

AAPL Newsletter

American Academy of Psychiatry and the Law



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American Medical Association 2015 Annual Meeting Highlights

Barry Wall, MD, Delegate, Ryan Hall, MD, Alternate Delegate, Jennifer Piel, MD, J.D. Young Physician Delegate



The American Medical Association's (AMA) June 2015 Annual Meeting in Chicago focused on policy, medical education, health initiatives, and elections for leadership positions. Dr. Steven Stack, an emergency medicine physician from Kentucky, was installed as President and Dr. Andy Gurman, a private practice orthopedic hand surgeon from Pennsylvania, was elected President-Elect. Dr. Patrice Harris, a child and forensic psychiatrist, who is a member of AAPL, was re-elected to her second term on the AMA Board of Trustees (BOT), where she currently serves in the position of BOT Secretary and will soon become the BOT's Chair.

The AMA Council on Ethical and Judicial Affairs (CEJA) presented reports on Ethical Practice in Telemedicine and Prescribing and Dispensing Prescription Medication Samples. Both reports were referred back for additional modifications. CEJA also presented its second official revised version for the modernization of the medical code of ethics. Code modernization, which started in 2008, is supposed to make both the

content and the presentation format of the medical code of ethics more appropriate for 21st-century medicine. Major revisions proposed at this meeting were to further define terms such as “must,” “should,” and “may” to make it more evident what discretion physicians have when dealing with ethics situations and to address medico-legal concerns with these terms. Use of the word “*must*” was proposed to indicate that an action is ethically required and physicians cannot use individual judgment or discretion. The example provided in the report was “Physicians who testify as fact witnesses in legal claims **must** deliver honest testimony.” *Should* was proposed to indicate an action or obligation that is strongly recommended as a matter of professional ethics, but which may have some exceptions such as special circumstances or considerations. The examples for the usage of *should* were “Physicians **should** routinely inquire about physical, sexual, and psychological abuse as part of the medical history,” and “In general, physicians **should not** treat them-

selves or members of their own families. However, it may be acceptable to do so in limited circumstances in emergency settings ... or for short-term, minor problems.” *May* was proposed to be defined as an action is ethically permissible when qualifying conditions are met. The example given for the usage of *may* was “Physicians **may** disclose personal health information without the specific consent of the patient to other health care personnel for purposes of providing care or for health care operations.” Although these changes were proposed, there was still concern regarding word usage in the code as well as the process by which the code was being presented to the House of Delegates. Until the modernized code is approved, the current existing AMA code of medical ethics is still in effect.

Among other general highlights, AMA delegates passed resolutions limiting non-medical exemptions for childhood vaccines; advancing military medical policies for transgender individuals (a resolution by a psychiatrist from the Gay and Lesbian Medical Association), supporting a two-year grace period for implementation of ICD 10 for purposes of CPT coding, supporting study by AMA on means to prevent violent acts against health care providers; and a call for more transparency and education surrounding Maintenance of Certification. In addition, the BOT issued a report regarding background checks for firearm purchases, which referenced and closely mirrored the American Psychiatric Association policy. However, there was debate on the floor as to whether the policy would require background checks for all purchases and transfers or only for purchases (e.g. may be limited times where transfers for safety such as with a suicidal patient should not be delayed). The report was referred

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COVER STORY

American Medical Association

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back to the BOT for more study.

Resolutions which had specific forensic psychiatric themes included; Mental Health Crisis Interventions resolution, Maintaining Mental Health Services by States resolution, and Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill. These resolutions encouraged the AMA to support identification, referral and treatment of the mentally ill along with education of law enforcement as a way to try to reduce incarceration of the mentally ill. Many of the recommendations made were consistent with the recently announced APA initiative with local governments called: 'Stepping Up' to Reduce the Number of People with Mental Illnesses in U.S. Jails.

“This year, the topics of Googling one’s patients (e.g. using social media to obtain information) and cultural sensitivity were discussed.”

In addition to the House of Delegates activities, CEJA also hosted an open forum to obtain input from members. This year, the topics of “Googling one’s patients” (e.g. using social media to obtain information) and “cultural sensitivity” were discussed. The primary concern in the social media discussion was patient privacy if a physician obtained or discovered information using social media. The discussion included examples of the doctor-patient relationship being potentially damaged due to information discovered, questions if information in social media was different from information printed in newspapers, and how state-maintained controlled substance databases could be affected. A point

raised by a delegate not related to AAPL is that social media is becoming more prevalent in forensic work in general, as well as in clinical work, as a way to reduce waste, fraud, or abuse. It was the contention of that delegate that if CEJA does issue an opinion on use of social media regarding patients, CEJA needs to keep in mind the potential benefit to society from physicians’ use of social media, as well as the potential harm to the patient. The AAPL delegation requested that if CEJA does issue an opinion on this topic, it should issue two separate opinions (one on clinical situations and one for forensic situations) or at least acknowledge that clinical use of social media may differ from use in forensic settings. No direct forensic concerns were raised in the cultural sensitivity discussion which focused more on how to define and teach the topic.

AAPL Delegate Dr. Barry Wall again served as Co-vice-chair for the psychiatric caucus. In addition, he again worked with the medical student section on resolutions regarding solitary confinement in adults. Dr. Wall’s work and input with the medical student section was influential in shaping the approved resolution regarding children at the last meeting and how the medical student section will approach correctional issues in the future.

AAPL Alternate Delegate Dr. Ryan Hall served as an election teller, which required him to assist in overseeing the election process and certifying the votes.

Young Physician Delegate Dr. Jennifer Piel again served as the Chair for the Young Physicians section’s Internal Resolution Committee (see attached photo).

The AAPL Delegation would also like to announce the Council’s appointment of a new Alternate Delegate, Dr. Linda Gruenberg, and a new Young Physician Delegate, Dr. Tobias Wasser. Dr. Ryan Hall has rotated out of the AAPL’s Young Physician Delegate position but will remain active in organized medicine. AAPL thanks Dr. Hall for his leadership skills within

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On The Question Of Being An Expert Psychiatrist

Charles C. Dike MD, MPH, FRCPsych



The visit of the Pope to the USA generated a rare sort of frenzy that crossed socioeconomic and political divide rarely seen

these days in the US.

Of particular note however, is the observation that one of the most powerful men in the world, leader of over 1.2 billion Catholics worldwide, celebrated mass regularly, a basic activity of ordinary (please excuse my use of this word) Roman Catholic priesthood. Surrounded by numerous Cardinals and junior priests, it would easily be understood and successfully argued that at the level of the Pope - his experience, age, authority, and so on - he did not have to celebrate mass. He could delegate it to junior priests, his mere presence alone being sufficient.

Please allow me to digress. A general surgeon friend of mine in private practice recently told me she was about to lose hospital privileges to perform surgery because she had not yet met yearly goals to maintain privilege; she would need a certain number of hernia repair, thyroid, gallbladder, breast and other specified surgery in order to be considered up to date and therefore, safe to practice, regardless of the fact she has been in practice for 20 years and is a seasoned surgeon by all account. Not meeting the required amount of surgeries meant she would no longer be considered proficient; she could no longer claim to be an expert in these surgeries some of which she could practically carryout with eyes closed. Quite understandable. Even I would not be comfortable subjecting myself to her knife if the data showed her numbers to be that low!

In my own practice, I was surprised one morning when my first

patient asked if her blood pressure which I had just taken, was in keeping with the “newly released” guidelines about normal blood pressure. I had not been aware that earlier that morning there had been discussion in the news about precipitous termination of research on blood pressure by the NIH due to robust findings suggesting that what we currently consider normal blood pressure for age was too high.

It wasn't until much later when I had a chance to read the New York Times that I understood what she had been talking about. Translation? A lot of our patients are informed and up to date. With multiple news media and social media network, patients get information as soon as (sometimes even before) they are published. A practicing physician/psychiatrist cannot afford to rely on old clinical information alone.

Along those lines, a psychiatrist colleague in solo private practice confided in me his embarrassment when a new patient informed him she was on Viibryd, a new antidepressant prescribed by her general practitioner. At the time, the psychiatrist had not heard of Viibryd but he was smart enough to immediately quell his rising knee jerk response to the patient that she must have made been mistaken because Viibryd was not an antidepressant. You can imagine his surprise when he later checked and, sure enough, Viibryd was there! As new psychotropic medications come on the market, it is sometimes difficult for psychiatrists long in private practice, especially if not in a large group practice, to become aware of them, understand their mechanism of action, important drug-drug interaction and side effects. In the old days (should I say good or bad old days?), pharmaceutical representatives served a critical function for these psychiatrists by making them aware of the new drugs they were promoting,

thereby prompting the psychiatrists to learn about them. I can almost hear sharp criticism from colleagues in academic institutions, large private practice groups who still get visits from drug reps, or the proactive solo practitioner who diligently seeks out new knowledge; “that is the reason for obtaining CMEs,” they assert. In reality, however, many of our colleagues are often caught unawares by new medications or new research in pathophysiology, pharmacology, psychotherapeutic interventions, neuroscience, genetics, and so on, that guide development of new biopsychosocial treatment.

Of course, practicing psychiatrists eventually become aware of new developments in the field, often when researching treatment alternatives for patients unresponsive to usual treatment. Additionally, they are often the first to recognize side effects to new medications not yet listed in the compendium of instructions or the medication insert. By virtue of their ongoing interaction with patients, including grappling with the challenges of managing complicated illnesses refractory to medications, working with other professionals involved in the patients' care and working with some difficult family dynamics or other socioeconomic realities that negatively influence their patients' illness, these practicing psychiatrists maintain their expertise and clinical acumen.

Its is difficult to explain how psychiatrists who have not treated patients for years and struggled with the challenges discussed above could still be considered experts in psychiatry. When my surgeon friend mentioned earlier learned of this situation, she was nonplussed. However, she recovered quickly and quipped; “What does it matter, you are not real doctors anyway, are you? Otherwise, how could anyone accept expert advice from a non practicing doctor in a field that is rapidly evolving?” I did not believe myself bright enough to respond to her tongue-in-cheek comment/question, so I let hang in the air. ☹

Everything You Need To Know About NCR/Insanity Acquittees - But Were Afraid To Ask

Graham D. Glancy, MB, ChB, FRCPsych, FRCP (C)

For my third and final newsletter article in the series I was about to write a review of the year from my viewpoint, when my eye was drawn to a series of articles in the Canadian Journal of Psychiatry. These articles are so central and quintessential to forensic psychiatry that I felt it my duty to draw the attention of our members to these articles³⁻⁷.

In Canada “not guilty by reason of insanity” (NGRI) has been referred to as not criminally responsible due to mental disorder (NCR-MD) since our laws were struck down by the Supreme Court of Canada (SCC) in the case of *R v Swain*². The SCC in this case made the decision that it was unconstitutional for an accused person to be held “at the pleasure of her majesty” and gave Parliament the task of modernizing the law, which duly ensued in 1992. The test remained a modified McNaughton test but the language was modernised and the scheme of gradual release into the community was clarified. The new language codified the established scheme of having provincial review boards regularly reviewing the accused (this is the term used to describe the person from the initial court assessment until they are absolutely discharged) and set a clear test that an absolute discharge was warranted unless there was evidence that the accused remained a significant threat to the safety of the community. This latter phrase was clarified in the case of *R v Winko* where in it was ruled that there must be affirmative evidence of this threat for the accused to be detained or to be given a discharge with conditions¹. It is important to note that all provinces and territories in Canada operate a federal criminal code. The code allowed the review board the provisions to detain an accused in a minimum, medium or maximum-security hospital or to discharge the accused

into the community with a variety of conditions. Typically these conditions would include reporting to the hospital at specified intervals, living in supervised accommodations, abstaining from drugs and alcohol, and not owning any weapons, amongst others. Once under this scheme, the accused is generally followed up by forensic services. This follow-up might include a significant stay in hospital, often with declining

“However another striking finding may be significant in that in Ontario 100% of review boards were attended by a prosecutor, whereas in Québec only 7.3% of boards had a prosecutor present.”

levels of security from maximum to minimum, with excellent outpatient care once the accused is discharged with conditions. This outpatient care commonly includes regular contact, outreach services by community psychiatric nurses and social workers, administration of medication, and supported housing. It might include early intervention, which could include recall to Hospital, if the situation warrants. It has commonly been said that this is the “platinum key” to psychiatric services. It has been suggested that the legislative changes made the NCR-MD option more attractive to people charged with relatively more minor offenses.

A recent series of papers, which represented the work of the “Trajecto-

ry Project,” was published in the Canadian Journal of Psychiatry³⁻⁷. A team of researchers across the nation was set up to study and accurately describe the characteristics of all those found NCR-MD immediately following the Winko decision referred to above. They looked at 1800 accused persons, who are the total of accused persons found NCR-MD between 2000-2005 in the three most populous provinces of Canada, namely Ontario, Québec, and British Columbia. These papers make compelling reading, and I will try to summarize some of the key findings.

Recently in Canada there has been an upswing in publicity regarding three or four sensational cases where the accused either claimed or were found NCR-MD. This led one esteemed journalist to call me regarding an article on the increased number of accused using the NCR-MD defense. I was able to reassure him that in fact the rate remained very low and this was confirmed by the study, which confirmed that in Ontario only 0.95 cases per thousand decisions resulted in a NCR-MD finding, although it was a significantly higher proportion in Québec (6.08 per thousand). There is no evidence that this rate is increasing, and in Ontario I was able to discuss these findings with the Chair of the Review Board, the Honorable Justice Schneider, who noted that the figures have been stable over the last approximately 10 years, and in fact suggested a recent decline in the last year. Despite some linguistic and cultural differences, the epidemiology of people in Québec and the other provinces is quite similar. A possible explanation for this disparity may be that Québec tends to use the NCR-MD schema as a kind of Court mental health diversion. The provincial delivery of care has a somewhat different model in Québec in that the follow-up tends to be delivered less by specialist forensic services throughout the province than in the other provinces.

One of the most important findings is that 72% of persons found

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Justice Kennedy Takes On Solitary Confinement In The Correctional System

Jeffrey S. Janofsky MD



"Sentencing judges, moreover, devote considerable time and thought to their task. There is no accepted mechanism, however, for

them to take into account, when sentencing a defendant, whether the time in prison will or should be served in solitary. So in many cases, it is as if a judge had no choice but to say: 'In imposing this capital sentence, the court is well aware that during the many years you will serve in prison before your execution, the penal system has a solitary confinement regime that will bring you to the edge of madness, perhaps to madness itself.' Even if the law were to condone or permit this added punishment, so stark an outcome ought not to be the result of society's simple unawareness or indifference."

So wrote Justice Kennedy in a concurring opinion in *Davis v. Ayala*¹. Ayala was found guilty of and was sentenced to death for a triple homicide. The Court held that any federal constitutional error that may have occurred by excluding Ayala's attorney from part of a Batson hearing was harmless error. While Justice Kennedy joined the majority opinion in all respects, he wrote separately on an issue that had, "no direct bearing on the precise legal questions presented" in the case. Based on Ayala's counsel's statement during oral argument that his client had "served the great majority of his more than 25 years in custody in 'administrative segregation' or, as it is better known, solitary confinement," Justice Kennedy went on to describe the history of solitary confinement. Justice Kennedy reviewed the existing legal and scientific literature, including Metzner & Fellner's work in JAAPL². While acknowledging that solitary confinement may be nec-

essary temporarily in some instances he concluded that, "the judiciary may be required, within its proper jurisdiction and authority, to determine whether workable alternative systems for long-term confinement exist, and, if so, whether a correctional system should be required to adopt them."

Although clearly dicta, Kennedy's thinking around the use of long term segregation in correctional settings is instructive for all of us who practice in correctional settings and/or who are interested in public policy.

In 2012 the APA published its Position Statement on Segregation of Prisoners with Mental Illness. The Position Statement and its back-

"Results disproved the researcher's hypothesis that inmates, with or without mental illness, would experience significant psychological decline in segregation."

ground material support Kennedy's opinion. The Position Statement notes that prolonged segregation for inmates with severe mental illness should be avoided, and that if an inmate with severe mental illness requires segregation access to out of cell mental health treatment and unstructured recreation time should be provided³.

A recent study by O'Keefe, *et al.* not cited in Kennedy's concurring opinion, tends to disprove Kennedy's reasoning, at least for segregation of inmates for one year or less. Noting that past studies on the deleterious mental health effects of segregation have been cross sectional studies that

had many technical defects, O'Keefe *et al.* designed a randomized trial to study "to parse out the effects of segregation from those of other prison environments."⁴ The researchers followed four groups for one year: inmates in general population and inmates in segregation, each group further divided into those with and without severe mental illness. Results disproved the researcher's hypothesis that inmates, with or without mental illness, would experience significant psychological decline in segregation. Instead both the mentally ill and non-mentally ill segregation groups showed a reduction in symptom severity. The author's emphasized several flaws in their own study, including problems with generalizability across correctional systems writing, "We do not claim, nor believe, that these data definitively answer the question of whether long-term segregation causes psychological harm."

Study of best practices for segregation of prison inmates remains an important issue that is difficult to study. Future work on this issue is crucial, however, in order to allow Justice Kennedy and other jurists to determine whether workable alternative systems for segregation exist, and, if so, whether a correctional system should be required by the Court to adopt them. ☐

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Ask The Experts

Neil S. Kaye, MD, DFAPA, and Graham Glancy, MBChB, FRCPsych, FRCP

I want to personally thank Bob Sadoff, MD, who has co-authored this column with me since 2008. His friendship and mentoring has been a critical influence in the development of my own career. As Bob steps down, I welcome Graham Glancy, MD as my new co-author. Graham is well known to AAPL members and has served as President of AAPL. He brings a new international view to the column and I look forward to writing together.

Neil S. Kaye, MD, DFAPA and Graham Glancy, MBChB, FRCPsych, FRCP (C), will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send question 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.: I worked really hard on a losing plaintiff case. The lawyer has asked me to reduce my bill due to the poor outcome. Is this allowed?



A. Kaye: My real advice is to avoid getting into this kind of situation. First, I require a retainer when I first get the case and my retainer agreement makes the following clear: I require payment in full for all work done prior to testimony. I also require payment for my expected time in court (billed by the day on most cases) in order to get me to come to court. I explain to the lawyer that paying me in advance is not just my requirement, but also helps her case. I am easily able to explain to the jury

that my opinion is truly unencumbered. Since I have already been paid in full, there is obviously no possible connection between my testimony and being paid, and thus I am impartial with respect to the trial outcome.

However, to answer the question more directly: There is nothing that prevents you from reducing your bill, should you so desire. In some cases I will agree to a fee reduction based on how I feel about the case and my relationship with the lawyer. I also will ask the lawyer what her reduction in billing will be and may agree to match that in some way. Forcing the lawyer to give back to her client seems logical, if I am being asked to do likewise.



A. Glancy:

Firstly would like to say how honored I am to step into the shoes of the great Dr. Robert Sadoff, one of the pioneers of forensic psychiatry. Dr. Sadoff has been instrumental in shaping forensic psychiatry as we know it today, so it is with great trepidation that I try and replace him as Dr. Kaye's co-author on this column.

I have to agree with Dr. Kaye regarding the importance of spending time on the initial stages of the referral so as to avoid difficulties later. It is at least helpful, if not essential to distill one's initial discussion with the lawyer into a written retainer agreement, which will request an agreed upon retainer fee prior to beginning the case. Time spent at this juncture of the referral avoids a lot of nastiness and potential misunderstanding later on. I concur that having a retainer fee in hand facilitates our role in maintaining objectivity and honesty.

Many lawyers in civil cases take a case on a contingent basis, whereby they are only paid according to the

outcome of the case. However we must be clear as forensic psychiatrists, the AAPL ethical guidelines strictly prohibit working on a contingency basis.

In certain cases it may be reasonable to accept a case at an hourly rate lower than the usual rate that one generally charges. A case that is especially worthy, or where it is clear that the client will not be able to afford the psychiatrist's usual fee schedule may fall into this category. In certain cases involving issues of social justice it is not unreasonable to work pro bono.

Returning to the question at hand, Tom Gutheil, MD reminds us that although forensic psychiatry can be stimulating and fascinating, it is also way of making a living. One must pay attention to the business aspects of the practice. That does not mean that one should be ruthless, but rather that our relationship with lawyers is an important component of the business. Sometimes in a case one finds that one has billed over the original estimate. However if, as in the case at hand, the outcome is poor, one may be tempted to write off the last part of the account or offer a professional discount. This maintains your relationship with the lawyer who is likely already somewhat disappointed. From a business point of view this may be worthwhile in the long run.

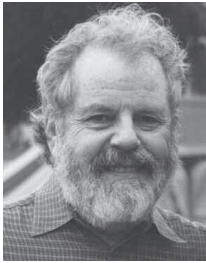
I am reminded of the quotation from the torah that Dr. Sadoff used in his high school valedictorian speech, "everything is foreseen, yet the choice is given". As long as we are careful to follow our ethical guidelines we can make certain choices.

Take Home Point:

Relationships with lawyers are always a combination of personal and professional. There is a risk in trying to please a referring lawyer of losing impartiality and objectivity. Yet, there is a reality in running your business, as to what decisions are good business decisions but still consistent with the ethics code of our profession. ☯

Whose Embryo Is It?

Stephen P. Herman MD



The case started like this: A Chicago physician, diagnosed with cancer, asked her boyfriend to provide sperm so that embryos could be

created to be used after her cancer treatment. The boyfriend agreed. There was no written contract. She had made no demands on her boyfriend, promising to assume all expenses. However, she and her boyfriend broke up. Despite advice from an attorney, the couple had not signed a co-parenting agreement, and so after the breakup, the conflict began.

The ex-boyfriend did not want the embryos used, while the woman did. The case was litigated. A lower court ruled in favor of the woman, saying her position outweighed the man's. An appeals court disagreed, saying that standard was not tenable. Instead, the lower court should consider a balance of interests. In the lower again, the judge again ruled in favor of the doctor, saying she and her now ex-boyfriend had made an oral agreement.

Each side's attorneys made arguments. The man's attorney said no embryos should be implanted if one party is in opposition. The woman disagreed, writing that her ex-boyfriend had at one time agreed to the plan. The case is still pending.

As we know, scientific advances have moved reproductive technology far along from what was ever dreamed before. For some divorcing couples, the issues of frozen embryos might be yet another factor to consider. More and more attorneys are facing this dilemma with their clients. The law is way behind. There is not a judicial presumption or solid case law to provide guidance.

A Tacoma couple produced two embryos through a surrogate. The couple divorced. The ex-husband

wanted any embryos created to be implanted in a surrogate mother and should be raised by a husband and wife – not a single parent. A court ruled in his favor.

Where is a solid argument here? It seems as though judges are flying by the seat of their robes. The ethical implications are enormous. However, uniform standards are lacking.

A Michigan couple fought for years over the fate of their frozen embryos after their divorce. The ex-wife wanted more children; the ex-husband did not. The judge ruled in the man's favor, saying that he had a right not to have the embryos implanted, since he did not want them.

“For some divorcing couples, the issues of frozen embryos might be yet another factor to consider.”

In the coming years, courts might rule in favor of men who do not want embryos used. But why is this a stronger argument than a woman's right to have the embryos implanted? There are no guidelines. The issue seems to be up to a judge faced with an almost impossible situation. Standard recommendations seem to be to consult with an experienced divorce attorney and try to sort it all out. The arguments can be strong for either side.

This conflict is the ultimate in custody disputes. Can this be a forensic issue? There will probably come a day when we will be asked to get involved. The forensic expert should stay away from offering a specific opinion. We are not trained to do this. However, we can evaluate each parent and provide psychiatric profiles to the court. This could help judges understand the context of parents' choices. Some may argue, however, that there is no role for us here. There are no easy answers. But it is an area of extreme interest. More behavioral research is needed.

What do you think? ☪

Everything You Need To Know

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NCR-MD had previous psychiatric hospitalizations. In fact most had two or more prior admissions. This suggests that the psychiatric system failed these patients and that we need to consider ways to prevent the situation becoming so dire as to lead to criminal charges. This might include measures such as better outreach services, more availability of emergency or safety beds, and as the authors suggest, better training of violence risk assessment for general mental health workers. This is also reflected in the finding that Québec has a lower offense severity than the other provinces. For instance homicide or attempted murder makes up 7% of the offenses across the board, but only 3.2% in Québec. Interestingly recent criticisms of forensic psychiatrists in the press, and even by the provincial psychiatric association, have been the most vociferous in the province of Québec. It is evident that two thirds of the offenses were offenses against the person. It is also of note that family members are most at risk of being the victims of violence, followed by mental health workers. This is in contradistinction to the public viewpoint that strangers are frequently the victims of violence perpetrated by the mentally disordered.

It would be of no surprise to our readers that 94% of the proband suffered from a psychotic spectrum disorder and a third of these had comorbid substance abuse. I was surprised that only a third had comorbid substance use disorders, a figure that is actually lower than the comorbidity in individuals suffering from major mental illness. It is possible that the presence of substance abuse increases the blameworthiness of the accused and perhaps led to guilty verdicts.

Previous impressions had suggested that accused persons spend less time in the NCR-MD schema in Québec than in other provinces. The findings of this project revealed that

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indeed there were significant inter-provincial differences. After one year 74% of people were still under the review board in Québec, compared with 92% in Ontario. The difference after five years was more striking, demonstrating that 19% of NCR-MD cases in Québec compared with 58% in Ontario were still under the review board. British Columbia was intermediate regarding all these findings. There was also a measurable difference between those who were still detained in custody (meaning in a hospital) in that after 5 years; only 23% were in hospital in Québec compared with 79% detained in Hospital in Ontario.

There are also significant differences in the practices of the Review Board between the provinces. For instance in Québec only 65% of the accused were represented by counsel, compared with 96% in Ontario. Considering that accused persons in Québec are discharged from hospital more quickly and received absolute discharge more quickly, it could be argued that they do not really need a lawyer. However another striking finding may be significant in that in Ontario 100% of review boards were attended by a prosecutor, whereas in Québec only 7.3% of boards had a prosecutor present. It is possible that this was one of the reasons for the more measured, conservative approach of Ontario. It is interesting to note that the HCR-20 was generally used by the clinicians in coming to their conclusions related to significant threat and risk management. In 87% of cases there was agreement between the clinical recommendations and review board decision. Factors that appeared significant in effecting the decision of a discharge with conditions included a lack of past offenses, a less severe index offense, and the presence of a mood disorder diagnosis. There was a strong trend, which did not reach significance, that the absence of sub-

stance abuse and personality disorder also contributed to the decision to discharge somebody with conditions. All these factors would be taken into consideration using a structured professional judgment instrument such as the HCR -20, which was generally used by clinicians and presented in evidence to the board.

In part four of the series, the recidivism rates were presented and discussed. The three year recidivism rate post index offense is 10% in Ontario and 21.5% in Québec, that is, twice as high. This is likely reflective of the fact that accused persons from Québec have the lowest severity of criminal offense originally, were

“It is interesting to note that the HCR-20 was generally used by the clinicians in coming to their conclusions related to significant threat and risk management.”

under the review board for a shorter period of time, and generally reoffended with a relatively minor offense. In fact the figures showed that people who had committed a severe offense had only a 6% recidivism rate involving an offense of any kind. In fact the recidivism rate of a severe violent offense within three years was an extremely low 0.6%. It is of note that following absolute discharge the recidivism rate rose to 22%. Despite the fact that these accused persons were noted to be doing well, cooperating with treatment, and were judged not to be a significant threat to the safety of the community at the time of their absolute discharge, after discharge they are often not given the services and structure of the review board schema and this leads to an upswing in recidivism. This recidivism is not necessarily a serious violent offense

against the person. The authors note that these figures should be compared with the general recidivism rate in the same time period, which would be 34%; and even more startlingly, against an inmate population treated for mental disorder and released, who have a recidivism rate of 70%⁸. This does demonstrate that the NCR-MD schema provides services that seem to manage people quite well and not only serve the needs of the accused but significantly reduces the recidivism rate and thereby protect the public.

Factors that predicted recidivism included number of previous offenses, substance use disorders, and rates of personality disorder. A severe index offense had an inverse relationship with recidivism. These findings suggest the clinicians and review boards, as noted above, are giving weight to the right factors in predicting whether the accused is a significant threat to the safety of the community.

In conclusion I would advise all forensic psychiatrists to review these articles in detail. In this article I have attempted to summarize some of the more salient findings. The findings were reassuring in that accused persons under the MD –NCR schema seemed to be receiving excellent services, which, contrary to some assertions, significantly reduce recidivism to lower levels. It was also reassuring to note that both clinicians and review boards, who are essentially in agreement, are taking the salient factors into account in coming to their conclusions. ☯

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Cheryl Regehr, PhD

By Philip Candilis, MD



The inspiration for public service was critical for the Provost of the University of Toronto, a long-time friend to the American Academy

of Psychiatry and the Law. Winner of AAPL's 2004 Amicus Award, Professor Cheryl Regehr grew up in a family that served as a haven for foster children with special needs – children who benefited enormously from the teaching and social work backgrounds of her parents. Now a social work scholar and educator herself, Dr. Regehr has made a career of forensic mental health and fosters a university environment that nurtures students focused on community and societal needs.

Trained in emergency and forensic mental health, Dr. Regehr studied both victims and perpetrators of sexual violence – writing her doctoral dissertation on factors that contributed to the resilience of rape survivors. Early attachment, quality of relationships, and cognitive orientation all mattered to those recovering from sexual assault.

Moreover it was the structure offered by the community that contributed to a better outcome. Support systems, counseling, and educational efforts joined personal factors to influence the choices available to survivors and underscore the importance of systemic solutions to broad concerns like sexual violence.

In student health for example, Provost Regehr advocates preventive education on sexual violence, robust mental health services, supports for those harmed, and procedural fairness for the accused – a systems-based process that values individual and community integration.

Traceable to her work in emergency management, Dr. Regehr draws on her leadership of the clinical team at Toronto's Pearson Airport, where most APA members recently landed

for their annual meetings. Planning for all aspects of an airport emergency allowed for a comprehensive view of problems that might arise for her as chief executive officer of a major university.

Studying trauma in emergency service workers was a related element of her work, as Cheryl explored the factors influencing recovery from the stresses of public safety. What effects does exposure have among those responding to emergencies, and is there a related effect on public safety? It is not inconceivable that PTSD and related symptoms will have an impact on decision-making in a crisis. In work presented over the past two years at AAPL, Dr. Regehr identified influences of clinicians' PTSD on suicide risk assessments as well as among police officers and paramedics.

“Studying trauma in emergency service workers was a related element of her work...”

Dr. Regehr's contributions to AAPL are long-standing. First presenting in 1988, Cheryl appears regularly to present results or participate on panels. Her work has appeared on eight separate occasions in the AAPL Journal. AAPL's strength is that it lies in the frequent start of important ideas in the clinical realm that then develop into research that is itself applicable to clinical practice, she says: “There are few organizations that exhibit that connection between research and practice.”

One project that stands out in Dr. Regehr's work is a collaborative project with current AAPL President Graham Glancy, analyzing Battered Woman's Syndrome (BWS) defendants who had killed their partners. Their analysis of the elements of the defense required by the Canadian Criminal Code led to a better understanding of the factors distinguishing BWS cases from others. The prolonged nature of intimate partner vio-

lence and the fatalistic sense that there was no way out emerged as a critical part of the mind-set of defendants who felt they would die if they did not protect themselves with deadly force.

Whether leading a social work research center, a sexual assault center, or a major international university, Professor Regehr has found the multiple perspectives of forensic work instructive in analyzing complex social and communitarian issues. “It's easy to hold a singular theoretical and political view,” she says. The challenge lies in seeing complex human behavior from the perspective of many constituents and stakeholders. AAPL Amicus Cheryl Regehr does exactly that. ☪

Everything You Need To Know

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Extremism, Radicalization, and Terror: Can Psychiatry Help?

Mustafa A. Mufti, MD



On August 8, 2015, a “normal” appearing young couple in Mississippi was arrested for attempting to travel abroad to join the Islamic State of Iraq and the Levant (ISIL). Muhammad Oda Dakhalla, a 22-year-old male, and Jaelyn Delshaun Young, a 20-year-old female, had no known legal history and potentially bright futures. Ms. Young, a high school honors graduate and cheerleader, was what the Vicksburg Post called “an all-American Girl.” Mr. Dakhalla was about to start graduate school in Mississippi. His taekwondo instructor described him as calm, attentive, and focused, adding that the charges did not fit his character at all.

It appears that that these two young adults’ political and religious views led them to being radicalized—willing to pledge their allegiance to a known terror organization. Charged with making supportive statements regarding ISIL, Ms. Young was allegedly pleased to learn about the attack on Marines in Tennessee, while Mr. Dakhalla allegedly indicated that he was willing to fight for ISIL. The question that comes to mind is what drove this young couple to this point? What, if anything, caused them to be vulnerable to this degree of radicalization?

We have all been witnesses to numerous unfortunate incidents where a person’s or group’s political, racial, or religious extremist views led them to acts of violent extremism and terror. The public’s immediate response is, “They must have been crazy.” There is debate among scholars regarding the degree to which mental health issues plays a role in the radicalization process—a subject for forensic psychiatric inquiry. Coleman and Bartoli, in “Addressing Extremism,” (<http://www.tc.colum->

[bia.edu/i/a/document/9386_WhitePaper_2_Extremism_030809.pdf](http://www.tc.columbia.edu/i/a/document/9386_WhitePaper_2_Extremism_030809.pdf)) stated, “Extremism is a complex phenomenon, although its complexity is often hard to see. Most simply, it can be defined as activities (beliefs, attitudes, feelings, actions, strategies) of a character far removed from the ordinary. In conflict settings it manifests as a severe form of conflict engagement. However, the labeling of activities, people, and groups as ‘extremist,’ and the defining of what is ‘ordinary’ in any setting is always a subjective and political matter.” For the purposes of this article we will refer to extremism as an ideology that is outside the mainstream of society or religion.

What would cause otherwise “normal” individuals to commit or plan an act of violent extremism, and is there any way to identify these individuals? Most individuals with extreme views never go on to commit a shooting in church or school, or become living bombs. What is the most common characteristic among individuals who commit terroristic acts? Unfortunately, for prevention purposes, the most common characteristic seems to be their apparent normality within society.

McGilloway and colleagues (Int Rev Psychiatry, 27:39–50, 2015) spoke of how the criminal justice framework concentrates efforts on small numbers of convicted terrorists. They suggested that we should look into ways to approach this as a population-based public health concern. Taking that into consideration, what are potential risk factors for violent extremism? What could and should we do if we feel one of our patients is heading down the path of radicalization? Perhaps we could obtain collateral information from family or friends or even go to the extent of notifying law enforcement agencies. However, if there is no imminent risk of harm, can we break confidentiality? What if we were not accurate in

our assessment? Could premature or inaccurate timing increase the risk of radicalization? One may consider doing standardized risk assessment such as HCR-20 on patients who may appear at risk, however its application in violent extremism may not be as specific as in the population it was normed.

Literature suggests that there is no single cause or route responsible for engaging in violent extremism. Radicalization is a process of change, hard to observe clinically. However, some individuals may be predisposed to this change. Some known risk factors for extremism include depression, social isolation, sense of inequality and injustice, and perceived discrimination. Researchers have suggested that by providing support and mental health treatment in the early stages we may be able to prevent the entry into the early stages of violent extremism.

What then can we do for those who have already been radicalized? A National Public Radio report indicated that more than 60 Americans have been accused of joining or supporting ISIL. If they are incarcerated with no effort toward de-radicalization, we risk their going further down this path or even “infecting” other inmates. The process of de-radicalization is one that is being studied both at home and throughout the world. Programs in United Kingdom, Denmark, Saudi Arabia and the United States are working to help solve this issue. Kruglanski and colleagues (Political Psychology, 35:69–93, 2014) note that many of these programs have a multifaceted approach. They consist of intellectual, emotional, and social components. In Minneapolis, Judge Michael Davis ordered Abdullahi Yusuf, another self-professed ISIL candidate, to attend a rehabilitation program after he pled guilty to attempting to join ISIL. We have yet to learn about the outcome of this program, but I am hopeful it will shed some light on this problematic issue. (1)

Mustafa A. Mufti, MD is a forensic fellow at University of Pennsylvania fellowship program

Reflections of an Israel Defense Forces Military Psychiatrist

Ziv Ezra Cohen, MD, Trauma and Stress Committee

“You have to allow me to serve,” he said. “Everyone in my family was a paratrooper. I know I can do it, too,” Yoni implored. After completing advanced training with Israel’s elite paratroopers, Yoni’s officers noted him to be sullen, withdrawn, and poorly motivated, and referred him for psychiatric evaluation.

As a grandchild of Holocaust survivors, a first generation American born to Israeli veterans of the Israel Defense Forces, a medical student in New York City during 9/11, and a psychiatry resident during the Iraq and Afghanistan wars, I had long been interested in the impact of trauma on individuals and society. Motivated by this interest, from 2011-2012 I had the opportunity to serve in the Israel Defense Forces (IDF) Medical Corps, Mental Health Branch, as a military psychiatrist, where I encountered Yoni.

Similar to the US Armed Forces, the bulk of a military psychiatrist’s work in the IDF involves evaluation, triage, and treatment of soldiers and officers. Much of the clinical caseload is “bread and butter” psychiatry, e.g., anxiety and depression, unrelated to the military environment.

In many cases, however, the military environment may be associated with exacerbation of pre-existing mental health issues. Individuals with personality disorders may find it difficult to adapt to the demands of the military and develop adjustment disorders or those with pre-existing depression and anxiety may worsen. Although operations associated trauma may result in posttraumatic stress disorder (PTSD) symptoms, the military psychiatrist must remain on the alert for other sources of trauma. A soldier posted to a base on Israel’s border with Gaza complained of insomnia due to anxiety about the constant rain of Hamas rockets. On exploration, it emerged that the patient had slept poorly since she

was fourteen following a terrorist attack in which a car was driven into a group of students. The patient endured prolonged and painful physical rehabilitation. Her current symptoms thus represented a reactivation of pre-existing PTSD.

While American service personnel enter the military with higher rates of adverse childhood events than their civilian counterparts,¹ in the Israeli setting, global stress index scores for adolescents are significantly higher than US norms and correlate with periods of political-military conflict.² Intergenerational trauma is also common in Israel, with many soldiers having primary family members who sustained Holocaust related trauma,³ combat trauma, or mass violence. This, in turn, affects soldiers’ subjective experience of the stresses of military service, and may manifest in adjustment disorders, anxiety disorders, or reactivation of PTSD.

“Intergenerational trauma is also common in Israel, with many soldiers having primary family members who sustained Holocaust related trauma,³ combat trauma, or mass violence.”

Given the easy access to firearms, there is always a concern for suicide. The IDF reported that 15 soldiers died by suicide in 2014; the number has fluctuated between 7 and 28 in the past 5 years.⁴ Although the exact standing force in the IDF is classified, the publicly available estimate of 160,000 suggests a suicide rate of

.009% per year, or slightly less than 1/10,000. This is somewhat lower than the suicide rate among US active duty personnel of 1.87/10,000.⁵ In 2006, the IDF instituted restrictions on service members taking their weapons home on weekend leave after noting that most suicides occurred on these visits.⁶ The suicide rate was subsequently reduced by half. Although certain psychiatric risk factors for suicide are common between the US and Israeli militaries, sociocultural risk factors differ. For example, suicide in the US military is associated with low psychosocial adaptation,⁷ whereas in the Israeli military it has been associated with excessive motivation to serve.⁸

The nexus between civilian trauma and military trauma in Israel is particularly apparent. Given Israel’s size (about the size of the state of New Jersey) and the nature of modern warfare, the “front” and the “rear” are more conceptual than realities. Family members worry about soldiers’ safety and soldiers worry about their civilian family members who may be subject to rocket fire or suicide bombers. This is captured by Israel’s Memorial Day, which is officially named, “Day of Remembrance for the Fallen Soldiers of Israel and Victims of Terrorism.” In Israeli collective consciousness the distinction between fallen soldiers and fallen citizens is blurred.

Like in the United States, where in 2014 the DOD estimated that 4.3% of women experienced unwanted sexual contact in the military,⁹ the past several years in Israel have seen growing awareness of military sexual trauma. A recent report by the IDF Advisor on Women in the Military found as many as 1 in 8 women soldiers experienced unwanted sexual contact in 2013.¹⁰ A specialty clinic for victims of sexual trauma in the IDF serves the needs of these soldiers.

Since 1998 gay men and women have been allowed to serve openly in the IDF, and since 1999 the IDF has had a progressive policy towards

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RAPPEPORT FELLOWSHIP AWARD 2015-2016

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

The prestigious AAPL Rappeport Fellowship was named in honor of AAPL's founding president, Dr. Jonas Rappeport, MD and offers the opportunity for outstanding senior residents with a dedicated interest in psychiatry and the law to develop and groom their knowledge and skills. The Rappeport Fellows will receive a scholarship to attend the AAPL forensic psychiatry review course and annual AAPL meeting in Ft. Lauderdale, Florida. Each fellow is also assigned a senior AAPL forensic psychiatry preceptor to guide their activities and training during their fellowship year. The Rappeport Fellowship Committee is pleased to announce the six Rappeport Fellows for 2015-16. The Fellows are Miguel Alampay, MD, JD, LT, MC, USN, Vivek Datta, MD, MPH, Brian Holoyda, MD, MPH, Darlinda Minor, MD, David A. Nissan, MD, LT, MC, USNR, and John P. Shand, MD.



Vivek Datta, MD, MPH

Dr. Datta is Chief Resident for Education at the University of Washington Medical Center, Seattle, where he directs the Neuropsychiatry Consultation Service. Born in London, England, Dr. Datta completed his Medical Degree with Distinction at the University of London. He was a Visiting Research Fellow in Psychological Medicine at the Institute of Psychiatry at the Maudsley, London and Clinical Lecturer in Psychiatry at Deakin University School of Medicine, Australia. After a short stint as House Physician and Surgeon at Barnet and Chase Farm Hospitals, London, he came to the US as a Frank Knox Memorial Fellow to complete his MPH at Harvard. During his residency training he has won numerous awards including the PRITE Fellowship of the American College of Psychiatrists, the

IMG Fellowship of the American Association of Directors of Psychiatry Residency Training, and the Diversity Leadership Fellowship of the American Psychiatric Association. As part of the latter, he serves as a member of the APA's Council on Psychiatry and Law and Committee on Judicial Action. He is interested in forensic neuropsychiatry and his current research explores criminal responsibility and legal defenses for criminal behavior in frontotemporal dementia. Upon completion of residency training, he will begin his Forensic Psychiatry Fellowship at UCSF.



Brian Holoyda, MD, MPH

Dr. Holoyda is a 4th year resident in General Psychiatry at UC Davis Medical Center. Dr. Holoyda developed an interest in forensic psychiatry during medical school, attending his first AAPL meeting in his third year and completing an elective rotation with Dr. Phillip Resnick in his fourth year. As a resident Dr. Holoyda has been vigorously active in pursuing forensic training and research experience. He has co-authored multiple papers and book chapters on a variety of forensic topics, including two first-author publications for the AAPL journal. He has presented at numerous conferences in the United States, as well as internationally in Canada, the United Kingdom, and Austria on topics including

bestiality, cult members who commit murder, and competency to stand trial in misdemeanor defendants. Dr. Holoyda is spending his fourth year of residency researching sex offenders who are hospitalized within the California state hospital system. He will then attend forensic psychiatry fellowship at UC Davis. His current academic interests exist at the intersection of group psychology and forensics and include cults, religious extremism, terrorist organizations, and mass suicide and homicide. In the future Dr. Holoyda hopes to develop a career in academic forensic psychiatry through which he can provide treatment, build a forensic practice, and continue to research and write on forensic topics.



David A. Nissan, MD

Dr. Nissan is a 4th year psychiatry resident at New York-Presbyterian Hospital/Weill Cornell Medical Center. Dr. Nissan attended the University of Rochester through a Naval Reserve Officer Training Corps scholarship, in his senior year serving as the Battalion Commander. As an undergraduate he was awarded the DeKiewet research fellowship to study Alzheimer's Disease, specifically the folding properties of synthetic peptides as a model for amyloid- β . He graduated Suma Cum Laude, double majoring in biochemistry and history, and was elected to the Phi Beta Kappa honor society. Dr. Nissan attended medical school at Weill Cornell Medical College, where he was elected the President of his medical school class, selected for the Alpha Omega Alpha honor society, and was awarded the Leonard Tow Humanism in Medicine Award. Dr. Nissan began psychiatric residency training at NYPH-WCMC

in 2012, and in 2013 was awarded a Janssen Resident Psychiatric Research Scholar award to study the demographics and impact of treatment-over-objection, and has presented this work at poster sessions at the APA meetings in 2014 and 2015. Dr. Nissan is currently serving as a Co-Chief Resident, and after completing residency in the spring of 2016 will return to active duty in the United States Navy.

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RAPPEPORT FELLOWSHIP AWARD 2015-2016

Once again this year, we received a high number of outstanding 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 outstanding for our field of Forensic Psychiatry. We would like to thank the members of the Rappeport Committee, all Rappeport preceptors, and our AAPL Council for their continuing support of this superb training opportunity!



Miguel Alampay, MD

Dr. Alampay was raised in both the US and Asia. After graduating Magna Cum Laude from Georgetown, Dr. Alampay continued on to Georgetown's Law Center where his academic focus was mainly on intellectual property and healthcare regulatory work. During this time, Dr. Alampay had the privilege of working with organizations such as Catholic Charities, the Whitman Walker Clinic, the VITA Program, and Klores & Associates. He has counseled clients in the areas of immigration, public benefits for HIV+ GLBTQ (Gay, Lesbian, Bisexual, Transgender, Queer) patients, tax law for low-income families, and catastrophic medical malpractice. Following law school, Dr. Alampay commissioned as an officer in the United States Navy and began medical school at the Uniformed Services University of the Health Sciences. He received his MD in 2012 and began his psychiatry training at Walter Reed. He was elected Chief Resident for the 2015-2016 academic year. Before that he served as Deputy Chief the prior year and was also Vice President of Walter Reed's intern class. His scholarly contributions include work in neuromodulation, traumatic brain injury, post-traumatic stress, forensics, eating disorders, and humor in mental healthcare. His work has been presented in both national and international fora. He was recently named the Washington Psychiatric Society's Resident of the Year for 2014, and completed the Institute for Contemporary Psychotherapy and Psychoanalysis' Fellowship in Contemporary Forms of Psychotherapy. He currently serves on the Board of the Washington Psychiatric Society, APA's Council on Psychiatry and the Law, and the board of the District of Columbia Bar's Lawyer Assistance Program. In addition to being a Rappeport Fellow, he is concurrently a GAP Fellow, and American Psychiatric Leadership Fellow. He is currently admitted to practice law in Maryland and the District of Columbia; and is licensed to practice medicine in Virginia.



Darlinda Minor, MD

Dr. Minor is currently serving as an Administrative Chief Resident at the George Washington University Psychiatry Residency Program. In addition, she has served on various committees (Teaching, Recruitment, Retreat Planning, Newsletter) in the residency program, and spearheaded many quality improvement projects. During her third year, she completed a yearlong forensic psychiatry rotation at the District of Columbia Department of Corrections. Dr. Minor has also created another forensic psychiatry rotation conducting juvenile evaluations in the Maryland Correctional Department. At the 2014 American Academy of Psychiatry and the Law (AAPL) annual meeting, she co-presented on four projects, including a panel presentation on liability in college suicides. She will also be co-presenting on several projects in the 2015 AAPL annual meeting. She has co-authored an article on decisional capacity in Amyotrophic Lateral Sclerosis, which was published in the Journal of American Academy of Psychiatry and the Law in June 2015. She currently serves on the Suicidology Committee of AAPL and has contributed a newsletter article for AAPL on behalf of the committee in January 2015. Upon graduation, Dr. Minor will be pursuing further training in forensic psychiatry as a fellow at the Case Western Reserve University.



John P. Shand, MD

Dr. Shand is Clinical Chief Resident at Case Western Reserve University. Dr. Shand has been serving on the Ohio Psychiatric Physicians Association's Ethics Committee (OPPA) for the past two years, and has written several articles for their quarterly newsletter on ethical issues as they relate to psychiatry and social media. In addition, he has addressed the stigmatization of mental health issues and patients, mental health parity, stigma related to film, and psychiatry and the law in journals including *The Lancet Psychiatry*, *JAAPL*, *Journal of Humanistic Psychiatry*, and *Australasian Psychiatry*. He has co-authored in the *Wiley Encyclopedia of Forensic Science* on topics of Therapeutic Jurisprudence and Civil Commitment, and has given a panel discussion at the APA on American Horror Film and Psychiatry. He has given numerous poster presentations on claims of amnesia in a court mental health clinic at venues including MWAAPL, AAPL, APA and the IPS, and has presented to the Cleveland CL-Society on the topics of factitious disorders, limbic encephalopathy, and erotomania. Dr. Shand plans to pursue a forensic fellowship, followed by a long career, in Forensic Psychiatry. He is honored to be a Rappeport Fellow. ☪

APA Assembly Report

Cheryl D Wills, MD, Alternate Delegate

The APA Assembly Met in Toronto, Ontario from May 15 – 17, 2015. The APA has implemented new branding in an effort to distinguish it from other professional mental health organizations. The logo, which features the ancient serpent-encircled rod of Asclepius superimposed over two hemispheres of the human brain, conveys the role of a contemporary psychiatrist as a physician who cares for all aspects of a patient's health – mind, brain and body. APA CEO/Medical Director, Saul Levin, M.D., M.P.A. said that the new logo will be used to represent the organization along with the APA seal which includes Benjamin Rush, the year 1844, and 13 stars that represent the 13 founders of the organization.

The APA Board of Directors has reviewed a reorganization plan for the APA that is scheduled to commence in November 2015. The plan, which has guiding principles of inclusivity, diversity and effectiveness makes it possible for each state to have two representatives funded to attend the fall Assembly Meeting. The plan was introduced, in part, to increase the overall diversity of the Assembly membership in terms of gender, ethnicity, age, professional practice interests, regional diversity (e.g. urban and rural), etc. The extent to which this component of the plan succeeds will depend on how the district branches choose to appoint delegates to the Assembly.

In 2014, the APA had its second consecutive year of increased growth in membership. There was a 4.4% increase in total members, a 3.1% increase in dues-paying members, 2.3% increase in early psychiatrist members, 4.6% increase in resident members, 26.6% increase in international members and a 37.1% increase in medical student members. It is hoped that this trend will continue.

The APA has been cognizant of member concerns about Maintenance of Certification (MOC), preparing for the changing healthcare environment,

diversity, fair reimbursement, parity, etc. and has implemented them into the Strategic Plan for the organization. The APA Assembly responded to member concerns about MOC requirements by forming an Assembly Workgroup on MOC and collaborating with other APA leaders to communicate concerns to the American Board of Psychiatry and Neurology. These encounters ultimately resulted in the APA requesting that the ABPN advocate to the American Board of Medical Specialties (ABMS) to eliminate part IV of the MOC requirements. The APA also is piloting a project designed to facilitate completion of the MOC process in several regions.

The President and CEO of ABMS, Dr. Lois Nora addressed the Assembly. She is a neurologist who comes from a family of physicians who routinely debate topics such as Maintenance of Certification among themselves (and with others). She stated that her comments to the Assembly were framed by “thoughtful letters” that she had received from 87 psychiatrists. “Board certification is of the profession, by the profession, and for the patients” and encourages innovation in assessment, including reducing the financial burden by permitting remote proctoring and having flexibility in what is accepted as lifelong learning. She opined that each physician should be substantively engaged in quality improvement in his or her specialty or subspecialty and part IV of the Maintenance of Certification addresses this need. The ABMS believes there cannot be a true MOC Program without continuous quality improvement.

Mental health parity has been garnering considerable resources to educate the public. The brochure and poster, titled “Fair insurance Coverage: It's the Law,” is available in both English and Spanish on the APA website. Members are encouraged to examine and to disseminate the resource to health care professionals,

patients and others who may benefit from being better informed about parity. The U.S. Department of Labor has expressed willingness to investigate any insurance plan that is not in compliance with the Mental Health Parity and Equity Act. A Confidential Practice Questionnaire has been developed to make it easier for psychiatrists to report unfair reimbursement practices.

The new DSM-5 consumer guide, titled Understanding Mental Disorders was released on May 1, 2015. It is a resource that is designed to help the public understand the nature of mental disorders and offers clinical and scientific information that may be used to augment discussions that psychiatrists have with patients and families about mental health.

There have been a number of enhancements added to Internet resources for APA members. There is an updated phone directory that requires a member to enter a username and password on the APA website to access it. The AAPI.org website of the American Psychiatric Press, Inc. has also been updated. By October, 2015, there should be links on the APA website to all of the APA product line websites to make it easier for members and others to access resources. A “find a psychiatrist” link will be added to the website and will serve as a centralized place for individuals to find psychiatrists. It will provide a timely referral mechanism that allows each APA member to opt in and to fine tune the data that is listed under his or her name.

The APA continues to partner with American Professional Agency for endorsed professional liability services. The plan has been reviewed and the following enhancements will occur: Coverage limits for punitive damages will increase from \$25,000 to \$250,000 and licensing board defense coverage will be increasing from \$5,000 to \$50,000. Also, medical payment coverage will increase from \$25,000 to \$50,000. Additionally, a consent to settle clause will be added to policies so that litigation will not be settled without the psychiatrist's knowledge. ☪

Social Media Comes to AAPL

Tyler Jones, MD Chair, Computer Committee

The 46th Annual Meeting is just around the corner. It's time to meet old friends and share new ideas. This latter notion is the cornerstone of a conference. And while presentations are always informative and presenters engaging, some of the best ideas are shared between presentations. The salons, ballrooms, hallways, and foyers are important spaces for attendees to talk and contribute ideas, meet other presenters, or discuss contents of a presentation they missed.

Social media is being used at other conferences to make that experience even better. In particular, Twitter, which uses 140 character messages, photo, or video to provide a medium to connect more effectively. Using Twitter during a conference, people in the audience can share ideas, provide opinions and analysis of presentations in real time. Questions can even be asked by the audience or suggested by members who are not able to attend the conference. This provides faster feedback and makes information more accessible. For our conference organizers Twitter can be used to know what's working or not, while it's happening rather than waiting until after the event for feedback.

Since there are often several sessions happening at once, using Twitter is one way to share what you're learning in a session to other members as well as a larger audience. Similarly, you can read tweets from sessions you weren't able to attend during or afterwards.

To that end, Dr. Annette Hanson had a wonderful idea to bring Twitter to our annual conference. And the AAPL council has agreed to support this experiment. This year we're encouraging live-tweeting and the video streaming of certain select presentations. We will have volunteers from the Computer and Technology and other committees moderating questions from the Twitter audience and using their own Twitter accounts to stream some of the presentations.

Presenters have already been

asked, via email from Dr. Hanson, to provide consent in advance for video streaming. We will be using Meerkat, a video streaming platform for Twitter to broadcast those select presentations. We will be putting together a schedule of streamed sessions for the AAPL website and the hashtags for the conference and the individual sessions to be used to follow the discussion. If you're interested in participating and have not yet been asked, please contact Dr. Hanson or me.

If you are not familiar with Twitter, I would like to offer a brief primer on using Twitter at conferences. Firstly, you will need a Twitter account from twitter.com. Set up is quick and can be done in 15 minutes. There are several apps for your smartphone of choice. For the iPhone, I use Tweetbot but the official Twitter app will also suffice. On the Android, Plume and Fenix are consistently reviewed highly.

“Using Twitter during a conference, people in the audience can share ideas, provide opinions and analysis of presentations in real time.”


Here are some pointers for getting starting using Twitter in general and, particularly in the context of a conference.

1. Twitter uses hashtags (keywords preceded by a #) that allow for others to find and follow tweets associated with the conference. We will be using the hashtag #AAPL2015 and the main account set up is @AAPL2015. It will be important for all who are interested in tweeting to use the above hashtag and be consistent. Everyone following the hashtag #AAPL2015 will see any tweet that uses it, making fol-

lowing the various activities of the conference easy.

2. Consider using a session hashtag. In a conference the size of AAPL there will be numerous sessions over 3.5 days. A session hashtag that includes the day and number code on the final program makes finding tweets of interest easier.
3. Tweet with care. By default, tweets are publicly available and while this is a benefit to reaching a broader audience not everyone will be ready for their presentation to reach a wider world. If the presenter requests their talk not be tweeted, be respectful of that. And be aware that your tweets live on. Even if you delete them, screen shots can and do still exist long after. Messages should be professional and educational.
4. Attributions matter. By starting your tweets with the presenters' username you ensure they are credited for the information. If you don't know their Twitter username be sure to clearly state who is speaking.
5. Tweet new information, behind the scene stories or photos.
6. Keep it simple. Although Twitter allows comments of 140 characters. If you limit yourself to 100, your followers can retweet with their own comments.
7. Follow everyone. Follow other live-tweeters, new followers of yours, fellow tweeters whose usernames appear in the event feed.

The idea behind utilizing this tool is to find ways to broaden the reach of our organization to international members and to promote membership in the organization. We hope that by beginning to introduce the use of social media we can simply engage people inside and outside of the conference, to have conversations, and deepen our already strong sense of community. By using Twitter we can be our own best advocacy group on what we're doing.

Please watch the aapl.org website for advance notice of the schedule of presentations to be live-streamed. You can also join our feeds: @AAPL2015, @clinkshrink, and @tylerjonesmd. 

We're Not Alone On This Forensic Island: Results From The 2014 AAPL Practice Survey

Anthony Tamburello, MD, Chair, Institutional and Correctional Psychiatry Committee; Camille Lacroix, MD, Private Practice Committee

Working in a subspecialty can at times feel isolating. Being surrounded by walls can amplify this feeling – whether they are the concrete walls of jail or prison, or the wood and plaster walls of a private office. The authors have found that AAPL committee membership in their primary areas of practice has been professionally supportive.

However, these committees only meet in person for an hour once a year. Furthermore, we note that many of us have “hybrid” practices that might include civil and criminal work, a mixture of private and institutional work, as well as teaching and research activities. The statutes and regulatory issues at play in each state may be an additional barrier to coming together as a group in these particular areas. The diversity of our work means that at times it is difficult to cover all areas that would be of use to members.

The Private Practice and Institutional and Correctional Psychiatry Committees independently discussed creating a survey to better understand the constituency of AAPL who would be served by our committees, with a focus on meeting the members’ ongoing needs for educational content and other support.

Together, with valuable input from the Medical Director of AAPL, Jeff Janofsky, and the Executive Director, Jackie Coleman, we developed the 2014 AAPL Practice Survey, which was distributed to 1453 AAPL members by e-mail in October. The survey posed questions about the time spent in various clinical and forensic activities and polled respondents on how they felt the AAPL committees could best serve their needs.

Out of 227 respondents, 86 (37.9%) do substantial private practice work (defined as >10% of professional time), 49 (21.6%) do substantial cor-

rections work, and 26 (11.5%) do both. Thus, over 70% of respondents participated in some work in these fields. Figures 1 and 2 are histograms of the percentage of work in private practice and corrections reported by survey respondents.

“We can conclude that a considerable number of AAPL members work either in part or exclusively in the areas of private forensic practice or correctional psychiatry.”

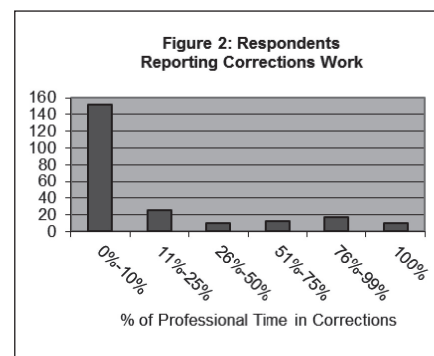
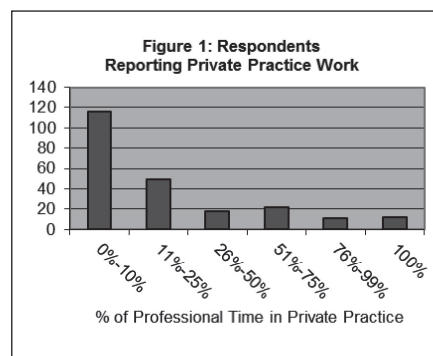
Respondents were active in forensic teaching activities - both clinical and didactic - for medical students, residents and fellows. Eighty-seven percent (87%) of respondents working in corrections reported some teaching work, as did 79% of those working in private practice, compared with 73% of those who did little or no work in either private practice or corrections. Figures 3 and 4 show the teaching activities of those reporting substantial private practice (figure 3) or correc-

tional work (figure 4).

According to the survey, respondents working in either private practice or corrections are active in AAPL based on committee participation. Twelve of those with private practice work reported serving on the Private Practice committee, with twenty in corrections serving on the Institutional and Correctional Psychiatry Committee. There was considerable cross-participation (seven private practitioners served on the Institutional and Correctional Psychiatry Committee), though rarely was dual committee membership reported.

Another important goal of the survey was to identify how our committees might be of value to both professionals in our areas and the AAPL membership at large. Options included CME, advocacy, practice guidelines, support, networking, practice management, mentorship and other (with an option for a free-text response). For those reporting private practice or correctional work, both groups identified the same top three categories as most valuable: CME, practice guidelines, and networking. Figure 5 shows the results of this question for all respondents:

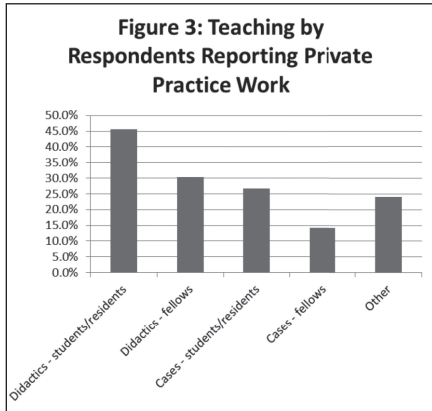
In regard to free-text suggestions for committee support, several called for maintenance of certification activities. Ideas for practice guidelines in corrections included proper care for the most seriously mentally ill inmates, medication-assisted treatment for inmates with substance-use disorders, and the evaluation of appropriateness of special accommodations in prison (e.g. bottom-bunk, single-cell). For private practitioners, potential



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We're Not Alone

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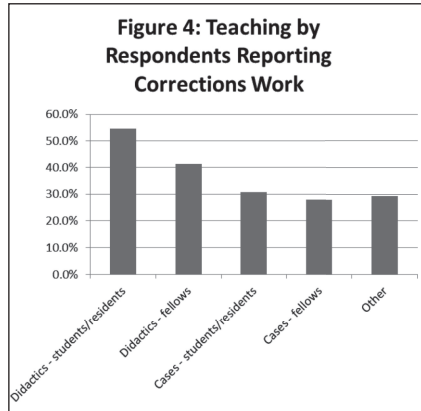


guideline suggestions include practice development and telepsychiatry.

The limitations of this survey bear mention. The response rate of 15.6% is low, though not unexpected for an e-mail survey of busy professionals. Selection bias is a likely confounder.

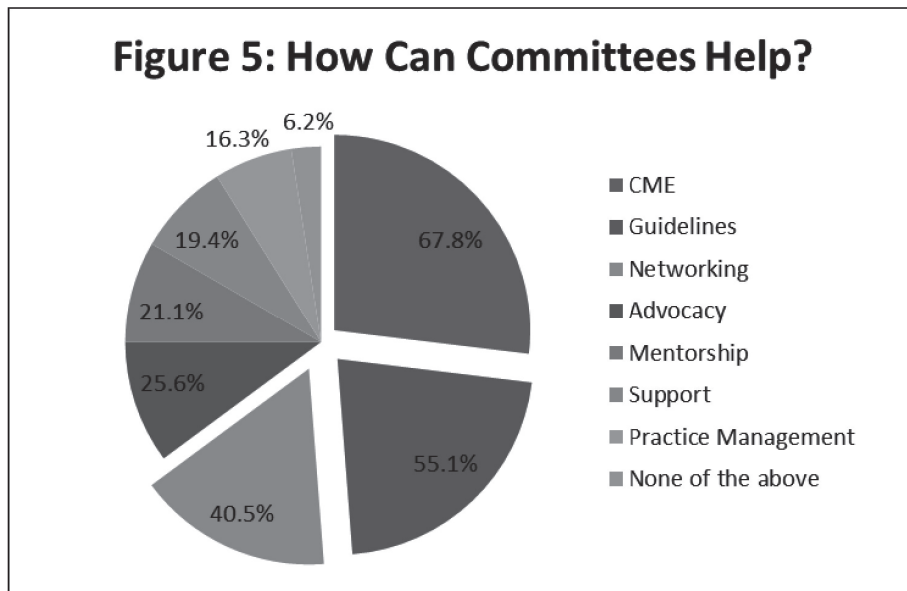
The initial e-mail invitation from AAPL identified the sponsoring committees and implied that the survey was targeted towards members working in these areas. A follow-up reminder e-mail clarified that we were interested in input from all AAPL members. We cannot confidently conclude that our results are representative of the entire AAPL membership.

We can conclude that a considerable number of AAPL members work either in part or exclusively in the areas of private forensic practice or



correctional psychiatry. We are often involved in the education of future forensic psychiatrists. We frequently participate in AAPL in the form of committee membership. We also learned that AAPL may serve these groups by supporting the development of CME and practice guidelines relevant to private practice and correctional psychiatry.

We invite those practicing in these areas that have not yet joined a committee to consider doing so. When the walls of your office make you feel like the only forensic psychiatrist with your particular professional problems, AAPL's practice committees are an excellent source of networking, mentorship, and support. ☺



AAPL COMMITTEES

- ADDICTION
- AWARDS
- BYLAWS
- CHILD & ADOLESCENT
- COMMUNITY FORENSICS
- COMPUTERS
- CORRECTIONAL
- CRIMINAL BEHAVIOR
- CROSS-CULTURAL
- DEVELOPMENTAL DISABILITY
- EARLY CAREER
- EDUCATION
- ETHICS
- FORENSIC HOSPITAL SERVICES
- FORENSIC NEUROPSYCHIATRY
- FORENSIC TRAINING
- GENDER ISSUES
- GERIATRIC PSYCHIATRY
- HUMAN RIGHTS AND NATIONAL SECURITY
- INTERNATIONAL RELATIONS
- LAW ENFORCEMENT LIAISON
- LIAISON WITH FORENSIC SCIENCES
- MEMBERSHIP
- PEER REVIEW
- PRIVATE PRACTICE PROGRAM
- PSYCHOPHARMACOLOGY
- RAPPEPORT FELLOWSHIP
- RESEARCH
- SEXUAL OFFENDERS
- SUCIDIOLOGY
- TRAUMA & STRESS

AAPL members who are interested in serving on committees for a three-year term are invited to send a letter to the President, Emily Keram, MD through the Executive Office by November 30, 2015. Committee members must be full voting members of AAPL.

Letters should indicate particular interests or qualifications for the committee appointment desired.

Royal College of Psychiatrists: Forensic Faculty Annual Conference - 2015

Jennifer Shaw, Professor of Forensic Psychiatry, Manchester, and John A. Baird, Consultant Forensic Psychiatrist, Glasgow

The 2015 residential meeting of the Forensic Faculty of the Royal College of Psychiatrists was held in Budapest, Hungary from March 4-6, 2015. Budapest is an ancient city with a rich, colourful and varied history and it is really two cities on either side of the Danube. Buda with its castle is built on a hill, while Pest, which is larger, is on flatter ground. Perhaps one of the most recent events of international importance for which the city is known is the uprising of 1956, when the population united against Soviet oppression. The movement had widespread popular support and although it was overwhelmed and crushed by Soviet military force, it was the first stage in the process that culminated with the collapse of communism in 1989.

The city is peaceful now and is very popular with tourists. The conference hotel had a wonderful central location overlooking the Danube.

The conference itself began with a session on gangs, with four complementary and lively speakers. Opening the session was Professor Decker from Arizona State University. He provided an overview of the concept of a gang and emphasised that it is a misunderstood concept. His view was "If you don't understand your problem, you're not going to deal with it." He expanded upon this with many examples of the need to understand the context, the behavior, the values and the role served for a gang member by being involved in a gang; they vary very much and generalizations about the nature, structure and function should be avoided. What was beyond doubt, however, was the mental health pathology to be found amongst gang members and the much higher rates of misfortune, morbidity and mortality, with, for example, the risk of being murdered being twenty times greater among gang members than within the general population. His thesis was that

attempts should be made to understand gangs and address the problems associated with them. A stable relationship and a job are two of the most significant factors that can support gang affiliates to lead more stable and pro-social lives.

The next speaker followed up on this message talking of the problem of gangs in Glasgow in the West of Scotland, where there is much more gang activity and gang affiliation than in any other parts of the UK. He made the same basic point that amongst gang members' depravations was invariably found and there were links to social breakdown, poor physical health and mental illness, with the last of those probably linked to very heavy drug misuse.

"The link between his mental state, his offending and his art was engagingly explored."

The third speaker gave the perspective from a high security hospital and described the additional challenges of managing gang affiliates who require inpatient care, the need for criminal intelligence and on occasion additional security, and again the high rate of psychopathology amongst these individuals with their mental health problems often obscured by co-existing criminal links, drug misuse and behavioral disturbance.

The last speaker was Paul Brannigan, a young man who spoke very candidly about his difficult early life as he grew up in the east end of Glasgow, his offending, his attempts at rehabilitation and the continuing difficulties which he experiences as a consequence of his early trauma, and with

which at times he still struggles, even though he has developed a very successful acting career for himself. Although he was not talking about this aspect of his life, it was known to the audience that he had had a number of successful roles, particularly the lead role in the film *The Angels' Share*, which was recognized by BAFTA.

The next session was rather different and dealt with medico legal issues arising from the trial of an elderly woman who was being prosecuted for war crimes arising from her involvement with the Khmer Rouge during the regime of Pol Pot in Cambodia. One of the speakers, Professor Seena Fazel of the University of Oxford, had examined the defendant and given evidence at her trial when the issue was one of fitness to plead. She had developed organic dementia. The ethics of trials of this kind was discussed. The proceedings against this defendant and her other co-defendants cost the country \$200 million dollars, which was calculated as \$100 for each victim of the regime of terror. Issues of cost benefit, value for money and overall worth inevitably arose in discussion.

This was followed by a session which dealt with the ethical issues of restrictive practices against the background of the European Convention on Human Rights, a very important piece of legislation to which the UK became a signatory about fifteen years ago now. The legislation itself is concise and clearly written, with similarities to the American Constitution, and like the Constitution the implications run and run. Legal experts set out human rights principles as they apply to the various forms of restriction that can be applied to patients who are subject to the mental health act. The convention requires there to be safeguards in the form of proportionality, entitlement and a system of independent review. One particular aspect of this was discussed in relation to a high secure hospital that had introduced a smoking ban throughout the whole institution. The conclusions of the exercise were that a complete cessation of smoking did not have the adverse consequences which had been anticipated, and

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International Academy of Law and Mental Health XXXIVth International Congress on Law and Mental Health

Marie Rose Alam, MD, International Relations Committee

The 2015 biannual meeting of the International Academy of Law and Mental Health (IALMH) took place in Vienna this year between July 12th and 17th. Vienna was a perfect backdrop to the conference. As if it were not enough that it was once the home of Sigmund Freud, no place sells history and culture better than Austria. Freud's physical home is now the Sigmund Freud Museum in Vienna. It is open to the public and contains some of its original furnishings, family videos, and original first publications of Freud's work. From castles, to gardens, to music, to art, to traditional and fine dining, and the longest, most varied, most creative coffee menus you'll ever see, Austria has something for everyone to enjoy. Walking into a subway station in Vienna also makes it clear that ethics here is a daily part of life. There are no ticketed gates into the subway stations, and an honor system of payment is used, with random ticket checks. To top it all, Vienna is home to the United Nations' International Atomic Energy Agency (IAEA), where John Kerry approved the Iran nuclear deal during the first few days of the IALMH conference.

The IALMH congress took place at Sigmund Freud University (SFU), a relatively new private university whose mission is the promotion of psychotherapy as a science, based on research, training, and other academic endeavors. It provides programs in both German and English. The modern feel of the SFU architecture was matched by the non-hierarchical nature of the meeting where participant badges were noticeably bare of all titles, and simply showed the participant's name and city of origin. Initially it was frustrating that the habit of reading a person's badge did not yield the expected information. However, by the end of the meeting, it was clear that less information on the badge meant

more information exchanged in conversation.

The meeting had an intense schedule. It lasted six days, with events beginning at 8:15 am and ending at 6:00 pm most days. The meeting began with a Sunday pre-conference session on Freud, psychoanalysis, and the law. Each subsequent day was divided into four sessions, with each session running about 15 rooms simultaneously. Each room had a topic theme that contained about five presentations over a two-hour period. The items I will highlight below just barely

“... under Soviet rule, diagnoses were created with symptoms that reflected characteristics of government opponents, rather than psychiatric illnesses as we understand them.”

scratch the surface of the breadth and depth of what was presented. Needless to say, the myriad of topics presented was enough to satisfy any palate. All the usual suspects of a psychiatry and the law conference were covered: criminal responsibility, competency to stand trial, involuntary hospitalization, outpatient commitment, seclusion and restraint, therapeutic jurisprudence, disability, the role of neuroscience in legal matters, medical ethics, human rights issues, child abuse, domestic violence, antisocial criminal behavior, sex offenders, paraphilia, suicide in forensic settings, neuropsychological testing, mass murder, filicide, arson,

custody, dual agency, capacity, PTSD and resilience, addiction, risk assessment, DSM-5, ICD-10, telepsychiatry, and the list goes on.

The second day of the conference included topics such as the disconnect between law and psychology, the use of neuroscience in public safety and American national security agendas, child murder by mothers and its relationship to evolution, and fetal alcohol spectrum disorder (FASD) as a mitigating factor in criminal cases. Another subject cluster addressed working with survivors of torture in various settings, from death row, to pre-trial detainees in Guantanamo. Yet another set of presentations highlighted LGBT mental health and human rights issues, and discrimination against vulnerable persons such as refugees, immigrants, and employees with mental health impairments. The second day also included presentations discussing the horrific past of German medicine, collectively entitled “Physicians and the Holocaust,” and detailed the role of physicians in the legitimization of murder of the mentally ill. Hundreds of Nazi medical records were reviewed in connection with interrogation transcripts. In addition, the history of expulsion of Jewish physicians from Germany through a 1933 law entitled “Law for the Restoration of the Professional Civil Service” was discussed. The presentation covered the lack of awareness and the denial of fascist actions in post-war German medicine, as well as the initiatives that led to its condemnation and the rebuilding of German bioethics.

A presentation entitled “‘Eating to Death’ in Prader-Willi Syndrome: Have Personal Rights Gone Too Far?” reminded me of Dr. Thomas Gutheil's words, “Rotting with your rights on.”

The United States was well represented. Other countries included France, Belgium, Germany, Austria, the United Kingdom, Spain, Portugal, Sweden, Switzerland, the Netherlands, Denmark, Italy, Greece, Georgia, Hungary, Romania, Australia, New Zealand, Brazil, Norway, Chile, Peru, South Korea, Taiwan, India, Canada, Japan, South Africa, Namibia, Algeria,

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Royal College

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although the decision was the subject of judicial review, and although the original review found in favor of a patient who was opposed to the ban, when this matter was appealed by the Hospital their appeal was upheld and the complete ban on smoking was considered to be compatible with the Convention.

The last session of the first day was an engaging historical presentation by Mike Jay, an author who had written a biography of James Tilly Matthews, an Englishman who was caught up in events in Paris around the time of the French revolution, and who on his return to England created a disturbance in the public gallery of the House of Commons which led to his arrest. He spent the remainder of his life confined in various “mad houses” while there was brisk debate about the state of his mind. It appears to have been a case where politicians wished his confinement to continue while the physicians responsible for his care could find nothing untoward about his mental functioning. Perhaps unsurprisingly, it was the will of the politicians that prevailed. A case nowadays would be dealt with very differently, and under Human Rights legislation his need for continued detention would be determined by a fully independent judicial body that would take evidence from politicians but would not be bound by it.

The second day of the conference began with a morning of research sessions. The topics were varied but had a common theme in examining aspects of the links between mental disorder, offending and the criminal justice system. One paper began by acknowledging the well-known link between serious mental illness and violence. Substance misuse was well known to be linked with an increased risk of violent offending and in those suffering from co-existing mental illness, the motivation of self-medication was often a driver.

In a session on Attention Deficit Hyperactivity Disorder (ADHD), the frequency and the importance of treatment was emphasised, but it was

reported that the rate of treatment of ADHD was considerably higher in the USA than in the UK and the reasons for this were discussed. The outcome in adult life was also examined and while in childhood in most severe cases all three symptoms were present, the inattention, the hyperactivity and impulsivity and the emotional lability, in the minority of cases who continued to satisfy diagnostic criteria into adult life, hyperactivity tended to lessen but the other main symptoms could persist.

The final research paper of the

“In both jurisdictions, it was only a minority of those suffering from serious mental illness that had any direct access with mental health services, and one unexpected finding was that those suffering from serious mental illness in prisons tended to have higher rates of criminogenic thinking, even than was found within prisoners as a whole.”

morning emphasized again the strong links between alcohol and offending, and the risk of overlooking alcohol in favor of other illegal drugs when, apart perhaps from cocaine, alcohol is the intoxicating substance about which we should be most concerned when attempting to reduce violent re-offending.

The final plenary session in the morning was a presentation of a detailed study of the delivery of healthcare to convicted prisoners suffering serious mental illness. Arrangements in New Zealand and the USA were compared. In both jurisdictions,

it was only a minority of those suffering from serious mental illness that had any direct access with mental health services and one unexpected finding was that those suffering from serious mental illness in prisons tended to have higher rates of criminogenic thinking, even than was found within prisoners as a whole. This was surprising because in many cases it was the serious mental illness which had led to the offending and the incarceration and it might have been expected that the individual would be motivated to seek care and treatment for their illness, but this was not found to be the case and the finding although seemingly valid remains unexplained.

The afternoon offered delegates a choice between a range of workshop sessions, and deserving mention were sessions on the community treatment of antisocial personality disorder, a challenging and in some ways controversial initiative well established now in west London and enjoying considerable success, and a session of film clips of films from general release which had a prison based theme.

On a different theme, there was a well-attended session on the Italian painter Caravaggio, who suffered from mental illness and who also was responsible for a homicide. The link between his mental state, his offending and his art was engagingly explored.

One tradition of the Forensic Faculty conference is the conference dinner, and again this was a very successful evening attended by about 150 of the delegates. There is always entertainment during the evening and this year for the first time the decision was taken to have an “open mike”, with delegates invited to come up and really do whatever they chose provided it entertained the company and did not go on too long. This initiative was very successful, hitherto unknown talent revealed itself from the most unexpected quarters and no careers were brought to a premature conclusion.

The tradition is that each year the venue alternates between continental Europe and the UK and in the spring of 2016 we will be in Glasgow from March 2-4, 2016. As ever, colleagues from AAPL will be made most welcome. ☺

Another “Sexy” Role for Forensic Psychiatrists

Abhishek Jain, MD, Sex Offender Committee

General medical and psychiatric providers might turn to their forensic-trained colleagues to help explain issues such as sexual aggression, inappropriate sexual behavior, and sex offender treatments, particularly after troubling patient-related events. Queries may especially arise in settings where these matters are not routinely a primary focus and health-care providers seek a better understanding to address patient-to-patient, patient-to-staff, or even staff-to-patient sexually assaultive or inappropriate behavior.

Why might our colleagues turn to forensic experts for these issues? The answer is perhaps similar to Dr. Graham Glancy’s recent response¹ regarding the forensic psychiatrist’s role in correctional psychiatry: forensic experts are well versed in balancing patient care and public safety, in maintaining objectivity (e.g., when assessing violent acts), are aware of unique forensic settings such as specialized sexual offender treatment sites, possess expertise in the relationships between mental disorders and crime, and are trained in assessing conditions such as paraphilic disorders.

Although forensic psychiatrists do not always have direct experience working in specialized sex offender sites, they often have knowledge of sex offender assessment and treatment through working in correctional settings, conducting forensic evaluations for criminal proceedings, and performing violence risk assessments. Furthermore, sex offender, sexual harassment, and physician-patient sexual violation laws are core topics in forensic training and are covered in the AAPL Landmark Cases. Thus, forensic psychiatrists often have perspectives that are helpful to their non-forensic colleagues, and can provide general background education, such as potential etiologies of sexually abusive, problematic, and aggressive behavior (e.g.

opportunistic, impulsive, predatory, paraphilic, etc.).

Moreover, questions from colleagues can serve as an impetus for forensic psychiatrists to familiarize themselves with characteristics of sexual offending behaviors and sexual offenders, as well as available assessments and treatment, hospital policies regarding inappropriate sexual behavior, and jurisdiction-specific mandatory duty to warn/protect and report abuse and the laws governing them. Colleagues may also seek guidance pertaining to documentation, online search of publicly available criminal records, referrals for sex offender treatment, and police or social services involvement.²

Regarding patient-to-patient sexual contact, Ford and colleagues wrote about the limited consensus among US inpatient psychiatric units regarding the management of sexual behavior between patients and offered a

“... an emergency room male nurse in Oregon pled guilty to charges related to sexually abusing ten women.”

model policy to evaluate sexual incidents. They recommended a clear definition of sexual behaviors, a balancing of patient rights with issues such as transmission of sexually transmitted disease, education regarding reproductive issues, and evaluation of non-consensual activity.³

Generally, delineating “acceptable” versus “inappropriate” sexual behavior can be particularly challenging and is often setting-specific.⁴ For example, a patient with schizophrenia masturbating in the privacy of her room might be considered

“acceptable” behavior, but the same behavior would be “inappropriate” if the patient repeatedly masturbates with her door open despite clear directives from staff not to do so.

Patient-to-staff sexual threats and assault can have a profound impact on staff morale and the patients’ therapeutic milieu. Most hospitals have policies or guidelines regarding the prosecution of such patients. Forensic psychiatrists may be called upon for guidance on treatment recommendations, sex offender evaluation, and evaluation of criminal responsibility. The uninformed psychiatrist should guide against automatically attributing the act to mental illness.

Staff-to-patient sexual aggression can be particularly distressing. In one example in September 2014, an emergency room male nurse in Oregon pled guilty to charges related to sexually abusing ten women. Following these allegations, the hospital enacted various interventions, such as the “Inappropriate Behaviors Response” training, and developed a systematic approach for reviewing and addressing patient complaints.⁵ A framework for responding to patient complaints may be a consideration.⁶

Although staff-to-patient aggression are typically low base rate occurrences, even one incident can lead to a systemic questioning of pre-employment screening procedures, hospital reporting mechanisms, and patient safety issues. Forensic psychiatrists may be able to lend some insight into understanding sexual predation and the limits of screening. Staff education regarding boundaries and the proper mechanism and channels to report suspicious behavior among colleagues can be particularly useful.

Overall, forensic psychiatrists working in general and medical settings may be consulted to provide guidance on all aspects of inappropriate sexual behavior. This presents another application of forensic training in primary clinical settings and a potential opportunity for collaboration in a multi-disciplinary team. (P)

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Reviewing Remaining Residuals Regarding PPACA

Lawrence K. Richards, MD

Surely most physicians are aware of the 2010 PPACA Act and the related SCOTUS rulings of June 2012 and June 2015. This paragraph reviews that briefly, then moves on to the lesser known subjects. In spring 2010 the Patient Protection and Affordable Care Act was passed and signed by President B. Obama. It has been referred to in the media as “Obama Care” or the Affordable Care Act, and sometimes just ACA. Little attention has been given to the patient and her/his protections. In June 2012, SCOTUS ruled 5-4 that the mandate forcing persons to buy health insurance was a tax and thereby upheld the Act. In June 2015, SCOTUS ruled 6-3 that subsidization of purchase of one’s health insurance that qualified for the government tax credit could come from either the federal exchange or a state exchange.

During the time span between those two USSC rulings, the most notoriety came from the problematic opening of the federal Health Insurance Exchange, HealthCare.gov, on Oct.1, 2013. Since then, there have been other ‘happenings’ of note. These include: several states opening their own Health Insurance Exchanges (HIX) marketplace, with the majority of states not doing so due to fears of expanding expenses; the Speaker of the House of Representatives saying regarding the 900+ page Act, “We had to pass it in order to find out what was in it;” and the President’s statement, “If you like your doctor, you can keep your doctor” later proving to be not quite true in all cases. Other concerns include, out of network services costs, and the subsidy case issue on who can give the tax credits that subsidizes the purchase of a policy off the HIX, argued in the USSC under King v. Burwell.

King v. Burwell is a subject of the poster to be presented at the Ft. Lauderdale AAPL Annual Meeting, so little more will be said on that

here other than to state that Chief Justice Roberts also wrote this PPACA opinion, which gave a reprieve to those expecting a calamity if the high court backed King, and made it legal for only the state HIX to give out these tax credits.

So, what remains? A lot. Even the Democrats who have been most vocal in backing “ObamaCare” have from time to time said there are parts that need fixing. Disclosure: this author has not read the 900+ pages.

The Media gives most of its coverage of the Republicans to those talking repeal, and while polls differ, most still show a small edge to those citizens favoring repeal—albeit this edge lessened in the polls after the King v. Burwell ruling.

“... this author sees several good features to ObamaCare, including parity, one of the essential benefits which a policy must have to be offered on a HIX ...”

There are several items connected to the PPACA which the author finds more interesting and potentially impacting. The two most immediate are: a) there are three other “subsidy” cases already at the federal Appellate level. The en banc U.S. Appellate Court for D.C. hearing on Halbig v. Burwell will probably see that court doing its best to “punt” off the SCOTUS ruling in King since it chose to defer action until after the King ruling; b) the case of the U.S. House of Representatives suing the President. It is at the district level now, and looking like it won’t be dismissed as the federal government wants; it

might go all the way to the Supreme Court.

There are extensions and ramifications in pseudopod fashion emanating from PPACA. One that didn’t get funded was the nearly half \$billion for Navigators. These were the future government employees to be hired to help all the citizens figure out which HC policy was good for them.

One proposal that got funded through federal startup and solvency loans but is failing is the non-profit Insurance CO-OPs. (“Consumer Operated and Oriented Plans.”) These may have been a persuasion for the insurance companies to collaborate with the PPACA. There are twenty three and only Maine’s is operating profitably. Massachusetts’ Cooperative spent over six times on administrative expenses as it got in premiums. Illinois’ Co-op (Land of Lincoln Health) projected a net income of \$28 Million for 2014, but had a net loss of \$17.7 Million. NY’s Cooperative was the lead in enrollment, but still had a \$35 Million loss. NY enrollment was 155,402 which was over 5 times its projection of 30,864 for a 504% achievement, while three states with lowest achievement, AZ, IL and MA, hit about 4% of their projections.

Despite all this, this author sees several good features to “ObamaCare,” including parity, one of the essential benefits which a policy must have to be offered on a HIX, and that 80% of the money taken in per year on premiums must be paid out in policy benefits.

To close, the SCOTUS June, 2012 ruling also disallowed what authors of PPACA wanted as nationwide mandatory Medicaid expansion. The PPACA’s form of federal financing for the states’ expansion of Medicaid always included early major federal largess followed by steady withdrawal, leaving each state to pick up more of the cost as time progressed. Author notes the latter is already occurring at rates greater than expected. Thus the federal government had to offer the subsidies on HealthCare.gov in order to “save” the PPACA! ☹

Update In Suicide Trends

Jason Beaman DO and Stephen Brasseux MD

The Centers for Disease Control and Prevention (CDC) maintains a database, the Web-based Injury Statistics Query and Reporting System (WISQARS), of violent deaths in order to aid in prevention efforts. WISQARS collects information about the type of death including suicide, homicide and deaths by legal intervention. This information is collected from the National Center for Health Statistics and the National Violent Death Reporting System. This article will summarize the newly released data with previous years (2012 and 2007) in order to better inform on suicide trends in the United States.

The data was taken directly from the WISQARS inquiry database located on the CDC's website. Crude rates (per 10000) were compared for all ages (without regard for race or gender). Crude rates for race and gender were then explored independent of each other and independent of age. The results are discussed below.

WISQARS separates groups based on age categories of 5 years, starting with 0-4 and ending at 85+. When the 2013 crude rates of suicide were compared to 2012 data, there was an overall increase (13.02 vs. 12.94). The highest increase was found in the 70-74 category (15.54 in 2013 versus 13.9 in 2012). There was an increase in every class from age 5 through 29, with the exception of the 15-19 age group (0.09% decrease). Age 30-34 was the only class that showed no change. The rate decreased in all classes from ages 35-59. The rate increased in all classes from ages 60-85, with the exception of the 75-79 group (-0.38 change).

Trends based on race were also examined. WISQARS categorizes race as White, Black, American Indian, Asian/Pacific Islander and Other. The highest increase in crude rate was found in the American Indian population (11.69 vs. 11.03). There only decrease was found in the Asian/Pacific Islander and Others

groups. There was an increase in the crude rates for both the White and Black groups (0.15 and 0.12 respectively).

Gender trends were not much different from 2012 to 2013. In 2013, the crude rate for a male was 20.59 compared to 5.67 in females. In 2012, the rate for males was 20.57 and 5.53 for females. When total suicides are examined, these rates have more meaning. In 2013, 32,055 males committed suicide compared with only 9,094 females.

To provide a more comprehensive picture, rates were also compared with the 2007 data. Crude rates of suicide increased in all age categories from 2007 to 2013 with the exception of two, 40-44 (-0.06) and 75-80 (-0.53). The largest increases were found in the 55-59 and 70-74 groups (3.58 and 3.37 respectively).

“As the United States becomes more assimilated with other cultures, the use of race classifications becomes less helpful (as seen by the large number included in the other category).”

Suicide rates increased in all races from 2007-2013. The largest increase was found in the White race (an increase of 1.91). The smallest increase was found in the Asian/Pacific Islander race category, 0.24. The rate for African Americans and American Indians increased from 4.84 to 5.38 and 10.24 to 11.69 respectively. Rates increased for both males (2.17) and females (0.89) from 2007 to 2013.

By utilizing the above data, trends become quickly discernable. The

most basic trend is that suicide rates, overall, are increasing. When examining trends based on age, comparisons of 2007 and 2012 with 2013 are very similar with one important exception, the 35-59 age group. From 2007-2013, the rates increased for most age groups. However, when this is narrowed down to 2012-2013, the rates decreased. This demonstrates that possible suicide prevention efforts targeting this demographic may be effecting positive change.

The suicide rates for the age group 70-74 decreased in both 2012 and 2013 when compared to 2007. This may reflect improved medical advances along with suicide prevention efforts. In contrast, suicide rates among adolescents increased in almost all categories when 2013 is compared to both 2007 and 2012. This is concerning given the amount of attention placed on this problem.

Race trends continue to demonstrate that the highest crude rate is found among the white population. This same category had the largest increase from 2007-2013. The rate in African Americans essentially remained the same. The gender comparisons provide continued evidence that males complete suicide at a much higher rate than females. This trend is widening as demonstrated by comparing the 2013 data to 2007 and 2012.

This data should not be considered without acknowledging its limitations. The source data is not complete and often depends on death certificate data or voluntary reporting by select states. Suicide is not always an obvious cause of death and as a result, these data may be underreported. While age and gender are usually steadfast categories, race is not. As the United States becomes more assimilated with other cultures, the use of race classifications becomes less helpful (as seen by the large number included in the “other” category). Further evaluation and manipulation of the data could help to understand the intersection of age, gender and race. This would allow focused prevention efforts for high risk groups. ⁽⁴⁾

Nobody Wants To Read Your Report

Andrew Nanton, MD, Early Careers Committee

Ouch. It's hard to acknowledge on those nights I'm up late writing, but we both know it's true: nobody is thrilled to read this report. No matter how carefully crafted, nobody is lining up to read it like they would a new Harry Potter novel. Obviously, a novel and a forensic report serve very different purposes, and it's hardly surprising that they would be received so differently. So why mention it?

Because taking a moment to consider the reader and purpose makes a report more effective.

Our written reports are arguably the most important thing we do as experts. Even though reports are not as exciting as testimony, they are the bulk of our communication to the court. Lawyers and judges are busy professionals with many demands on their time. If you think a lawyer with dozens of active cases is likely to clear her schedule to read your 300-page report, you might want to reconsider some of those assumptions. The least effective report is the one that sits unread.

The following suggestions are offered assuming that you are already dividing your report into a data section without interpretation of the data, and an opinion section for interpretation without introducing new data. An excellent source for basic report content and structure is Grisso's 2010 article¹. Despite familiarity with the basics, it's easy to follow a template without taking the time to consider the assumptions it makes. Here are a few items to consider when taking a step back to consider the wider context of the report:

1. Who will read this report?

A report cannot be all things to all people. A judge who has presided over disability hearings for 30 years is likely to be quite familiar with mental illness. A report for a newly-minted public defender, on the other hand, should assume very little exposure to psychiatric jargon and concepts. It's not possible to know every-

thing about all participants in every legal proceeding, but you need to know if forensic psychological or psychiatric testimony is presented regularly. Explaining everything is a reasonable default, but can be antagonistic to a more sophisticated audience, who will also grill you on the inevitable over-simplifications you have made. Titrate the detail of your explanations accordingly.

2. What question will this report answer?

Let's say, for example, you are writing a competency evaluation. The central matter is the evaluatee's present level of function. There are a multitude of pieces of information that you will collect over the course of such an evaluation. Ask yourself if each particular bit of information helps to answer the question. A detailed history of childhood trauma may have been relevant to explore during the interview while you were ruling out PTSD, but if it does not speak to the

“The writing advice to journalists to “kill your babies” is relevant even outside of a filicide report.”

present level of function it may not belong in that competency report.

The writing advice to journalists to “kill your babies” is relevant even outside of a filicide report. It refers to cutting parts of your writing that, despite the effort you have spent, simply don't belong in the final product. Perhaps you found an evaluatee's account of their painful divorce evocative, and you have written several paragraphs that capture the pain they described. Or maybe it took you a page to untangle the relationships between all 8 people who live in the

evaluatee's home. You may have started writing up summaries of records or parts of the interview before you had all the information you wanted and before arriving at an opinion. Re-reading with your opinion in mind, the question then becomes: Does this information help to answer the forensic question? No? Cut it.

3. Does it tell a story?

A report is a piece of technical writing. It will never “tell a story” the way a novel does, but it can still benefit from chronology as an organizing principle. A report organized by topics such as work history and legal history can make this difficult, and it's worth considering on a case-by-case basis if those topics make the report in front of you harder or easier to understand. Collapsing several headings into a more generic one to allow chronological organization often makes sense, particularly if the information in those headings is low-yield.

When you find yourself needing to skip around in the timeline, try to identify a few events as landmarks. For example, you could give the exact date of the evaluatee's first arrest and then note if the arrest was before or after their first hospitalization. Even if the date is in another part of the report, anticipate the reader's question about how the events are connected chronologically. Outside of the opinion section of the report, you can simply include such statements as context rather than offer an interpretation.

When you reach the opinion section, the story your report needs to tell is the story of how you arrived at your opinion. The pertinent positives and negatives we all learned about in medical school are relevant touchstones for this process. Their presence or absence guided you. Your opinion should summarize this journey from objective collection of information to firm conclusion. How did you weigh each of these against the whole? Include relevant discussion of past diagnoses with which you agree or disagree, and why.

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Financial Crimes Against the Elderly: A Call to Action

Sherif Soliman, MD, Chair Geriatrics Committee

I recently had the opportunity to meet Professor Philip Marshall, Brooke Astor's grandson. Mrs. Astor, the "first lady of New York," was heir to the Astor fortune and spent decades as a tireless philanthropist. Prof. Marshall took the courageous step of filing a petition for guardianship of his grandmother in 2006. The petition and ensuing guardianship proceedings exposed financial exploitation of Mrs. Astor by Anthony Marshall and Attorney Francis X. Morrisey. It revealed that Mrs. Astor, a woman of extraordinary means, was living in substandard conditions while her son enriched himself. While the petition simply sought to protect Mrs. Astor, it set off a chain of events that led to Anthony Marshall's 2009 conviction on 14 counts including first and second degree grand larceny, offering a false instrument, and conspiracy. Mr. Morrisey was convicted of five charges including conspiracy, scheme to defraud, and forgery. This tragic case took elder financial exploitation from the shadows to the front pages.

Prof. Philip Marshall has devoted himself to raising awareness of these crimes. He has testified before congress, has shared his personal story at numerous conferences, and has founded a website, beyondbrooke.org, devoted to advancing the cause of elder justice. His outstanding work in this area has inspired me to think more deeply about the role of forensic psychiatry.

Elder financial exploitation has been called the "crime of the 21st century." The explosive growth of the elder population, the unique vulnerability of this population, and the accumulated wealth over lifetimes of hard work have contributed to this epidemic. A recent MetLife study estimated the financial toll at 2.9 billion dollars in 2010, up a staggering 300 million dollars from their previous survey, taken just two years prior.¹

Forensic psychiatrists are uniquely positioned to lead the fight against

elder financial exploitation. Our training enables us to understand the psychological mechanisms that underlie the relationship between the perpetrator and the victim. We can assess decision making capacity of victims, assess criminal responsibility in perpetrators, and identify risk factors which increase victim vulnerability. We also have the training necessary to communicate this information to courts and to the public. I am therefore issuing a call to action for myself and my colleagues. Many including Dr. Bennett Blum have already made substantial contributions to our understanding of undue influence and financial crimes against the elderly. We should work to continue to improve education, prevention, and prosecution of financial crimes against the elderly.

Educational programs are vital to both prevention and prosecution.

"Individuals who are isolated are more likely to welcome contact from potential perpetrators and less likely to report perpetrators because they do not want to lose the companionship."

Signs of elder financial exploitation should be taught as part of the geriatric curriculum in medical school, residency, and, of course, geriatric medicine and psychiatry fellowships. This should include victim risk factors and signs of exploitation. Spar and Garb² have identified psychological "red flags" for undue influence, a key mechanism of elder financial exploitation. In addition, Hall and Hall³

have identified signs of financial exploitation and characteristics of both perpetrators and victims. Recognition is of course only the first step. Every physician should be familiar with local reporting mechanisms and requirements.

Combatting elder financial exploitation is a multidisciplinary challenge. Educational programs must extend to other professionals including attorneys, accountants, bank employees, financial planners, and estate planners. Here the focus should be on recognizing suspicious circumstances and unusual patterns of activity. Elders should also be educated about common scams and suspicious behavior. These thefts often occur over a protracted period of time and are only discovered long after the perpetrator has spent the money. Ideally, suspicious transactions should trigger immediate investigation so as to prevent the loss in the first place.

The old adage, "An ounce of prevention is worth a pound of cure," rings especially true with regard to financial crimes against the elderly. Prevention begins with public awareness of the problem, the risk factors, and the signs of elder financial exploitation. A key modifiable risk factor for financial exploitation is isolation. Individuals who are isolated are more likely to welcome contact from potential perpetrators and less likely to report perpetrators because they do not want to lose the companionship. Therefore, a good prevention program should include reaching out to elders who are isolated. Public awareness may motivate family members to maintain contact with elderly relatives. Community and religious organizations can also be helpful in this regard. The caveat is that these organizations should implement policies to prevent and detect elder financial exploitation, since employees of such organizations have themselves been perpetrators. Another potentially useful tool would be a legal framework that allows financial institutions to delay certain suspicious transactions for a reasonable period in order to allow for appropriate investigation.

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Reflections

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transgender soldiers.¹¹ Mental health involvement with LGBT soldiers is significant and ranges from supportive psychotherapy to assessing gender dysphoria and helping the soldier to find an appropriate military unit.

An important aspect of the IDF is its social function. Since its founding in 1948, Israel has absorbed 2.4 million immigrants from Europe, North Africa, and Asia.¹² A new nation needed to be formed out of the old, and the IDF was viewed as important in integration.¹³ The IDF psychiatrist is therefore likely to encounter cultures quite different from his own, requiring sensitivity to culturally mediated expressions of psychiatric symptoms and theories of illness.

The IDF continues to enjoy broad prestige in Israeli society, and failure to complete military service carries a stigma. A psychiatrist discharging an unfit soldier may face fierce opposition by soldiers and their families. Conversely, others called to serve may reject military service for personal or ideological reasons, and welcome exemption or discharge from service. Further complicating matters, the IDF sees itself as a positive social force, believing that successful completion of military service will increase chances of future success in civilian life. The decision about whether to discharge a soldier based on mental illness is therefore often highly ambiguous and involves weighing clinical data with additional information from family, the soldier's commanders, and consideration of the soldier's particular job and the needs of the unit.

All these factors create the potential for issues of dual agency. Is the psychiatrist primarily the servant of the patient or of the military? What guides decisions when the interests of the soldier and of the military clash? In addition, the IDF psychiatrist is an agent of "society," tasked with carrying out the social mission of the IDF, and must consider issues

of justice. In the case of the paratrooper with depression, coming to a decision about his fitness for duty involved not just assessing the severity of his depression, response to treatment, and disability, but weighing the needs of the military and the soldier's self-concept as coming from a military family. Fortunately, all of these interests were harmonized by recommending that he be assigned to Battalion Headquarters, where he could remain, officially, a paratrooper, but removed from the stress of combat. ☪

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Nobody Wants

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4. It's the little things

Finally, after all of that hard work, there are a few other considerations to review. Odds are, every single person who reads this report will first turn to the conclusion. Why not put it on the first page? Yes, it lacks context there, but it will be taken out of context anyway. If a lawyer is looking at four different reports turned to different pages, is yours labeled with informative headings? Do you have a report template with adjustments to font, line spacing, and margins to improve readability? None of these things are the center of your report, but your report is not the center of the universe. Acknowledge that it will be one of many sources of information, and make it easy to use.

These are just a few considerations, and there's much to learn in order to continuously improve our reports. Many of us are familiar with forensic resources for report writing, such as *Psychological Evaluations for the Courts*². Another useful perspective comes from resources for general legal writing. Though it is somewhat less specific to our work, it's valuable to hear directly from the

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Meeting Highlights

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the AAPL American Medical Association Delegation.

In addition, the AAPL delegation wishes to recognize the American Association for Geriatric Psychiatry, who joined the House of Delegates and Psychiatric section council at the most recent meeting. Given the overlap between forensic and geriatric psychiatry, it will be helpful having the geriatric psychiatrists at the meetings. ☞

Nobody Wants

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legal community what they would like to see in legal writing. A great starting point is Garner's *Legal Writing in Plain English*³. This book is a topic-by-topic guide, with exercises. A more general style guide by the same author, who has written a number of authoritative works about legal writing, is Garner's *Modern American Usage*⁴. This is an excellent desktop reference for punctuation, word choice and style. As a bonus, it is a delightful read for writing nerds and language curmudgeons. ☞

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Another "Sexy" Role

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International Academy

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Palestine, Israel, Iran, Pakistan, China, and Russia. Most of the presentations were in English, but some were in Spanish and French. A presentation on psychiatry in the former USSR highlighted some of the systemic political abuse of the profession. For example, under Soviet rule, diagnoses were created with symptoms that reflected characteristics of government opponents, rather than psychiatric illnesses as we understand them. This allowed the government to detain such individuals under the pretense of having a serious mental illness simply because they opposed the government or were political dissidents.

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INFORMATION ABOUT THE NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE (NCCHC)

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

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For more information contact the NCCHC at 773-880-1460 or info@ncchc.org.

International Academy

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The third day included presentations on epigenetics, interdisciplinary cross-training in law and mental health, cyber-bullying, mental harm and the law, and cyberspace terrorism. There was a presentation cluster dedicated to ethical and legal considerations in organ transplantation, while another addressed various refugee mental health problems in Lebanon and Jordan. In yet another presentation, we learned of a court system in Rwanda where female survivors of rape bring their perpetrators to justice.

The fourth and fifth days of the conference were ethics heavy, with various presentations regarding ethics and end of life care, physician assisted suicide, organ donation of mentally ill persons, guardianship, and free will in forensic evaluations.

Some of the highlights of this conference were the thoughtful and well-organized social events. Aside from a pre-conference evening reception and farewell reception, there were two major social events at renowned locations. One evening, the group had St. Stephan's Cathedral all to itself for a chamber orchestra performance by the Festival Strings of Vienna.

The program included Pachelbel's Canon in D Major, Vivaldi's Violin Concerto in A minor, Mozart's Salzburger Symphony, and Grieg's Suite Aus Holbergs Zeit. Another evening, a cocktail reception was held for the group at the ballroom of the city hall of Vienna, the Rathaus. This was quite an elegant affair, with Viennese waltz music performed by the Ladies' Orchestra Tempo di Valse

The next IALMH congress will be held at Charles University in Prague in July 2017. The exact dates are not yet determined. If Vienna was any indication, it will be another beautiful event worth attending. I hope to see you all there. ☺

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Financial Crimes

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These cases are notoriously difficult to prosecute. Transactions often have the facade of legitimacy. Victims are often reluctant to pursue criminal charges due to shame, fear both of the perpetrator and of losing their independence, and emotional attachment to the perpetrator. When they do cooperate with prosecution, they can often make poor witnesses. These victims are at greater risk of becoming ill or dying during the process. They sometimes suffer from neurocognitive disorders that make it difficult to recall details of the suspicious transactions. Forensic psychiatrists can assist in determining whether the victims were competent to enter into the contested agreements, whether the victims were vulnerable to undue influence, and whether there are indicators of undue influence in the relationship.

Criminal prosecution is one legal mechanism for protecting these vulnerable victims. Others include civil action to invalidate contracts where the victim was incompetent to enter into the agreement, durable power of attorney, and, in cases of extreme disability, guardianship. Our practice at the interface of psychiatry and the law places us in a unique position to combat these crimes through education, prevention, and prosecution. While I have focused on the role of forensic psychiatry, legislators, prosecutors, primary care physicians, and financial professionals all have a role to play. There is no better time to get started. ^(P)

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Octavio Choi, M.D., Ph.D., Assistant Professor of Psychiatry, OHSU
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