AAPL Newsletter
American Academy of Psychiatry and the Law
September 2016 • Vol. 41, No. 3

AAPL at the APA Awards

Ryan C.W. Hall MD

At the recent APA meeting in Atlanta, Georgia, several AAPL members were recognized at the 60th Convocation of Distinguished Fellows, as was the AAPL organization as a whole. Current APA President, and former AAPL president, Renée Binder presided over the ceremony in which several senior AAPL members received special presidential commendations.

In alphabetical order, AAPL members who were recognized by special presidential commendation include:

Dr. Larry L. Faulkner, who is the president of the American Board of Psychiatry and Neurology. His notable past work includes being Dean at the University of South Carolina and a past president of the American Academy of Psychiatry and the Law.

Dr. Jeffrey L. Metzner, who is a Clinical Professor of Psychiatry at the University of Colorado. He is notable for his work on psychiatric care provided in jails and prisons, as well as advising judges, special masters, monitors, state departments of corrections, city and county jails, as well as the US Department of Justice. He has also been involved in the National Prison Project and was involved in the first and third editions of APA's guidelines for psychiatric services in correctional facilities.

Dr. Donna M. Norris was also recognized with the Distinguished Service Award (established by the APA Board of Trustees in 1964 to honor individuals and/or organizations who have contributed exceptional meritorious service to the field of psychiatry and/or the American Psychiatric Association). Dr. Norris specializes in child and forensic psychiatry. She is also the past APA secretary-treasurer, the first woman and first African-American APA speaker of the Assembly and secretary of the American Psychiatric Foundation. She was recognized for her contributions to psychiatry, including advocacy for the mental health needs of underserved populations and the advancement of women in leadership roles.

The organization of AAPL as a whole received the Organizational Distinguished Service Award. AAPL was recognized for its leadership and excellence in forensic psychiatry through its core principles of being dedicated to enhancing practice, teaching, and research. It was noted that we currently have more than 1,800 members in North America and around the world and that through our annual meetings, we frequently facilitate the exchange of ideas and practical clinical experience through publications and regularly scheduled national and regional meetings.

A separate newsletter article will cover the Guttmacher Award, but again we want to acknowledge and recognize Dr. Kenneth L. Appelbaum, Dr. Jeffrey L. Metzner, and Dr. Robert L. Trestman for receiving this honor at the 2016 meeting.

This year's winner of the Isaac Ray Award was Dr. Elissa P. Benedek. The Isaac Ray Award was established in 1951 to honor one of the original founders and fourth President of the APA, Isaac Ray, and honors psychiatrists who have made outstanding contributions to forensic psychiatry or to the psychiatric aspects of jurisprudence. The Isaac Ray Award is co-sponsored by AAPL. Dr. Benedek is an adjunct Clinical Professor at the University of Michigan. Her career in forensic psychiatry has spanned over 50 years, with a focus on research and policies impacting child abuse, trauma and neglect, as well as ethics in psychiatry. She was the second female president of APA in 1990 and has also served on the APA's Board of Trustees. She is also a past recipient of the Guttmacher Award.

Last, but certainly not least, we need to acknowledge the Assembly Warren William's Speaker's Award. Although the awards were not presented directly at the Convocation, they were listed in the program. This award was established in 1984 in memory of past speaker Warren Williams, MD, and is administered

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Manuscripts are invited for publication in the Newsletter. They should be submitted to the editor via email to aaplnewsletter@gmail.com

The Newsletter is published in January (deadline for submission is November 15), April (deadline February 1), and September (deadline July 1).

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COVER STORY

AAPL at the APA Awards

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by the APA Area Councils to recognize outstanding recent or current activity/contribution in the field of psychiatry and mental health. The founder of AAPL, Jonas R. Rappeport, was a recipient of the award this year. Dr. Rappeport is a distinguished life fellow of the American Psychiatric Association. He graduated from the University of Maryland School of Medicine, as well as completing his training there. His academic appointments have included the University of Maryland School of Medicine, University of Maryland School of Law, and Johns Hopkins University School of Medicine. Besides being a founder and past president of AAPL, he has also been a president of the Maryland Psychiatric Society. He has also won the APA Isaac Ray Award for Contributions to Law and Psychiatry.

Richard J. Bonnie, JD friend of AAPL, who is the Harrison Foundation Professor of Law and Medicine and Professor of Public Policy at the University of Virginia. He was recognized for several of his achievements, such as work on *Ending the Tobacco Problem: A Blueprint for the Nation*; his work on juvenile justice reform; and his work on the Commission on Mental Health and Law Reform for the Chief Justice of Virginia.

Although not directly affiliated with AAPL, other notable events at the Convocation included former First Lady Rosalyn Carter, who spoke on her longstanding work toward mental health treatment and improvements for patient care; The William C. Menninger Memorial Convocation lecture, which was given by Tom Frieden, MD, MPH, current Director for Centers for Disease Control and Prevention; and the Human Rights Award which was awarded to David Satcher, MD, PhD, served as the former Surgeon General of the United States from 1998 to 2002.

Dr. Donna Norris receives her award from Dr. Renée Binder.

First Lady Rosalyn Carter addresses the audience.

From left to right, First Lady Rosalyn Carter, Saul Levin, MD, MPA, APA CEO and Medical Director, Jacquelyn Coleman, CAE, AAPL Executive Director, Jeffrey Janofsky, MD, AAPL Medical Director, Rahn Bailey, MD, APA Membership Committee Chair

"I Saw a City in the Clouds"

Susan Hatters Friedman MD

Welcome to the September issue of the AAPL Newsletter. September not only signals the end of summer and heading back to school, but also, of course, time to register for AAPL. This year's program in Portland promises not to disappoint, with its courses, panels, workshops and new research.

As I'm sitting down to write this column, for it to be in your hands by September and well in advance of the AAPL meeting, I've just returned from a much-needed summer girls-trip to Europe with my daughter. And for once in a great while, a vacation without a conference in the middle! Perhaps unsurprisingly, I've been doing some reflecting about the personal importance of taking a break.

Summer has always been a time I associate with relaxation with family and fun in favorite locations. Time to nurture the soul and to refuel, before heading back to the grind. But some of us forensic psychiatrists just might be workaholics….

I've written previously about the potential benefits of taking a sabbatical [1], but vacations are important too. Attending a conference lecture by Professor Tom Gutheil as a young resident, I was struck that his contracts include that he will be unavailable to testify in the month of August. And yes, it has stuck with me since, that this highly productive leader in our field thinks vacation is important enough that it is routinely spelled out in his contracts with attorneys.

Vacations increase, rather than decrease, productivity, and it seems that other nations are on to this. Internationally, the US lags behind in vacations for its workers [2], that is, regarding the minimal paid vacation time received by law. (For example, the European Union's vacation floor is 20 days. [2]) Add to that, a lot of us save up our vacation time for "later". But then, we have a hard time using it, worrying about coverage or our services or our patients if we take a longer trip. But somehow, our colleagues in other countries are able to routinely take longer leave, attend international conferences, even take sabbaticals, and still be quite productive.

Research demonstrates benefits of vacation. It turns out that relaxing and pulling away from one's work over vacation are positive for one's health and wellbeing even after vacation. [3] One study found that middle aged men at high risk for coronary heart disease have decreased risk of mortality with the frequency of annual vacations. [4] However, working during vacation negatively affects health and wellbeing after return. [3] (Those of us know who we are. Seriously, statistically speaking, how often can proofs possibly arrive when one is on the way to the airport?) While we as forensic psychiatrists are lucky to have a fantastic career, and a welcoming professional home with interesting colleagues and intellectual stimulation, I've been informed that AAPL meetings don't technically count as "vacation" for some reason. One should come to AAPL, but also take a vacation. Just some food for thought.

In this edition of the Newsletter, President Dr Emily Keram discusses the theme of Trauma and Transformation. Dr. Charles Dike (this year's AAPL program chair) writes about the upcoming lunchtime speakers—make sure to get your lunch tickets early. Jackie Coleman's illuminating Executive Director column provides guidance about how presentations are chosen for AAPL, and how our future submissions might improve in order to increase chances of acceptance.

You'll find this issue full of amazing AAPL member accomplishments and awards, including the Guttmacher award and AAPL's award given by American Psychiatric Association president Dr Renée Binder, at this year's APA meeting, among others. The work that our colleagues representing AAPL are doing in the APA Assembly and at the American Medical Association are described in their own articles as well. We're also excited to share articles from colleagues in related disciplines, with Criminology Professor James Oleson writing about High Intellect Crime, and Law Professor Michael Corrado writing about preventive detention in Europe. Internationally as well, Dr Joel Watts writes about Canadian law. Dr Jeff Janofsky, Medical Director, describes the *Moore* case, and one might expect to "watch this space."

The incoming Rappeport fellows for 2016-17 are introduced in this issue. You'll find two thoughtful Fellow's Corners, from current forensic psychiatry fellows—about forensic evaluations in a second language, and about taking the stand. Please do encourage your fellows to make contact if they would be interested in writing for the Newsletter. As well, this issue holds multiple thought-provoking committee articles, with topics ranging from child abuse reporting, risk management, modelling habits, biases, elder abuse, to what toxicology screens may miss, and the well regarded Ask the Experts column.

Hope you enjoy reading this issue of the Newsletter—perhaps not counting that as your "vacation" though. See you in Portland!

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Trauma and Transformation

Emily A. Keram MD

I have been honored to serve in as the 42nd President of the American Academy of Psychiatry and the Law (AAPL) and look forward to passing the baton to the extraordinarily capable hands of Michael Norko, MD, in October.

Among the humbling opportunities the AAPL Presidency brings is the prospect of distilling years of forensic experience into a theme that underlies the Annual Meeting and the Presidential Address. In my final President's Report, I will discuss the selection of my theme, Trauma and Transformation.

Without design, my clinical and forensic careers have focused on trauma and its aftermath. This work has occurred across disparate settings. I have been a staff psychiatrist at the Santa Rosa Community Based Outpatient Clinic for almost 20 years, treating veterans from WWII to the current conflicts. For many years my forensic cases primarily involved allegations against law enforcement of excessive force, wrongful death, and inadequate training stemming from their contacts with mentally ill subjects. As a result of providing mental health training to law enforcement officers I established a small private practice treating first responders. I volunteer with the First Responder Support Network, a nonprofit that, among other activities, offers a week-long, peer support driven retreat to traumatized first responders. For the past twelve years, I have consulted as an expert witness, judge's expert, and physician monitor in a number of cases involving Guantanamo detainees. Finally, I have been an expert witness in cases involving domestic terrorism.

Practicing across such a wide range of demographic, occupational, and geographic contexts has often brought me into contact with people who experience similar or related traumatic events very differently. For example, while treating veterans of Iraq and Afghanistan, I have been involved in the cases of over a dozen Guantanamo detainees, six of whom I evaluated face-to-face. I have worked with patients who contemplated or attempted Suicide by Cop and patients who, in their role as law enforcement officers, have shot behaviorally disordered mentally ill subjects. I have worked with lawyers, paralegals, and judges who are negatively impacted by their exposure to traumatic material while at the same time registering and managing my own response to the same disturbing evidence.

Through repeated experiences of hearing related trauma narratives from different viewpoints I have witnessed the impact of trauma on the individual and society, both in the immediate aftermath of the event and in the longer term. I have been aided in this journey by the opportunity to treat individuals at the VA and in my private practice over many years and through different tasks over the life cycle. Similarly, because of the evolving rules of the Military Commissions and policies on indefinite detention, I have worked on some detainee cases for many years.

Years spent working with the same patients and on the same cases, as well as my own reactions as an American living through the post-9/11 era, have repeatedly exposed me to two important aspects of trauma. The first relates to the chaos created in its immediate aftermath. The second, and most important, is the powerful force unleashed by traumatic disruption that challenges and changes our individual and societal identity in often astonishingly fundamental ways.

I have developed a profound appreciation for the transformative potential of trauma. Consequently, I have become interested in the factors that determine whether this transformation will have positive or negative consequences for the individual and the collective. In selecting my theme, Trauma and Transformation, I hope to share some of what I've learned and to encourage AAPL members to explore the impact of trauma on their forensic cases, their own lives, and the communities in which they live and with which they identify.

I am extremely fortunate and grateful to have Charles Dike, M.D., as my Program Chair. Dr. Dike immediately understood what I am attempting to communicate by the selection of my theme. I would like to discuss some of the ways in which the theme will be represented at the Annual Meeting.

Two of our luncheon speakers demonstrate the transformative potential of trauma on the individual. Zak Ebrahim, who will be speaking on Thursday, is the son of El-Sayyid Nosair. In 1990, Mr. Nosair shot and killed the leader of the Jewish Defense League in Brooklyn, New York. While in prison, Mr. Nosair helped plan 1993 bombing of the World Trade Center. Mr. Ebrahim will share his memories of growing up in a radicalized family and his rejection of its ideology. Emmanuel Jal, who will speak on Friday, is a former child soldier from Southern Sudan. Mr. Ebrahim will discuss his rescue and rehabilitation from his the trauma of his early life. He has transformed from child soldier to artist and musician and founder of Gua Africa, a charity that assists individuals, families, and communities devastated by war and poverty.

In addition to presenting trauma's transformative effect on individuals, I wanted to share my experience of understanding traumatic events from different viewpoints and the potential these events have to transform communities, nations, and public policy. Law enforcement contacts involving use of force demonstrate trauma's tendency to drive people to the extremes of reaction. I have learned that addressing and ameliorating the aftermath of trauma requires the diffi-

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Texas, Intellectual Disability and the Death Penalty - Moore v. Texas

Jeffrey S. Janofsky MD

On June 6, 2016 the United States Supreme Court granted certiorari in *Moore v. Texas*.[1] AAPL, along with the Constitution Project, and the Southern Center for Human Rights had filed an amicus brief supporting certiorari.[2]

The question the Court accepted for appeal was whether, in determining whether an individual may be executed it was a violation of the Eighth Amendment and the Court's decisions in *Hall v. Florida*[3] and *Atkins v. Virginia*[4] to prohibit the use of current medical standards on intellectual disability, and to require the use of outdated medical standards.[5]

Moore was convicted of being the shooter in a botched 1980 robbery. He was found guilty and sentenced to death that same year. He has been on Texas' death row ever since. He has had several direct and habeas appeals and has been twice re-sentenced to death. During his latest habeas appeal Moore raised many claims, including a claim that the Eighth Amendment barred his execution because he was Intellectually Disabled. The Texas trial habeas court concluded that Moore met the definition of Intellectual Disability under the current guidelines of the AAIDD (American Association on Intellectual and Developmental Disabilities) and under both the DSM IV and the DSM 5. The Court found that both Moore's impairment in adaptive functioning and his corrected IQ score placed him in the range of mild Intellectual Disability. The Court found that he was therefore barred from execution under *Atkins* and *Hall*.

The Texas Court of Criminal Appeal reversed. The Court held that the state habeas trial court erred by relying on current medical standards rather than the twenty-two year old standard in *Ex parte Briseno*[6] that the Texas Appellate Court had adopted in prior cases for *Atkins* claims. The Appeals Court held that it was up to the Texas legislature to change the law, not the Court. Using the *Briseno* standard, the Texas Appeals Court then analyzed the presence of Intellectual Disability based on IQ scores that were not statistically corrected. The Texas Appeals Court also did not consider adaptive functioning at all. The Texas Appeals court found that Moore was not Intellectually Disabled and reimposed the death penalty. Moore appealed to the U.S. Supreme Court.

"The Texas Appeals court found that Moore was not Intellectually Disabled and reimposed the death penalty. Moore appealed to the U.S. Supreme Court."

AAPL's amicus brief reviewed the history of the diagnosis of Intellectual Disability both pre and post *Atkins*, how the Court in *Atkins* relied on DSM-IV-TR's now outdated definition of Intellectual Disability, and how subsequent Courts before *Hall* tended to rely on strict IQ cutoffs to define Intellectual Disability. We then reviewed the DSM 5 approach, which expressly states that diagnosis of Intellectual Disability should be based on both clinical assessment and standardized testing of intelligence, as well as evaluation of adaptive functioning. We wrote that the Texas Appellate Court's exclusive reliance on statistically uncorrected IQ tests alone, without also analyzing impairments in adaptive functioning, was not appropriate. We then applied this analysis to several cases, including Moore's.

I have previously written in this column about the APA's and AAPL's amicus brief in *Hall*.[7] In that brief we updated the Supreme Court on changes in the professional understanding of Intellectually Disability. The majority and minority opinions both quoted extensively from our brief.

AAPL has only signed on to one other amicus brief asking for certiorari in the Supreme Court. The chance that the Supreme Court will accept any case is very low. The Court receives approximately 7,000 to 8,000 petitions for a writ of certiorari each year, and hears only about 80 of those cases.[8] I hope AAPL's certiorari amicus brief played even a part in the Court's acceptance of this important matter.

AAPL will almost certainly review and participate in the writing of an amicus briefs on the merits in this matter. I will keep you informed of our progress.

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MUSE & VIEWS

What's in a Name?

A Florida woman was arrested in May for shooting a missile at an occupied car. A closer look at the police report shows the woman's legal name, Crystal Metheney. When contacted by a reporter regarding the detained woman's unique name, an employee for the Polk County Sheriff's office replied, "Sir, this is Florida. We have a lot of interesting names here."

Source: www.eonline.com

Submitted by William Newman MD

AAPL: Ask the Experts-2016

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

Neil S. Kaye, MD, DFAPA and Graham Glancy, MB, ChB, FRC Psych, FRCP (C), will answer your 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.: What is the role of advocacy?

A. Kaye: Advocacy is an important part of the role of the forensic psychiatrist. However, one must be aware of the AAPL Ethics Guidelines that insist on striving for objectivity and impartiality in reaching an opinion. Many AAPL members thus are uncomfortable being placed in an advocacy position.

However, the SCOTUS in Ake v. Oklahoma (470 US 68) ruled that an indigent defendant is entitled to an expert psychiatric witness to assist in the defense. The majority opinion in Ake was penned by Justice Marshall. Writing for the Court, Marshall said: "without a psychiatrist's assistance to conduct a professional examination on issues relevant to the insanity defense, to help determine whether that defense is viable, to present testimony, and to assist in preparing the cross-examination of the State's psychiatric witnesses, the risk of an inaccurate resolution of sanity issues is extremely high. This is so particularly when the defendant is able to make an *ex parte* threshold showing that his sanity is likely to be a significant factor in his defense."

Clearly, the role of the forensic psychiatrist as defined by the SCOTUS includes advocacy. Further, any good expert knows that in order to be persuasive, one must be passionate and that proper emotional modulation during any presentation improves the listener's experience.

The real key here is to marry these two approaches. Be impartial in reaching an opinion but once that opinion is reached, it is appropriate to advocate for that opinion with passion and verve.

A. Glancy: This question becomes even more pertinent in Canada since the health advocate is one of the 7 roles expected of a physician according to the CanMEDS framework. The central role of medical experts in the samples include: communicator, collaborator, manager, scholar, and professional. In some respects being a health advocate is a role that the forensic psychiatrist should be expected to take in certain situations. For instance when advocating for services for the the mentally ill in correctional facilities, or for other important to initiatives in healthcare for our client base it is appropriate for us be a health advocate.

In his role as president of AAPL, Dr. Larry Faulkner made a convincing case for instituting subspecialty status in forensic psychiatry. Dr. John Bradford and I and took on this role in Canada. This is a type of advocacy that should be encouraged.

At one point in a particularly vitriolic cross-examination a lawyer asked me about a statement made in an article regarding advocating for services for our population. When I answered, perhaps unwisely in retrospect, that the article was meant as advocacy, he craftily countered "just like you're being an advocate now-is that not correct doctor?" The point is that when you are retained as an independent expert you are not an advocate for the patient. It is reasonable to defend your position, sometimes vigorously, but you are not the advocate. The use of the adverb vigorously means intellectually vigorous, not physically or emotionally. It is always important to try to keep your equilibrium and to maintain a professional manner, even in the most trying of circumstances.

Take Home Points:

Advocacy for your opinion is different than advocacy for the defendant in a criminal matter or for a particular side in a civil matter. It is always appropriate and professional to advocate for your impartially reached opinion and on behalf of our profession.

My group is looking for examples of attorneys' resisting their own retained expert's input. We don't mean the cases where the expert turns down the case as meritless, but ones where, say, the expert thinks something is essential to the opinion but the attorney feels it puts a bad light on the case or the parties, or where the expert's suggestion for a template or outline of the best structure for the direct examination is resisted or dismissed. Extended content is welcome, as well as approaches that members have used. Examples (which will be attributed only at the request of the sender) may be sent to gutheiltg@cs.com.

Thanks in advance.

Ramping Up

Jacquelyn T. Coleman CAE

The May Semiannual Meeting saw the introduction of the draft Annual Meeting program to the Education and Program Committees and the Executive Council.

It will be available by the time you read this. Dr. Dike's article in this same issue is about the lunch speakers, a very exciting group.

I am going to tell you about the program itself.

We had 232 abstracts, the second-highest in our history (2014, Chicago was the highest.)

Needless to say, there was heavy competition for the available slots and the Program Committee and Dr. Dike had their work cut out for them.

A bit about the process: when the abstract submission deadline is reached, the abstracts are assigned randomly to members of the Program Committee. Scientific Papers and Research In Progress are judged separately from other submissions. This year, each member of the Program Committee had over 30 abstracts to rate, within a three-week period. One numerical rating is given for each abstract. The range is 1-7, with 7 being the best. Comments are encouraged.

After the ratings are made, the Program Chair sifts through all the submissions, considering quality, the number of submissions on the topic, and the pertinence of the topic to the field and to the meeting itself (if the President has designated a theme).

You may know that committees are required to make a submission every two years. Committee submissions are rated on the same basis as all other submissions. The acceptance rate for committees' submissions is better than the rate for submissions as a whole.

This year, for the first time and at the recommendation of the 2014 Program Committee, the Education Committee decided to make available on request the ratings and comments for submissions that were not accepted. Twenty-one submitters asked for their ratings. It is possible for a submission to receive very high marks for quality and still not be accepted. As I mentioned above, in addition to the rating, the number of presentations submitted on the topic is important. The Program Chair may prefer a similar offering with a different approach, or perhaps there are a lot of submissions featuring the same key speakers, or the program is lacking in some topic and preference is given to a submission on that topic. With an overall acceptance rate of 50-60 percent, and adding these other factors, you can see how high-quality presentations don't always make the cut. There are a number that are clearly going to be accepted, and there are a number that are clearly going to be rejected, but it's in the middle where the agonizing decisions have to be made. You can ask any former Program Chair about that!

This year, we are looking at a program with a 57 percent acceptance rate overall. However, since most posters are accepted and as many as possible scientific papers and research-in progress submissions are accepted, the key numbers for most presenters are the following: Only 25 panels were accepted, 28 were rejected. For workshops, 16 were accepted and 31 rejected. There has been a consistent problem with many workshop submissions: the requirement for active audience participation in a learning activity. "Questions and answers" and "discussion" do not qualify as audience participation for a workshop. Submissions should be very specific about what the active learning activity will be. The question that is on the submission form for a workshop that asks the nature of audience participation does NOT mean who should be in the audience!

There were 8 courses submitted and 4 of those didn't make it. There are never more than four courses accepted because they would take too much time from the program. Some courses that were well-received in the past were not accepted this year in order to allow for new topics. Additionally, the course's appeal to the entire membership is also considered when determining which courses to accept.

For topics this year, the favored categories of submission were corrections, criminal issues, and "Special Topics." The last is a category I would like to see refined, but it is sometimes hard to figure out where a particular submission belongs. In 2013, the Education Committee changed its topics to conform to the list used by the American Board of Psychiatry and Neurology to help members choose topics that conform to the expectations of what they will be tested on.

I hope this article highlights the quality of the presentations you will hear in October, but it should also highlight, for those whose submissions didn't make it this year, that competition is fierce, and each year will be different. Don't be discouraged.

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Trauma and Transformation

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cult tasks of learning and validating different reactions to the same traumatic events, finding common ground, and holding to the middle.

Our third luncheon speaker, Christy Lopez, J.D., is a Deputy Chief in the Civil Rights Division of the U.S. Department of Justice. Ms. Lopez heads the Special Litigation Section's police practice group, which has primary responsibility for conducting "pattern-or-practice" investigations of law enforcement agencies. Ms. Lopez led the team that investigated the Ferguson Police Department and is the primary drafter of the Ferguson Report. She also led investigations of the Chicago Police Department, the New Orleans Police the Los Angeles Sheriff's Department, the Newark (New Jersey) Police Department, and the Missoula, Montana investigation, which was the Division's first investigation focusing on the collective law enforcement response to allegations of sexual assault.

I wanted to provide an opportunity for AAPL members to learn more about the law enforcement policies and procedures and national efforts by law enforcement agencies to improve their response to mentally ill citizens in crisis. On Thursday evening it will be my pleasure to present a Presidential Symposium, "Police Response to Persons with Mental Illness." In 2012, the Portland Police Bureau and the United States Department of Justice entered a settlement agreement following several high-profile incidents. The agreement resulted in the creation of the Bureau's Behavioral Health Unit, members of which will describe its four tiers of police response to the mentally ill: Crisis Intervention Training, the Enhanced Crisis Intervention Team, the proactive Behavioral Health Response Team, and the Service Coordination Team. On a national level, the International Association of Chiefs of Police (IACP) has established a Blue Ribbon Committee on Improving Police Response to Persons with Mental Illness. Chief Louis Dekmar, who initiated the committee, will outline its goals for nationwide advancement this area.

I hope you will find meaning and inspiration in the Annual Meeting theme of "Trauma and Transformation." I look forward to hearing your thoughts about the program in Portland.

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NCCHC to Celebrate 40th National Conference in Las Vegas

The National Commission on Correctional Health Care will celebrate its 40th annual national conference October 22-26 at the Paris Hotel in Las Vegas. At the five-day conference – the country's largest conference for correctional health professionals – clinicians, administrators and others will gather to learn about latest advancements and best practices in delivering health care behind bars.

Health professionals working in the nation's jails, prisons and juvenile detention facilities face unique issues and challenges. For four decades, NCCHC has provided an opportunity for them to come together, learn from experts and one another, discuss common challenges and share solutions. Approximately 75 people attended the first conference, which helped to spur the national movement to improve correctional health care; a record crowd of close to 2,000 is expected at the 40th.

"For 40 years, NCCHC has been the source of quality education for health care professionals working in the country's correctional facilities," said Nancy White, MA, LPC, chair of the Education Committee. "Our 40th conference not only marks a milestone in NCCHC's history, but also celebrates the organization's reach and impact." White is the American Counseling Association liaison to the NCCHC board of directors.

This conference also marks the 25th anniversary of the organization's Certified Correctional Health Professional (CCHP) program, the largest certification program in this field. Currently more than 3,400 professionals are CCHP-certified.

Special activities to commemorate these anniversaries, along with the 40th anniversary of the *Estelle v. Gamble* decision, are also being planned. *Estelle v. Gamble* was the landmark Supreme Court case that in 1976 established prisoners' right to health care.

The conference features eight in-depth preconference seminars and more than 100 concurrent sessions, and offers up to 32 hours of continuing education credit. Topics on the agenda include hepatitis C, HIV, mental illness, substance abuse and the NCCHC health care standards, which help facilities use resources efficiently while improving quality of care. The exhibit hall will feature hundreds of products and services to support correctional health care.

All conference activities take place at the Paris Hotel in Las Vegas. For more information, visit www.ncchc.org/national-conference-on-correctional-health-care.

Tri-State AAPL's First Winter Conference in Miami

Title: Revisiting Court Ordered Outpatient Treatment, Competency, EED, Sex Offender Evaluations, Psychiatric Malpractice, the Insanity Defense, and Peer Review of Forensic Evaluations: Civil & Criminal
When: Friday, December 9, 2016 - Sunday, December 11, 2016
Where: The Betsy South Beach

The meeting objective is to provide specific presentations on forensic cases, discussion of relevant topics in forensic psychiatry, and advance best practices in forensic evaluations through a peer review process in an informal and social tropical setting. If you are interested in presenting a topic or forensic case for peer review, please contact Eric Goldsmith at (212) 486-2754 or via fax (212) 486-2758 or e-mail at eric.goldsmith@gmail.com.

Registration:
Registration in the amount of $50.00 is due by November 1, 2016. (no fee for spouses/partners)

Visit www.aapl.org to download the registration form or contact the AAPL Executive Office at 800-331-1389 or office@aapl.org for more information.

Please Note: Registration is limited so please send your check out early. In addition, as there is a peer review component to this conference Tri-State AAPL asks that you maintain confidentiality to what is presented. There will be no recordings or tapings made of the presentations.

Room reservations:
There are no requirements to stay at The Betsy. However, a discounted room rate of $275/night (plus $20 daily resort fee) at The Betsy can be made by calling the hotel directly at (305) 531-6100 and specifically ask for IN HOUSE Reservations and reference Tri-State AAPL Room Block.

Taking a Stand

Jacqueline Landess MD, JD

It was the night before my first jury trial. I nervously read and reread my opinion in the case, searching for inconsistencies or flaws which might open me up to an attack by the opposing counsel. As an attorney, I was no stranger to the adversarial nature of the legal system, but I had never been put on the stand and cross-examined, at least not in "real life." I ordered take-out as I pored over my report, and observed that it somehow felt like my last meal. I tried to rationalize the situation. I thought, "Well, look. The guy is going down for murder either way. The only difference your opinion may make is to allow him a sentence other than life without parole. Even if the jury doesn't agree with your opinion, it's no sign of failure on your part." I struggled a bit with these thoughts and feelings, and reflected upon the case.

It was my first murder case. The defendant's crime did not evoke much sympathy, though he was clearly not a psychopath or even antisocial. He had, by his own admission, made a series of reckless decisions which culminated in methamphetamine intoxication and, in my opinion, a resulting psychosis. His memory for the murder was relatively clear, though he could not identify a motive. The crime appeared to be senseless and no matter how vigorously I culled through the records in the case, I could not readily understand why this man had murdered a person he loved, seemingly without provocation. I did, however, believe that he had diminished capacity to premeditate the act, given his psychotic state at the time of the crime.

The day of the trial came. I felt relatively confident with the direct portion of my testimony. While explaining the concept of substance-induced psychosis, I noticed several members of the jury nodding and taking notes. I gave myself an internal high five. I tried my best to explain my role in the case and how I came to my opinion. I had weighed materials from both the defense and the prosecution, examined interviews with other parties and of course interviewed the defendant himself, in reaching my conclusion. I was as objective and unbiased as I could be; in addition, this had been a court-ordered evaluation, meaning I was not hired by the defense or the prosecution. Then the dreaded cross-examination came.

The first comment from the district attorney was a snarky remark about our failure to connect prior to the trial, despite my attempts to reach her. It became immediately clear that her sole purpose was to discount my opinion and methods, by any means necessary. As the cross-examination progressed, we gradually digressed from the central issues in the case, at least from a psychiatric standpoint. I was asked to comment on aspects of the case that I could not; for instance, at one point I was asked how long it would take to kill someone by strangulation. As I admitted that I did not know, the district attorney appeared to smirk. I found myself wondering why I had even attempted to render an opinion in this case, when it appeared that the level of respect for that opinion was about as great as my desire to sit on the stand for three hours. Despite the rigors of cross-examination, I stood steadfast in my opinion that the defendant had been psychotic at the time of the murder.

As I walked away from the courtroom, I felt frustrated and foolish. How had I imagined my role as a forensic psychiatrist? I am obligated to deliver an opinion that is truthful and promotes justice while still respecting the rights of the individual. I am to maintain my humanity in the face of acts and crimes which often defy human understanding. I thought I had done those things. But why then did I feel like I had failed on some level? The not-so-subtle message sent by the DA was "garbage in, garbage out." I had not anticipated the urge to defend the entire psychiatric profession when called to the stand.

Certainly, there are limits to what we do and the opinions we render. We cannot go back in time and observe or interview a defendant at the time of the crime. We are left with the pieces of a puzzle that we must gather and attempt to align, much like a detective, in rendering the most reasonable, medically probable and unbiased opinion that we can. So if we do these things, the assumption is that we arrive at a close approximation to the "truth" of what occurred, while acknowledging the limitations of human knowledge and expertise. What bothered me the most, I realized, was that no aspect of my opinion was acknowledged as legitimate or "truthful" by the opposing counsel, despite the 50-plus hours I had put into the case. Despite my own countertransference toward the defendant, which was certainly not positive. Despite the efforts I made to weigh each piece of evidence equally in rendering my opinion.

I realized that perhaps my job that day was not only to advocate for my opinion and educate the jury, but also to advocate for the field of psychiatry and understanding of mental illness. As a psychiatrist, I know mental illness and the disruption and devastation that accompanies its symptoms. I have witnessed psychosis and the impact that psychosis has upon reasoning, decision-making, insight and judgment. I appreciate that any act must be understood in context of that person's cognition, emotions, and environment. I also have faith in the law and the necessity of laws to rule and govern human behaviors. It is a difficult task to influence and convince a layperson that these are not merely vague and unsupportable beliefs I hold, but scientifically reliable and valid concepts. It is even more challenging to accomplish this when your words are distorted, motives inferred, and the legitimacy of your profession questioned during a rigorous cross-examination.

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High-IQ Offenders: Too Much of a Good Thing

J.C. Oleson JD, PhD, Associate Professor of Criminology, University of Auckland

The criminal genius is an extraordinarily popular figure in literature and film: *Crime and Punishment*'s Rodion Raskolnikov, *Sherlock Holmes*' Professor Moriarty, *The Ususal Suspect*'s Keyser Söze, *The Girl with the Dragon Tattoo*'s hacker-heroine Lisbeth Salander, and *The Silence of the Lambs*' Dr. Hannibal "The Cannibal" Lecter. Although not usually satisfying formal diagnostic criteria, such characters are often characterized as elite psychopaths.[1] Of course, there are real-world analogues to these fictional villains: *Catch Me If You Can* author Frank Abagnale, the 1924 thrill killers Nathan Leopold and Richard Loeb, Unabomber Theodore Kaczynski, University of Alabama shooter Professor Amy Bishop, and NSA whistleblower Edward Snowden all possessed above-average intelligence (operationalized as IQ). Yet, despite the public's fascination with the criminal genius in newspaper pages and silver screens, little is known about actual high-IQ offenders.

The linkage between intelligence and crime has been studied since Lombroso, and although many sociologically-trained criminologists have regarded the association with "a curious mixture of faith, indifference, and contempt,"[2] there is now a general consensus that low intelligence (as IQ) is related to delinquency and crime. Indeed, "[t]here is likely not another individual level variable that is so consistently associated with crime and other forms of antisocial behaviors than IQ."[3] Specifically, offenders appear to have a mean IQ score approximately 8 to 10 points lower than non-offenders. Above-average intelligence, on the other hand, is widely regarded as a protective factor.[4] This understanding accords with several studies of gifted delinquency (IQ = 115+) in which only severe emotional disturbance seemed to be enough to overwhelm their intelligence and incline otherwise law-abiding youths to crime.

On the other hand, the gifted are not a unitary class. On the IQ distribution, the exceptionally gifted (with an IQ of 160) are as divergent from the bright (with an IQ of 115) as are the bright from those with borderline mental retardation (with an IQ of 70, accompanied by other diagnostic criteria). Educational psychologist Leta Hollingworth proposed an optimal intelligence: although children with 125-150 IQs have much in common with average peers and can establish satisfying relationships, children with IQ scores of 150+ often struggle to form attachments with others.[5] Could super-optimal intelligence cease to operate as a protective factor and begin to function as a risk factor?

In a study of self-reported offending, an international index sample of high-IQ adults possessing 130+ IQ scores (N = 465; mean IQ = 148.7) reported higher – not lower – prevalence rates for 50 of 72 measured offenses than controls (N = 756; mean IQ = 115.4). Indeed, for seven of the nine offense types measured in the study—sex, violence, drug, property, white-collar, professional misconduct, and miscellaneous crimes—prevalence rates (i.e., the percentage of the sample reporting an offense) of the index group were higher than those of controls. For white-collar crimes, property offenses, and professional misconduct, rates were significantly higher. Controls reported higher prevalence rates only for vehicular and justice system offenses. Overall, the lifetime prevalence rate for aggregated offenses was almost 10% higher for the index group than it was for the control group: 93.8% versus 84.7%. This finding is not what would be predicted by a model that assumes an inverse, linear relationship between IQ and crime.[6] The index group also reported higher incidence rates (i.e., the number of offenses reported per person among those reporting an offense) than did the control group. This finding, too, is inconsistent with a model that assumes an inverse, linear relationship between IQ and crime.

One explanation for the finding might be found in Travis Hirschi's influential theory of social bonds as an explanation for delinquency and crime.[7] Hirschi proposed four elements of the social bond: *attachment*, consisting of closeness to others, especially parents; *commitment*, consisting of self-interest that has been invested in social conformity; *involvement*, consisting of engagement in conventional activities that limit offending opportunities; and *belief*, consisting of assent to conventional social norms. In 44 semi-structured follow-up interviews, members of the index group articulated themes that aligned closely with the four components of the social bond. Specifically, many expressed weakened *attachment*, citing examples of stigmatization, isolation, and alienation. Some expressed weakened *commitment*, indicating skepticism about the value of conventional measures of achievement. A few expressed weakened *involvement*, noting that they had engaged in criminal actions during periods of unemployment or had rejected licit opportunities to engage in crime. And many expressed weakened *belief*, indicating that independence of thought, legal hypocrisy, and/or post-conventional moral reasoning led them to think in socially discrepant ways.

People with high IQs are, by definition, a small group (only 2% of the population is expected to possess a 130+ IQ), and they very well might – as the linear model of IQ and crime predicts – be less predisposed to antisocial behaviour. But individuals who have high IQs and superior executive function, and do turn to crime, possess the cognitive abilities to become successful criminals.[8] Cyril Burt observed that bright delinquents,

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A Review of Canadian Mental Health Acts

Joel Watts MD, FRCPC, DABPN (Forensics)

Civil mental health legislation directly affects access to psychiatric treatment for the most vulnerable people in our society.[1] Akin to the autonomy states enjoy in the United States to craft mental health legislation for their citizens, provinces in Canada have jurisdiction on the provision and organization of the public health care system (including of course psychiatric care). They also establish their own criteria and laws allowing families, police and caretakers to intervene with regard to persons incapable of recognizing their own mental health needs. While in principle, federal law tries to ensure that all mental health services are provided equally throughout the country, significant differences exist amongst provinces with regards to civil commitment. Often, legislation evolves only as a result of local high profile and rare events.

Around the world, the aim of committing a person to hospital is to reduce their dangerousness and to offer treatment. The power of the state follows the *parens patriae* principle – the duty to help citizens incapable of taking care of themselves. Civil commitment is also in line with the duty of the state to protect its citizens against dangerous persons (so called "police powers"). According to the Canadian Psychiatric Association (CPA), involuntary hospitalization must be linked to a thorough assessment of the patient and an appropriate treatment. The CPA recognizes, however, that many Canadian provinces (among others Ontario and the Northwest Territories), do not link civil commitment and treatment; this results in an involuntary hospitalization without treatment due to the lack of consent from the patient. Some authors argue that a person's freedom is further limited where the law does not allow the possibility of linking the commitment and the treatment of patients (who are often also incapable).[2]

Civil Commitment

In Canada, a person who is committed involuntarily must:

- Have a disease or a mental dis order that is defined by law;
- Present a probability that they will harm themself or another person because of their disorder, or present a risk of mental or physical deterioration;
- Be deemed incapable of making the decision to be hospitalized or to receive treatment.

"According to the Canadian Psychiatric Association (CPA), involuntary hospitalization must be linked to a thorough assessment of the patient and an appropriate treatment."

All Canadian jurisdictions use "mental disorder" as a definition, but Quebec and Ontario define this quite loosely. In other provinces, the definition is more specific and sometimes linked to the necessity of treatment (British Columbia, Saskatchewan, Manitoba, Ontario [with regards specifically to the "deterioration" criteria], Nova Scotia, and Newfoundland). British Columbia and Manitoba even excluded some patients from involuntary commitment, such as those affected by an Antisocial Personality Disorder, for which there is little to no recognized treatment.[3] To be committed involuntarily in Saskatchewan, Nova Scotia, and Newfoundland, the patient must be incapable of consenting to treatment. This criterion prevents a patient who is "fully capable" from being deprived of their freedom without possibility for treatment to reduce his risk.[1]

All Canadian mental health acts include a criterion concerning a "harm" that the patient could inflict on himself or on others. Four jurisdictions limit this criterion to "physical harm" (Ontario, Quebec, Nunavut, and the Northwest Territories). Although Quebec refers to "immediate and severe danger", according to some authors[3], this definition is sometimes extended to non-physical harm. Similarly, in Ontario, some decisions from the Consent and Capacity Board seem to interpret psychological harm as a form of physical harm. New Brunswick and Yukon specifically refer to psychological harm. However, for many years, dangerousness criteria in civil commitment statutes have been expanding, and many courts have ruled that these principles are consistent with the Canadian Charter of Rights and Freedoms.[1]

At present, seven Canadian provinces refer to "dangerousness" as "significant physical or mental deterioration" (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, and, under specific conditions, Nova Scotia and Newfoundland). In Ontario, for a patient to be committed for more than 72 hours, the physician must indicate that the patient is incapable to consent to treatment, and needs treatment. Again, courts in Ontario and Manitoba have found these physical or mental deterioration criteria consistent with the Canadian Charter of Rights and Freedoms.

Treatment Authorization and Involuntary Treatment orders

Being able to treat a patient who is involuntarily hospitalized is a major preoccupation of clinicians who don't want to be simple jailers. What should we do with a patient who is too dangerous to be released yet refuses a treatment that would allow them to eventually regain their freedoms?

In five Canadian provinces, the state delegates a representative whose responsibility is to authorize the treat-

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RAPPEPORT FELLOWSHIP AWARD 2016-2017

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

This year again, the committee has selected six outstanding Rappeport Fellows! The prestigious AAPL Rappeport Fellowship was named in honor of AAPL's founding president, Dr. Jonas Rappeport, MD. It offers the opportunity for outstanding senior residents with a dedicated career interest in forensic psychiatry to receive mentorship by senior forensic psychiatrists. In addition, fellows will receive a scholarship to attend the AAPL forensic psychiatry review course and annual AAPL meeting in Portland, Oregon. The Rappeport Fellowship Committee is pleased to announce the six Rappeport Fellows for 2015-16 are as follows: Dr. Lara J. Cox, Dr. William Conner Darby, Dr. Christopher Fischer, Dr. Ariana Nesbit, Dr. Jason Quinn, and Dr. Rocksheng Zhong.

Dr. Lara J. Cox

Dr. Cox is starting her second year of fellowship in child and adolescent psychiatry at the New York University School of Medicine, where she also completed her training in adult psychiatry. Over the course of this coming year, she will be rotating through the outpatient clinics at Bellevue Hospital Center and the NYU Child Study Center, as well as completing an elective in the New York City juvenile justice system. She is interested in trauma-informed mental healthcare delivery in juvenile justice settings, as well as in the overlap between trauma-related symptoms and disruptive behaviors including conduct disorder. Dr. Cox has given several presentations on trauma and conduct disorder, including talks at the 2016 Annual Meeting of the American Psychiatric Association and the 60th Annual Congress of the Asociácion Española de Psiquiatria del Niño y el Adolescente in San Sebastián, Spain. She has also published a paper on the neurobiology of conduct disorder. Before residency, Dr. Cox completed the five year Clinical Scientist Training Program at the University of Pittsburgh, earning a master's degree in clinical research in addition to her medical degree. She first became involved with the American Psychiatric Association as a medical student there, serving on the national board of the Psychiatry Student Interest Group Network for several years. She went on to be elected as the Resident Fellow Member Trustee on the APA's Board of Trustees, serving as the trustee-elect from 2013-2014 and a full voting member of the board during her year as the trustee in 2014-2015. Dr. Cox will finish her child psychiatry fellowship in June 2017 and plans to complete a fellowship in forensic psychiatry thereafter, with the eventual goal of working in the juvenile justice system. Her Rappeport mentor is Dr. Joseph Penn.

Dr. William Conner Darby

Dr. Darby is a fourth year psychiatry resident at UCLA. He has an interest in the ethical challenges that arise practicing at the interface of psychiatry and law. He has applied this interest to multiple presentations at national meetings for the APA, AAFS, ASAP, and now AAPL on such topics as involuntary outpatient commitment, physician-assisted suicide, the death penalty and mental illness, capacity determinations in adolescent populations, and disability evaluations. Dr. Darby is second author on a paper on capital punishment for the mentally ill, two textbook chapters: one on forensic psychiatric ethics and the other on diminished capacity and responsibility. He is co-developer with Dr. Robert Weinstock on the ethical model of Dialectical Principlism which he applied to a paper on informed consent for potentially dangerous patients that won The Shirley Hatos Twenty First Century Psychiatry Prize awarded for the best original paper by a UCLA affiliated resident. Dr. Darby is currently a member of three AAPL committees. He plans to complete a forensic fellowship next year and to pursue a career in academic forensic psychiatry. His Rappeport mentor is Dr. Emily Keram.

Dr. Christopher Fischer

Dr. Fischer is a Child and Adolescent Psychiatry fellow at the University of Southern California. He completed his General Psychiatry residency training at the University of California, Los Angeles Neuropsychiatric Institute. He received his MD from the University of California, San Diego. Prior to medical school, Dr. Fischer received a Masters of Science in Financial Analysis from the University of San Francisco. He has written articles on juvenile adjudicative competence, juveniles as defendants, neuropsychiatric risks of concussions, factitious disorder, malingering, and deception detection. Within AAPL, he is a member of the Child and Adolescent Psychiatry and the Law, Human Rights and National Security, and the Liaison with Forensic Sciences committees. In addition to Psychiatry, he is also passionate about international affairs, having worked abroad and studied Russian, Spanish, and German. In the future, he looks forward to combining his interests in international affairs, Forensic Psychiatry, and Child Psychiatry. He is honored to receive the Rappeport fellowship and is excited about beginning his fellowship training in Forensic Psychiatry this coming year. His Rappeport mentors are Drs. Jessica Ferranti and Susan Hatters Friedman.

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RAPPEPORT FELLOWSHIP AWARD 2016-2017

Dr. Ariana Nesbit

Dr. Nesbit is a fourth-year resident in General Adult Psychiatry at the Cambridge Health Alliance/Harvard Medical School. She attended medical school at the University of Vermont, where she was inducted into the Alpha Omega Alpha Honor Medical Society. She won awards for her research, for outstanding academic achievement in the basic sciences, and for excellence in psychiatry. Dr. Nesbit developed an interest in law and ethics while in medical school, and she first explored the field of forensic psychiatry during an elective rotation with Dr. Debra Pinals. Dr. Nesbit has co-authored multiple forensic textbook chapters on treatment refusal and involuntary treatment. She has also written about or presented on topics that include the neurobiology of pedophilia, civil commitment for substance use disorders, and prearraigned arrestees. She serves on the Cambridge Health Alliance's Program Evaluation Committee, Ethics Committee, and Institutional Review Board. Dr. Nesbit is also a member of the Forensic Hospital Services and Ethics Committees of the American Academy of Psychiatry and the Law. She is spending her fourth year of residency working towards a Master of Bioethics Degree from Harvard Medical School. His Rappeport mentors are Drs. Ryan Hall and Renee Sorrentino.

Dr. Jason Quinn

Dr. Quinn is currently beginning his fifth (PGY-5) year of his psychiatry residency at the University of Toronto, focussing on his interest in Forensic Psychiatry. He is interested in the interaction between public policy and mental health. In response to changes to the Canadian Criminal Code, he published an article in JAAPL reviewing how international jurisdictions have attempted to address the issue of justice for victims of offenders found Not Criminally Responsible. He has presented on this topic and others in a variety of large group contexts. He also has an interest in teaching and has lectured to the undergraduate medical students at U of T as part of their pre-clerkship curriculum. Dr. Quinn plans to apply for a PGY-6 year in Forensic Psychiatry at a Canadian institution. His Rappeport mentors are Drs. Gary Chaimowitz and Britta Ostermeyer.

Dr. Roksheng Zhong

Dr. Zhong is a rising fourth-year resident and Clinical Research Scholar in the Department of Psychiatry at the Hospital of the University of Pennsylvania. He obtained his A.B. in Psychology from Harvard College and M.D. and M.H.S. from Yale School of Medicine. His interests revolve around the intersection of psychiatry, cognitive science, law, and ethics. He has written and presented papers on decision-making in moral dilemmas, pediatric resuscitation practices, and defendants' remorse in criminal justice. Dr. Zhong is currently involved in the development of a model graduate medical curriculum on clinical informed consent. After residency, he plans to continue his training as a fellow in forensic psychiatry. His Rappeport mentor is Dr. Cathy Lewis.

The American Academy of Psychiatry and the Law is pleased to announce the 30th Annual Rappeport Fellowship competition. Named in honor of AAPL's founding president, Jonas R. Rappeport, MD, the fellowships offer an opportunity for outstanding residents with interests in psychiatry and the law to develop their knowledge and skills.

The meeting will be held in Denver, CO from October 26-29, 2017. Immediately prior to the Annual Meeting, Fellows will also attend AAPL's Forensic Psychiatry Review Course, an intensive, comprehensive overview of psychiatry and law. At the Annual Meeting, Fellows are encouraged to attend the many excellent educational sessions, and to meet with AAPL preceptors, who can assist them in exploring interests in psychiatry and the law. Travel, lodging, and educational expenses are included in the fellowship award, and a per diem will be paid to cover meals and other expenses.

Residents who are currently PGY-3 in a general program, or PGY-4 in a child or geriatric subspecialty training program and who will begin their final year of training in July 2017, are eligible. Canadian PGY-5 general psychiatry residents and Canadian PGY-6 child residents are eligible. The Rappeport Fellowship Committee will accept two nominations from each residency program. Nominations must be postmarked byApril 1, 2017. Contact the AAPL Executive Office for more information.

The Use of a Second Language in Forensic Evaluations

Wilhem Rivera MD and Carla Rodgers MD

Evaluating persons from various linguistic backgrounds is an important skill for forensic psychiatrists. According to the 2011 US census, there are over 60 million people in the United States who speak a language other than English at home. Over 22% of these are not able to speak English well, or at all [1]. Even among the speakers of the top ten other languages, English-speaking ability varied greatly. Less than half of those who spoke Korean, Chinese, or Vietnamese, for example, spoke English "very well." The proportion of those who spoke English "very well" among Russian, Spanish, French Creole, Arabic, and Tagalog speakers ranged from 52-67% [1]. This leaves a large proportion who has difficulty communicating with others, especially when they come in contact with the legal system.

Some commentators consider working with evaluees from different linguistic backgrounds a part of the new field of "Transcultural Forensic Psychiatry."[2] Consequently, forensic evaluators who speak a foreign language are part of the field's evolving sensitivity to language as an expression of culture, and offer a service to those who may have been marginalized by the legal system. The need for bilingual professionals has been recognized by US agencies like the FBI, CIA and the US Dept. of Education, which have issued mission statements that recognize the need for bilingual performance and instruction [3-5].

When evaluating a limited English proficiency (LEP) individual, there is a special benefit in understanding the foreign language. This is because understanding the evaluee's primary language decreases decision-making bias, adds collateral information, and allows the expert to exercise some judgment when processing the interpreter's information. Although experts in transcultural psychiatry have cautioned forensic evaluators about performing evaluations with a limited knowledge of a language [2, at p. 634], two recent studies have reported that thinking in a foreign tongue reduces decision-making bias by reducing the emotional reactions that occur when receiving information in one's primary language [7,8]. Having an expert interpreter along with an understanding a foreign language may consequently provide for improved quality of information.

Some commentators caution that evaluations performed with untrained interpreters, like a non-proficient evaluator, may lead to failure in identifying thought distortions and delusions because of the tendency to omit sensitive material. [9] A systematic review of patient language proficiency and interpreter services showed that conducting an evaluation in a non-primary language can lead to an incomplete or distorted mental status examination.

There are no formal studies that assess bilingual practices in forensic psychiatry. The closest we've come is studying how interpreters help the evaluation of mental status and diagnosis. Two studies about professional interpreters point out that they can nonetheless improve clinical care more than untrained interpreters, that mental status exams are the same when compared with interviews by a bilingual psychiatrist, and that expert interpreters may improve disclosures [10,11].

In our experience, most English-speaking psychiatrists who perform an examination in another language will use an interpreter, even if they have some second language proficiency. However, others feel they gain more by conducting the evaluation in the second language as long as they are proficient. Making professional inferences from a mental status examination and about an evaluee's state of mind are at the core of the matter for forensic experts. We hope that a recent survey circulated to the AAPL membership will help clarify some of the issues that arise in conducting these specialized evaluations.

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The Double Track in Continental European Criminology

Michael Louis Corrado, Arch Allen Professor of Law, Emeritus, University of North Carolina Law School

In the 2009 case of *M. v. Germany*[1] the European Court of Human Rights upheld the German notion of a "double track," under which dangerous criminals could be given a determinate term in prison as retributive punishment, to be followed by an indeterminate term of preventive detention that would last as long as the prisoner remained dangerous. The Court found that there was nothing inherently wrong with the idea of punishment followed by preventive detention, and pointed to similar practices in a number of other European countries.

The law had been challenged before the European Court by a detainee. The German government had defended the law as an "escape valve" which allowed it to keep the sentences for ordinary prisoners low, indeed, among the lowest in Europe. Those criminals that inspired the greatest fear among the public would be given over to the double track, to remain in prison indefinitely, and ordinary criminals could be given mild sentences proportional to their crimes. In this way popular outrage was contained and at the same time the prisons were not overburdened.

But although the European Court had no problem with the *idea* of the double track, it found a couple of problems in the way the law was implemented. For one thing, Germany had increased the maximum length of preventive detention from ten years to make it indefinite, and had done so retrospectively. Prisoners already sentenced to preventive detention when the maximum had been ten years were now liable to remain detained indefinitely. The Court held that this retroactive extension of the period of detention violated the European Convention on Human Rights: "no retroactive sentence increases" (something that for us comes under the ex post facto prohibition) was a principle that the Court believed should apply to preventive, as well as to punitive, sentences.

And the Court also found a problem in the fact that there wasn't much to distinguish the conditions during the retributive or punitive term of the sentence from the conditions during the preventive term. If there was no distinction between the two terms, then the second term would have to be considered punishment just like the first term, and the Court held that that also violated the Convention. Preventive detention had to be clearly distinguishable.

The detainee's appeal was granted, and Germany (and much of Europe) began a period of soul-searching on the question of the double track. Ensuring that the second track would be significantly different from the first would be expensive, for one thing. But its also true that punishment is traditionally surrounded by limitations: in addition to non-retroactivity, the accused is protected by the requirements that there be a criminal act and that punishment be proportional to the crime, to name just two. Importing the non-retroactivity prohibition on punishment into preventive detention raised this question: should preventive detention enjoy all the same limitations that punishment does? Take the requirement of proportionality: the possibility of tacking on a period of preventive detention means that that limitation is worthless. It will be up to the judge in every serious case whether the proportionality restriction applies to you or not. The fate of the double track in Germany is now up in the air.

The double track had been introduced into German law by the Nazi government in 1934, but the idea did not originate with Nazi (or with Fascist) ideology. Its history goes back at least fifty years before that to a period during the late nineteenth century when a movement to individualize the treatment of criminals ran up against the problem of the so-called "persistent," or incorrigible, offender. Criminologists who claimed training in social science or in psychology had argued that the classical approach to punishment was ineffective and that individual treatment entrusted to experts promised a more effective approach to crime. This argument pointed away from the classical idea of the fixed punishment proportional to the crime and toward an indeterminate sentence of individualized treatment that would change the character of the criminal for the better. But, they added, some criminals could not be corrected. They had been corrupted from birth, or by previous stays in prison; they were beyond salvation, and for them only segregation was appropriate, segregation that would (failing some miraculous recovery) last the rest of their lives.[2]

The first fruits of this "progressive" approach to crime were seen in reforms proposed in the 1880s and 1890s in Switzerland, France, and Norway, reforms providing for segregation *instead of* punishment for persistent offenders. The general single-track idea of segregation for persistent offenders entered into the criminal justice systems of various countries in Europe – including the dictatorships in Hungary, Spain, and Yugoslavia. A 1909 draft proposal in Germany followed this lead but was never enacted into law.

The double track itself, a compromise between the measures provided for by classical retributive theory and those provided for by positivist preventive theory, put punishment together with preventive detention, and appeared first in New South Wales in Australia in 1905. Criminals having previously committed several serious offenses would be given the ordinary sentence of punishment to be followed by detention at "His Majesty's pleasure." The compromise approach was followed, within ten or so years, in other parts of Australia and elsewhere in the British Empire.[3]

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The Double Track

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In the 1930 Rocco Code adopted by the Fascist government in Italy, the double track appeared once more. There was no hint that a mental or psychological defect was required, and hence no provision for placement in mental hospitals. (Commitment of the dangerous mentally ill was and remains a separate issue.) For those labeled "habitual offenders," "professional offenders," or "offenders with criminal tendencies," there was a presumption of social dangerousness, and judges were required to implement the double track. Although the presumption was abolished after the fall of the Fascist regime, the double track remains in the statute book to be implemented on a case by case basis.

Marco Pelissero, Professor of Law at the University of Turin, has written that the use of the double track in Italy has declined drastically in Italy since the Second World War, and the ECHR's decision in the *M. v. Germany* case may result in its abandonment. That is not to say, though, that preventive measures are out: in many ways – including notably the preventive aspects of the "anti-mafia" legislation – Italy has replaced the double track with a multiplicity of preventive measures, many of them within the criminal penalties.[4] An example of such a measure would be the American institution of the "three strikes" law: the dangerous offender is held longer, but under the guise of punishment rather than prevention.

Germany followed the lead of Italy's Fascist government with the 1933 *Act Concerning Dangerous Habitual Criminals*. The requirements for preventive detention, under the Act, were these:

a. there was a third conviction for a serious crime, and the defendant gave the general impression of being a dangerous habitual criminal, or

b. there were three offenses (with or without conviction) and the defendant gave the impression of being a dangerous habitual criminal.

If those requirements were satisfied, then the sentence was required (for *a*), or permitted (for *b*), to be aggravated up to five years for minor crimes, and up to fifteen years for felonies. But *in addition*, if "the protection of the public requires such a measure," the court had to pass a sentence of preventive detention – which could be indefinite.[5]

After World War II many things changed in Germany and in Europe. For one thing effective constitutional courts were introduced to enforce the human rights provisions of constitutions, and the European Court of Human Rights took on the job of enforcing the European Convention on Human Rights. But the double track did not disappear from German criminal law, or from Italian criminal law, or from the law of many other continental European countries. One thing that did change in Germany was the outside limit on the period of detention: Detention, which had been for an indefinite period in some cases, was given a ten-year limit.

Then, in the late 1990s, the German legislature brought back the possibility of indefinite detention, and the detention of prisoners sentenced under the earlier maximum of ten years was extended indefinitely. The prisoner known as "M." (German law reports do not publish the full names of defendants), complained about this retroactive imposition of an indefinite sentence, and brought the case to the European Court of Human Rights, which upheld his appeal and reprimanded Germany on several fronts, as we have seen.

According to Joerg Kinzig, Director of the Institute for Criminology at the University of Tuebingen, the situation in Germany today is very much in flux. The federal legislature and the legislatures of each of the German states have passed legislature providing for the construction of new detention facilities to provide the necessary distance between conditions under the punitive sentence and conditions under the preventive sentence.[6] It is worth pointing out that the commitment of dangerous offenders to preventive detention (Article 66 of the German Criminal Code) is distinguished from the commitment of mentally ill offenders to psychiatric hospitals (Article 63 of the Code). "[P]reventive detention requires that the perpetrator is responsible for his criminal behavior. The idea behind this measure is to protect the public from habitual offenders."[7] The ECHR and the German Constitutional Court have said that detention in preventive detention facilities must be distinguishable from detention in prisons, and one way in which that might be done would be to provide therapy for detainees. but up to the present there has been no serious requirement of treatment.[8] Though the detainees are, in theory, to be given assistance in adjusting to life outside prison, these are institutions designed first and foremost to protect the public from dangerous offenders.

References:

1. ECHR Application number 19359/04, 17 December 2009, no. 45. The Court found (¶ 70) that at least seven other member states of the Council of Europe had "systems of preventive detention in respect of convicted offenders who are not considered to be of unsound mind:" Austria, Denmark, Italy, Liechtenstein, San Marino, Slovakia and Switzerland.
2. Enrico Ferri, The Positive School: Three Lectures Given at the University of Naples, Italy on April 22, 23 and 24, 1901 (1901; trans. Ernest Untermann), chapter one.
3. N. S. Timasheff (1939-1940), "The Treatment of Persistent Offenders Outside of the United States," 30 Am. Inst. Crim. L. & Criminology 455, 458 (1939-1940).
4. Marco Pelissero (2013), "The Doppio Binario in Italian Criminal Law," in Preventing Danger, supra, pages 107-125.
5. Hermann Mannheim (1935), "German Prevention of Crime Act, 1933," 26 J. Crim. L. & Criminology 517, 520-22 (1935).
6. Joerg Kinzig (2013), "The ECHR and the German System of Preventive Detention," in Michele Caianiello and Michael Corrado, Preventing Danger: New Paradigms in Criminal Justice (2013), pages 71-95.
7. Kinzig, page 76.
8. The German court has held that the preventive detention provisions did not maintain the "constitutionally required" distance between preventive detention and prison

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APA/AAPL Manfred S. Guttmacher Award Lecture

APA Annual Meeting 2016

Abhishek Jain MD

At the 2016 American Psychiatric Association (APA) Annual Meeting in Atlanta, Georgia, the annual Manfred S. Guttmacher Award was presented to Kenneth Appelbaum MD, Robert Trestman MD, PhD, and Jeffrey Metzner MD for their "Oxford Textbook of Correctional Psychiatry."

Established in 1975, the Guttmacher Award annually recognizes an outstanding contribution to forensic psychiatry literature. The award is cosponsored by the APA and AAPL, and supported by a grant from Professional Risk Management Services (PRMS), Inc.

As award recipients, Drs. Appelbaum, Trestman, and Metzner also delivered the Guttmacher Lecture, in which they cogently outlined psychiatry's role in the correctional system, including ongoing treatment needs, future research directions, and involvement in policy initiatives.

Dr. Appelbaum highlighted that "correctional psychiatry is truly coming into its own as a subspecialty." He discussed that, over the years, psychiatric issues in jails and prisons have had limited attention, despite that 15-20% of inmates are estimated to meet the criteria for severe mental illness. As is oft stated, more psychiatric patients are incarcerated than hospitalized - which is frequently correlated with de-institutionalization and state psychiatric beds being reduced from 558,000 in 1955 to 35,000 in 2010.

Dr. Appelbaum also described a slight increase in 2016 APA presentations on topics related to correctional psychiatry. Searching terms "prison," "jail," "corrections," "inmate," "detention," and "incarceration" in the annual meeting programs, he found one symposium and one poster at the 2014 meeting, one workshop at the 2015 meeting, and at least three symposia, three workshops, one scientific and clinical report, and one lecture at the 2016 meeting. He attributed current APA President, and past AAPL President, Renée Binder as playing an instrumental role in this change.

Similar trends were not readily apparent in Dr. Appelbaum's review of the Institute on Psychiatric Services annual meeting programs in 2014 and 2015. He pointed out that the American Journal of Psychiatry (AJP) included three papers related to the criminal justice system in 2015, which is an increase from no papers in 2014. However, outside of a review of this Guttmacher Award-winning textbook, there have been no AJP publications related to correctional settings or the criminal justice system thus far in 2016.

Dr. Appelbaum identified key areas to further develop the field of correctional psychiatry: recognizing it as a field of growing complexity; research and expanding its evidence-base; refining guidelines and standards of practice; rehabilitation; reforms to the criminal justice system; and respecting frontline clinicians. He estimates that 1500 to 2000 psychiatrists are needed in the correctional system, however currently only 341 (less than 1%) of the 35,089 APA members self-identify as working in correctional or forensic facilities.

Dr. Trestman discussed "The Educational and Research Needs for Correctional Psychiatry." He first summarized their textbook's wide-ranging applicability, such as to clinical trainees, more advanced practitioners, and administrators. Unique clinical considerations include population characteristics (e.g., 70-80% of inmates have substance use issues) and dual reporting responsibility (e.g., to correctional officers for safety concerns). More advanced practitioners may appreciate nuances, such as issues surrounding levels of care and pod placements, awareness of specific medication abuse, (e.g., crushed bupropion), and management of personality disorders (e.g., borderline personality disorder may be present in 10-12% of incarcerated men and greater than 20% of incarcerated females). Dr. Trestman emphasized the importance of understanding and managing accreditation standards, particularly in a complex environment.

Dr. Trestman described the drastic reduction of research in correctional settings. Prisons were primary sites for research through the early 1970s; for example, about 85% of new drug trials were conducted in prison at that time. However, through appropriate ethical concerns that were raised, such as Beecher's 1966 New England Journal of Medicine article, the pendulum has perhaps swung to prisoners being "overprotected" from research. For instance, over the past 15 years, less than 30 randomized controlled trials have been conducted in correctional settings. Yet, efforts, such as revised ethical considerations and research standards in prison populations, have not come to fruition.

Dr. Trestman highlighted that specialized research needs in this population include neuroimaging, and neuroendocrinology, and overall more studies in epidemiology, assessment methodologies, psychotherapy, pharmacotherapy, co-occurring disorder management, and risk reduction approaches.

Dr. Metzner presented "The Role of Professional Organizations in Establishing Standards of Care in Correctional Health Care." In the 1970s, the American Medical Association (AMA) found that jail health services were inadequate, disorganized, and unstandardized. The AMA and other organizations collaborated and established a program that eventually became the National Commission on Correctional Health Care (NCCHC). Dr. Metzner described the NCCHC's role in establishing standards for healthcare services in jails and prisons.

Dr. Metzner highlighted the APA Council on Psychiatry and Law's influence in areas such as restraints and seclusions, staffing ratios, and

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APA Assembly Report

Cheryl D. Wills MD, AAPL's Alternate Representative to the APA Assembly, Debra S. Pinals MD, AAPL's Representative to the APA Assembly

The APA Assembly Meeting was held in Atlanta, GA from May 13 – 15, 2016. The organization has completed its rebranding process which includes a new logo and mission statement – "The APA represents medical leadership for the mind, the brain and the body." The membership has grown to 36,490 members – the highest number in 13 years – and there is a budgetary surplus due to membership dues and sales of DSM-5 and related publications. The lease on the APA headquarters property in Arlington, VA expires at the end of 2017 and it will be relocating to 800 Maine Ave, SW in Washington, DC in late 2017.

AAPL Past President Renée Binder has completed her term as APA President. The theme of her presidency was "Claiming Our Future." She accomplished many noteworthy projects during her term, including bringing correctional psychiatry to the forefront of discussions about psychiatric care delivery to underserved populations and recognizing AAPL's contributions to the APA.

The following activities have been developed by the APA as part of its mission to educate the members:

An education innovation lab was made available to members the Annual Meeting. The highly interactive lab, which was designed to permit psychiatrists to be active participants in learning, contained a collaborative break space, a brain break area and a theater with comfortable seating. Also, the APA's Cultural Competence webpage, titled "Best Practice Highlights for Treating 6 Diverse Patient Populations," is now available to members seeking to contextualize their assessment and treatment of individuals of various cultures. In addition, APA members have free access to a CME course on a trending topic that changes monthly. The e-mail has one of the highest open rates of APA correspondence and members have responded positively to the service. The program, which is hosted through the Learning Management System, is one of many educational opportunities available on the website. Lastly, there is a webpage for APA members who have life membership that consolidates resources and opportunities. New information will be added to the page in response to feedback from APA life members.

"[APA President, Renée Binder] accomplished many noteworthy projects during her term, including bringing correctional psychiatry to the forefront of discussions about psychiatric care delivery to underserved populations and recognizing AAPL's contributions to the APA."

The APA has been interfacing with the U.S. government regarding many challenging matters that are important for members and patients. The White House has appointed a Task Force of Parity Enforcement that is charged monitoring and enforcing mental health parity. The Task Force's first open meeting was held at the APA Annual Meeting in Atlanta.

The Helping Families in Mental Health Crisis Act (H.R. 2646), which focuses mental health resources on patients and families who need it most, has bipartisan support in Congress. The APA and other mental health stakeholders are encouraging members of Congress to work through the details, including the funding, so that they may advance this legislation. If enacted in its entirety, the bill would, among other things, address the prohibitive cost of second generation antipsychotics for patients in need.

The FDA is reviewing a proposal to reclassify ECT from a Class III (high risk) to a Class II (low risk) medical device. The proposal is generally supported by the APA which prefers that the classification change apply to all mental disorders for which ECT is indicated. The proposal, in its current iteration, restricts the class change to treatment resistant severe major depressive disorder with or without bipolar disorder and individuals who require a rapid treatment response due to the severity of their physical or mental health status.

An effort by psychologists in Hawaii to expand their scope of practice to include medication prescribing privileges was recently defeated. Iowa became the fourth state to permit psychologists to prescribe psychotropic medication on May 27, 2016. The APA has hired four regional assistants to aid the District Branches with their efforts to respond to psychologists' scope of practice bills. The APA takes no position on whether District Branches should try to defeat these bills or to refine them by focusing on protocols for prescriber eligibility. As many as five psychologist prescribing bills will be introduced in the next calendar year.

The APA has actively responded to several statutes that used "religious freedom" to cloak and sanction discrimination. The emotional impact of such legislation can have a profound impact on patients and our practices. The APA Program Committee chose to withdraw an invitation to a presenter whose presentation supported the spirit of such legislation as the presentation was not grounded in evidence-based literature.

The APA Board of Trustees Ad Hoc Group on Telepsychiatry has developed a toolkit for members that contains videos on various aspects of telepsychiatry, including training, teaching, policy and clinical matters.

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American Medical Association 2016 Annual Meeting Highlights

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

The American Medical Association's (AMA) June 2016 Annual Meeting in Chicago focused on policy, medical education and practice, health initiatives, and science and technology. Dr. Andrew W. Gurman, a private practice orthopedic hand surgeon from Pennsylvania, was inaugurated as President of the AMA and Dr. David O. Barbe, a family practice physician from Missouri, who is Vice President of Regional Operations at Mercy Clinic, was elected to President-Elect. In addition, Dr. Patrice Harris, a child and forensic psychiatrist and AAPL member, transitioned into her role as Chair of the AMA Board of Trustees.

The Pulse Nightclub mass shooting in Orlando, which left 50 people dead, occurred during the Annual Meeting. This galvanized the House of Delegates to pass a late resolution on "Gun Violence as a Public Health Crisis." In doing so, AMA declared that gun violence represents a public health crisis that requires a comprehensive public health response and solution. It also called for the AMA to lobby to lift the congressional ban on gun violence research, which has barred federal funding of gun violence research since 1996. Even in the aftermath of several recent mass shootings, Congress extended the ban just last year.

After eight years of revision efforts by the Council on Ethical and Judicial Affairs (CEJA), the House of Delegates approved the passage of a revised AMA Code of Medical Ethics. The last major code revision occurred in 1957, with modifications in 1980 and 2001. The new code simplifies the navigation of the code and related opinions, making the document easier to apply to the daily practice of medicine, and reflects comments and input from the AAPL Delegation as well as other AAPL members.

CEJA holds an open forum at every AMA meeting to obtain members' input on current ethical issues. The committee heard testimony on the issues of dual loyalties such as those found in the military, sports medicine, hospital-employed physician tensions that may arise, conflicts of interest for mandated reporters, and reporting of impaired colleagues (including the pressures to send them back to clinical practice). Testimony was also heard on medical tourism both in and out of the country.

Telemedicine is now practiced widely and has changed access to care. Since physicians and patients interact differently in this model, there are different levels of accountability for physicians, which became a focus of this year's annual meeting. New policy entitled "The Ethical Practice in Telemedicine" passed and indicated that while participating in Telehealth and Telemedicine, the physician has an ethical responsibility to uphold their fundamental fiduciary obligation by disclosing any financial or other interests in the telehealth or telemedicine application and to take steps to minimize any conflict(s) of interest. Guidelines advise site users to arrange for follow up care when it is indicated, be proficient in the use of the relevant technologies in conducting diagnostic evaluations or prescribing medication, establish the patient's identity, confirm that the teleservices are appropriate for the patient's individual situation, and promote the continuity of care when possible.

Another resolution relevant to AAPL was "Support for Persons with Intellectual Disabilities Transitioning to Adulthood," which aims to bolster transitional services from juvenile to adult systems for the intellectually disabled. Dr. Wall testified in support of the resolution while providing context on legal and other difficulties states face in implementing such services after *Olmstead v. L.C*. Further, the AAPL delegation noted that providing appropriate services and transitions for this population should occur throughout adulthood, not just at the point of transition to adult services. Other resolutions that the House of Delegates passed included several LGBT matters, including "Clarification of Medical Necessity for Treatment of Gender Dysphoria" and "Updating Sexual Orientation and Gender Identity Policy."

A highly debated resolution was entitled "Religiously Affiliated Medical Facilities and the Impact on Physician's Ability to Provide Patient Centered, Safe Care Services." The authors requested a report on the impact of denial of care, presumptively limited to certain religious facilities, which includes difficulty patients face having to travel distances for access to care in certain regions due to service consolidation. A revised adoption calls for a study of hospital consolidations in both secular hospitals and religiously affiliated hospitals to assess impact on patient access to services resulting from consolidation.

Two competing resolutions on physician assisted suicide were heard. A resolution regarding "Opposition to Physician Assisted Suicide and Euthanasia," which would have maintained AMA's current stance against physician-assisted suicide, was not adopted. Instead, in the wake of several states passing legislation allowing physician-assisted suicide, a resolution entitled "Study Aid in Dying as an End of Life Option" was passed. CEJA will now take up this matter. Of note, the American Psychiatric Association Council on Psychiatry and the Law will release a resource document later this year addressing mental capacity in end-of-life decision making.

Other relevant topics in forensic psychiatry included passage of policy resolutions entitled "Electronic Health Records and Meaningful Use," "Reducing Firearms Violence," "Fraudulent Use of Prescriptions," and "Physician–Patient SMS Text

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AAPL Annual Meeting 2016 Lunch Speakers

Charles Dike MD, Program Chair

The Terrorist's Son: My Path to Peace

Zak Ebrahim

Zak Ebrahim was only seven years old when, on November 5, 1990, his father, El-Sayyid Nosair, shot and killed the leader of the Jewish Defense League. While in prison, Nosair helped plan the bombing of the World Trade Center in 1993. In one of his infamous video messages, Osama bin Laden urged the world to "Remember El-Sayyid Nosair. For Zak, a childhood amid terrorism was all he knew. After his father's incarceration, his family moved more than twenty times, haunted by and persecuted for the crimes of his father. Though his radicalized father and uncles modeled fanatical beliefs, the hateful ideas never resonated with the shy, awkward boy. The older he grew, the more fully Zak grasped the horrific depths of his father's acts. The more he understood, the more he resolved to dedicate his life to promoting peace. In his book, The Terrorist's Son: A Story of Choice, Zak traces his remarkable journey to escape his father's terrible legacy. Crisscrossing the eastern United States, from Pittsburgh to Memphis, from a mosque in Jersey City to the Busch Gardens theme park in Tampa, The Terrorist's Son is the story of a boy inculcated in dogma and hate—a boy presumed to follow in his father's footsteps—and the man who chose a different path.

Transforming the Police: The Department of Justice Civil Rights Division and Police Accountability

Attorney Christy Lopez

Christy E. Lopez is a Deputy Chief in the Civil Rights Division of the U.S. Department of Justice. Ms. Lopez heads the Special Litigation Section's police practice group, which has primary responsibility for conducting "pattern-or-practice" investigations of law enforcement agencies, and for filing suit or negotiating a remedial agreement where such a pattern or practice is found. Ms. Lopez led the team that investigated the Ferguson Police Department and is the primary drafter of the Ferguson Report. She is currently leading the team investigating the Chicago Police Department. She also led the investigations of the New Orleans Police Department, the Los Angeles Sheriff's Department, the Newark (New Jersey) Police Department, and the Missoula, Montana investigation, which was the Division's first investigation focusing on the collective law enforcement response to allegations of sexual assault. This investigation was also the Division's first pattern-or-practice case to focus on a prosecutor's office. Ms. Lopez was also the Deputy Chief overseeing the Division's recent successful litigation against the towns of Colorado City (Arizona) and Hildale (Utah), in which a jury found that the towns' law enforcement agency enforced the edicts of the a religious sect rather than the rule of law. Ms. Lopez helped formulate and draft the DOJ statement of interest in the Floyd litigation challenging the New York Police Department's stop-and-frisk practices, as well as DOJ guidance released last year on preventing gender bias in the law enforcement response to sexual assault and domestic violence. Ms. Lopez currently serves as an Advisor on the American Law Institute (ALI) Principles of Law, Police Investigations Project.

Ms. Lopez has been awarded the Flame Award by the National Association for Civilian Oversight of Law Enforcement (NACOLE) for her long-term commitment to police accountability and civilian oversight. In 2015, Ms. Lopez was awarded the Department of Justice's highest employee honor, the Attorney General's Exceptional Service award, for her work leading the Ferguson Police Department pattern-or-practice investigation. In 2013, Ms. Lopez was awarded the Attorney General's John Marshall Award for her work leading the New Orleans Police Department investigation and consent decree negotiation. Ms. Lopez served as a federal court monitor from 2003 to 2010 for Senior District Judge Thelton E. Henderson of the Northern District of California. In that role, she assessed and reported on the Oakland (California) Police Department's implementation of a federal consent decree. She authored the 2010 American Constitution Society Issue Brief, "Disorderly (mis)Conduct: The Problem with 'Contempt of Cop' Arrests," and has taught law school courses on unlawful racial, national origin, and religious profiling. A California native, Christy received her B.A. from the University of California, Riverside, and her J.D. from Yale Law School. She clerked for Alaska Supreme Court Justice Robert L. Eastaught from 1994 to 1995. She is licensed to practice law in Washington DC and California.

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Story of a Warchild

Emmanuel Jal

Emmanuel Jal was born into the life of a child solider on an unknown date in the early 1980s in the war-torn region of Southern Sudan. Through unbelievable struggles, Emmanuel managed to survive and go on to emerge as a recording artist, achieving worldwide acclaim for his unique style of hip hop with its message of peace and reconciliation born out of his personal experiences. Despite his accomplishments in music and film, one of Jal's biggest passions is Gua Africa, the charity he has founded to work with individuals, families and communities to help them overcome the effects of war and poverty. Besides building schools, the charity provides scholarships for Sudanese war survivors in refugee camps and sponsors education for children in the most deprived slum areas in Nairobi. Gua Africa is now fundraising to complete phase 2 of Emma Academy, the education center in Leer named after the British aid worker Emma McCune who rescued Jal from a life as a child soldier. In the outbreak of violence in South Sudan since December 15th 2013, Gua has changed its focus to keeping its existing schools open and ensuring their teachers are paid and students are safe. In December 2010, Jal released "We Want Peace," as part of the wider campaign of the same name calling for peace, protection and justice for all in Sudan ahead of the January 2011 referendum, but also calling for an end to all conflicts affecting innocent people around the world. The campaign was supported by A-list artists and leading figures from diverse fields, including Peter Gabriel, Alicia Keys, George Clooney, Richard Branson, President Jimmy Carter, Kofi Annan and many more. In 2012 he organized and hosted the first of its kind Peace Dinner and Concert in Juba, South Sudan on International Peace Day, supported by H.E Dr. Riek Marchar, Vice President of South Sudan alongside legendary US hip hop artist DMC. Through his peace movement We Want Peace Emmanuel Jal is working alongside African artists such as Juliani (Kenya), Vanessa Mdee (Tanzania), and Syssi Mananga (Congo Brazzaville) to spread passion and awareness about Afrcia's at risk elephant population. Through the new campaign Stand For Elephants, these artists have released the new peace anthem TUSIMAME (Let's Stand) now available on iTunes and Mdundo.

Jal still undertakes his Lose to Win Challenge, which sees him raising funds for Gua Africa, Africa Yoga Project and My Start for Windle Trust International.

APA Assembly Report

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The Group recommends that the APA take a leadership role, on a national and state level to provide education about and advocate for telepsychiatry as a resource to reduce problems related to access to care.

The APA On Tour program presented a panel discussion about the mental health impact of human trafficking at the Annual Meeting. Trafficking affects about 20.9 million people worldwide and most survivors have mental health concerns. Also, about 87% of individuals who have been trafficked had contact with healthcare professionals while they were being trafficked. The focus of the presentation was identification and treatment of survivors.

On April 18, 2016, the APA and the APA Foundation held the inaugural APEX Awards at the Mayflower Hotel in Washington, DC. The event, hosted by award winning journalist, Cokie Roberts honored individuals who have demonstrated the highest levels of mental health advocacy and who are working to reduce the incarceration rate of Americans with mental disorders. The orange-tie event featured the Netflix Series "Orange is the New Black." Stars of the show walked the orange carpet and participated in a discussion about how the show has introduced viewers to what inmates who have mental disorders may experience and how they may be treated.

Awardees included House Minority Leader Nancy Pelosi (D-Calif.), who advocated for the Mental Health Parity and Addiction Equity Act and who supports health care reform that integrates mental health care and primary care; Senator Al Franken (D-Minn.), who introduced the Comprehensive Justice and Mental Health Act of 2015, which decriminalizes mental illness and promotes use of MH courts, Jail Diversion, and enhanced access to community based MH care; and Florida State Senator Miguel Díaz de la Portilla (R-Miami-Dade County, 40th District) authored a law that authorizes judges to use treatment in lieu of incarceration for juveniles and U.S. Veterans with general discharges who have mental and substance use disorders. The law also allocates funds for a forensic hospital diversion program.

MACRA the Medicare Access and CHIP Reauthorization Act of 2015 is the new value-based reporting program that will replace meaningful use. The Center for Medicaid and Medicare Services will be moving towards a performance-based funding system. The APA plans to work with members so that they will have the ability not to be penalized under the new system.

The APA has partnered with the American Professional Agency (APA, Inc.) to develop nine risk management courses that will be offered to APA members at no cost. Members may receive AMA PRA Category 1 Credit™ and those who complete the required three hours of coursework will be eligible to receive a 5% discount on their professional liability insurance through APA, Inc. The courses, which were created in response to member's request for such resources, may be accessed at can be found at http://www.psych.org/psychiatrists/practice/riskmanagement.

California's New Amended CANRA:
Further Erosion of Psychotherapist-Patient Privilege

Subhash Chandra MD, Stacy-Ann Phillip MD, Douglas Tucker MD, Sexual Offenders Committee

California Assembly Bill 1775 is an amendment to the existing Child Abuse and Neglect Reporting Act (CANRA) which took effect on 1-1-15, and mandates certain persons (including psychotherapists and other mental health caregivers) to report suspected cases of child abuse or neglect, including sexual exploitation. This amendment expands the definition of "sexual exploitation" to include downloading, streaming or accessing child pornography via any means, including viewing this material on the Internet. Under the act, failure to report known or suspected instances of child abuse, including sexual abuse, is a misdemeanor[1]. This new law has important implications for the performance of mental health assessments and delivery of mental health care in California, and it may serve as a model for other states in the future.

The stated purpose of child porn laws is to reduce sexual exploitation of the filmed or photographed victims by limiting the market for these materials in the first place, as well as preventing further transmission of the obscene images of the victim which would further extend the victimization. In addition, these laws are meant to prevent online child pornography offenders from committing sexual offenses involving hands-on contact with a child. Research indicates that roughly 1 in 8 online offenders (12%) have an officially known contact sexual offense history, and 1 in 2 online offenders (55%) admitted to a contact sexual offense in the studies that had self-report data. However, over a 1.5- to 6-year follow-up, 4.6% of online offenders committed a new sexual offense of some kind, 2.0% committed a contact sexual offense, and 3.4% committed a new child pornography offense[2]. According to a Swiss study, watching child pornography alone is not a risk factor for committing hands-on sex offenses. Out of 231 men charged with accessing illegal pornographic material, 2 (1%) also involved a hands-on sex offense, and only two men recidivated with a hands-on sex offense in a 6-year follow-up[3]. In general, evidence suggests that child pornography users are more likely to have a prior hands-on sex offense, but evidence also demonstrates that those without such prior history are unlikely to commit such acts in the future. Given this data, excessive mandated reporting may not only hinder the foundation of a therapeutic relationship, but also unnecessarily flood an already inundated legal system.

Although child porn offenses are now punished harshly, many other expressions of sexuality in children are tolerated or promoted. For example, in the popular TV series 'Toddlers and Tiaras' (now off-air), a 4-year-old girl donned fake breasts in one episode, and a 3-year-old was dressed as a prostitute in another[4]. French Vogue magazine sparked outrage for its racy photos of a ten-year-old girl lying provocatively in a chest-revealing dress, stilettos, and heavy makeup[5]. Many millions of individuals knowingly and legally download, stream, or access videos in which children are depicted in this fashion, but this is not considered to be "obscene," and is thus not reportable. At what point should these images be considered "sexual exploitation" under the existing CANRA law? In September 2013, French legislators moved to ban child beauty pageants, considering them to represent "hyper-sexualization" of minors under age 16, and proposed fines and jail time for violators including parents and sponsors[6]. Russian lawmakers also introduced a bill to ban child participation in beauty pageants and penalize the law breakers[7].

Prisons have already become our nation's largest de-facto mental hospitals, and they do not have the mission or resources to provide effective rehabilitative services for all inmates who need them. The large population of child porn offenders created under the new CANRA amendment will likely add to the existing demand for correctional mental health services, and could draw resources away from those with more severe mental disorders.

This new law intends to prevent sexual exploitation by expanding the prosecution of those with sexual interest in children. However, it may inhibit patients from seeking mental health care for problems with sexual deviance, and criminalize therapists if they address child porn use without notifying the legal authorities[8]. These offenders are aware that disclosure of their thoughts can bring them severe embarrassment and disgrace. This law will further discourage potential patients from seeking help, and encourage reticence during therapy since the mere possibility of disclosure may impede the development of the confidential relationship necessary for successful treatment[9].

Currently, all 50 states have laws mandating a duty to warn or protect against imminent or direct harm to children by sexual victimization, and thus allow client confidentiality to be broken[10]. Under the new CANRA amendment, reporting is mandatory once the therapist becomes aware that child porn has been accessed, without any consideration of the potential for imminent or direct harm to a child. The law does not differentiate between a client who downloaded child pornography recently or many years ago, nor between individuals with ready access to children (e.g. preschool teachers) and those with no such access[11].

The Tarasoff duty to protect potential victims has existed for many years, and remains challenging for

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What Toxicology Screens May Miss: Dextromethorphan

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Many forensic psychiatrists have had the experience of evaluating a case in which substance induced psychosis is in the differential diagnosis due to presenting symptoms including, but not limited to, rapid onset, no clear past history or unusual presentation of a psychotic disorder, disorganized behavior with euphoric or religious themes, and disrobing behaviors. However, there may be no toxicology results available to support the diagnosis. Many times these cases present as an "excited delirium" or a unspecified psychotic disorder, which results in the individual being brought to the hospital or having interactions with law enforcement. Often, forensic psychiatrists become involved because of an injury to or death of either the individual with the psychosis (e.g. dying of self-harm or in police custody after struggle) or someone around them, such as a family member, was injured. Increasingly, due to changes in drug laws, the drug economy (e.g. smoke shops), and the spread of information through the Internet, there is increasing use of nontraditional drugs, such as synthetic stimulants (e.g. bath salts and flakka), synthetic cannabinoid derivatives (e.g. spice, K2), and abuse of over the counter medications (e.g. decongestants), in order to obtain a high and avoid detection.[1] Many of these substances are not screened for on routine urine drug tests, are often used in combination with other drugs (e.g. alcohol or cannabis), which may be misidentified as the significant causative agent. If they are detected, they may be dismissed as just appropriate over the counter use (e.g. cough syrup).[2-4] This creates the possibility that there are more episodes of substance induced psychosis occurring than most physicians recognize.[4,5]

One such compound that can create this dilemma is dextromethorphan (DXM), which is found in many over-the-counter cough suppressant formulations, such as Robitussin DM and Coricidin. Common street names for DXM are Triple C's, Robotripping, Robo, Red Devils, and Dex.[6] It is commonly used by adolescents and young adults due to its relatively low cost, availability (pharmacy or drug store, available over the counter), innocuous presentation (e.g. parent more concerned about marijuana in adolescent's room than bottle of cough syrup) and simplicity of use.[4] Unlike pseudoephedrine, which has to be chemically modified to make methamphetamine, dextromethorphan just needs to be consumed in large quantities to obtain an intoxicating effect. Queries for the term "Robotripping" on Google and YouTube yield approximately 42,000 and 2,000 search results, respectively. This suggests how easy it for individuals to learn about its euphoric effects and how to consume the compound (for example, see the YouTube video entitled, "DXM ... Everything you ever wanted to know about ROBOTRIPPING!").

The medical literature concerning DXM notes that it has effects similar to phencyclidine (PCP) and ketamine when taken in higher than recommended doses.[4,6,7] Although levels may vary depending on individual genetic factors (CYP450 2D6 alleles), some studies report PCP-like effects occurring at doses of 120mg or 2mg/kg.[6,7] Psychiatric symptoms seen with excessive DXM use include dissociative events (out-of-body dream state, disorientation, depersonalization, fugue state), hallucinations, delusions often linked with paranoia and/or religious meaning, euphoria, diminished concentration/confusion, irritability/agitation and manic states.[2,3,5-8] Physical symptoms of DXM intoxication include ataxia, nystagmus, hyperthermia (resulting in behaviors such as removing clothes), tachycardia, speech abnormalities (i.e. confused, repetitive, slurred), potential effect in reducing seizure threshold, and dry mouth.[2,5] There are also reports that suggest that there is a withdrawal syndrome seen with frequent DXM consumption.[5]

Although many may experience a euphoric effect from dextromethorphan intoxication, much like that seen in PCP or ketamine, some individuals may exhibit aggressive and/or disruptive behaviors that result in self-harm or hostile acts.[5,6] There is a growing medical literature to support dextromethorphan-induced self-harm deaths and homicides.[6,9] For example, in 2009, Logan and colleagues reported a case series of five deaths resulting from abuse of dextromethorphan obtained over the Internet.[10] A more recent study by Modi, et al discussed a case of suicidal and homicidal behavior in a middle aged woman abusing dextromethorphan.[11] In addition, there have been other studies, mostly of ER experiences, noting unusual behaviors or disease states that were misdiagnosed. An example is a paper by Majlesi and colleagues looking at dextromethorphan abuse masquerading as a recurrent seizure disorder.[2] What many of these papers have in common is that the initial presentation was often assumed to be due to another condition, that standard labwork did not recognize the dextromethorphan abuse, and that dextromethorphan abuse was only discovered after the historian asked direct questions about its use.

In conclusion, dextromethorphan is an often underappreciated substance of abuse that can result in psychotic symptoms.[5] Given that, by the time a forensic psychiatrist becomes involved in a potential case of substance induced psychosis, it may not be possible to obtain additional or more thorough toxicology screens. Therefore, forensic psychiatrists need to be aware of presentations that are consistent with dextromethorphan intoxication, as well as its street names such as Robotripping and Triple C's, how it is obtained and

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Personal Biases and Professional Recommendations:

Modeling Prescribing Habits in Medical Education

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When I was a medical student, I worked with an attending psychiatrist who, despite authoring numerous peer-reviewed articles and book chapters, struggled to explain why he refused to prescribe a certain antipsychotic to a patient with schizophrenia. This was not one of the latest medications, touted by pharmaceutical representatives as a magic bullet for psychosis. Nor was this a medication that I had seen other physicians avoid prescribing.

Research suggested this medication was similarly efficacious to others in the same class and with a similar list of possible adverse effects. After a nagging persistence, I soon learned that the reason my attending avoided this antipsychotic was because he once had a patient who developed neuroleptic malignant syndrome after this medication was initiated.

These "n of 1" stories are not uncommon in the world of medical education. Medical students and residents frequently encounter them as they learn to adapt their prescribing habits to the attending du jour. The attending tells the team, "I once had a patient who had a remarkable improvement after we began this mood stabilizer." The fellow explains he once treated a patient who went into delirium tremens despite being detoxed with a particular benzodiazepine. The resident admits that despite what "the book says," he prefers starting patients with depression on a specific combination of three medications, because he has had great success with that regimen. Since early learners and young physicians have fairly limited patient experiences, they are easily influenced by the habits of their superiors assimilating these practices into body of medical knowledge. If the evidence, however, suggests no inherent problems in certain prescribing habits, then is there a mistake in developing these habits?

Perhaps, but perhaps not. In the complex world of medicine, physicians learn to respect both the art and the skill of diagnosing patients and formulating treatment plans. There can be an overwhelming amount of information that floods our virtual inboxes, disseminating guidelines and advice from the constantly evolving world of clinical research.

While we have an obligation to incorporate these best practice guidelines into our work, we may also simplify the process by sticking with what works. Conversely, we learn from bad outcomes, which then influence future decision making. For example, the psychiatrist whose patient developed Steven Johnson syndrome decides to use different mood stabilizers for his patients with bipolar disorder. In this way habits are formed.

Habits are also formed when prescribers use treatment interventions in ways that are not officially approved. Patients in the emergency room too frequently receive neuroimaging for soft indications. Broad-spectrum antibiotics are prescribed indiscriminately.

A recent article[1] from The Journal of the American Medical Association shows that off-label prescribing of antidepressants has been increasing and in particular for insomnia and pain. Furthermore, the researchers observed that the indications for prescribing these antidepressants are often not documented in the chart.[2]

These realities of clinical medicine put the learner in an uncomfortable quandary. How does the astute medical student reconcile the apparent dichotomy between what is taught in the lecture halls of undergraduate medical education and what is taught in the clinics and hospitals of the clinical years? The solution begins with the individual educator. Attending physicians must remain transparent and have an obligation to disclose to the student when their clinical practice does not comport with practice guidelines, FDA recommendations, or even best practices.

Croskerry suggests we should identify cognitive biases (of which there are over 100 affecting clinical decision making) and use a "debiasing" strategy to avoid them.[3]

The medical learner is a sponge, ready to soak up the information disseminated from superiors and ready to shape future practices to what is modeled from residents and attendings. We must, therefore, assess our own clinical decision-making and prioritize honesty when teaching our students. Students should learn the value of critical thinking and the ability to assess the biases that affect them. Although there is often not a correct answer guiding our clinical practice, we must admit when our medication choices might be based on idiosyncratic beliefs, relied upon by heuristics, or contravene the management decisions made by our colleagues. These are the behaviors we should strive to model for our learners when faced by clinical uncertainty.

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Optimizing Collaboration and Achieving Standard of Care:

A Model for Therapeutic Risk Management of the Suicidal Patient

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The processes involved in the management of suicide risk, especially when a provider lacks confidence and comfort in the area, can be intimidating and overwhelming. Without a framework and approach to the assessment of suicide risk, a provider can easily become lost in a litany of details. Furthermore, reliance on a "check-list" approach to suicide risk assessment can strain the therapeutic relationship, resulting in a less nuanced suicide risk formulation that lacks patient investment and collaboration. The Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC) utilizes a clinical risk assessment and management model, Therapeutic Risk Management of the Suicidal Patient (TRMSP), that is medicolegally informed and optimizes patient-centered care.[1] In this brief article, we outline the major components of the TRMSP model (augmenting clinical risk assessment with structured instruments, stratification of risk in terms of both severity and temporality, development and documentation of a safety plan) with the goal of encouraging widespread implementation of a TRMSP model.

Practicing clinical risk assessment and management that is patient-centered, supportive of the treatment process, and maintains the therapeutic alliance is at the core of therapeutic risk management, as conceived by Simon and Shuman.[2] Grounded within the goals of therapeutic assessment,[3] the approach utilizes components that are designed to increase empathetic connections and improve collaboration between the provider and patient. As a result, this framework strengthens the therapeutic relationship, models direct and responsive discussion about self-directed violence (which may be historically avoided by both providers and patients), and ultimately improves the patient's sense of self-efficacy by allowing the patient to take ownership in the process.[4-6] TRMSP supports both the patient's treatment and the provider's role in suicide assessment and management by providing a framework to minimize defensive practices that can actually cause more harm[2]. Risk management necessitates practicing and documenting a thoughtful suicide risk assessment that informs clinical interventions to mitigate risk, and the elements employed in a TRMSP approach are easily accessible to providers across disciplines and settings. Yielding a suicide risk assessment and management process (with attendant documentation), the TRMSP model should not only meet, but likely exceed, the standard of care for assessing and managing suicide risk.

Clinical risk assessment can be best understood as an inductive process[7] directed by the goal of collecting specific patient data to guide clinical judgment, treatment, and management. This process involves the integration of factors that elevate or reduce the risk of a patient acting on his or her intent to engage in suicide-related behavior. Because there is no standard of care for the prediction of suicide, providers are faced with the challenging task of how best to structure a suicide risk assessment to yield a formulation that minimizes false-positives and false-negatives. Complete reliance on unstructured clinical risk examinations (free-form clinical interviews), or those guided chiefly by clinical experience alone,[8] may result in missed aspects of risk assessment. To minimize this possibility, we argue that providers should augment risk assessments with structured assessment tools. The MIRECC website (http://www.mirecc.va.gov/visn19/clinical/assessment_tools.asp) features some usebul instruments. Use of structured measures can improve the depth of risk assessment by assuring that factors (e.g., frequency and intensity of suicidal ideation and identifying reasons for living) that might otherwise be overlooked are included. Use of suicide-related measures can also serve an important medicolegal function as the risk assessment is anchored in not only subjective data but also quantitative data yielded from reliable and valid measures. Scores from structured instruments can also be invaluable as they provide critical information about a patient's baseline which can facilitate subsequent risk assessments and can be an important element for consideration when determining whether hospitalization or alternate interventions are warranted. It is important to keep in mind that although structured scales may augment systematic risk assessment, they do not replace it. No single assessment or series of assessments are able to accurately predict the emergence of a suicidal crisis. Therefore, the best clinical risk assessment will likely combine interview and structured assessment data, guided by clinical judgement.

After conducting a clinical evaluation augmented by structured risk assessments, the provider is next faced with estimating the patient's level of risk for suicide. This estimation, or the suicide risk formulation, guides decision making surrounding suicide risk management, and ultimately informs both short and long-term intervention approaches. Traditionally, level of risk is stratified according to severity using modifiers such as low, medium/intermediate, and high. This one-dimensional stratification, without an accompanying temporality component, lacks the precision necessary to accurately capture the nuances of suicide risk to appropriately guide clinical decision-making. For example, imagine assessing a patient in a mental health outpatient

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Out of the Shadows:
Combatting Elder Abuse

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Her biggest fear was going to a nursing home. 96 year-old (at the time of the assault) Miss Mary lived with her 70 year-old son and his wife until her son's health precluded him from providing care. She was then placed in a nursing home. She left the nursing home to live with her grandson, Billy, and his wife, Susan. Over the five years that she lived in their trailer, Billy and Susan forced her to do all of the house work, took a substantial portion of her Social Security income, and sold off her assets to enrich themselves. One night while Susan was in the hospital, Billy came home and sexually assaulted Miss Mary. He brutally raped her, beat her, and threatened to kill her. The attack lasted six hours. When he fell asleep, she called 911. She said, "Get a cop out here. I'm hurt. There's a maniac in the house."

In spite of her extensive physical injuries, Miss Mary's family did not believe her. At trial, the only people on her side were victim advocates. The prosecution team marshalled medical evidence and victim support resources to support and assist Miss Mary in presenting her account of the attack. After employing multiple delay tactics, defense attorneys attempted to cast Miss Mary as an unreliable witness. With the support of prosecutors and victim advocates, she courageously recounted the details of the assault. Her nephew was convicted of sexual battery and sentenced to 40 years in prison. Miss Mary continued to receive support from victim advocates as she coped with her physical and psychological wounds. She died in 2007, three years after the attack, in a place she most wanted to avoid—-a nursing home. In reflecting on her ordeal, Miss Mary noted, "I had to pay for what he did." Her tragic story is told first hand in an elder abuse training video, *"He Wouldn't Turn Me Loose:" The Sexual Assault Case Of 96-Year-Old Miss Mary* as well as a training video produced by the Office for Crime Victims, *In Their Own Words: Domestic Abuse in Later Life*.

Elder abuse consists of physical abuse, sexual abuse, financial exploitation, emotional abuse, and neglect. It can affect anyone regardless of socioeconomic status. In 2006, Professor Philip Marshall filed a petition seeking to remove his father, Anthony Marshall, as guardian for his grandmother, well known New York philanthropist Brooke Astor. The petition detailed financial exploitation by Anthony Marshall and Attorney Francis X. Morrisey. They engaged in a pattern of isolating Ms. Astor, deceiving her into believing she was running out of money, and selling her assets. They even forced her to sell one of her most prized possessions, a 1917 oil painting, *Flags, Fifth Avenue,* by Childe Hassam. Professor Marshall's courageous act not only saved his grandmother from further exploitation but 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.

The Geriatric Psychiatry and the Law Committee will highlight these two stories of elder abuse at the upcoming AAPL meeting with special guest presenters. Cheyenne Shepherd, who prosecuted the rapist in Miss Mary's case will participate by videoconference in our workshop, and Philip Marshall will discuss his compelling family experience in a workshop and course.

The U.S. Census Bureau estimates that the number of Americans age 65 and older is expected to more than double from 2010 to 2050, from 40.2 million to 88.5 million. This rate of growth will pose new challenges to both the legal and healthcare communities. Elder abuse is estimated to affect 10% of people over the age of 65. This is likely an underestimate because elder abuse is vastly underreported. Some reasons elders fail to report abuse or exploitation include embarrassment, fear of losing independence, fear of not being believed, and a reluctance to pursue criminal charges particularly when the perpetrator is a family member.

Forensic psychiatrists are uniquely positioned at the interface of mental health and the law to combat elder abuse. Our knowledge of the psychological mechanisms used to exert undue influence can help courts and policymakers better understand and prosecute exploitative relationships. We can help identify risk factors and indicators of abuse and exploitation. We can also help train general practitioners to identify, document, and report signs of abuse. Such contemporaneous, high quality documentation can be invaluable in prosecuting these cases. We can also assist with victim interventions such as assessing victim impact and recommending appropriate interventions to protect victims while preserving their autonomy to the extent possible. These presentations will hopefully begin a dialogue on the many ways that forensic psychiatrists can join the fight to protect elders.

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setting presenting with the following: daily suicidal ideation with stable intensity and frequency over the past week; history of several suicide attempts; recent psychiatric admission (1.5 months ago) for increasing suicidal ideation; history of substance use with sustained sobriety since discharge from the psychiatric inpatient unit; engaging in outpatient treatment and utilizing a safety plan; recently moved into stable housing and has begun working at a new job. It is a challenging task to determine the level of severity for this particular patient given that their history of multiple suicide attempts, recent sobriety, and recent psychiatric admission suggest an elevated level of risk. Their improved housing and new employment, however, suggest engagement in activities that may serve as protective factors. These types of cases present a potential conundrum for sound clinical and medicolegal decision-making. If classified at high risk, we typically look to hospitalization as an option, which seems unwarranted given the fact that this patient is likely at their baseline and that hospitalization may potentially be an impediment to psychosocial improvements (e.g., unnecessary hospitalization may jeopardize new housing and employment which are serving to decrease desire for suicide). Similarly, classification at low risk presents other potential disadvantages given the presence of known risk factors; namely, medicolegal vulnerability if the patient encounters a significant psychosocial stressor in the following days that reactivates the suicidal mode[9] and acutely triggers self-directed violence behaviors. In the TRMSP model, we handle this dilemma by utilizing a two-dimension risk stratification that denotes both severity and temporality (acute or short-term versus chronic or long-term).[10-12] For the patient considered above, the baseline factors suggest high chronic risk, whereas the current presentation of baseline suicidal ideation with accompanying positive changes, suggests low acute risk. Including both severity and temporality in risk stratification allows the provider to demonstrate awareness and consideration of risk and protective factors that function to maintain chronic risk over time, while also acknowledging other short-term changes that can fluctuate to directly influence risk levels acutely.

Many providers continue to rely upon "no harm" or suicide prevention contracts despite no empirical evidence demonstrating that these practices reduce risk.[13] The TRMSP model relies upon the collaborative development of a safety plan. Safety planning involves the hierarchical organization of six concrete steps that can be used to help an individual cope with a suicidal crisis. Whereas suicide prevention contracts tell the patient what *not to do* during a crisis, the safety plan offers[14] a set of individualized strategies of what *to do* when faced with warning signs of a suicidal crisis. Furthermore, by utilizing a collaborative process, safety planning can be an instrumental piece to enhancing the patient's own self-efficacy and can be a mechanism by which patients can begin to build their own confidence and comfort in being able to cope with suicidal crises. One can learn more about the VAMC safety planning process online (http://www.mentalhealth.va.gov/docs/va_safety_planning_manual.pdf)[15] and in the articles referenced.

As providers, it is essential to weigh the medical ethical principles of autonomy, nonmaleficence, and beneficence[16] in our decision-making when working with patients who are suicidal. The TRMSP model provides a framework to help guide suicide risk management given these guiding principles. Furthermore, its inclusion of the patient's perspective and empathy achieved within the therapeutic relationship underlies collaborative patient-centered care and maximizes positive outcomes for those that need and deserve the highest standard of care. Although TRMSP likely surpasses the standard of care, without accordant documentation, medicolegal protection would suffer. It is essential that the provider document the suicide risk assessment (including the use of structured instruments), the formulation of risk utilizing two-dimensional stratification, and the collaborative development of the safety plan. We hope that this article supplies new ideas for the provider working with patients who are suicidal and may be the foundation and impetus for new practices within centers of care. Interested readers are referred to the TRMSP website (http://www.mirecc.va.gov/visn19/TRM/), and article 1, 17-19.

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Taking a Stand

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As I spoke with my colleagues and program director after the case, I realized I had indeed accomplished my objectives. I had never lost my composure or responded defensively to the questions asked. I had acknowledged what I did not know. I had not retreated from my opinion. I had done my job. Perhaps it was a trial by fire, but I came out intact. I came to the jarring realization that the concept of justice is somewhat of a moving target, influenced by politics, perception and personal motives. Sometimes, the role of the expert witness is merely a footnote in a lengthy saga already written. But this is not always the case. Over the course of my fellowship year, I observed and participated in other trials, cases and evaluations. I became more adept and confident in educating the court while transparently stating the limitations of the work that we do. Though there will still be a sense of anticipation when I walk into a courtroom to testify, the frame has shifted. I anticipate the possibility that others will attempt to discredit my profession and opinion, but I can maintain my confidence because I performed my job with integrity, honesty and transparency and sought the truth while acknowledging my obvious human limitations.

The Double Track

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sentences since they did not provide a "clear therapeutic orientation." Christopher Michaelson, "'From Stasbourg with Love' – Preventive Detention before the German Federal Constitutional Court and the European Court of Human Rights," 12 Human Rights L. Rev. 149, 163 (2012). On the newly designed structures built in response to the court's holding, see COE Press Release, Bergmann v. Germany, ECHR application no. 23279/14, 7 January 2016, page 2: "a newly constructed centre for persons in preventive detention, a separate building on the premises of Rosdorf Prison ("the Rosdorf centre"), where persons in preventive detention are placed in individual apartment units and extensive possibilities for therapeutic treatment are being provided.

Toxicology Screens

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administered, and that individuals may be using it to avoid producing positive urine toxicology screens (e.g. wanting to get high while on probation). Increased sensitivity to and inquiry about dextromethorphan use may allow forensic psychiatrists to be more accurate in identifying causation when encountering substance-induced psychosis.

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Optimizing

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A Review of Canadian

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ment of a patient who is incapable to consent to treatment. In Saskatchewan and Newfoundland, the attending physician holds such authority, while in British Columbia, the director of the psychiatric department grants such authorization. In New Brunswick, the court makes decisions for incapable patients, or for capable patients who refuse treatment. In Quebec, the Superior Court decides for an incapable patient who categorically refuses treatment. These jurisdictions all propose treatment in keeping with the principle of "the best interest of the patient".

In other Canadian provinces, a private "substitute decision maker" system is used to treat a patient who is incapable to consent to treatment. In Alberta and Prince Edward Island, the substitute decision maker must act in the best interest of the patient. In all other jurisdictions, decision makers must abide by the previous capable wishes of the patient (wishes previously expressed by the patient when they were capable), even if they are not in their best interests. In Manitoba and Nova Scotia, the legal test is a "modified best interests" test, which is a compromise between these two principles. In reality, few patients have clearly expressed prior wishes about treatment, and the substitute decision maker decides based on the best interest of the patient.

What do we do with a patient who is no longer dangerous but not yet capable, and refuses all outpatient treatment (the famous revolving door patient)? Nine provinces have versions of involuntary treatment orders that can be applied to outpatient care. In British Columbia, Manitoba, and Prince Edward Island, they are called "temporary leave", a period during which the patient can be brought back to the hospital if they refuse treatment during a limited period as outpatient. In Alberta, Saskatchewan, Ontario, Nova Scotia and Newfoundland, there are more prolonged forms of this order called Community Treatment Orders (CTO). Quebec also has treatment orders, but they apply more widely to inpatient and outpatient care. Usually, to be eligible for a CTO, the patient must have had a minimal number of hospital days during the preceding years. In Alberta and Saskatchewan, a patient is eligible during his first psychiatric hospitalization. In practice, in many jurisdictions, treatment orders and CTO's are underutilized due to the perceived complexities in obtaining, implementing and renewing them.

As we can see, despite the so-called universality and equality principles that theoretically underpin the Canadian public health care system across the country, provincial jurisdictions have varied approaches to balancing autonomy and liberty interests of individuals and intervention powers of the state to help those in need and protect society from dangerous persons.

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clinicians to adhere to in the face of ambiguous dangerousness and imminence of harm. It has been recommended that clinicians focus less on the imminence of the threat, and more on a demonstrated capacity to carry out the threat[12]. This new law will reduce the ambiguity by setting a clear but extremely low bar for mandated reporting of child porn offenses. Its usefulness is questionable, without any consideration of the patient's capacity to commit an actual hands-on sexual offense.

California's new CANRA amendment represents a significant erosion of confidentiality in the psychotherapist-patient relationship. It will predictably inhibit access to treatment by many potential patients, and its value in identifying future sexual perpetrators and their victims is doubtful. Unfortunately, psychiatrists and other mental health caregivers did not mount any meaningful opposition to this law, and we will now have to deal with the consequences.

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High IQ Offenders

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"tactfully and wisely handled...are among the most hopeful cases that the psychologist is called upon to study...[but Burt also warned that]... [w]rongly treated, they turn into criminals of the most dangerous and elusive type."[9] If an IQ score above a certain threshold (e.g., IQ 150) can operate as a solvent on Hirschi's social bonds, as the qualitative analysis indicated, then the relationship between IQ and protective effects might be curvilinear, switching direction from positive to negative.

James Oleson is an Associate Professor of Criminology at The University of Auckland. His monograph, *Criminal Genius: A Portrait of High-IQ Offenders*, will be published in October 2016 by the University of California Press.

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solitary confinement in correctional settings. For example, the NCCHC website states, "Many national and international organizations have recognized prolonged solitary confinement as cruel, inhumane, and degrading treatment, and harmful to an individual's health . . . It is well established that persons with mental illness are particularly vulnerable to the harms of solitary confinement. As a result, federal courts have repeatedly found the solitary confinement of the mentally ill to be unconstitutional, and in 2012, the APA adopted a policy opposing the 'prolonged' segregation of prisoners with serious mental illness, which it defined as longer than 3 to 4 weeks. Subsequently, in April 2016, the NCCHC adopted 17 principles to guide correctional health professionals in addressing issues about solitary confinement.

Drs. Appelbaum, Trestman, and Metzner also addressed audience questions regarding practical issues including confidentiality, limited resources, and legal challenges. Compellingly, Dr. Trestman analogized that trying to engage patients and provide psychiatric treatment with limited confidentiality is akin to a surgeon attempting to perform surgery in an unsterile environment.

Overall, this textbook and lecture emphasize the critical role of correctional psychiatry and its important place in the broader field of psychiatry. Needs exist for further mental health education, training, resources, research, and policies in jails and prisons.

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EOE

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Messaging and non-HIPAA Compliant Electronic Messaging." A policy entitled "Weapons, Hospital Workplace and Patient Safety Issues" was adopted, advocating that hospitals and other healthcare delivery settings restrict guns and Tasers on their premises, particularly in emergency departments and psychiatric units.

Drs. Piel and Gruenberg testified on "Medical Reporting for Safety Sensitive Positions" that looked for AMA to advocate for uniform policy on mandatory reporting of significant medical conditions that may pose a risk to public safety. Testimony reflected concern for the ambiguity in the meaning of "safety sensitive," who defines the conditions, the specialty of the reporting professional and how laws vary from state to state. The AMA will study the issue for report to the House in November 2016. Dr. Piel served as Chair of the Young Physician Section's reference committee for the third year.

For more information visit http://www.ama-assn.org/sub/meeting/index.html.

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