 sex offenders met the criteria for a paraphilia (Dunsieith, 2004). A study examining the characteristics of sex offenders' petition for civil commitment found more than half of them met criteria for paraphilias (Becker et al, 2003). Paraphilias are established mental illnesses since their inception in the DSM-III (1980) as a subset of the category of "psychosexual disorders." The DSM5 subcommittee directly addressed this question by defining anomalous sexual behaviors or interests as disorders *only if they cause some impairment in functioning or pose a risk of danger to self or others*. Although paraphilias, by definition, may be difficult to control, sexual behavior in general is largely

thought to be under voluntary control. However, one could argue that sexual behavior, like appetite, is multifactorial including components that are entirely biological and involuntary. An example of this is the Kluver Bucy Syndrome in which we understand the symptoms of hyperphagia and hypersexuality as resulting from bilateral lesions of the anterior temporal lobe.

“NGRI sexual offenders are required to register with the local authorities, monitored with GPS and can be found sexually dangerous and civilly committed.”

Shifting legal arenas briefly to civil commitment, in particular, commitment of sexually dangerous persons negates the position of sexual behavior being voluntary, however. Despite limited research, experts in commitment evaluations of sexual offenders are expected to determine the ability of an individual to control their future sexual behavior. In order to be found a sexually dangerous person, an individual must suffer from a mental abnormality which puts them at risk of committing future sexual offenses. The construct of civil commitment for dangerous sexual offenders originated with the first sexually violent predator (SVP) statute in Washington State in 1990. The constitutionality of SVP statutes have been upheld in U.S. Supreme court rulings of *Kansas v Hendricks* and *Kansas v. Crane*. In *Kansas v. Hendricks* the Kansas Supreme Court identified paraphilias (pedophilia) as mental abnormalities and authorized civil commitment for offenders who are “unable to control”

their dangerousness. This duality perhaps exemplifies the legal contradictions and poor understanding of sexual disorders even today.

NGRI defenses in defendants who commit sexual offenses are certainly a consideration if the defendants suffer from a non-paraphilic mental illness. There exists a high comorbidity of mental disorders in paraphiliacs (Kafka, 2012). The most common co-existing disorders in paraphilic sex offenders are affective and anxiety disorders. Psychotic disorders are rare. In those individuals who have a psychotic illness and commit a sexual offense, the psychosis is often coincidentally coexisting and not typically related to the sexual behavior.

Little research literature exists regarding NGRIs in sexual offending. Novak and colleagues (2007) examined 42 individuals who had been found NGRI for sexual offenses. They found 2/3 of defendants were diagnosed with psychotic disorders. However the majority of defendants were not found to have psychotic symptoms at the time of the offenses, and authors raised the concern that the proper legal standard for insanity may not have been utilized. Another study examining paraphilic sexual murders and nonparaphilic sexual murders found men with paraphilias more likely to meet the volitional prong of the NGRI defense, which is only available in some states. In other words, paraphilic offenders had more difficulty controlling or conforming their conduct to the requirements of the law, rather than lacking knowledge of wrongfulness of their behavior. This raises the issue, again, of whether sexual behavior is under voluntary control and whether mental disorders of sexuality compromise one's control.

In the spirit of the law, an NGRI acquittee should not be subject to the same legal obligations as a guilty defendant. However, in many jurisdictions, NGRI sexual offenders are required to register with the local authorities, monitored with GPS and can be found sexually dangerous and

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Forensic Faculty Annual Residential Meeting

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prominently in the debate. A clear swing of almost 20% in favor of the motion demonstrated the impact of the various contributions on the audience; even those opposed to the motion acknowledged they awaited the publication of ICD-11 with interest.

The second full day of the conference began with a series of provocative and, in many cases, unexpected research findings. Professor Louise Howard of the Institute of Psychiatry demonstrated the very high rates of intimate partner victimization experienced by those who suffer from serious mental illness. Professor Connor Duggan compared the evaluation of risks and benefits in psychological treatments with the much more robust scrutiny faced by pharmacological treatments and warned that psychological therapies can be ineffective and, even worse, harmful. Dr Nigel Blackwood told us about the growing evidence of the existence of demonstrable neurological abnormalities in people who have antisocial personality disorder with psychopathy, contrasting them with persons with antisocial but not psychopathic personalities. Professor Jenny Shaw described the risks associated with transitions in health-care while Dr Seena Fazel discussed the limited evidence base supporting the predictive power of risk assessment.

Professor Jeremy Coid led us through the surprising finding of high rates of a wide range of psychopathology in members of street gangs – a sociological phenomenon well studied in the USA, but only recently being explored by psychiatrists in the UK. Severe Post Traumatic Stress Disorder, psychosis, anxiety, depression and substance misuse problems are all common. The discussion then focussed on possible links with failure of care in early life.

Guidance on the treatment of schizophrenia was given by Professor Peter Jones who explored the response of patients with first episode of schizophrenic illness to a range of psychiatric treatments, and concluded that

the range of outcomes raised the likelihood that it is not one illness but several. He subsequently discussed the investigation of entirely novel treatments which may become available, based upon theories that certain aspects of what is now considered schizophrenia may due to inflammatory or immunological conditions. He showed us that clozapine is the only drug which has an advantage in treatment resistant illness, and that switching from one conventional antipsychotic drug to another or prescribing high doses of conventional medications shows no benefit. If augmentation of clozaril is required, sulphiride is recommended as the best choice for positive symptoms and aripiprazole for negative symptoms.

The day concluded with a series of parallel workshops on a broad range of topics, including research papers on homicide-suicide and mental disorder; violence and psychosis; health screening of people in police custody; validation of new risk assessment instruments for patients discharged from secure services; and predictors of absconson. Other workshops covered topics such as psychiatric sequelae of military service, morbidity and mortality in forensic services, medical education and leadership, payment by results, and service development.

On the morning of the final day, delegates were given a choice of master classes on risk management, court room skills, organic psychiatry and bipolar disorder. The final session gave a fascinating overview of the consequences of the conflict in Northern Ireland at an individual and population level, presented eloquently by Dr Adrian Grounds and the distinguished Northern Ireland politician, psychiatrist and psychotherapist, Lord Alderdice.

As with any successful conference, social events were as prominent and as important as the formal academic programme. Social events included a fun run through the streets of Belfast, and Belfast city tours. The conference dinner was well attended and included the

award of prizes for essays to medical students from across the United Kingdom who were sponsored by the Faculty to attend the conference. A particular highlight was a reading by the T S Eliot prize-winning poet, Dr Sinead Morrissey, from the Seamus Heaney Centre for Poetry in Northern Ireland. Her poem, inspired by the 18th century British prison reformer, John Howard, was particularly apt for the occasion and the audience.

Although it is difficult to condense a busy program of three days into a few themes and underlying messages, on their journey home many delegates will have reflected on an event which challenged their core principles, e.g. on the real evidence base for modern risk assessment or the demonstrable benefits of compulsory treatment in the community. No profession, particularly a relatively young sub specialty such as forensic psychiatry, can stand still. Progress can only be enhanced by challenging “accepted” norms, principles and beliefs and by expanding our thinking, informed by robust research and discussion in our own and other disciplines. There can be no doubt that the practice of forensic psychiatry has been enhanced by the proceedings in Belfast in March 2014. ⁽⁴⁾

Getting Off?

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civily committed. Attorneys seeking NGRI for sexual offending defendants should be educated about these potential complications. As outlined by Weiss and Watson (2008), in some cases a plea bargain in which the reporting duties to the sex offender registry board are negotiated, may be the preferred course.

Paraphilias are widely accepted as mental illnesses in sexual dangerousness civil commitments, but not in insanity evaluations. Why is there such disparate understanding of sexual behaviors? One should question what scientific research supports. Does the research support that paraphilic sexual behaviors are not entirely under volitional control? If so,

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An Experience with Electronic Medical Records

Natasha Cervantis MD

This day was bound to come, and it was inevitable. As I write this, the jail I work in is finalizing what is soon to be our Electronic Health Record (EHR) that will replace our current system of paper-based charting. The website of the Office of the National Coordinator for Health Information Technology that contains the 2014 list of certified complete EHR products or EHR modules revealed 1,109 certified EHR systems currently available.¹ Despite this wealth of options, our jail management believed only a custom product would do, so, if it's not included already, we will soon contribute to the growing list.

Our jail system has gradually transitioned from a system of mostly free text to a series of new "templates" tailored for various types of clinical visits. Most of these have included a variety of "checkboxes" intended, I am sure, to simplify and streamline our documentation process and also comply with certain outside mandates. But, for the most part, individuals who do not actually have to use the forms developed them. We have retained free text capability, to some extent. The psychiatric note template has remained free text with only one check box. And for the latter, I am grateful. A series of blank lines, with no constraints for describing the patient's history or mental status seems ideal to me. I enjoy being able to describe patients with full sentences, include quotes from them in their own words, and being able to discuss findings and plans in detail, even though this may be more time consuming than using checkboxes. It also helps me remember each patient better if I am able to write something unique about each patient, even if that day it's something to the effect of "screamed multiple expletives, slammed fists on table and had to be escorted out of the room in handcuffs by custody." I have requested that our "blank" psychiatric note stay exactly

the same in our customized electronic record, a suggestion I hope is taken under serious consideration. The residency program where I trained, Johns Hopkins, has recently integrated their psychiatric records with a well known electronic medical record system, and the psychiatric note section is "a big text box where the traditional narrative will still have a home."² Who can argue with that? In my opinion, psychiatrists should know what is relevant to write in the record and not be restricted to pre-printed choices for their words. And if they do not know how to chart, the remedy should focus on the psychiatrist, not a change in the fundamental

"I enjoy being able to describe patients with full sentences, include quotes from them in their own words, and being able to discuss findings and plans in detail, even though this may be more time consuming than using checkboxes."

record keeping method. In their 2011 article entitled Empty Words in Psychiatric Records: Where Has Clinical Narrative Gone?³ Gutheil and Simon describe the unfortunate trend of medical records becoming "hollow shells of verbiage rather than appropriate chart content" due in part to issues involving cutting and pasting information, auto-population of chart content, checkboxes that promote a checklist approach to diagnosis, and other documentation shortcuts.

Our upcoming transition to elec-

tronic records made me recall a recent forensic evaluation I was involved with. The file was so heavy that I chose to pay a law student to pick up the records from the attorney's office rather than have them mailed. It involved at least a couple of thousand pages of records of all sorts. Upon receiving the box, I proceeded to divide the records into manageable piles, opting to sort the inpatient psychiatric records I had by decade, as the defendant's history spanned from the 1980's to 2011. There were only a few pages from the 1980's. The 1990's comprised about 3 inches, the 2000's another 6 inches, and I had probably a bit less than 3 inches from 2010 and 2011. With a rough estimate of an hour per inch for record review, I proceeded to review the records from the 1980's and 1990's, thinking I would surely be done with those in one afternoon. I started to review the year 1990, and my heart sank. My hours estimate was going to be way off. That decade comprised around 400 pages of words in the form of actual, full, sentences. What I had was solid narrative from top to bottom on most pages. In my time estimate, I had neglected to factor in that the year 1990 was 1990 B.C. (That's B.C. for "Before Checkboxes.")

Despite the realization that I was going to need much more time to review the records, what followed was actually a thoroughly enjoyable experience. There was a noticeable and significant shift in the records toward the end of the 1990's, to the 2000's and the current decade toward using more templates and checkboxes and less narrative. From 2000-2011, the actual volume of paper was greater than the 1990's records, but the relevant or useful information was minimal. Diagnoses from the 2000's and later varied considerably and seemed generally unsupported by the minimal notes and checkboxes in the history and mental status exams.

But the 1990's records showed a kind of record keeping that is rare to find in our current systems, at least

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“Your Drugs Made Me Do It”

Susan Hatters Friedman MD; Ryan C.W. Hall MD; Chri Kenedi MD, MPH, James Knoll IVMD

The 2013 film “Side Effects” starring Jude Law and Catherine Zeta-Jones is based around a fictional mariticide in which the defendant claimed she was NGRI due to side effects of a fictional SSRI. However, claims of medication-induced insanity are nothing new. In fact, in an 1857 murder trial, Abraham Lincoln was the prosecutor in a case in which the defendant successfully pleaded NGRI because the crime was committed under the effects of chloroform related to a surgery. (Spiegel & Suskind, 1997)

There are clearly times when psychotropic medications can trigger unusual behavior—such as mania from antidepressants and paradoxical reactions to benzodiazepines. It is estimated that 8-25% of those with traditional bipolar disorder and 44% with rapid cycling bipolar can experience a manic episode with the addition of an antidepressant. Over half (50-80%) of bipolar patients are prescribed antidepressants at some time in treatment. (Sidor & MacQueen, 2012) Much less frequently, it has been estimated that 0.3 to 0.7% of individuals can have a paradoxical reaction to a prescribed benzodiazepines. (EnMichel & Lang, 2003)

In addition, violent and self-destructive behavior can also occur in the context of routine medical treatment. Pegylated Interferon and Ribavirin, the mainstay of treatment for Hepatitis C, have been associated with a significant risk of suicide (1% of patients under therapy) as well as aggression towards others. Other medications associated with increased risk of violence includes steroids (both anabolic and corticosteroids), errors in thyroid replacement and medications with possible disinhibiting or hallucinatory properties such as mefloquine used to treat malaria.

However, there are few “clean” cases where it is evident that a medication is solely responsible. This would require that the defendant was

only on one medication, 100% compliant, followed up frequently, and where the negative outcome occurs in close proximity of starting the medication, with no other questionable behavior. In the real world, more than one medication is often prescribed; 60% of psychiatric outpatients are prescribed 2 or more medications. (Mojtabai & Olfson, 2010) Confound that with low rates of compliance and potentially other exposures to illicit drugs or alcohol, and it can become hard to determine when medication was a genuine cause of behaviors as opposed to criminal behavior being creatively blamed on medication. Even in cases where a medication may potentially precipitate symptoms contributing to criminal behavior, finding a clear and isolated causal nexus between medication and the proscribed behavior is likely to be problematic.

“Even in cases where a medication may potentially precipitate symptoms contributing to criminal behavior, finding a clear and isolated causal nexus between medication and the proscribed behavior is likely to be problematic.”

Fluoxetine has been cited in more medication defense criminal cases in the United States than any other psychotropic. (Mason, 2002) In a study using nationwide data from the Netherlands, the association between antidepressant prescriptions and lethal violence was analyzed over a 15-year period from 1994 to 2008. (Bouvy & Liem, 2012) Indeed, the results show-

ed a significant *decrease* in lethal violence (homicide and suicide) during a period in which exposure to antidepressants increased.

In the research world, the Adverse Drug Reaction (ADR) Probability Scale is often used to estimate the likelihood that a medication resulted in an adverse drug reaction. Some of the factors may be hard to apply to forensic evaluations such as “adverse event improved when the drug was discontinued” or “adverse reaction reappears upon administration of placebo” because in most forensic cases some form of additional medication treatment will be started (e.g. benzodiazepine, neuroleptic) at the same time the suspected medication is discontinued. In addition a psychotropic-induced medication effect can result in a condition which can last longer than the time a medication is detectable in the blood stream (e.g. manic symptoms potentially lasting for weeks after medication stopped). Determining causation can be difficult in the forensic world because oftentimes the available records are not detailed enough. Real world challenges may include records that: lack sufficient documentation of symptoms, are not in proximity to the event, lack toxicology data, and miss co-occurring behavior such as substance use. A determination may be made on subjective reports by the defendant—who often has reasons to minimize other possible explanations (“What I am accused of is so unlike me – It must have been my medications!”) and hypothetical conclusions from experts (“an antidepressant ‘could’ have caused a mania”).

For a successful defense of involuntary intoxication (a *Mickey Finn* defense), not only must the defendant have been under the effects of the substance/medication at the time, but the intoxication must have been involuntary or unexpected (including by prescription) and importantly, the defendant’s mental state must have met the legal test for insanity. (Goldstein, 1992) Thus, depending on location and legal test (M’Naughten or

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Medical Records

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our local ones in Western New York. The majority of all documentation from all disciplines was narrative, but two time periods stood out in particular. An inpatient stay from June 14, 1990 - July 3, 1990, and an Emergency Room visit from August 12, 1990. Not only were they lengthy narratives, but they were also detailed and legible. And written by a second year (later third year) resident, no less, who had, for example, expanded on the patient's report of hallucinations by writing: "this writer was not impressed with the patient's complaints of command auditory hallucinations. Secondary gain seemed to be a major motivation and the hallucinations did not jive with his lack of a consistently and significantly depressed mood." And later, "He became rageful (sic) once again, ripping his shirt and then threatening many staff and security guards with a chair at the end of the hallway before finally succumbing to the show of force." I envisioned this same record being generated in 2014 being reduced to checked boxes next to the words "hallucinating" and "angry" under Mental Status Exam. Further notes from 1990 elaborated on extensive collateral information, inconsistency in symptoms, and detailed antisocial behaviors. This was good stuff. Helpful stuff. Particularly because a central issue for me, in 2012, was trying to determine what mental illness this particular defendant had, if any. It was a breath of fresh air, really, to be able to get a true sense of what this person was like. Ultimately, it proved to be some of the most useful data, even though it was recorded 22 years before my evaluation.

As I read the records and took notes of my own, I wondered what had become of the resident who wrote those chart entries in 1990. I was curious if the resident had eventually gone into forensic psychiatry. Even though most of that decade's records were quite thorough, his notes were remarkably detailed and thoughtful. The kind of writing we are encouraged to do for

forensic evaluations during fellowship training. It seemed to me that this was a resident who should have gone into that field. I did some searching and, thanks to LinkedIn, I was able to find his contact information. Turns out he was still in New York, and was, in fact, doing some forensic private practice work. I decided I needed call this psychiatrist whom I had never had any contact with, introduce myself, and let him know how useful his notes written 22 years ago had been for my current evaluation.

I can only imagine how strange my enthusiastic call must have sounded initially: "Hi, my name is Natasha Cervantes. You don't know me, but I'm a forensic psychiatrist in Buffalo and I'm working on a case that had records from 1990 that you wrote when you were a second year resident... I just wanted to let you know what a pleasure it was to read your notes..." I don't have hard data, but I suspect that completely random calls from one psychiatrist to another psychiatrist solely to discuss their record keeping (much less their record-keeping from two decades before), are relatively uncommon, and when they do occur, are often tied to some kind of legal proceeding unfavorable to the psychiatrist that wrote the records, and not of a congratulatory nature.

So, I'm pretty sure I made his day. We had a nice conversation about forensic psychiatry, and how it had seemed to me that his notes from residency seemed to foreshadow that career path for him. He told me he had completed his forensic fellowship at Bridgewater State Hospital in Massachusetts, and had, in fact, worked with Dr. Tom Gutheil. And I wasn't surprised. Now I just hope that when we finally transition to our electronic record, that our blank slate and our ability to write narratives will be preserved; I wouldn't mind a random call in 20 years from another psychiatrist telling me my records were useful. That would make my week. ☺

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Drugs Made Me Do It

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ALI or Product Rule), the analysis is different. Knowledge of wrongfulness related to the ingestion of a drug is a different consideration from the ability to conform one's conduct to the law, under the effects of the same drug. Cases of substance-induced mania or psychosis leading to violence or suicidal acts are qualitatively different than cases in which non-violent crimes (such as fraud) are allegedly linked. This is one type of case in which there might logically be different outcomes depending on state insanity law—because it may be more likely for the offending medication to have caused a decrease in ability to refrain from an act, rather than meeting the stricter standard of the medication changing the actor's knowledge of wrongfulness.

Criminal behavior is often multi-causal, and each case must be considered in the totality of its circumstances. A clear timeline of symptoms, medications and offense should be constructed. Just as in other NGRI evaluations, rational vs. irrational motivation for the offending must be considered. ☺

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Guns and Mental Illness

Ryan Hall MD, Susan Hatters Friedman MD, Abhishek Jain MD, Renee Sorrentino MD

More than 30 mass shootings, defined as four or more victims not including the shooter, have occurred in the United States since the December 14, 2012 Newtown, Connecticut shooting.¹ Although mass shootings account for less than 1% of all homicides,² and studies typically find that only a small proportion of all violent crime is attributed to mental illness,^{3,4,5} these recent tragedies continue to ignite significant national debate, media coverage, and public concern regarding firearm legislation, particularly related to mental illness.

On May 3, 2014, at the American Psychiatric Association's Annual Meeting, the authors of this article presented a three-hour symposium titled "Taking Aim at a Loaded Issue: Guns, Mental Illness, and Risk Assessment." We reviewed the history of gun legislation as it relates to mental illness, the public policy implications of incorporating mental health issues in gun control, and the role of gun screening and firearm safety in routine clinical practice.

The national debate over gun rights and gun control is certainly not new, with firearms playing a critical role throughout United States history and the nation's relatively high gun ownership rate compared to other countries. The debate has famously included the two-century long argument whether the Second Amendment protects gun ownership as an "individual right," such as for personal protection, or only applies to a "collective right," such as for the purposes of a militia. The Supreme Court held, relatively recently in 2005, that the Second Amendment "protects an individual right to possess a firearm unconnected with service in a militia."⁶

Today, firearm legislation can be complex, fraught with political agendas, and particularly challenging to interpret when federal, state, and local laws intersect. Furthermore, laws restricting firearm possession by individuals with mental illness can create

an additional layer of confusion when trying to understand gun legislation. Clarifying which conditions qualify as a "mental illness" is very important. It is also necessary to appreciate the intention, goal, practicality, limits, and any potential drawbacks of legislation that specifically targets individuals with mental illness.

"Psychiatrists may be surprised to learn that in 1996 Congress passed a law preventing the CDC from funding research on gun control"

When writing and enacting public policy regarding mental illness and gun rights, considerations include: are the mentally ill really more violent than people without mental illness, what type of harm (to self or others) and violence (impulsive versus premeditated) can be prevented, what is the impact of the policy on our patients, and what is the impact of the policy on psychiatric practice. Within the last two years the Obama administration has suggested policies, and several states such as Florida, New York and California have enacted laws directly impacting these areas.

In January 2013, the Obama administration released "Now is the Time,"⁷ a 23-point plan for reducing gun violence. It proposed to make the schools in America safer (e.g. mental health first aid training, emergency plans), limiting access to firearms and ammunition (e.g. changes in background checks, assault weapon ban), and improving access to mental health care particularly for young people. Part of improving the background check system included encouraging states to provide "mental health records" to the National Instant

Criminal Background Check System (NICS), which at the time 17 states were essentially not providing for reasons such as concerns over HIPAA violations, citizen privacy, and security of the information.

The mental health community welcomed many of the suggestions made in "Now is the Time," such as encouraging funding to train 5,000 new mental health providers and encouraging research on the topic of mental illness and gun violence. However, some expressed concerns about privacy rights, federal expansion of "Tarasoff," and the general power of the federal government. Although the "Now is the time" proposals did not gain much traction on the federal stage, several of the recommendations have filtered down to the state levels in some forms.

While Florida is famous for the gun "gag law" for doctors (FL 790.338 Medical Privacy Concerning Firearms), which was recently upheld in the 11th U.S. Circuit Court of Appeals, Florida has also passed laws which are in line with the "Now is the Time" proposal. In particular, a 2014 law may require reporting a patient to the NICS system if the patient was brought to the emergency department involuntarily for an evaluation, even if the patient subsequently agrees to sign into the psychiatric hospital voluntarily.⁸

In New York, the *Secure Ammunition and Firearms Security (SAFE) Act* was passed in January 2013, which, like proposals in "Now is the Time," set restrictions on the amount of ammunition a gun can hold and set limits on assault rifles. Additionally, the SAFE act requires mental health professionals to report patients, who are "likely to engage in conduct that would result in serious harm to self or others," to the local director of community services. The director would then pass the information on to the department of criminal justices services (DCJS), who would support or revoke the patient's firearm license.⁹

In some states, such as California, provisions exist to confiscate guns from individuals on a list for a felony

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conviction, a domestic violence restraining order, or a history of mental illness.¹⁰

Although these laws attempt to protect individual and public safety by addressing potentially dangerous persons' access to firearms, these laws also introduce concerns such as breaching patient confidentiality, deterring patients from seeking treatment, and damaging doctor-patient relationships. There are also concerns regarding limitations with resources and enforceability. Patients may have realistic concerns about the confidentiality of mental health treatment if their psychiatrist has an increased duty to report. Similarly, psychiatrists may have concerns about dual agency and becoming *de facto* agents of the state.¹¹

Practical legal considerations must be also clarified. For example, what standard of proof is needed for physicians to report patients? If a felon is not permitted to purchase guns, he or she has to be found guilty beyond a reasonable doubt; for psychiatrists to report, the standard of proof is unclear. Likewise, liability concerns, such as a failing to report or breach of confidentiality by excessive reporting, should be addressed.

Furthermore, because only a small percentage of gun violence is perpetrated by the mentally ill, even if efforts are successful in preventing people with mental illness from possessing weapons, this would only prevent a small proportion of gun violence, potentially giving a false sense of security, and further stigmatize those with a history of mental illness unfairly.

Overall, not enough longitudinal data exists to determine which of these public policy interventions will be effective, survive court challenges, and potentially discourage people from obtaining mental health services.

The public's demand for gun safety in response to the national tragedies involving gun violence has inextricably led to psychiatry. A 2013 survey

found that 85% of the public supported the prohibition of guns in persons who were involuntarily committed or declared mentally incompetent by court, and about one-third of the public also supported the restoration of gun ownership rights in these individuals if they are no longer dangerous.¹²


However, does psychiatry have a solution to eradicate gun violence? At this time the answer is not entirely clear, but psychiatrists may have a role in primary prevention of firearm-related deaths by restricting suicidal patients from gun ownership. This is particularly striking when considering that about two-thirds of firearm-related deaths are actually suicides and not homicides, firearms are the most common method of suicide in the US,¹³ research demonstrates an increased risk of suicide among individuals with firearm access,¹⁴ and the vast majority of persons who commit suicide suffer from mental illness. It is unclear if we would have the same impact in preventing homicides.

Although the APA guidelines include inquiry of firearms when evaluating suicidal patients, little is known about what percentage of practitioners inquire about firearms in non-suicidal patients. Additionally, surveys suggest that only a small minority of mental health personnel knows enough about guns to understand the different types of firearms, the potential risks associated with a specific type of firearm, or how to counsel patients and families about gun safety. In one study, the majority of psychiatry residency training directors did not seriously think about providing firearm injury prevention training to residents.¹⁵

As we psychiatrists attempt to identify our role in firearm safety, we must acknowledge the poverty of research in this area. Psychiatrists may be surprised to learn that in 1996 Congress passed a law preventing the CDC from funding research on gun control; President Obama asked that this ban be lifted in 2013. The Institute of Medicine has also outlined research priorities about gun violence prevention.

We also have to consider educating

ourselves regarding firearm safety and its place in day-to-day clinical practice. Incorporating gun safety as an educational requirement in residency and beyond could be one reasonable step.

Our involvement as psychiatrists in the gun debate could be one of providing policy makers and the public about what we know and do not know about mental illness, accurately share our clinical experience and the evidence-based data, and identify areas for further research and education. Reiterating that mass casualties from gun violence are rare and difficult to predict, and reminding the public that most people with mental illness are not violent, can be one starting point. 

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Dear Editor:

I am writing in response to the article in the April 2014 AAPL Newsletter, "Inside Out: Are Publicly Accessible Sex Offender Registries a Good Idea?" In their otherwise excellent review and commentary on the ill-advised policies involving public notification (PN) and sex offender registries (SOR), the authors included the statement that "open SORs and PN can have the unintended effect of interfering with successful communi-

ty reintegration...." In my view, interfering with successful community reintegration is exactly the intended effect of these laws. They represent our society's horror and disgust that uniquely attach to sex crimes, our desire to stigmatize these offenders, and our attempts to have these people be somewhere else even when our sentencing structure does not permit continued incarceration. This is most effectively accomplished by sex offender civil commitment laws (not discussed in the article) that have

swept our country, in which community reintegration (successful or otherwise) is actively blocked, with the collusion of all three branches of government.

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Prescription Drug Monitoring Programs

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There is little disagreement amongst health care providers, legislators, public health officials and government executives that prescription abuse is an epidemic and needs to be addressed. It is also important that prescribers be engaged in and be part of the solution curtailing this epidemic. However, there are several ethics and legal issues that arise from laws such as New York's. Legal issues include standards of care and evidentiary standards for the information contained in these databases. Ethical issues include confidentiality, dual agency conflicts for prescribers, and informed consent.

Standards of care for prescribers are established from a combination of case law and statutory law. In states like New York, new statutory requirements generated by the PDMP will expand the standard of care, and may open new avenues for malpractice claims. These may include negligence in not checking a PDMP database prior to prescribing. Additionally, it is unknown what the evidentiary standard for information contained in the PDMP will be. This information may be admissible in criminal and civil courts. In New York, the Commissioner of the PDMP may disclose information from the PDMP without a subpoena to the wide range of medical and legal officials listed above. This would effectively give these individuals and their agencies access to mental health records for certain

individuals, without subpoena.

In addition to legal issues, there are also some important new ethics issues raised by PDMPs. Confidentiality is a prominent concern in the medical community, and psychiatric illness is particularly attended by significant stigma. PDMPs would allow for limited breaches in confidentiality that are mandated by the states that have employed them. As mentioned above, some of these breaches newly allow information to flow to individuals working in executive branch positions, including law enforcement. New York's PDMP also encourages providers to report suspicious prescribing to the Bureau of Narcotic Enforcement. Aside from the obvious confidentiality issues this raises, this also creates a new dual agency for the prescriber, in which he/she is both health care provider for the patient and agent for the state. This can place providers in a precarious position: having to choose between patient care and law enforcement. Unknown is the liability of a prescriber who reports suspicious activity by a patient or provider, when subsequently no criminal or illicit civil activity is found to have occurred.

There is little argument that prescription narcotic abuse is a growing epidemic in the United States, and that the solution will likely be complex and will involve many disciplines. PDMPs are a new, innovative mechanism aimed toward curtailing

prescribing practices that contribute to this growing epidemic. However, PDMPs raise interesting legal and ethical issues that have the potential to place prescribers in compromising positions with their patients and their colleagues. It is important to allow prescribers to address these issues and contribute to the formation of PDMPs in order to protect their autonomy and their patient and collegial relationships. ⁽⁴⁾

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45th Anniversary

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Juan, Puerto Rico in early December. Some New Yorkers fondly consider Puerto Rico to be a 6th borough of New York City. The AAPL members in Puerto Rico warmly and enthusiastically supported this expansion and it continues annually to this day (as does the Annual Meeting).

On Saturday January 24, 2015, Tri-State will present its annual conference on the topic of Forensic Psychiatry: Past, Present and Future. There will be presentations on civil cases, criminal cases, addiction psychiatry, correctional psychiatry and child and adolescent forensic psychiatry. In the evening, Tri-State will host a celebratory dinner to joyfully commemorate 45 successful years with a look to the future. All members of AAPL are warmly invited to attend both the conference and the dinner. For those members outside of the Tri-State area, January is a particularly easy time to get great theatre tickets and dinner reservations at some of the country's leading restaurants. Specific details will be sent to AAPL members later in this year. Come to New York and celebrate with us. ☎

Drugs Made Me Do It

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Intellectual Disability and the Death Penalty

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the APA's brief repeatedly in the opinion.

Interestingly in his dissent, Justice Alito also focused in part on the APA's brief. He wrote that the majority opinion was, "based largely on the positions adopted by private professional associations," which Judge Alito believed was a departure from prior court precedent. Justice Alito continued, in "prior cases, when the Court referred to the evolving standards of a maturing 'society,' the Court meant the standards of American society as a whole. Now, however, the Court strikes down a state law based on the evolving standards of professional societies, most notably the American Psychiatric Association (APA)."

Writing the amicus brief required the talents of amici counsel Aaron Panner for the American Psychiatric Association and Natalie F.P. Gilfoyle of the American Psychological Association.

The content of the brief had significant input from James Harris who was the lead author for the DSM-V Intellectual Disability section, as well as APA Committee on Judicial Action members guided by Committee chair Paul Appelbaum. Although AAPL signed onto the brief, AAPL as an organization was not able to contribute to the brief's content, given the tight time constraint from the time we received the draft brief to review until the filing deadline. ☎

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Marriott Harbor Beach Resort
Ft. Lauderdale, Florida

Forensic Psychiatry Review Course
October 24-26, 2016

47th Annual Meeting
October 27-30, 2016

Hilton Portland & Executive Tower
Portland, Oregon

Forensic Psychiatry Review Course
October 26-28, 2017

48th Annual Meeting
October 26-29, 2017

Hyatt Regency
Denver, Colorado



STATE OF CALIFORNIA

BOARD CERTIFIED/BOARD ELIGIBLE STAFF PSYCHIATRISTS

The California Department of State Hospitals (DSH) is recruiting psychiatrists for our facilities throughout the State to work with an extremely interesting and challenging forensic and civilly committed patient population. You will have the opportunity to consult directly with experts in the fields of psychiatry such as **Stephen Stahl, MD, PhD** and **Charles Scott, MD**. The diverse locations of our Hospitals offer the opportunity to choose an environment which appeals to your personal interests. Monthly salaries for Board Certified psychiatrists start at **\$18,622 - \$23,496** and for Board Eligible **\$18,146-\$22,833**. We allow for a flexible work schedule (e.g. four 10-hour workdays). In addition, some of DSH's other excellent benefits including medical, dental, and vision packages, **CalPERS retirement system with lifetime retirement pension** (defined benefit plan), license fee reimbursement, DEA fee waiver, malpractice insurance, tax-deferred compensation up to \$35,000 per year, paid vacation, 12 paid holidays plus one personal holiday, and seven days per fiscal year of CME leave. Voluntary on-call duty is compensated hourly over and above base salary. For consideration, email CV to Laura Dardashti, MD, at: Recruit.Psychiatrists@dsh.ca.gov or visit our website to fill out an on-line application. Phone: 916.651.5330.
Web: http://www.dsh.ca.gov/jobs/psychiatry_jobs.asp

Providing Expert Witness Testimony?

ARE YOU AT RISK?

Working outside the clinical psychiatry setting does not mean you are not exposed to professional risks. If your expert opinion or testimony results in litigation or an administrative action, you could end up with a financial loss - a risk many policies will not cover.

Get a policy that covers all forensic activities. Contact us today for your free quote! There's no such thing as a no-risk profession.

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DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES, TULANE UNIVERSITY SCHOOL OF MEDICINE in New Orleans, LA, is recruiting for several general and forensic psychiatrists (clinical track) for our growing department, at the Assistant/Associate Professor level, salary commensurate with experience. Candidates must have completed an approved general psychiatry residency and be board certified/eligible in general psychiatry and forensic psychiatry, respectively. Responsibilities will include direct patient care, teaching of medical students and house officers, and research (clinical and basic science) at various state hospitals, state correctional institutions, and at Tulane University Health Sciences Center. Time allocations will be based upon individual situations. Applicants must be eligible to obtain a Louisiana medical license. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Applications will be accepted until suitable qualified candidates are found. Email (poneill@tulane.edu) or send CV and list of references to Patrick T. O'Neill, MD, Interim Chair, Department of Psychiatry and Behavioral Sciences, Tulane University School of Medicine, 1440 Canal Street TB48, New Orleans, LA 70112. For further information, you may contact Dr. O'Neill, at 504-988-5246 or poneill@tulane.edu. Tulane is strongly committed to policies of non-discrimination and affirmative action in student admission and in employment.

Getting Off?

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why is this understanding not adopted by the criminal arena? Such discrepancies within our field potentially compromise our integrity. ☹

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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 allows faculty one day per week to pursue academic projects. Opportunities include competency and insanity evaluations, court testimony, medical student and resident supervision, and patient care.

Academic rank begins at the level of assistant professor and may be higher depending on credentials and experience. We provide very competitive pay and benefits, and will pay for moving expenses.

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
choi@ohsu.edu

Nominations Sought

The Nominating Committee of AAPL will be presenting a slate of Officers and Council candidates at the Semiannual Business Meeting in May, 2015.

Any regular 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); Treasurer (three-years); 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 Graham Glancy, MB, Chair, Nominating Committee, AAPL, P.O. Box 30, Bloomfield, CT 06002 by March 31, 2015.



AAPL Newsletter

American Academy of Psychiatry and the Law
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Charles Dike, MD, MPH, FRCPsych, Editor

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