AAPL Newsletter
American Academy of Psychiatry and the Law
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American Medical Association 2019 Annual Meeting Highlights

Barry Wall, MD, Delegate; Jennifer Piel, MD, JD, Alternate Delegate and Young Physician Delegate; and Tobias Wasser, MD, Young Physician Delegate

Patrice Harris, M.D., speaks at her inauguration as President of the American Medical Association.

The American Medical Association's (AMA) 2019 Annual Meeting was held in June in Chicago. Although the opening session was interrupted by a group of protesters advocating for Medicare for all, meeting participants focused on policy and education related to clinical practice, healthcare delivery, professional education, and the regulation of medicine.

In her opening address, AMA President Barbara L. McAneny, MD, an oncologist from New Mexico, described the great work of physicians despite our country's broken healthcare system. She emphasized the growing concern about physician burnout. In her travels around the world, she found that professional burnout is pervasive, but that the root cause differs in the US as compared to many other countries, where lack of resources is a central cause. In the US, regulatory burdens, electronic medical records, and liability concerns add to physician demands and time. Dr. McAneny emphasized the importance of preserving the patient-physician relationship and how this is a central AMA value that the organization will continue to fight to maintain. By way of example, she described the AMA's efforts to push back against government overreach with changes to Title X and the importance of protecting women's ability to access reproductive care.

The theme of women in healthcare was one of many topics emphasized during the meeting. It was the 100th anniversary of the first female physician delegate to the AMA House of Delegates. The 2019 meeting also marked the first time in the organization's history that women held the positions of the immediate past president, president, and president-elect. The AAPL delegation proudly shared that at the conclusion of the meeting, Patrice Harris, MD, MA, a child and forensic psychiatrist from Atlanta, was installed as the AMA President. Dr. Harris has been instrumental in leading the AMA's opioid task force. Additionally, Rebecca Brendel, MD, JD, forensic psychiatrist and bioethicist, was appointed to the AMA's Council on Ethical and Judicial Affairs (CEJA). CEJA is responsible for investigating ethical questions and advancing reports to guide physicians in ethical decision-making.

After debate at several meetings, delegates adopted CEJA's report on physician-assisted suicide. CEJA's report aims to balance the complicated ethical considerations and take into account physicians who practice in states where physician-assisted suicide is legal. The report retains the AMA's longstanding position against physician participation in assisted suicide as incompatible with the physician's role as healer, but also offers a methodology for physicians to use their conscience in making individual decisions with their patients.

A Board of Trustees Report on physician competence, another report that had been discussed at multiple meetings, was adopted at the 2019 Annual Meeting. This report addresses the physician's commitment to competence and the importance of practicing informed self-assessment of one's ability to practice safely.

Delegates further considered a number of resolutions and reports with mental health and forensic implications. Among these, delegates declared that health, in all its dimensions, is a basic human right. Delegates also voted to advocate that healthcare services provided to minors in detention and border patrol stations focus solely on the health and well-being of the children and not be used to make detention decisions without consent of the minor. The AMA voted to support evidence-based care, legislation, and intervention services to address the specific needs of children with incarcerated parents. A number of resolutions aimed to improve the health of gender and sexual minority

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COVER STORY

2019 AMA Annual Meeting

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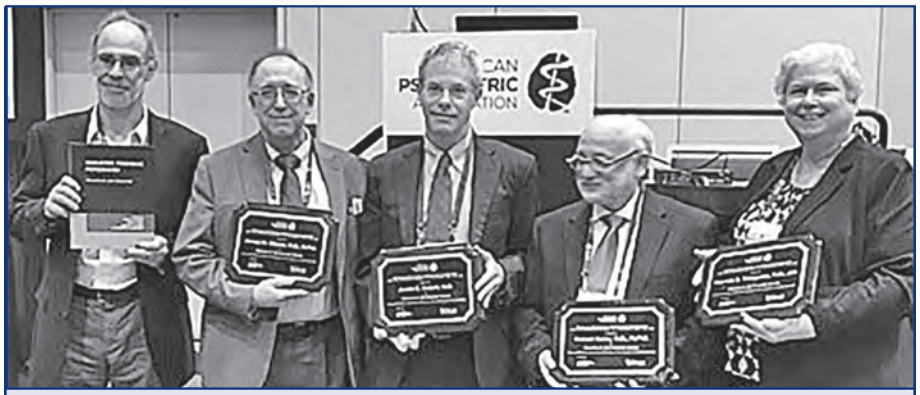
populations. One resolution adopted by the House calls for the AMA to oppose laws which mandate reporting to parents of minors who question or express interest in exploring their gender identity in psychotherapy.

Several resolutions addressed stigma and improving care for persons with substance use disorders. Delegates adopted policy to use clinically accurate, non-stigmatizing terminology regarding substance use in all future communications from the AMA. The House of Delegates also passed a resolution to support the alignment of federal privacy law and regulations (42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) for treatment, payment, and health care operations while ensuring protections are in place against the use of Part 2 Substance Use Disorder records in criminal proceedings. This would allow for improved record-sharing for persons receiving care for a Substance Use Disorder. They passed other resolutions in support of 1) implementing childcare resources within substance use treatment facilities; 2) increasing legal access to naloxone in public spaces; 3) inclusion of naloxone administration in basic life support training; and 4) efforts to work with stakeholders to dispel the myths of bystander overdose (via inhalation or dermal contact) with fentanyl and other synthetic derivatives. Delegates oppose any implication that a diagnosis of Substance Use Disorder during pregnancy represents child abuse.

The AAPL delegation was busy at this meeting. Barry Wall, MD, served on the Section Council of Psychiatry's interview committee to select persons running for elected office in the AMA. Dr. Wall testified in reference committees on 1) the use of appropriate language when referring to persons with intellectual disability; 2) the handling of de-identified patient information; 3) the use of recordings in independent medical examinations; and 4) the alignment of HIPAA and 42 CFR Part 2. Jennifer Piel, MD, JD continued to serve on the Young Physician Section Reference Committee and to draft testimony for the Young Physician Section. She testified to the role for judicial oversight in involuntary commitment for substance use disorders. Tobias Wasser, MD, testified that, if the task of obtaining informed consent is delegated, it should be to members of the health care team with the requisite knowledge of the patient and awareness of informed consent criteria and processes.

You can find more information on the actions of the AMA House of Delegates at the 2019 Annual Meeting at https://www.ama-assn.org/about/house-delegates-hod.



The **Manfred S. Guttmacher Award**, established in 1975, recognizes an outstanding contribution to the literature of forensic psychiatry in the form of a book, monograph, paper, or other work published or presented at a professional meeting between May 1 and April 30. Congratulations to the 2019 Guttmacher Award recipients James Ellison, MD, MPH, Jacob Holzer, MD, Robert Kohn, MD, and Patricia Recupero, M.D., J.D for their publication Geriatric Forensic Psychiatry: Principles and Practice.

The Importance of Whistleblowing in Advocacy: Lessons from an AAPL Member

Richard L. Frierson, MD

Editor's Note: Please see the article by Dr. McPherson in this issue of the *Newsletter* for more on her experiences.

Advocating for forensic patients, other persons in detention, and for the profession of forensic psychiatry can be difficult. Because many persons challenged by mental illness or others lawfully or unlawfully detained are not in the best position to advocate for themselves, family members and mental health professionals may need to step forward. For example, in 1979 a meeting of a group of concerned parents of persons with mental illness that occurred around a kitchen table eventually led to the formation of the National Alliance on Mental Illness (NAMI). (1) The American Psychiatric Association (APA) and AAPL routinely engage in advocacy through the support of amicus briefs that advocate for policies that benefit persons with mental illness and that benefit the practice of forensic psychiatry. However, engaging in advocacy as an individual, outside of an organized group, can be a daunting task. In some circumstances advocacy requires tremendous courage. Such courage is almost always needed in the case of whistleblowing.

Recently, AAPL member Pamela McPherson, MD was named a co-recipient of the 2019 Ridenhour Prize for Truth-Telling. (2) The prize, named for Ron Ridenhour, a journalist who exposed the horrific events of the My Lai massacre of civilians during the Vietnam War, is presented to a citizen, corporate or government whistleblower, investigative journalist, or organization for bringing a specific issue of social importance to the public's attention. (3)

Since 2014, Dr. McPherson has served as a subject matter expert for the Department of Homeland Security's Office for Civil Rights and Civil Liberties (DHS-CRCL). In that role she has been a member of a team of many experts (including a primary care physician, psychiatric physician, facility management expert, sanitation expert, investigators, DHS-CRCL attorneys, etc.) that monitor detention facilities that are operated to house immigrants seeking asylum in the United States.

Dr. McPherson helped expose to the United States Senate Whistleblowing Caucus the serious health risks to children who are separated from their parents and detained as part of the current US administration's zero tolerance policy at the southern border. According to media reports, experts witnessed reports of children's fingers being crushed in cells originally designed for adults, a 16-month-old boy who had lost a third of his body weight in detention, incorrect doses of vaccines being administered, missed diagnoses, etc. (4) Additionally, Dr. McPherson was especially concerned about the psychological trauma that children in these detention centers were experiencing, especially the layer of hopelessness caused by indefinite detention. In a March 19th, 2019 letter to the Whistleblowing Committee from Dr. McPherson and Dr. Scott Allen, an internist and Professor of Clinical Medicine at the University of California - Riverside, they expressed concerns that DHS-CRCL may not be investigating complaints at family detention centers, concerns about detaining children under the age of two and the psychological trauma that can result, and concerns about the expansion of family detention, which constitutes knowing endangerment of children and has resulted in real harm. While Dr. McPherson had previously expressed concerns about the detention of children in DHS reports and written testimony to Congress, she was especially concerned about a proposal to overturn the *Flores* settlement agreement which outlines the requirements of detention of juveniles by Immigration and Naturalization Services (INS), now part of DHS. (5, 6) This settlement agreement establishes minimum standards for initial detention and a policy favoring release of minors. It also requires that children who remain in federal custody be placed in the least restrictive environment and mandates provision of information, treatment, and services.

Furthermore, since initially expressing concerns in reports to DHS and Congress, Dr. McPherson and Dr. Allen had not been asked by CRCL or DHS to further review medical and mental health care in family detention facilities. Scott Shuchart, a senior advisor for the DHS Office for Civil Rights and Civil Liberties, resigned his position when it became clear to him that the department's family separation policy violated the civil and human rights of migrants and asylum seekers. According to the concerns expressed in their letter, "detention of innocent children should never occur in a civilized society, especially if there are less restrictive options, because the risk of harm to children simply cannot be justified."

Dr. McPherson has a career-long history of evaluating conditions of confinement. While completing her child fellowship at the University of New Mexico, she was involved in inspecting conditions of confinement at Juvenile Detention Centers as a result of two juvenile suicides. She established the first mental health services at the Bernalillo County Juvenile Detention Center as a result of the suicides. Since that time, she has served as a consultant evaluating conditions of confinement at juvenile institutions in Montana, Iowa, Louisiana, Detroit, Los Angeles, and San Francisco. She currently works at a community mental health center in Shreveport, LA and teaches child and forensic fellows at Louisiana State University (LSU).

As AAPL members, there is much

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Does the U.S. Constitution Mandate an Insanity Defense?

Jeffrey S. Janofsky, MD

Earlier this year the US Supreme Court granted certiorari in *Kahler v. Kansas* to determine whether Kansas' statute abolishing the insanity defense and allowing only a *mens rea* defense violates the Fourteenth Amendment's due process guarantee. Prior to passage of the statute on January 1, 1996, Kansas had since statehood allowed a common law insanity defense based on the *M'Naghten rule*. (1) After passage of the statute, Kansas only allowed mental disease or defect as a defense in a criminal case if "as a result of mental disease or defect, [the defendant] lacked the culpable mental state required as an element of the crime charged." (2)

AAPL, along with the American Psychiatric Association and others have submitted an amicus brief in support of a Constitutional requirement for the insanity defense. (3) The brief argues that due process bars criminal punishment of a defendant who because of mental disorder did not know that his conduct was wrong, and that modern understanding of the nature of mental illness provides additional support for recognition of a traditional insanity defense. Our brief takes no position on which insanity defense definition should be constitutionally required.

Kahler had been happily married until 2008 when his wife began an extramarital affair. Divorce proceedings were started and Kahler became increasing depressed and despondent. He sought psychiatric care and was prescribed medications but was frequently non-compliant with treatment. In March 2009 he was arrested for assaulting his wife and he became estranged from his two daughters who he believed took his wife's side in divorce proceedings. He lost his job. Around Thanksgiving 2009, Kahler drove to his estranged wife's grandmother's house, where he knew his wife and children were spending time over the holiday weekend. He killed his wife, his two daughters and his wife's grandmother, but spared his son who was also present.

Kahler was charged with capital murder. At trial, Kahler admitted that he had shot the four family members. Kahler called a forensic psychiatrist to support his argument that severe depression had rendered him incapable of forming the intent and premeditation necessary for capital murder under Kansas law. The defense psychiatrist testified that Kahler was suffering from severe major depression at the time of the crime, but that he was not psychotic. The defense psychiatrist further opined that Kahler's ability to manage his own behavior had been "severely degraded" so that he had no ability to "refrain from doing what he did." Kahler's attorney did not ask the defense expert to opine on whether Kahler had the capacity to premeditate or form the requisite *mens rea*. A forensic psychiatrist called by the prosecution opined that Kahler was, "capable of forming the requisite intent and premeditation." The prosecution psychiatrist testified that Kahler showed planning by bringing a weapon and killing those whom he blamed for his problems, while sparing the son that he did not blame. The prosecution expert also opined that Kahler's behavior was consistent with a revenge motive.

At trial, Kahler moved to have the court declare the Kansas statute which abolished the insanity defense unconstitutional under the Eighth and Fourteenth Amendments. The trial court denied the motion and instructed the jury in accordance with the statute. The Kansas Supreme Court affirmed. The Court rejected Kahler's argument that substantive due process requires consideration of the defendant's ability to know right from wrong. The court acknowledged that Kansas was one of four states that had abolished the traditional insanity offense and had adopted the *mens rea* approach. The Kansas Supreme Court cited a prior Kansas Supreme Court case which had upheld the Kansas statute based on its conclusion, "that the affirmative insanity defense is a creature of the 19th century and is not so ingrained in our legal system to constitute a fundamental principle of law."

Our brief first outlined the history of the insanity defense noting it has existed in some form in Western culture long before the establishment of the English common law, and that by the sixteenth century in England, insanity was a well-recognized defense. We pointed out that at the time of the founding of the United States "the insanity defense had become firmly established … cases in American courts and English courts in the early 1800s continued to forbid the criminal conviction of mentally ill persons who could not appreciate the wrongfulness of their conduct." We reviewed the pre-Hinckley status of the insanity defense where "the ALI formulation, or some close variant, governed in the federal courts and in "a majority of the country's jurisdictions." We then reviewed post-Hinckley changes to the insanity defense where most states and the federal government retained an insanity defense that, at a minimum, excused from criminal responsibility those individuals lacking the mental capacity to understand the wrongfulness of their conduct. This left Kansas and five other states with legislation abolishing or significantly limiting their longstanding recognition of the insanity defense.

We argued that the states that have upheld the abolition of the insanity defense as constitutional have done so based on a misunderstanding of the place of the insanity defense in the history of criminal law. We argued that, based on all relevant data, the insanity defense was clearly established as a common-law principle at the time of the adoption of the

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Teaching How to Teach

Joseph R. Simpson, MD, PhD

At AAPL's founding fifty years ago, one of the main goals that was set was the promotion of the teaching of forensic psychiatry. I think that any fair-minded observer of the last half-century would have to conclude that the organization has succeeded in achieving this goal in phenomenal fashion. There are now over 40 ACGME-accredited fellowship programs in the US, as well as eight Canadian programs. The AAPL *Journal* and the Annual Meeting are premier educational vehicles for the field, setting the benchmark for what a well-trained forensic psychiatrist should know.

Recently I have been reflecting on medical education, and specifically the typical paradigms for the training of residents and fellows. Often this training proceeds using the model pejoratively but not wholly inaccurately referred to as "monkey see one, do one, teach one." In other words, in many spheres of residency education, the transmission of knowledge takes place mostly by observation and example. It has been my experience that there is a sort of unspoken assumption that once one has received the knowledge and skills necessary to perform in our profession, one is also automatically qualified and able to teach effectively. Advances in the understanding of how to deliver effective training may not always find their way into the slowly-changing world of medical education, especially in its postgraduate phases. Most of us can attest to the variable quality of the didactic lectures and practical supervision we received during our residency, and perhaps in our fellowship as well.

Any professional who is motivated to maintain and improve their skills has the potential to impart knowledge to those who are newer to that endeavor. But in medicine, there is often a gap in our training, i.e., training on the best strategies for conveying our knowledge effectively. While many psychiatrists feel naturally drawn to teaching, others dread even the thought of it. I suspect that, for some, this may be due to a lack of exposure to much formal guidance on how to go about the task. How does one pitch the material at the right level for one's audience? How and when should feedback and constructive criticism be given? Given the shortage of doctors in most specialties and especially in psychiatry, as well as workforce projections indicating that the number of medical students and residents currently in the pipeline won't be sufficient to keep up with the need, it is imperative that those who do enter the profession receive the best training possible. That means that in educating the next generation of psychiatrists and forensic subspecialists, we should make use of as many of the excellent clinicians and forensic practitioners out there as possible.

Teaching one's craft is one of the best ways to build a professional legacy. It multiplies your impact and your reach – you can only treat so many patients or perform so many evaluations in your career, but if, through teaching, you contribute to the skillsets of a cadre of well-trained successors, your ultimate influence on the field is much wider.

I encourage everyone who is currently involved in teaching to investigate ways to improve your teaching skills. For those who oversee faculty within a residency or fellowship program, ask yourselves if the program provides educational support and guidance to help them maximize their effectiveness. Also, are there practitioners sitting on the sidelines at an affiliated hospital, clinic, correctional facility or courthouse whom you'd like to recruit as teachers? If so, an offer of some "training of the trainers" may entice them to volunteer. After that you could have regular check-ins with them to find out how the rotation is progressing for their trainees, and whether any fine-tuning or modifications are needed. This should make them feel supported and boost their confidence that their efforts are taken seriously.

It is common for a resident or fellow to simply be paired up with a clinician (for example, in a jail or prison) with the unspoken assumption that they will pretty much figure out the mechanics of the teaching process on their own. In that type of situation, neither teacher or learner may feel empowered to speak up if the learning experience isn't optimal. If this scenario sounds completely unfamiliar to you, then I would say that your program is in good shape when it comes to its educational component. But otherwise, ask yourself, what resources can my program tap into to improve the teaching skillsets of our faculty and therefore the educational experience for our trainees? There are bound to be some skillful teachers in your vicinity who can help set up a program for teaching how to teach, and in all likelihood, they will enthusiastically dive in and get to work. If teaching the next generation of practitioners multiplies one's impact, then teaching the next generation of teachers grows it exponentially.

The Annual Business Meeting of the American Academy of Psychiatry and the Law will take place on Friday, October 25 at 8:00 a.m. at the Marriott Waterfront, Baltimore, Maryland.

The agenda will consist of reports and election of officers and councilors. The slate as approved at the Semi-Annual Business Meeting is as follows:

President-Elect: Liza Gold, MD
Vice President: Michael Champion, MD
Vice President: Charles Dike, MD
Secretary: J. Paul Federoff, MD
Treasurer: Stuart Anfang, MD

Councilors:
Anthony Tamburello, MD
Ryan Wagoner, MD
Nathan Kolla, MD, PhD

Ask the Experts

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

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

This information is advisory only, for educational purposes. The authors claim no legal expertise and should not be held responsible for any action taken in response to this educational advice. Readers should always consult their attorneys for legal advice.

Q: In my fellowship, I thought I learned about the "standard of care." Out here in the real world, there seem to be multiple definitions/standards. Please explain!

A: Kaye

Welcome to the real world! The "traditional" definition of standard of care is: what a similarly trained psychiatrist would do in a similar circumstance; the level at which the average, prudent provider in a given community would practice; or, the degree of care or competence that one is expected to exercise in a particular circumstance or role.

This implies simply average care. Experts are commonly used to help establish the standard of care, as are textbooks, journal articles, clinical guidelines, consensus statements, and known or accepted treatises. Remember, a standard of care may not be the ONLY standard of care; there are often very different ways of treating a person and all may be within the "standard."

However, what at first seems simple is not. There has been an effort to use "specialist"-level care as the yardstick in some cases. In this scenario, a generalist could be held to the standards of a specialist. A primary care doctor prescribing antidepressant medication would be held to the same level of care as a board-certified psychiatrist. Case law in this area is evolving and worth tracking; court rulings have been inconsistent. As an example, Texas courts have held primary care doctors to the same level of care as a psychiatrist, while a Delaware court recently found that the standard of care for mental health treatment by a primary care doctor is substantially below that of a psychiatrist.

Further, at least one renowned AAPL member has convincingly testified that the standard of care should be individualized. This is akin to identifying the type of care that that specific patient needs (rather than limiting the deliberations to "like clinicians, like circumstances.") Presenting the specific patient's needs and expectations to the jury is powerful. Rebutting the idea that a patient must be at the mercy of a guideline or average treatment approach can create empathy in jurors, many of whom may have felt victimized by our impersonal, profit-driven health care system.

Last, and perhaps most interesting, is the notion of "best practices" as an evolving standard. I was recently in a med-mal case where the doctor signed a contract with the employing hospital agreeing to adhere to "best standards" in delivering care. This would seem to be a higher standard of care such as "benchmark" or "best in class" rather than the traditional definition of standard (average) or usual care.

Medicare/CMS has a Best Practices Pilot Program underway and for over 25 years has published "Best Practices Guidelines." The best practice may have appeared as an improvement in care outcomes in one or more peer-reviewed articles but not yet been included in a national guideline or widely accepted in a majority of healthcare facilities. For example, using antiseptic-impregnated caps on IV catheters. That is currently a best practice, but is not yet in national journals. The issue is, when does a best practice become a standard of care, as demonstrated in the evidence-based literature. The CDC Best Practices Workgroup consisted of 25 CDC staff members with varying backgrounds (e.g., epidemiology, behavioral science, program design and management, evaluation, policy development) and topic expertise (e.g., chronic disease, infectious disease, injury prevention, environmental health). The workgroup reviews the literature to find models and frameworks for classifying evidence, including best practices.

The concept of "benchmarking" is well accepted in the manufacturing, management, and business worlds, and the potential for these to be applied to healthcare delivery is real. While "best practices" is currently focused on an institutional level in assessing health care delivery, the concepts and techniques employed could be easily insinuated into individual patient care.

A: Glancy

I will address the deliberate indifference standard. The deliberate indifference standard in a prison is a higher evidentiary **bar** to meet for the plaintiff than "outside the standard of care" in a hospital. To prove deliberate indifference, the plaintiff must prove that the prison official, who may be a worker or a psychiatrist, had a somewhat culpable state of mind. We should note that this is an American concept and is not used in Canada or the United Kingdom. It is likely that in these countries the case below would have been dealt with as a case of medical negligence. As in many cases of medical negligence, the issue may have been that the psychiatrist had a duty of care and therefore a duty to act.

Bober and Pinals (1) discussed this in the context of what is a typical case in which the jail psychiatrist may have to administer care. The case involved

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The Shrink Next Door: A Tale of Boundary Violations

Meghan Musselman, MD

On May 21, Wondery, the network behind the popular true-crime podcasts *Dr. Death* and *Dirty John*, launched *The Shrink Next Door.* Written and hosted by Joe Nocera, a columnist for *Bloomberg*, *The Shrink Next Door* tells the story of a psychiatrist-patient relationship gone wrong. The podcast focuses on the thirty-year relationship between psychiatrist Isaac "Ike" Herschkopf and his patient, Martin "Marty" Markowitz. In six episodes, Nocera tells how, as Markowitz's psychiatrist, Herschkopf isolated Markowitz from his family and friends, became president of Markowitz's business, created a charity almost entirely funded by Markowitz, and included the charity and his family in Markowitz's will. Nocera began the podcast due to a personal connection. He lives next door to Markowitz's Hamptons home, which Herschkopf managed to commandeer and present as his own for 26 years, while Markowitz was relegated to the back chambers of the mansion.

As I tuned in to the podcast every Tuesday for weeks, I cringed at each boundary violation and worried the publicized acts of one psychiatrist could affect public perception of psychiatry as a field. Dr. Herschkopf violated many basic boundary guidelines, including failure to maintain therapist neutrality, ensure no personal relationship with the patient, and preserve relative anonymity of the therapist. (1) However, Herschkopf's response to the allegations in the podcast was that in 1981, the APA's ethics guidelines looked quite different than today's guidelines, primarily in that there was no mention of "boundaries." (2) This comment prompted me to review the evolution of boundary violations in psychiatry. Has so much changed over the last 30 years? Where are we headed in the next 30?

Treatment boundary issues have been evident since the earliest days of psychoanalysis. However, the concept of treatment boundaries did not arise until the twentieth century. In the 1970s and 1980s, more and more professional licensing boards and ethics committees began to recognize the damage inflicted on patients by boundary violations, and a greater body of literature on boundary violations began to accumulate. (3) Still, until the late 1980s, "boundary violations" referred to sexual relations with a patient. Work by Thomas Gutheil, Robert Simon and others in a series of articles expanded the concept of "boundary violations" to include nonsexual boundary issues. (4) The body of literature on nonsexual boundary issues remains limited. Much of what is known about nonsexual boundary violations evolved from a process of looking at cases of sexual exploitation and observing that a sexual boundary violation is often the outcome of repeated nonsexual boundary violations, often termed "the slippery slope." In a 2002 article on the topic, Miller and Maier postulated that the limited knowledge about nonsexual boundary violations could be, at least in part, due to nonsexual boundary violations being more covert and difficult to recognize, particularly in their early stages. (5) The boundary violation allegations against Dr. Herschkopf, however, are not subtle. Nonetheless it took thirty years, loss of relationships and loss of money for the acts to come to light.

In a 2004 review article on boundary violations, Sarkar noted that sexual boundary violations are likely underreported due to patient's feelings of shame and guilt. (6) While the literature on nonsexual boundary violations is less robust, one could imagine similar feelings of shame and guilt associated with such violations. Nocera spoke to other patients of Dr. Herschkopf, who felt he had "crossed a line," but never reported him. These individuals told Nocera they feared Herschkopf's retaliation, that he would somehow publicly humiliate them. Markowitz did eventually report Dr. Herschkopf both to the American Psychiatric Association (APA) and the New York State Department of Health. In 2016, after four years of investigation, the APA scheduled a hearing. However, weeks before the hearing, Dr. Herschkopf resigned from the APA, and the APA notified Markowitz that they no longer had jurisdiction in the matter. The New York State Department of Health has an ongoing investigation of Dr. Herschkopf. (7)

The Shrink Next Door not only raised for me questions of how far we have come in terms of boundary violations but also the question of what the future holds. The growth of social media has provided a new set of boundary challenges for younger psychiatrists. The Internet has provided both patients and clinicians the ability to quickly and easily access personal information, and has also created alternative modes of communication. Psychiatrists are cautioned against accessing patient information via social media forums, as there is a risk for boundary crossings. (8) A counterargument is that the Internet can be a useful source of collateral information. There's potential to find information to support one's suspicions for factitious disorder or discover if a patient's statements are indicative of truth or delusions of grandeur. (9) In addition to the boundary issues in searching patients online, social media comes with other boundary risks. Patients may "friend request" their doctors on social media platforms, thus gaining access to private material and blurring the line between professional and social relationships. The American Medical Association's social media guidelines do not explicitly forbid accepting friend requests from patients but do advise physicians to "consider separating personal and professional content online" and "maintain appropriate boundaries"

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Testifying Before A State Legislative Committee

Stephen P. Herman, MD

Earlier this year I had the unique experience of testifying before the Arizona House of Representatives Committee on Health and Human Services. Arizona is a complicated state. It is infamous in so many ways, ranking dead last nationally in elementary school teachers' pay; riven by charter school scandals which have enriched the bank accounts of former legislators; spawning ground for Insys, the pharmaceutical company whose founder, John Kapoor, was convicted of racketeering for bribing doctors to prescribe Subsys, a fentanyl-containing painkiller; pulpit of Steven L. Anderson, a Tempe pastor and Holocaust denier, forbidden to enter the European Union because of his hate-filled diatribes; and territory of former Maricopa County Sheriff Joe Arpaio, found in contempt of federal court for ignoring its order to cease targeting Latinos for arrest because they looked like they were illegal immigrants.

And yet, this state has recently elected an openly bisexual U.S. Senator, is one of only two states that doesn't follow Daylight Savings Time - a plus in my book - is home to many Native American tribes with 85,000 residents who speak Navajo and over 10,000 fluent in Apache, and has gifted the world such notable people as Geronimo and Chief Cochise, Cesar Chavez, Stevie Nicks, Steven Spielberg, Charles Mingus and Linda Ronstadt.

State government is surprisingly responsive to residents. Using the online service Request To Speak (RTS), any resident can register to speak about any bill before a committee in the Senate or House.

I took advantage of that opportunity and testified on February 21, 2019. The Chairwoman of the House Committee, Representative Nancy Barto, had introduced three bills for consideration. They all related to immunizing children. The first bill extended the concept of the "personal beliefs" exemptions to include religious exemptions, even though such exemptions were already permitted. The second added additional language to the Vaccine Information Statement required of all health professionals to give to parents and adult patients. The third bill stated that antibody titers should be offered as reasonable alternatives to vaccination.

The Arizona Medical Association came out swinging against all three bills, encouraging its members to register their opposition and testify.

So this is what it was like: I arrived at the House of Representatives at 8:30 AM, as required. The 9 members of the committee were seated, 5 Republicans and 4 Democrats. Among the Republicans were the Chairperson; a former radio talk show host; two members who had supported bills to prevent ACA exchanges from funding abortions; and a member who had co-sponsored a bill requiring all women seeking an abortion to answer a set of personal questions in addition to their general medical history. Among the Democrats were two members who had been in the legislature for several years; and two first-term legislators, one, with an MPH from the University of Arizona, who had also studied epidemiology in evidence-based policy and social epidemiology at the Johns Hopkins Bloomberg School of Public Health, and the other, an emergency room physician.

Representative Barto read her bills. She emphasized that she wasn't against immunizations, just federal and state intrusion into people's privacy and their First Amendment right to act as they saw fit. She briefly commented on those present who were permitted to testify. She announced that each person testifying would have two minutes. First there would be an "educational and objective discussion" about vaccinating children. It was presented by several members of a group who used emails from parents and the contents of various Internet sites to suggest that immunizing children could lead to autism, other serious disorders, and death. This presentation lasted close to two hours.

It was now about 11 AM. Chairwoman Barto told the audience that she knew there were doctors waiting to testify. She promised to allow their testimony shortly, because, she said, she respected their dedication to their patients and their concerns about getting back to the office.

However, several parents of children with autism spoke first, each for their allotted two minutes. Some of them were crying. They recounted how shortly after their children received one or more immunizations, they became autistic or fatally ill. The former radio talk show host, acting as timer, reminded the parents that they were approaching their two minutes. However, he allowed them to continue if they went over.

It was now noon. The physician on the Committee respectfully asked the Chairperson to permit the doctors to speak. There was some discussion among committee members.

At 12:15 PM I was allowed to speak. I was reminded by the timer that I had two minutes. I began by saying that I had several family members who were lawyers and that I was brought up with the highest respect for the law. I told the Committee that I always have a copy of the United States Constitution on my desk, that there are long-accepted limits on the First Amendment and that medical science is unequivocal about the need for immunizations. I briefly mentioned Andrew Wakefield, the former UK doctor and now unlicensed "expert witness" in the U.S. and his debunked paper first published in *The Lancet* in 1998. I said I had compassion for parents of children with severe special needs or of those who had died. In the blink of an eye, the former radio talk show host *cum* timer told me I had 30 seconds left.

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Is Your "Fat Burner" Dietary Supplement Really Fertilizer?

By Ryan C. W. Hall, MD

Note: This is the first article of a new Newsletter feature, "In the News," edited by Dr. Hall. The column will discuss topics reported in the lay news that relate to forensic psychiatry (e.g. illicit substances, interesting court rulings, studies which may impact quality of care).

A recent story appearing in the *Sacramento Bee* newspaper and on the Fox News website describes how a California man received a three-year federal prison sentence for selling diet supplements containing 2,4-dinitrophenol (DNP) on multiple websites. (1, 2) He pled guilty to selling misbranded drugs across state lines. (2) He had made more than $700,000 selling the supplements as a weight loss agent/"fat burner." DNP is not FDA-approved for human consumption and is considered to be a toxic compound. What made this a sensational news story that garnered national attention was that the individual was also selling DNP on the now-defunct website TheFertilizerWarehouse.com. (2) This highlighted DNP's potential legal industrial uses (fertilizer, pesticides, wood preservatives, developer, dyes) and gave rise to headlines such as "Sacramento man gets 3 years for selling toxic fertilizer as diet pill." (1-5)

Although this is a recent case, concerns over DNP date back to the 1930's, when the substance was banned for dietary purposes under the Food, Drug and Cosmetic Act of 1938. (5) At that time, DNP was classified as "extremely dangerous and not fit for human consumption." (5) The compound has had a resurgence in the Internet age, especially among bodybuilders, which resulted in the British Food Standards Agency issuing a public warning about DNP's negative health effects in 2003. (6) In 2016, the FDA, in partnership with Interpol, found 110 websites selling DNP as a weight-loss agent as part of Operation Pangea IX (the ninth International Internet Week of Action, a.k.a. IIWA), which targeted websites that illegally sold dangerous, counterfeit or unapproved prescription medications, supplements, or drugs. (4)

DNP, a synthetic, water-soluble yellow compound found in powder or crystalline form, does have a physiologic effect that results in weight loss. (3, 5) It is often sold as capsules or tablets (100 mg, 200 mg) or purchased in bulk quantities (kilograms) on the Internet. (5) Historically, DNP was one of the first anti-obesity therapies used in the early 1900's. (3, 5) The primary mechanism of action is that DNP interferes with the Krebs cycle. (5) Instead of energy being stored as ATP, it is converted to thermal energy due to uncoupling of oxidative phosphorylation. (5) Since DNP did not cause an increase in nitrogen excretion when medically studied, it was postulated that it resulted in fat being metabolized at a much greater rate than muscle protein. (5) This made it an attractive "fat burner" for individuals who were interested in losing weight while maintaining muscle mass. Many websites specifically target bodybuilders and include instructions on how to use DNP as part of a stacking regimen (staggered and phased use of multiple compounds such as "cutting agents," weight loss agents, and anabolic steroids) and the need to exercise in cool places due to DNP's thermal effects. (5, 7) It was generally estimated that for every 100mg of DNP absorbed there is an 11% increase in metabolic rate. (5)

There have been over 60 case reports documenting mortality associated with DNP. (5) Given the elevated heat production, hyperthermia is the most frequent symptom that leads to mortality (the classic symptom complex associated with DNP toxicity is hyperthermia, tachycardia, diaphoresis and tachypnea). (3, 5) Other adverse effects include hepatotoxicity, cardiac changes, nephrotoxicity, agranulocytosis, cataracts, hearing changes, and dermatologic effects (dermal absorption leads to skin breakdown; oral absorption may lead to rashes of varying degrees). (3, 5) Potential neurologic/psychiatric effects are confusion, agitation, convulsions, coma, and peripheral neuropathies. (5) There is also animal data which shows DNP is potentially carcinogenic and teratogenic. (5) The onset of symptoms in cases of overdose, either accidental or intentional, is 7-8 hours after ingestion. (5) Although DNP is toxic to all individuals, some are much more sensitive to the effects than others, as evident from the wide range for toxicity (1 to 46 mg/kg/day). (3)

Although oxidative uncoupling is thought to be the primary mechanism of action, DNP is postulated to have several secondary effects which also result in weight loss. One of the secondary pathways is that DNP is thought to affect thyroid hormone levels and pituitary regulation. (8) DNP is also thought to stimulate glycolysis, resulting in an increase in pyruvic and lactic acids. (5) The lactic acid effects, as well as hyperthermic effects, may actually be important for forensic psychiatrists to be aware of since these states also frequently contribute to "excited delirium" deaths. (9, 10)

Oftentimes, websites selling DNP look official and will have testimonials about the quality of the product, but it becomes difficult for the uninformed consumer, or even the medical professional, to be able to distinguish what is potentially an appropriate or benign dietary supplement from one which can cause harm. DNP may be listed on the ingredient label or referred to by other names (e.g. Aldifen, Chemox, Dinofan, Dinosan, Dnoc, Nitro Kleenup, Mitcal, Nitophen, Sulfo/Solfo Black and Tertosulphur). (3, 5) Even if not listed on the bottle, there is potential for DNP to be in a supplement. One British study in 2015 looking at bodybuilding supplements bought at stores (of note, DNP is not legal in

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RAPPEPORT FELLOWSHIP AWARDS, 2019-2020

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

The prestigious AAPL Rappeport Fellowship was named in honor of AAPL's founding president, Dr. Jonas Rappeport, MD. It offers the opportunity for outstanding senior residents with a dedicated career interest in forensic psychiatry to receive mentorship by senior forensic psychiatrists. Rappeport Fellows will receive a scholarship to attend the AAPL forensic psychiatry review course and the annual AAPL meeting held October 24-27, 2019, in Baltimore, MD, and a one-year mentorship by two Rappeport Fellowship Committee members. We wish to thank the AAPL Executive Leadership, the Rappeport Fellowship Committee members, and all Rappeport preceptors for their ongoing support of this superb training opportunity! The Rappeport Fellowship Committee and AAPL are excited to announce the 2019-20 Rappeport Fellows: Dr. Lisa Harding, Dr. Nathaniel Morris, Dr. Gowri Ramachandran, Dr. Dustin Stephens, Dr. Natasha Thrower, and Dr. Ashley VanDercar. Congratulations! Please join us in Baltimore and extend a warm welcome our 2019 Rappeport Fellows at AAPL's 50th birthday party!

Lisa Harding, MD

Dr. Lisa Harding currently serves as Chief Resident of Intervention Psychiatric Services at Yale Psychiatric Hospital, utilizing neuroimaging (fMRI, PET), brain stimulation (transcranial magnetic stimulation, electroconvulsive therapy, deep brain stimulation, vagal nerve stimulation), and ketamine. Her first three years of residency were completed at the University of Kansas. While there, Dr. Harding developed a forensic psychiatry lecture series for the psychiatry clerkship and received the Resident Teacher of the Year Award, the Student Voice in Excellence Award for Top Resident Clerkship, and the Outstanding Resident Award in Neurology/Psychiatry. Dr. Harding is an APA Diversity Leadership Fellow and was assigned to APA's Council of Psychiatry and Law. She is also an APA Foundation Ambassador with special interest in bridging faith-based practices and psychiatry. She was awarded a grant to educate community faith leaders on mental illness. She is currently interviewing for a forensic psychiatry fellowship position. Her Rappeport mentors are Dr. Susan Hatters Friedman and Dr. Joseph Penn.

Nathaniel Morris, MD

Dr. Nathaniel Morris is Chief Resident for inpatient psychiatry in the Adult Psychiatry Residency Training Program at the Stanford University School of Medicine. He completed his undergraduate studies at Cornell University and graduated magna cum laude with a degree in biological sciences. He subsequently earned his medical degree from Harvard Medical School. His interests include mental health policy, addiction, criminal justice reform, and medical education. He has authored articles in JAAPL, JAMA, JAMA Internal Medicine, Academic Psychiatry, Psychiatric Services, and Annals of Internal Medicine, among other journals. In addition, he is a frequent contributor to media outlets, including the Washington Post and Scientific American, on topics related to psychiatry. He presented two sessions on writing as a clinician during the 2019 APA meeting. In 2020, he will begin his forensic psychiatry fellowship at the University of California, San Francisco. His Rappeport mentors are Dr. Sara West and Dr. Nathan Kolla.

Gowri Ramachandran, MD

Dr. Gowri Ramachandran is Chief Resident for inpatient psychiatry services at The George Washington (GW) University Hospital. She conducted genomic variation research on differences in enamel thickness between primate species at Duke University before attending medical school at the University of Toledo. Since completion of a forensic psychiatry elective at GW, she has spearheaded a wide array of research projects, from exploring variables that may contribute to the onset of violent behaviors/tendencies, to assessing nutrition and health metrics in long-term forensic hospitalizations, discussing physician responsibility in matters of gun safety, and understanding obstacles to regulating synthetic substance use, and has presented her findings at AAPL and APA annual meetings. She is concurrently pursuing her MBA with a focus on healthcare through the George Washington University School of Business. In 2020, she will start her forensic psychiatry fellowship at the University of California, Davis. Her Rappeport mentors are Dr. Renée Sorrentino and Dr. Alan Newman.

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RAPPEPORT FELLOWSHIP AWARDS, 2019-2020

Dustin Stephens, MD, PhD

Dr. Dustin Stephens is a PGY-4 resident at Harbor-UCLA Medical Center. He has worked closely with the Office of Diversion and Reentry and past Rappeport Fellow Dr. Kristen Ochoa, providing mental health diversion and adjudicative competency evaluations. He graduated with Alpha Omega Alpha honors and an Outstanding Achievement in Medical Research Award from the University of Kentucky College of Medicine and completed a PhD in behavioral science and epidemiology focused on high-risk behaviors among people who inject drugs. This research helped to shape public health interventions for opiate, heroin, and fentanyl abuse/overdose in rural Appalachia. He was awarded an NIH/NIDA T32 research training grant, followed by a postdoctoral research year at Eastern State Hospital in Lexington, KY. He has numerous publications, including several papers on mental health diversion in press or under review. He desires to conduct policy-directed research focused on optimizing community-based diversion and reentry programs, threat assessment, homelessness/access to care, and ethics. In 2020, he will begin his forensic psychiatry fellowship at UCLA. His Rappeport mentors are Dr. Catherine Lewis and Dr. Ryan Wagoner.

Natasha Thrower, MD

Dr. Natasha Thrower is a Chief Fellow in Child and Adolescent Psychiatry at Baylor College of Medicine in Houston, Texas. She earned a BS in Integrative Biology from the University of California, Berkeley before graduating medical school from University of California, Davis. She completed her psychiatry residency at the Harvard Longwood Program in Boston where she served as Chief Resident of inpatient psychiatry at Brigham & Women's Faulkner Hospital. Dr. Thrower gained experience providing expert testimony in mock trials through her participation in trial advocacy workshops at Harvard Law School. She co-authored articles on suicide risk assessment and management, and pitfalls for physicians dating online, and presented on problematic online activities in adolescents and human sex trafficking at our 2016 AAPL meeting. She completed training for physicians to conduct human rights forensic evaluations and plans to volunteer at Baylor's Human Rights and Asylum Clinic, opening this summer. In 2020, she will begin her forensic psychiatry fellowship at The University of California, Davis. Her Rappeport mentors are Dr. Joseph Penn and Dr. Jackie Landess.

Ashley VanDercar, JD, MD

Dr. Ashley VanDercar is chief resident, in her fourth year of adult psychiatry training, at University Hospitals / Case Western Reserve University. She was born and raised in Florida, receiving bachelor's degrees in philosophy and biology from the University of South Florida and her law degree from Florida International University. After law school, she worked for several years as in-house counsel and risk manager for a pain management facility in Tampa, then in 2012 went to medical school at the University of Miami. During residency, she has co-authored two legal digest articles in JAAPL and an article on the insanity defense in Psychiatric Annals. She serves on AAPL's Addiction and Judicial Action committees – and chaired the Judicial Action committee's 2018 panel: "Recent Cases and Why They Matter." She has given several forensic psychiatry presentations at APA meetings. She is also a Cotswold-Looney Fellow for the Group for the Advancement of Psychiatry (GAP). In 2020, she will start her forensic psychiatry fellowship at Case Western Reserve University. Her Rappeport mentors are Dr. Britta Ostermeyer and Dr. Ryan Hall.

AAPL is pleased to announce the 33rd Annual Rappeport Fellowship competition. Registration to the Forensic Review Course and 2020 Annual Meeting along with travel, lodging, and educational expenses are provided to the winners. Contact the AAPL Executive Office for details.

Seymour Pollack, MD: A Teacher without Comparison

Kaushal "Kal" Sharma, MD

In this 50th anniversary year for the American Academy of Psychiatry and Law, it is worth paying tribute to an early maverick in the field of forensic psychiatry. I first met Seymour (he wanted his forensic fellows to address him by his first name) in May 1977. I arrived from Detroit to be interviewed for a fellowship position at the University of Southern California's Institute of Psychiatry, Law and Behavioral Sciences. I was an hour late for the interview, having been lost in the Los Angeles freeway system. This was in the early afternoon, and to my surprise Seymour had not yet arrived. He frequently worked until midnight, and thus it was not uncommon for him to start his day late.

During the interview, which lasted about three hours and caused me to miss my flight back to Detroit, he did most of the talking and asked me only two questions. First, why did I want to be a forensic psychiatrist? He tried to convince me of the moral dilemma of being a physician and the "do no harm" oath, given that I would be testifying against the best interest of the "patient." It was only later that I realized that he wanted me to think about such issues on a deep level.

The second question he asked me was, "What is a FACT?" No matter what I said, he disagreed with me. Once again it took me a while to realize this was his style. At the end of the interview he offered me a one-year fellowship position and being a masochist, I accepted. At the end of that year he asked me if I wanted to stay for another year as a senior fellow. This offer and acceptance were repeated four times, and I ended up doing a five-year fellowship. Near the end of fifth year he passed away from complications of heart surgery; depriving me of a sixth year of fellowship and his tutelage.

Dr. Pollack's style of teaching taught me that every forensic opinion had at least two sides and that I should be able to convincingly prove why my opinion was well-supported by reason, logic and facts. He believed a forensic psychiatrist should be "TLC:" he should be a Tactician, a Logician and a Clinician. He believed every report should include a counter-argument to the examiner's opinion. He wanted his fellows to be "an investigator" and contact relevant peripheral sources and witnesses. Sometimes we spent more time talking to witnesses than interviewing defendants.

Perhaps the most important takeaway from his teaching was to learn concepts which can be applied to other cases. Everything I learned about forensic psychiatry, I learned from him and I know less than half of what he knew.

Dr. Pollack also wrote more than his share of scientific papers, gave numerous lectures around the world, was the third President of AAPL, was a founding member of the original Board of Forensic Psychiatry, and worked on numerous cases that attracted media attention (Sirhan Sirhan, Patty Hearst, and Charles Manson, to name a few).

Attending numerous conventions as well as AAPL and American Academy of Forensic Sciences meetings, it became apparent to me that Seymour was a giant in the field of forensic psychiatry. His ability to argue sometimes scared professionals who were perhaps less prepared. In over 40 years of forensic practice, I have met many incredible forensic experts, but he was truly a colossus. It is fitting that in 2019, a milestone year for AAPL, we pay tribute to Dr. Seymour Pollack, who almost 60 years ago started the forensic fellowship at USC, one of the oldest and most established fellowships in the country. We cherish him and his teachings by passing knowledge to the next generation of colleagues.

Established in 1986 the Seymour J. Pollack Distinguished Achievement Award recognizes psychiatrists who have made notable contributions to the teaching and educational functions of forensic psychiatry. The American Academy of Psychiatry and the Law has awarded the following individuals with this exceptional honor.

1986	Zigmond M. Lebensohn, MD
1987	Ephraim R. Gomberg, MD
1988	Gene L. Usdin, MD
1989	Andrew S. Watson, MD
1991	Phillip J. Resnick, MD
1992	Martin D. Orne, MD, PhD
1993	J. Richard Ciccone, MD
1994	Robert Simon, MD
1995	Thomas Gutheil, MD
1996	Richard Rosner, MD
1997	not given
1998	Alan Stone, MD
1999	Elissa Benedek, MD
2000	Howard Zonana, MD
2001	Paul S. Appelbaum, MD
2002	Joseph D. Bloom, MD
2003	Jeffrey L. Metzner, MD
2004	Carl P. Malmquist, MD
2005	Ezra E.H. Griffith, MD
2006	Renée L. Binder, MD
2007	John M.W. Bradford, MB, ChB
2008	Jonas Rappeport, MD
2009	Henry Weinstein, MD
2010	Park Dietz, MD
2011	Liza Gold, MD
2012	Larry Faulkner, MD
2013	Robert Weinstock, MD
2014	Sally C. Johnson, MD
2015	William H. Reid, MD, MPH
2016	Richard L. Frierson, MD
2017	Alan Felthous, MD
2018	Debra Pinals, MD
2019	Ray Patterson, MD

Game of Thrones and The Origins of AAPL at the APA

Karen B. Rosenbaum, MD

The series finale of the acclaimed HBO series *Game of Thrones*, based on the series of novels by George R.R. Martin, coincided with the 175th APA meeting in San Francisco this past May. *Game of Thrones* and the APA also collided for me personally when I wandered into a *Game of Thrones* exhibit at an AT & T store in San Francisco and was thrilled to get a picture of myself on the Iron Throne. Most of my forensic psychiatry colleagues (with a few exceptions) in the AAPL meetings were generally unimpressed by this uncanny intersection of important events, but at the Cornell-Columbia reception, many of my psychodynamically-oriented colleagues were visibly excited about going back to our respective accommodations to find out who won the game that started in 2011. I wondered if most forensic psychiatrists are perhaps more practical than clinical psychiatrists, are just busier, or are generally above such concerns as the language of High Valerian (invented by a neolinguist for the show and currently studied by many thousands), swordfighting, dragons, Night Kings, witches, and which hero or antihero will die in the next episode.

Several months ago, I was tasked with finding pictures of past AAPL presidents for the upcoming 50th AAPL anniversary. I was to go into the historical archives at Weill-Cornell. Unfortunately, AAPL's beginnings took place before the digital age, and there were no pictures in past newsletters. I did, however, find some interesting quotations from past presidents, starting with the first president, Dr. Jonas Rappeport. In the very first newsletter, Volume 1, Number 1 he wrote:

> *"What—another organization!! Is it really necessary to have another meeting, to pay dues to another society and to receive more 'stuff" from yet another group?? Prior to the APA Annual Meeting of 1968 (Boston), I invited all of the Directors of Forensic Psychiatry Fellowship Training Programs and several others involved in teaching Forensic Psychiatry to a pre-convention meeting. My goal was to exchange ideas about our individual programs and increase our knowledge of each others' work…Toward the end of the meeting it became clear that the group did not want to let this type of 'get together' terminate (that happened before). It was a clear call to organize and continue our relationship. 'Oh my! I thought—another organization!! Like a good therapist I told myself; sit back, shut up, listen, and wait.'"* (1)

AAPL was born at the following APA meeting in Miami in 1969 with the help of the APA Committee on Psychiatry and the Law and several other forensic psychiatrists including Joe Satten, Sy Halleck, Bob Sadoff, and Herb Thomas. The first AAPL meeting was set for November 14, 1969 at the Friendship International Hotel in Baltimore, MD, which is why we have the AAPL meeting in Baltimore every ten years.

Dr. Rappeport, founder of AAPL, identified himself as a therapist. As a therapist, I finally gave in to finding out what *Game of Thrones* was all about, because patient after patient wanted to discuss it with me. I tend to have more practical tastes in entertainment, preferring realistic dramas (such as Showtime's *The Affair*, a series I presented on at this past APA along with Dr. Susan Hatters Friedman and Dr. Fernando Espi (2)) and memoirs, over fantasy and sci-fi (with the exception of *Star Wars* of course). However, once I started watching the show in April, I did not stop until I was caught up three weeks later.

In their article "Psychoanalyzing 'Game of Thrones'," Valasquez et al. (3) explain how the characters "personify the 10 personality disorders identified in the Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5)." They use characters such as Arya Stark and Bran Stark to explain the various personality disorders.

While I agree that there is merit to their analysis, I believe that the characters in *Game of Thrones* do not need to be pathologized, and exhibit the range of normal human characteristics including ambition, greed, jealousy, rage, gluttony, revenge, and other more complex emotions.

The characters are flawed but complicated. Some surprise the audience with dramatic spiritual growth, and others remain true to their nature throughout the series. It is the complexity of the characterization and the interplay of their personalities that I found to be most compelling, and the backdrop of 'political fantasy' seemed natural, dragons and all.

As a forensic psychiatrist, the themes that most interested me included mass murder, patricide, revenge fantasies, incest, genetic predisposition to mental illness, mercy, and honor. I strongly believe that pop culture can be helpful in thinking about the human condition in new and interesting ways. Although I did not know him personally, I wonder if Dr. Rappeport would agree.

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Legislative Update

Tobias Wasse,r MD and Christopher R. Thompson, MD,
Government Affairs Committee

The AAPL Government Affairs Committee (GAC) was established in 2017 as a new AAPL committee as part of Immediate Past President Christopher "Kip" Thompson's strategic initiative to expand the visibility and national impact of AAPL's educational mission. One component of this work was for AAPL to partner in 2018 with the Consortium for Forensic Science Organizations (CFSO), an association with representation from: the American Academy of Forensic Sciences, the American Society of Crime Lab Directors, the International Association for Identification, the National Association of Medical Examiners, and the Society of Forensic Toxicologists - American Board of Forensic Toxicology. AAPL is now the sixth member of the CFSO and is working with CFSO's legislative analyst Beth Lavach to track legislation relevant to our organization's mission.

In the committee's second year, we were quite active in tracking and contributing to the development of several pieces of legislation at both a state and federal level. Through AAPL's work with the CFSO, we have contributed to several relevant federal legislative initiatives. Below is a sample of legislation being monitored and actively contributed to by the GAC:

1) The First Step Act
   Signed into law by President Trump in December 2018, the Act reforms the federal prison system in order to reduce recidivism. Among its many provisions, it retroactively applies the Fair Sentencing Act, restricts the use of restraints on pregnant women, expands compassionate release for the terminally ill, mandates de-escalation training for correctional officers and employees and improves feminine hygiene in federal prisons. The Department of Justice has recently started to assemble work groups to begin to carry out various provisions of the Act, and forensic psychiatrists are being sought to help identify clinical and correctional evidence-based risk assessment tools.

2) Threat Assessment, Prevention, and Safety (TAPS) Act (H.R. 6664)
   Introduced by Congressman Brian Babin of Texas in August 2018, the TAPS Act seeks to create a task force of subject matter experts who will assist in creating a national strategy to prevent targeted violence through threat assessment and management. The goal is for the national strategy to provide resources, training, and assistance in establishing and operating locally-driven, multidisciplinary threat assessment and management units as well as a specialized school threat assessment program. The GAC gave feedback and recommendations to the Congressman's legislative aides about increasing mental health representation in the act's recommendations and about modeling its recommendations on similar, successful programs in certain states (e.g. the Los Angeles County Department of Mental Health's School Threat Assessment and Response Team (START) program).

3) Juvenile Justice Reform Act (signed into law December 2018)
   This legislation is designed to accomplish the following goals relevant to juvenile correctional psychiatry, a field in which a number of AAPL members practice:
   - Support a continuum of evidence-based or promising programs (including delinquency prevention, intervention, mental health, behavioral health and substance abuse treatment, family services, and services for children exposed to violence) that are trauma informed, reflect the science of adolescent development, and are designed to meet the needs of at-risk youth and youth who come into contact with the justice system.
   - Develop a long-term plan to improve the juvenile justice system in the United States by examining current scientific knowledge regarding adolescent development and behavior, and the effects of delinquency prevention programs and juvenile justice interventions on adolescents, with the goal of then implementing those with proven success.

4) Opioid Crisis Response Act of 2018
   This is multi-layered federal legislation that authorizes uses of funding from grants from the 21st Century Cures Act. The goals of this legislation related to correctional and forensic psychiatry are to:
   - ease physician restrictions for medication-assisted treatment medication-assisted treatment (MAT) of substance use disorders
   - integrate and make more interoperable state prescription drug monitoring programs and data sharing practices among states
   - standardize and facilitate telemedicine prescribing of controlled substances

5) Violence Against Women (VAWA) Reauthorization of 2019

Passed by the US House in April 2019, this Act has several provisions relevant to forensic psychiatry. They

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Multiple Loyalties: Forensic Psychiatry at the Border

Pamela McPherson, MD
Human Rights and National Security Committee

As I write this column, the United States Department of Health and Human Services has announced that a former internment camp for Japanese-Americans in Oklahoma will be used to detain unaccompanied children apprehended at the border. (1) This follows a letter to Congress from the Secretaries of the Departments of Health and Human Services and Homeland Security noting that funds cannot be used for "unaccompanied minors' activities that are not directly necessary for the protection of life and property, including education services and recreation". (Ref. 2, p. 2) Like mental health and medical care, these are mandatory detention services for youth, which are critical for healthy development. Even before fundamental services for children were threatened, the detention of migrant children and families was widely condemned by professional medical organizations. The American Psychiatric Association (APA) immediately opposed family separation and has voiced opposition to proposed changes to the *Flores* settlement which would allow unlimited family detention. (3,4) Our professional organizations have acted on the ethical principles of beneficence, justice, and non-maleficence to advocate for necessary health care services and prevent harm.

Last spring, many felt called to action during family separation and the call to restrict *Flores*; many physicians spoke out and joined protests. Some contributed by conducting evaluations for asylum hearings, documenting immigrants' narratives, speaking publicly, or conducting research. A few provided direct care to families. I became a whistleblower. I and my colleague, Dr. Scott Allen, wrote to Congress. Our experience as subject matter experts for the Department of Homeland Security Family Residential Centers informed our decision to notify Congress of the ongoing and future threat to children posed by the proposed expansion of family detention. Ethical principles and our medical and psychiatric knowledge contributed to our decision but could not direct our actions.

Whistleblowing is not taught in medical school or residency. The guidance of attorneys at the Government Accountability Project ensured that our actions conformed to whistleblower protections. It was gratifying that over a dozen professional organizations immediately supported our disclosures and the ethical obligation of professionals to advocate for human rights. We were buoyed by over 800 letters sent to the Physicians for Human Rights in support of our action. The constant support of colleagues and family remains invaluable.

Forensic psychiatrists are well aware of the ethical and human rights challenges of providing adequate services in detention facilities and the issue of dual loyalty. For me, contractual obligations to the DHS and our professional ethical obligation to support health and human dignity were conflicting loyalties.

One surprise on becoming a whistleblower was experiencing multiple loyalties. As I considered how my actions or inaction would impact others, whistleblowing raised questions of competing loyalties to detainees and government employers, colleagues and patients at my regular jobs, and my family. Because I am a subcontractor, I had loyalty to the DHS contractor and other professionals working as DHS mental health subject matter experts. I considered my mentors and relationships at local courts. These loyalties were and will be considered at multiple decision points. Fortunately, legal representation from the Government Accountability Project continues, and the support from professional colleagues, friends, family, and the public has been tremendous.

As physicians and parents, Dr. Allen and I shared the country's outrage over family separation but as subject matter experts for the Department of Homeland Security we acted on our ethical responsibility to inform government officials of the risks posed by the detention of children.

For those who may consider whistleblowing, go slowly. Analyze your reasons for action. Consider whether there are alternative solutions. Make peace with your decision. Make a list of your loyalties. Seek counsel, and reevaluate your decision. Breathe. With the guidance of counsel, talk to family, mentors, and colleagues. Decide if you want to make one statement, or if you want to make a difference.

Go slowly. You will learn law not covered in landmark cases: the Whistleblower Protection Act. You will ride the waves of the news cycles. You will question your decision. Others will question your actions. Go slowly. You may not see the hoped-for change that prompted your whistleblowing, or you may save lives or inspire others. As you tread unfamiliar ground, take the time to be at peace with each step. Go slowly. Breathe.

A year after the horrors of family separation shocked the nation, many children are still separated from their parents. Physicians have a role to play when health is threatened. Medical ethics calls for physicians to promote care that supports health and human dignity. Many physicians have heard this call and advocate for the human rights of immigrating families. As you acknowledge the actions taken by colleagues, know that your kindness fuels their courage. You may be inspired to action through the Human Rights Committee of AAPL, the APA, the Physicians for Human Rights Asylum Network, or other organizations. You may use your voice and medical knowledge to call out the risks that threaten mental and physical health. Heeding the call of medical ethics may not be easy, but know that your

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Perspectives on Trainee Involvement in AAPL

Selena Magalotti, MD and Cathleen Cerny-Suelzer, MD
Forensic Training of General Psychiatry Residents Committee

Perspectives of a Trainee, for Trainees – Selena Magalotti, MD

During the 2019 AAPL semi-annual committee meetings, a few of us attendees discussed the importance of recruiting residents and fellows to AAPL committees, both to bring fresh perspectives and to stimulate interest in forensic psychiatry. However, as a trainee myself, I know firsthand that getting involved with a national organization may initially feel overwhelming, and could be a barrier to trainees joining. To that end, my purpose in writing this piece is to share my fantastic experiences with AAPL in the hopes it will help motivate trainees to get involved. I also hope to encourage forensic psychiatrists to think about recruiting trainees to work on their AAPL posters, presentations, and committees. Participation in AAPL has been one of the strongest influences on my training career and was a major reason I ultimately decided to pursue forensic psychiatry fellowship.

My first experience with AAPL was at the 2017 Annual Meeting in Denver. I was bright-eyed and excited about forensics. I knew just a few people attending the meeting, but I did not know any of them well. I had been to conferences by myself in the past and although they were enjoyable, I typically felt slightly out of place. I figured my experience at AAPL would be similar. I was wrong. People were warm and welcoming! The meeting was exciting and stimulating! After a week at the AAPL Annual Meeting, I returned home to my child psychiatry fellowship with a new professional identity – I was going to be a forensic child psychiatrist.

Beyond the plethora of great lectures, panels, and workshops, what was so influential about that conference?

1) I attended the Annual Review Course. This is a three-day course that covers the breadth of forensic psychiatry. Though typically attended by forensic fellows in preparation for their certification exams, the Review Course was still very useful as an earlier trainee, as it helped me get acquainted with the field. There is also a mixer for Review Course attendees, which is a great opportunity to meet other trainees and network.
2) One of my forensic mentors suggested I go to some committee meetings on the Wednesday afternoon before the Annual Meeting. Even if not yet a member of a committee, people are welcome to attend and observe any of the Special Committee meetings (please see http://www.aapl.org/committees for a listing of those committees). The committee members were excited to have trainees attend the meetings, and were eager to provide opportunities for trainees to collaborate on projects.
3) The AAPL Annual Meeting is a great size for networking and getting to know people. AAPL fosters this through lots of group activities at no additional cost, such as a mixer for trainees interested in fellowship, regional chapter meetings, and the Women of AAPL reception. There are also daily lunch lectures, for an additional fee. These can facilitate making connections with the attendees at your table while listening to great speakers. All these events are great opportunities to feel a part of a larger community.
4) I felt like I belonged. This was not only because the meeting attendees were welcoming, but also because I finally found people with similar mindsets to me. I was introduced to this whole community that shared my intrinsic awareness and interest in medicolegal topics, risk assessment, the justice system, and how psychiatrists navigate the litigious landscape in which we practice. This was the cherry on top - I was hooked.

To the residents thinking about attending the AAPL Annual Meeting - please come! I encourage trainees to attend the Review Course if able, go to a couple of committee meetings, and meet some new people at the lunch lectures. Apply for the AAPL Rappeport Fellowship in your eligible year.

Fostering ties with forensic mentors and getting involved with AAPL as a resident is very useful regardless of whether you are set on becoming a forensic psychiatrist, on the fence about whether to pursue a forensic fellowship, or just have an interest in learning more about the medicolegal topics that affect all of us as psychiatrists. To my fellow trainees, I hope you feel empowered and excited to get involved and make an impact on our community.

An Attending's Perspective – Cathleen Cerny-Suelzer, MD

Dr. Magalotti's comments above echo my own experiences as a trainee. Although I entered psychiatry training with my sights set already on forensic fellowship, it was my first AAPL chapter meeting that solidified the deal. My PGY-2 self was thrilled to find an organization of friendly, inclusive professionals who shared my fascination with psychiatric aspects of criminal behavior. It was through AAPL that I met career mentors, made life-long friends, and developed a professional identity. My main role for 13 years has been in residency training, but it is AAPL that has engaged my scholarly side and kept me active as writer, presenter, and committee member. As chair of the AAPL Forensic Training of General Psychiatry Residents Committee, it is a real pleasure for me to welcome in-training members like Dr. Magalotti. I do firmly believe that having

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Royal College of Psychiatrists Forensic Faculty Annual Conference Vienna 2019

Dr. Louise Robinson, Dr. Mary Whittle, Dr. John Baird, Dr. Navneet Sidhu, and Esme Beer

The Forensic Faculty of the Royal College of Psychiatrists held their annual meeting this year in Vienna, March 6th through 8th.

Vienna, the capital of Austria, is a city rich in history and culture and nowadays it is a city of elegance and calm, but its history is long and turbulent. As recently as the Second World War, its population suffered considerably as a result of the atrocities of the Nazi regime.

Preliminary to the event, a full day was arranged for about forty delegates at Justizanstalt Göllersdorf, a hospital outside Vienna administered by the prison system for male NGRI offenders. We had a tour and a lively question-and-answer session with Dr. Alexander Dvorak, Senior Psychiatrist.

The theme of the first session of the conference was forensic psychiatry's contribution to public safety and well-being. We learned of the very high risk of suicide during the first few days after a person is charged with offenses related to the viewing of indecent images of children. It is police officers who can make the difference for such offenders, particularly when they employ specific practical measures.

The next speaker continued the theme of suicide and described research which showed that when domestic gas was altered to render it less toxic approximately thirty years ago, the rate of suicide in the population fell significantly. What had clearly happened was that those who would have used domestic gas did not switch to any other method. The same alteration in behavior patterns was observed in relation to the decrease in all homicides in Scotland when police specifically targeted the carrying of knives. Are there implications for the controversial topic of gun control in the US?

Next, we had a presentation on homicide by patients suffering from mental disorders. Among a number of important findings was the observation that two-thirds of the victims of patients who were under the care of mental health services when they committed their homicide, were also patients in the same service. This has implications for risk management planning.

The afternoon started with an address by the President of the Royal College of Psychiatrists, Professor Wendy Burn, who reported on the staffing crisis which continues to affect the whole of medicine in the UK, with too few newly-qualified and young doctors available to fill posts. On a more positive note, the College's, Choose Psychiatry' campaign is already bringing dividends in the form of a considerable increase in recruits to core psychiatric training - now all we have to do is retain them! See https://www.youtube.com/user/RCofPsychiatrists for more information about this recruitment campaign.

Another highlight from the afternoon was the contribution experienced forensic psychiatrists can make to wider problems of public safety. The overall theme was freedom from torture, the investigation of abuses of power, and the exploitation of vulnerable individuals. A succession of speakers described the various arrangements in which they were involved. We learned of the European Committee for the Prevention of Torture, which is organized by the Council of Europe. None of the speakers dealt with North America, but perhaps a similar session devoted to the arrangements which exist in North America would be of interest to delegates at a future AAPL meeting.

The second day of the conference began with a number of other items of international interest. An informative session discussed illegal drug use, the range of substances known as "novel psychoactive substances," and responses to the problem of self-harm among female prisoners.

The last session of the day described the impact of cultural factors within the New Zealand prison system and secure mental health system, including the substantially higher rate of imprisonment among Maori or Pacific Islanders. This is another topic which could be of interest at a future AAPL meeting.

Among other highlights was a session where five medical students from different medical schools across the United Kingdom presented short papers based on their area of study. Attendees were hugely impressed with all five presentations. Have medical students been actively involved in AAPL meetings?

The afternoon finished with a session on the assessment and risk management of violent extremists.

The five medical student finalists with the Chair of the Forensic Faculty, Professor Pamela Taylor and the competition organizer Dr Aideen O'Halloran. Left to right they are Professor Taylor, Andrew Taylor, William Perchard, Dr O'Halloran, Lavin Assad, Esme Beer and Lucia Almazan Sanchez

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Prenatal Alcohol Exposure (PAE) in Forensic Patients: Why Does It Matter? Part II

Mansfield Mela, MBBS
Developmental Disability Committee

In the first part of this two-part discussion on why neurobehavioral disorder (ND) associated with PAE matters to forensic specialists, I discussed the relationship PAE has with the traditional assumptions of the criminal justice system (CJS). PAE in patients was noted to be overrepresented in the contact points of the CJS. PAE's neurocognitive deficits influenced the legal nexus (1). This article focuses on the forensic psychiatrist's role and skills in the treatment, rehabilitation and disposition of individuals with ND-PAE/fetal alcohol spectrum disorders (FASD). Multiple forensic professionals are expected to intervene in managing the neurocognitive manifestations of PAE, which requires advanced knowledge of biopsychosocial approaches, as well as a deeper understanding of the unique mental, medical and neurocognitive consequences of PAE.

Appropriate and supportive intervention by the forensic psychiatrist begin with the recognition of the telltale signs of neurocognitive deficits such as failing to follow simple instructions, behaviors suggestive of noncompliance, irrational risk-taking behaviors and repeated past failures and actions related to unawareness and defective cause-and-effect reasoning. Intervention should then be informed by the results of a comprehensive assessment, which links identified neurocognitive deficits with the patient's strengths and ensures that those around the patient (caregivers, family, and members of the treatment team) all understand and support the patient. The professional who seeks to positively impact the patient should build a strong therapeutic alliance, adopt realistic and objective expectations, and align interventions with the specific deficits identified.

In addition to the requisite social and behavioral interventions of ND-PAE/FASD, context specific supervision, structure, support and team cohesion are important treatment variables that seek to inform specific interventions. Experts should strive to facilitate the individual patient's resilience, instill hope and strengthen the patient's willingness to change (2). Residential stability, addressing trauma – frequently associated with the patient's past – and protecting the patient from toxic and exploitative relationships are essential factors that support the positive trajectory of care, as reported in conduct-disordered youth with FASD (3). Strategies that combine and channel the patient's artistic, athletic, helpful, caring, generous and friendly attributes also improved forensic outcomes (4).

Before treatment with medications, most forensic psychiatrists ensure that other treatments found to be effective have been adequately tried in their patients. First, they train multidisciplinary team members, and adopt respectful and kind attitudes towards the patient. In ND-PAE/FASD, addressing the patient by name using first-person language, being alert to nonverbal cues and always stressing something positive about the patient strengthen the relationship (5). Group participation is often not ideal but if groups occur, the facilitator should follow up with the patient with ND-PAE/FASD to reinforce lessons on a one-on-one basis.

The "handle of the law" can be extended for therapeutic purposes. Diversion is the preferred option for those with ND-PAE/FASD in the CJS, in whom severe cognitive deficits make a custodial sentence harmful or inappropriate. Although the threshold for the legal tests may not be reached, fitness to stand trial and criminal responsibility assessments provide an opportunity to develop a potentially successful and comprehensive plan, if based on estimated deficits. Similarly, the offender at the end of a sentence, comprehensively assessed, and linked with services in the community, is an example of using the law to support treatment approaches.

Modification of communication with patients will take the form of limiting distractions, conveying only one idea at a time, using visual aids (diagram, lists, demonstration and pictures) to support learning and retention. Questions should be asked in a non-leading manner. Instructions should be written down and read by the patient. Information should be presented repeatedly and in simplified and concrete ways to the patient, who should then be requested to summarize, in their own words, what was communicated (6).

The targets for psychotropic medication use are based on dysfunction of monoamine systems (dopaminergic, serotonergic, and noradrenergic) in ND-PAE/FASD. Virtually all classes of psychotropic medications have been prescribed for patients with ND-PAE/FASD, with varying and at times atypical responses (7). Prescriptions are off-label and the rationale for use should be explained to the patient and/or the responsible decision-maker (e.g. conservator, guardian) and contemporaneously documented. To enhance medication effectiveness, clusters of symptoms separate from the diagnostic criteria form a unit of response specific to pathogenesis. Pharmacological treatment of antisocial personality disorder is directed at clusters: cognitive/perceptual organization (dopamine), impulsivity/ aggression (serotonin), affective instability (noradrenaline) and anxiety/ inhibition (adrenaline). For example, antipsychotics can reduce the high novelty-seeking associated with dopamine sensitivity (8).

Studies in ND-PAE/FASD showed high rates of stimulants, antipsychotics, antidepressants, mood stabilizers and anxiolytics prescribed, in that order. The benefits of these medications, combined with psychosocial interventions, are heralded as the future direction for treating neurocognitive

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Moon Rocks: The Caviar of the Cannabis Industry?

Irina Tardif and Ryan C. W. Hall, MD
Psychopharmacology Committee

Even though FDA Commissioner Scott Gottlieb, MD said "Controlled clinical trials testing the safety and efficacy of a drug, along with careful review through the FDA's drug approval process, is the most appropriate way to bring marijuana-derived treatments to patients," (1) most individuals using marijuana or marijuana derivatives are using products or formulations which are not FDA approved. Although there are four oral FDA-approved marijuana-derived or synthetically-derived cannabinoid medications (Marinol, Syndros, Cesamet, Epidiolex) (2), hundreds of different cannabis strains with various processing techniques and pathways of absorption are currently available. An example of such a combination is the product which goes by the slang term "Moon Rocks," given its shape, bumpy irregular dusty/crystal texture, and potent effects ("sends you to the moon"). Urban Dictionary defines moon rocks as:

> "[T]he strongest form of cannabis on the market. It's a nugget of marijuana bud dipped in hash oil and kief. Final product carries approximately a 50% THC rating." (3)

Moon rocks are also known as "Cannabis Caviar" due to their high potency, complexity and various "flavors" based on the components. (4-6) A gram of moon rocks costs between $20 - $35 and is usually more expensive than other marijuana products. (4, 5, 7) Based on the primary strain used, moon rocks have been advertised to have "medical benefits," such as treating anxiety, chronic pain, muscle spasms, and insomnia, even though marijuana and its derivatives have not been FDA-approved for these conditions. (5, 6, 8)

Moon rocks are made by submerging a whole bud in hash oil, followed by rolling the product in kief and leaving it to dry. (4-6, 9) Traditionally, high-content THC strands of marijuana are the basis for the nugget (dried chunk of the marijuana flower) or "nug." (10)

Another component of moon rocks is the hash oil [AKA dab, wax, budder, honey oil, butane hash oil (BHO) or cannabis oil]. (11, 12) This product can be made via different extraction processes such as CO_2, ice water, or, most commonly, liquid solvents that precipitate out the resin. (13, 14) Due to the flammable and toxic nature of many of the solvents involved in making hash oil, the processing can be dangerous. For example, the BHO extraction process uses highly volatile butane which can result in flammable vapor during the resin processing. There have been several BHO-related processing injuries and fatalities from explosions in numerous states. (14)

Kief is a crystal-like substance that forms in the resin glands that make up the hair-like strands present in the flowers and leaves of the female part of the plant. (6, 15) Kief contains terpenes (compounds which affect smell and flavor) and cannabinoids like THC and cannabidiol CBD. (15) There are several devices used to separate kief from plant matter, with the simplest one being a three-chamber herb grinder that lets kief crystals fall through a screen for collection. (15)

Moon rocks can be smoked; usually glass pieces or pipes are used due to the kief and oil making it harder to keep paper delivery forms lit. (5, 6, 9) Kief, oil and bud can also be added to an edible product, either as broken-up rocks or as individual ingredients. (4)

The use of high-potency cannabis products increases the risk of health and behavioral complications. For example, one study links increased use of hash oil with higher levels of physical dependence, impaired emotional control, cannabis-related academic/occupational problems, poor self-care, and cannabis-related risky behavior. (16) Epidemiologic studies demonstrate that cannabis use can increase the risk of psychotic disorders. (17) Another study indicates that users of high-potency cannabis are three times as likely to have a psychotic episode as people who never use cannabis, and the risk is fivefold in people who smoke high-potency marijuana every day. (18) In a reanalysis of the MacArthur Violence Risk Assessment Study, "persistency of cannabis use" after an acute psychiatric admission was associated with an increased risk of violence. (19)

Discovering during a forensic interview that an individual uses moon rocks can lead to deeper questioning to better understand an individual's usage pattern, experience level with intoxicants, and level of investment in a substance use culture (e.g. degree of paraphernalia owned and used).

It may also be relevant to determining the likelihood of a psychotic episode being substance-related and for violence risk management implications. For those who manufacture moon rocks, questions related to the dangers of the extraction technique (e.g. how solvents are obtained and treated) and steps taken to avoid harm or detection may show levels of intent and understanding of engaging in illicit behavior.

As discussed above, moon rocks are more than ordinary smoked marijuana, and the effects are far from being known and studied in the manner that Commissioner Gottlieb advocates. This is a product that "connoisseurs," not novice or infrequent users, would likely know about or use. Therefore, it is understandable why some consider moon rocks to be the "caviar" of the marijuana trade. For forensic examiners, understanding the significance of this reputation can lead to new avenues of exploration or understanding in a forensic interview.

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Physician Stress/Physician Well-being

Sutapa Dube, MD and Andrew P. Levin, MD
Trauma and Stress Committee

Although physician well-being has become the focus of intense interest in recent years, this area has been studied intermittently over the last 90 years. Studies from the 1920s indicated that doctors suffered from high suicide rates. (1) Current statistics indicate that an estimated 300-400 physicians commit suicide each year, (2) the equivalent of 1-2 medical schools classes annually. A subsequent study found that one in sixteen surgeons reported experiencing suicidal ideation. (3) This number does not take into account physicians who leave their practice due to work stress or burnout, nor those who are sanctioned for using substances to cope with work-related stressors. Suicide is the leading cause of death among male residents and second only to cancer in female trainees. (4) This article will provide a general overview of the factors that contribute to physician dissatisfaction, secondary trauma in psychiatrists, reasons why physicians do not seek out care/help, and programs that address physician health and satisfaction.

According to Shanafelt and Noseworthy (5), upwards of 50% of physicians experience professional burnout. They identified seven factors that contribute to physician burnout, including: workload, efficiency, flexibility/control over work, work-life integration, alignment of individual and organizational values, social support/community at work, and meaning derived from work. With regard to psychiatrists, Boscarino et al. (6) noted that we are at higher risk for secondary or vicarious trauma. Vicarious trauma is defined as "symptoms of apathy, exhaustion, irritability, cynicism, and disillusionment which can alter cognitive schemas of safety, trust, power, and intimacy." (7) Psychiatrists, as well as other mental health workers, work closely with traumatized patients but rarely have a regular process to manage their experience of vicarious trauma. Vicarious traumatization is additive resulting in lasting effects on the psychiatrists' mental health and physical wellbeing, such as disturbed sleep, low mood, worsening physical health, anxiety, etc. (6) Although there is no systematic research on forensic psychiatrists, one prominent forensic psychiatrist has publicly discussed his personal struggle with PTSD resulting from forensic work. Dr. John Bradford, an expert on sex offenders, stated "I knew there was something wrong but there was a lot of denial on my part… if you're a psychiatrist and a tough forensic guy you think you can blow anything off, right? And that's what I did." (8)

"Vicarious trauma is defined as 'symptoms of apathy, exhaustion, irritability, cynicism, and disillusionment...'"

Although stigma has inhibited physicians from acknowledging and addressing their personal struggles, several have come forward publicly to highlight these issues. An outspoken advocate for physicians with mental illness, Dr. Adam Hill, discussed his own mental health crisis, including suicidal ideation and alcohol abuse, in an essay in the *New England Journal of Medicine*, writing "I want to normalize this conversation… I was no longer ashamed. I have this story too… I've recovered from that." (9) Beyond stigma, physicians also fear that acknowledging a mental health disorder could have a negative impact on their careers. In discussing her bout with depression, Rahael Gupta, a medical student at University of Michigan School of Medicine, noted, "I spoke with a surgeon who is absolutely wonderful… But he told me: 'As someone who values wellness I think what you're doing is great, but I have to be honest — if a student on their residency application said they were depressed, I would think twice about giving them an interview'." (1) As of 2013, 43 states ask questions regarding mental health in their medical license applications. (1) However, change is slowly taking place, as highlighted by the example of North Carolina, where questions regarding mental health on the medical license renewal application have been replaced by a statement urging doctors to obtain treatment for conditions affecting patient care. (1)

Medical schools are developing programs specifically targeting mental health issues in students and trainees. The Boonshoft School of Medicine at Wright State utilizes a psychiatric practitioner to aid medical trainees in real time. The provider's cell phone number is given to faculty and trainees, so they can self-refer or anonymously refer a colleague directly. Additionally, these services are provided confidentially, without use of the patient's health benefits, and in this way destigmatizes the care that is being provided. The University of California at San Diego (UCSD) School of Medicine's Healer Education, Assessment and Referral (HEAR) program also focuses on destigmatizing mental health care for physicians. Through the HEAR program, trainees and faculty can access an anonymous web-based "stress" questionnaire to assess their symptoms and self-refer to dedicated mental health providers. Based on the success of the UCSD program, a similar program has been piloted at University of California, Davis as well. Other schools use curricula, such as the Healer's Art, to focus on the human aspects of being a physician and encouraging self-care. (11)

Beyond medical school interventions, web-based resources are also being used to address physician burn-

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Sexsomnias: Forensic Considerations

Renée Sorrentino, MD; Brian Holoyda, MD, MPH, MBA;
Susan Hatters Friedman, MD
Sexual Offenders Committee

At the APA's Annual Meeting in San Francisco, members of the Sexual Offenders Committee joined other colleagues to present about sexsomnia. Attendees included Dr. Colin Shapiro, the psychiatrist who first coined the term in 2003. Dr. Tony Fernando, a sleep specialist and psychiatrist from the University of Auckland, described the types of sleep disorders, including insomnias, excessive sleep, and parasomnias. The American Academy of Sleep Medicine defines parasomnias as physical acts that are undesirable and occur while one is asleep, falling asleep, or during arousal from sleep. Sleep talking, sleep walking, and sexual behavior during sleep are considered disorders of arousal, occurring in the early, non-REM portion of sleep. The lifetime prevalence of sexual acts during sleep is 7%, with a lower prevalence of 2.7% in the past 3 months (1). The most common sexual behavior during sleep is attempted sexual intercourse and the second most frequent is fondling. Other acts such as masturbation, sleep orgasms, and sexual vocalizations occur (2, 3). Sleep studies may be helpful in making the diagnosis. Collateral history from the partner or family is helpful, as well as family history. Triggers include stress, fatigue, substance use, and overactivity (4). Treatments include sleep hygiene, safety measures (avoidance of co-sleeping), addressing the triggers, and potentially pharmacotherapy or CPAP.

Sexsomnia has arisen in the courtroom in the context of sexual offense allegations. Defendants accused of sexual offenses have offered a history of sexsomnia to explain their behavior. Depending on the jurisdiction, sexsomnia may play a role in the affirmative defenses of automatism or not guilty by reason of insanity (5). In theory, a defendant may also present evidence of parasomnic sexual behavior to present evidence of diminished capacity for a sexual offense, depending on the requisite *mens rea* for a given charge. Reviews of sexsomnia cases have demonstrated differing outcomes of the use of the diagnosis in court. In their review of nine cases involving sexual behavior in sleep, Ingravallo and colleagues found that eight of nine defendants were acquitted following the presentation of a parasomnic or related diagnosis (6). In ten Canadian cases, however, only five defendants were acquitted (Organ, 2015). One defendant was found to be not criminally responsible on account of mental disorder (akin to an NGRI finding) and due to a subsequent finding of lack of dangerousness, received an absolute discharge. Lastly, in their review of eight American defendants with repeated sexual behavior in sleep facing criminal charges, Mohebbi and colleagues noted that all defendants were found guilty of their charges, except one whose judgment was reversed and remanded on appeal. The final outcome of that case was unreported (7).

Forensic evaluation may play a role in cases of alleged sexsomnia. Sleep experts may assist in coordinating a sleep study to evaluate for the presence of parasomnic behavior. The forensic psychiatrist may assist by assessing an individual's psychiatric history, substance use history, and psychosocial variables related to one's relationship, sexual, and legal history in order to identify alternative rational motives for sexual offending. Important considerations pertinent to the evaluation include the defendant's incentive to malinger and the difficulty of linking a parasomnic disorder diagnosis to one's past behavior. The diagnosis of a sleep disorder does not necessarily indicate that sexsomnia accounted for the behavior at the time of the alleged offense. In terms of policy considerations, it is relevant to question the potential legal outcomes of a sexsomnic defense. For example, it remains unclear what benefit may result from a finding of not guilty by reason of insanity for sexsomnia, if the individual is subsequently transferred to a state hospital setting that is typically meant to serve the severely mentally ill.

Traditionally, sexsomnias have been conceptualized as primary disorders of sleep. The question of whether sexsomnias are similar to other problematic sexual behaviors remains unanswered. Does a sexsomnia tell us anything about an individual's sexual orientation or interests? For example, if a sexsomnia results in sexual touching of a prepubescent individual, is the sexsomniac pedophilic? Are there similarities between sexsomnias and other problematic sexual behaviors including paraphilic disorders? Might we use the evidence-based literature on sexual offending to estimate future risk in sexsomnias that involve problematic sexual behaviors? Although there is no specific data on the population of sexsomniacs who engage in sexual offending behaviors, it is possible that some of these individuals share characteristic features with sexual offenders in general. In the absence of a knowledge base in this area, one could argue that sexsomniacs who present with problematic sexual behaviors should undergo a psychosexual evaluation to determine if a paraphilia is present and if there are identifiable risk factors for engaging in future problematic sexual behaviors. For example, sexsomniacs who have engaged in sexual touching of prepubescent individuals could be tested with objective tools such as the penile plethysmograph to determine if a deviant sexual interest is present. Such a study would help elucidate whether sexsomnias represent an underlying sexual orientation or whether they are incongruent with sexual orientation. Such findings could have important risk and treatment implications. Without a standardized approach to sexsomnias, which may result in problematic sexual

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Martin Manley: Beyond Suicide Risk Assessment

Sherif Soliman, MD
Geriatric Psychiatry and the Law Committee

On August 15, 2013, at 5:00 AM, a caller from Overland Park, Kansas called 911 to say: "I want to report a suicide at the south end of the parking lot of the Overland Park Police Station at 123rd and Metcalf." (1) The caller was Martin Manley, and the suicide he was reporting was his own. Moments after making the call, he took a pistol and fired the fatal shot. He died on his 60th birthday.

Approximately 123 lives are lost daily to suicide in the US, and 45,000 annually. Adults 85 years of age and older have the second highest rate of suicide. (2)

Martin Manley left behind a detailed suicide note. His website was divided into 34 categories and 44 subcategories (3). His reasons for suicide are instructive. While age 60 is not considered "geriatric" by most definitions, Mr. Manley's reasons for ending his life were about aging. Three key points emerge as particularly helpful: Mr. Manley's fears and perceptions of aging, his argument that he was not depressed, and his apocalyptic view of the future. Note that I am not offering diagnostic opinions in this article, but because an understanding of Mr. Manley's reasons for suicide could help prevent other suicides.

He wrote of his fear of aging. He had a pessimistic view of the aging process, likely influenced by ageist stereotypes. He believed that he would become disabled or victimized by burglars. He writes, "The thought of being in a nursing home, physically or mentally disabled, was the single scariest thing I had ever thought about - at least on this earth." Mr. Manley's views about aging should prompt us to examine our cultural stereotypes of aging.

A major stereotype is that aging is a time of decline rather than a time of growth and wisdom. He writes, "I began seeing the problems that come with aging some time ago. I was sick of leaving the garage door open overnight. I was sick of forgetting to zip up when I put on my pants. I was sick of forgetting the names of my best friends. I was sick of going downstairs and having no idea why. I was sick of watching a movie, going to my account on IMDB to type up a review and realizing I've already seen it and, worse, already written a review! I was sick of having to dig through the trash to find an envelope that was sent to me so I could remember my own address - especially since I lived in the same place for the last nine years!"

The forgetfulness he describes is not consistent with normal aging, and would have warranted further evaluation. We must redefine the popular view of aging. This could reduce some of the fear and anxiety many feel as they approach older adulthood.

Mr. Manley wrote, "I was not depressed. Anyone who says I was is either ignorant or a liar. I stressed out at times – especially in the workplace, because my tendency was to work myself to death. But, I was 'retired' for 18 months before I ended my life and I didn't have any stress during that time. In some respects, I feel like I was retired the last 15 years of my life because doing sports statistics could hardly be considered 'work.' In any event, I can't imagine anyone being more free of stress than I."

Why did he assert that he was not depressed? One possibility is the stigma of mental illness, particularly among this generation of elder Americans.

Mr. Manley offered a pessimistic view of the future. He cited tragic events that occurred in the previous year, particularly the shooting at Sandy Hook Elementary School in Newtown, CT on December 12, 2012. He predicted economic collapse, widespread suffering, and a nuclear terror strike within his lifetime.

Martin Manley would not have been judged a serious suicide risk. Although a necessary element of prevention, assessing an individual and listing risk factors are not enough. I suggest a three-pronged public health approach to reducing geriatric suicide. First, reach out to elders who are living alone. Isolation is not only a risk factor for depression and suicide, but also increases risk for victimization, e.g. elder abuse or financial exploitation. Second, combat ageist stereotypes and the stigma of mental illness in media and popular culture. Third, assess suicide risk factors as part of routine preventative health.

Mr. Manley's tragic suicide with his detailed "suicide note" offer a rare glimpse into the mind of a man who died by suicide. As such, it offers several learning opportunities. As forensic psychiatrists, we may be called upon to do retrospective assessments or psychological autopsies. Life insurance policies often exclude death by suicide unless the decedent was not of sound mind at the time of the suicide. Was Mr. Manley of sound mind? That would depend on how restrictive a definition one applies. Looking at the issue broadly, he exhibited some cognitive distortions, in that he viewed catastrophic events as not only possible, but virtually inevitable. Again, without offering any diagnostic opinion, this may have suggested an underlying mood disorder. Of course, the need for retrospective assessment also comes up in medical malpractice cases, testamentary capacity, and other assessments such as contractual capacity.

In detailing his reasons for dying by suicide, Mr. Manley gives us an opportunity to examine his decision-making process and gain a deeper understanding of his reasons for dying by suicide. Since the information is publicly available, it can be discussed freely, unlike most undisguised clinical material. While it represents one man's reasons, his website offers important lessons for forensic and geriatric psychiatrists.

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The Rise of Deep Learning

Daniel S. Mundy, MD
Technology Committee

"Machine learning" and "deep learning" are trendy phrases; one might easily dismiss them as business-tech catchphrases, slowly awaiting their place on the historical lexicon shelf with "proactive," "disruptive," and "paradigm shift." But dismissing them is a failure to identify a massive technological leap in computational problem-solving – one that is silently present in our everyday lives, and one that will soon become entrenched in most fields of law and medicine, whether you want it to or not. Identifying how our field may guide the technology, particularly around issues of bias and discrimination, is critical.

When we think of algorithms, we tend to think of human-made flowcharts: ACLS protocols, cholesterol-lowering strategies, and rating scales. An expert utilizing a traditional algorithm can typically visualize a series of numbers, boxes, and lines, all thoughtfully placed by a committee of experts designing the tool. We can usually imagine the research data that informed the careful placement of each box and line.

Machine learning (ML) agents, while still algorithms, are very different. A series of traditional algorithms is used to create a ML algorithm that, untrained, has no classification or predictive power. Here is where the "learning" part comes in. Very similar to how a toddler learns from constant trial and error, the ML agent adjusts its own algorithm in response to whether it is correct. The result is an algorithm that is dictated by complicated statistical equations or "boxes and lines" representing mathematical relationships between abstract representations, hence giving rise to the "black box" analogy which is frequently used to describe artificial neural networks. Identifying what one node represents in a neural network is as easy as identifying what one specific neuron is doing in the occipital cortex. It is no surprise that image recognition agents, perhaps the earliest mass successes in the field, strongly resemble our own neural networks, with similar complexity.

Aspects of our everyday lives are made convenient by ML. Traffic prediction, search engine results, email spam filters, and voice assistants heavily rely on this technology. Self-driving cars are no longer the territory of The Jetsons; you can buy one today, and this reality punctuates the futuristic nature of this already present technology.

"Identifying how our field may guide the technology, particularly around issues of bias and discrimination, is critical."

In the practice of medicine, ML has already been employed in the clinical setting of fields more governed by "visual" diagnosis: ophthalmology, radiology, pathology, and dermatology (1). In psychiatry, the implementation is primarily at the research level, with a focus on neuroimaging and molecular biology (2). Natural language processing, a computational field that benefited greatly from ML, is also in the research phase (3).

At the time of writing, there is only one published article on the application of ML specifically in forensic psychiatry (4), though the implications are evident in closely related fields that have been using this approach for years: criminology and Internet advertising.

The topic of "ML risk assessment algorithms" in criminology is far beyond the scope of this article, but a few facts should bear stating. Since the 1970s, algorithmic risk assessments have been designed and utilized in different stages of criminal proceedings: pretrial detention, probation hearings, and parole hearings (5). More recently, ML algorithms have played a controversial role in sentencing. Despite ample criticisms around more traditional algorithms used in this manner, ML is presently being implemented in these assessments, and it is foreseeable that ML algorithms will become the norm in this very similar field (6).

Before taking umbrage at a comparison of our scholarly and ethical field to Internet advertising, consider how technology has allowed massive amounts of personal data (some freely given away, some taken surreptitiously) to inform tech companies. Mark Zuckerberg's one-line response at his Senate hearing explains how Facebook's net worth is over one-half trillion dollars: "Senator, we run ads." (7) In order to sell ad space effectively, technology companies utilize ML to make predictions based on untold amounts of personal information, though the readily available data includes search history, purchase history, geographic location, identification of friends and family, political leanings, interests, occupation, level of education, race, sexuality, and so forth. These companies have successfully utilized data-gathering and ML analysis to become embedded in our society.

Not all data used for advertising is explicit, though – for example, someone's mood. The fields of natural language processing and sentiment analysis allow these algorithms to assess how we feel about topics, or how we feel in general. An illustrative example is Facebook's suicide risk detection algorithm, capable of identifying current and past posts, as well as responses by friends, and notifying authorities if warranted (8); some might argue this is tantamount to practicing medicine, psychiatric risk assessment, and law enforcement. I am not aware of any forensic psychiatrist who was asked to weigh in on this, harkening back to my original point: the technology will progress, with or without our consent.

Actuarial risk assessment in forensic psychiatry, also algorithmic, similarly dates back to the 1970s (5), and

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President's Column

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we can learn from Dr. McPherson's experience. After she shared her personal experience with me, I asked her what she learned. Before making a public disclosure, it is preferable to effect change through the organization that has sought your expertise. In Dr. McPherson's case, because changes were not enacted after her initial written reports, and the indefinite detention of juveniles was possibly being expanded, the need for public disclosure was great. Becoming a whistleblower not only takes courage, but preparation. First and foremost, while not necessarily a factor for Dr. McPherson, the whistleblower should consider the risk of loss of future income from the work that was performed which led to the discovery of the information that will be publicly disclosed. Second, there is the potential for retaliation by the company or government agency which employed the whistleblower, including tremendous amounts of hostility and the potential for a clinician to be blacklisted in their field. Because the decision to become a whistleblower can impact not only the clinician, but family members as well, family discussions may be necessary prior to making a public disclosure. Finally, prior to public disclosure, it is always advisable to consult with legal counsel. In Dr. McPherson's case, she utilized the Government Accountability Project, a not-for-profit organization that provides legal defense to whistleblowers in the public and private sector. (7)

Fortunately, Dr. McPherson has not experienced negative repercussions. In fact, she has received support from family, friends, and colleagues, including the AAPL Human Rights and National Security Committee of which she is a member. Finally, Dr. McPherson, along with Dr. Allen, were awarded for their work by Physicians for Human Rights (PHR) at the PHR annual gala in April of this year. On behalf of AAPL, I congratulate Dr. McPherson for her work in exposing the fact that traumatizing children is not a political issue, but one of human dignity. Well done.

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Child Column

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I wrapped it up on the dot. He was delighted.

And that was it.

I later found out that although the three bills were successfully voted out of committee along party lines, the full House refused to hear them. Governor Ducey, a Republican, announced that he would never sign an anti-vaccination bill. They were dead in the water.

This was a fascinating, eye-opening, learning experience. I had spent several hours researching my testimony and originally had an 11-page statement. I whittled it down to four pages and read it out loud several times to make sure it came in under two minutes.

Testifying in court is familiar to most of us; testifying for a legislative body might not be. Here are some suggestions:

1) Ask yourself why you are interested in a particular bill and whether you can add something to the debate;
2) Do your homework. Get a copy of the bill and read it carefully. Make sure you understand its context in public policy;
3) When testifying before a Committee, know who the members are, their political backgrounds and their legislative histories. (This is all easily available on the Internet.)
4) Check the requirements for testifying in your locale. How much time will you have? What are the protocols for whom you are addressing and for answering questions posed by a committee member?
5) When you are finished, thank the Chair of the committee and its members.

I found my experience to be a unique opportunity to use my forensic skills and to learn new ones. Perhaps you will, too.

Geriatrics

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Medical Director

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Fourteenth Amendment. Our brief educated the Court on the difference between "general *mens rea* – the blameworthy intent required to render conduct criminal under the common law – rather than the contemporary technical definition of *mens rea* as the mental state defined to be the element of a particular crime defined by the legislature."

Our brief further argued that imposition of criminal punishment on the mentally ill persons who are unable to know that their conduct is wrongful undermines the moral basis of the criminal law. We argued that while under the Constitution, States have latitude in articulating the type of understanding that is consistent with the culpability concept, the mens rea approach fails to capture the constitutional requirement of a capacity to distinguish between right and wrong conduct.

The second section of our brief was meant to educate the Court on clinical aspects of major mental illness, and how clinical experience and scientific literature show that severe mental illness can seriously impair an individual's ability to know the wrongfulness of his or her conduct. We pointed out to the Court that while only a small percentage of the mentally ill commit violent acts, sometimes psychotic symptoms can be directly linked to violent behavior and that, "[i]ndividuals experiencing delusions and hallucinations often lack the ability to perceive the wrongfulness of their actions."

Our brief concludes by emphasizing that forensic mental health professionals have developed expertise in accurately evaluating criminal defendants and assisting the court when the insanity defense is asserted. Our brief refers to the *AAPL Practice Guideline on the Insanity Defense* noting: "Forensic psychiatrists have an ethics-based obligation to adhere to the principle of honesty and to strive for objectivity in conducting insanity defense evaluations … In evaluating the defendant's mental state at the time of an alleged offense, the forensic psychiatrist has an obligation to conduct a thorough assessment and to formulate opinions based on all available data, no matter who initiated the request for the evaluation."

Kahler v. Kansas will be heard during the Supreme court's fall 2019 term.

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(4) The Nevada Supreme Court subsequently found that state's legislative abolition of the insanity defense unconstitutional under the Nevada State Constitution.
(5) AAPL Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense, 42 JAAPL S3 (2014 Supp.)

Fellows' Corner

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with patients. Psychiatrists are also at risk of establishing a doctor-patient relationship by providing casual medical advice over social media. (1) As social media continues to evolve with new platforms, alterations in privacy settings and psychiatry trainees who are more attuned to social media guidelines for appropriate boundaries may struggle to keep up.

While boundary crossings and violations are an expected and useful tool in therapy, *The Shrink Next Door* is a reminder that if left unchecked, progressive violations can lead to exploitation and harm to the patient. As social media continues to evolve with new platforms and alterations in privacy settings, creators of guidelines for appropriate boundaries for psychiatrists who use these platforms may struggle to keep up.

The Shrink Next Door is also a reminder of the stigma we must overcome as psychiatrists. Nocera states in the podcast that his research into Dr. Herschkopf did not affect his view of psychiatry. He has written about his own mental health struggles and has a psychiatrist and psychologist he trusts. (1)

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AAPL members who are interested in serving on a committee for a three year term are invited to send a letter to the President William Newman, MD through the Executive Office by November 8, 2019. Committee members must be full voting members of AAPL. Letters should indicate particular interests or qualifications for the committee appointment desired.

For a complete list of committees visit the "About AAPL" tab at www.aapl.org.

Ask The Experts

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an 18-year-old man who is said to have a previous history of ADHD and learning disability, who was sentenced to six months. He was initially sent to a boot camp, but reported that voices were telling him to quit or escape. He was therefore sent to jail. On admission, he told the caseworker he heard voices telling him to hurt himself, and he was referred to the psychiatrist, who diagnosed schizoaffective disorder, personality disorder, learning disability, and substance use disorder. He subsequently was released and had two more admissions to the jail. During the course of his release, he was involuntarily admitted to two separate psychiatric units and then discharged. A year and a half after his initial presentation, he returned to jail and attempted to hang himself. He told the doctor he did this so he would get back on his original medications. He also admitted to lying about his voices on various occasions. He was caught stealing from his cellmates, and he was found not to be taking his medications. As a result, his medications were discontinued. A month later, he hanged himself and died.

His father alleged deliberate indifference. The Court of Appeal ruled that in order to establish deliberate indifference, the plaintiff would need to prove that the jail official not only subjectively perceived facts from which to infer a substantial risk, but also that they, in fact, drew the inference and then disregarded the risk. They did conclude that since the jail officials had placed the patient on an elevated watch status previously on several occasions that they, therefore, had subjective knowledge that he posed a risk of suicide.

In ruling in such a manner, the Court demonstrated its inability to grasp the dynamic risk posed by people who repetitively self-harm. Bober and Pinals note that even though this case was not ruled to represent deliberate indifference, the court noted that it was close to it. These authors commented that this underscores the complexity of correctional psychiatry. This includes the fact that correctional psychiatrists do not have full control over the treatment environment (2). I would also add that it demonstrates how vulnerable the correctional psychiatrist is to the courts, who from their lofty perch, may display an inability to grasp the realities of dealing with people with complex comorbidities, including borderline and antisocial personality disorders. Additionally, the courts do not seem able to differentiate between psychiatric hospitals, which have significantly higher levels of training, staff, and facilities, and jails and prisons, which are security institutions which happen to be in the difficult situation of dealing with psychiatric morbidity with limited staff and facilities as well as a different mandate.

One of the consequences of a finding of deliberate indifference is that it means that correctional psychiatrists may be liable for a violation of the citizen's constitutional rights including those covered by the Eighth Amendment (3). This may include government employees or possibly private contractors. This can also open up a defendant to US Code Section 1983 civil rights claims, which are not covered by malpractice insurance.

Unfortunately, we do tend to bring the situation upon ourselves, particularly when we aspire to deliver the same standard of healthcare in jails and prisons that "should be" available in the community (4). Since the community includes specific psychiatric units and hospitals, this claim should be seen as it is intended, that is, but a lofty and noble aspiration.

As in other branches of medicine, the best protection for a correctional psychiatrist is to perform as good an assessment as possible; good documentation; consultation where available; and to practice in good faith.

Take Home Points:

Most jurisdictions use some version of the "reasonable practitioner" concept in defining the standard of care. That standard is a standard of adequacy, not of excellence. There are multiple ways a lawyer or expert may try to define the standard of care, and it is important to be clear on definitions when doing your work. Standards evolve and change; staying current in the clinical field is critical to the practice of forensic psychiatry. Correctional psychiatrists may be liable for a finding of deliberate indifference, which can remove immunity as a government employee or private contractor.

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Sexsomnias

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behaviors, the risk for future sexually dangerous behaviors is both unknown and untreatable. Future directions in the area of sexsomnia include developing a better understanding of the etiology, presentation, and associated risks and may determine whether such a diagnosis can constitute a legitimate legal defense.

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In The News

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Britain) or the Internet found 14 out of 98 tested supplements contained some amount of DNP. (3) Samples purchased on the Internet were more likely to have DNP than those bought in actual storefronts. Potential causes for the DNP being in the samples ranged from intentional misidentification of the ingredients (DNP used to "boost" weight loss potential of supplements marketed as legal) to potential cross-contamination from multiple supplements being processed at the same site. (3, 11)

As these recent news stories indicated, it is important for forensic psychiatrists to be aware of potential problems and complications that could arise from dietary supplements since toxic compounds like DNP can lead to direct legal actions (e.g. civil product liability, truth in advertising violations, criminal action for selling a substance) or explain a negative outcome, such as confusion or unexplained deaths with hyperthermia.

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Human Rights

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action is inspirational and courageous. Remember that the call to promote health and human dignity must be answered.

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Royal College

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Emphasis was given to not only the high prevalence of mental disorder within the group, but also to the fact that the group itself was not homogeneous. Individuals become extremists by many routes.

Next year's conference will be in Liverpool – another city of great interest and diverse history which always rewards a visit. Maybe we'll see you there!

The Nottingham Conference:
A Student's Perspective
Esme Beer, Medical Student, University of Glasgow Medical School

I was fortunate enough to be awarded the opportunity to attend the Faculty of Forensic Psychiatry's Annual Conference 2019 as a result of the essay I submitted for the medical student essay prize competition.

You can read my full essay and those of my fellow prize winners on the College website: https://www.rcpsych.ac.uk/members/your-faculties/forensic-psychiatry/prizes-and-bursaries?searchTerms=Forensic%20faculty. Overall, I thoroughly enjoyed the conference, finding it particularly interesting hearing about current research advances in the field during the research symposium workshops. As a medical student, I was apprehensive about being able to follow and understand the complex topics discussed. However, the captivating nature of the talks made them possible for me to follow.

I would like to take this opportunity to thank the College for the opportunity to attend and present at the conference. It was a very inspiring experience and certainly one that will shape my future career.

Sexsomnias

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MUSE & VIEWS

A man went to his psychiatrist and said, "Every time I drink my coffee, I get a stabbing pain in my right eye." The psychiatrist replied, "Well, have you tried taking the spoon out?"

Submitted by
Kaustubh G. Joshi, M.D.

Prenatal

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disorders. Doses should be started low and increased slowly, paying attention to emerging side effects. Patients should be supported through regular follow-up, witnessed administration and laboratory blood tests and body fluid monitoring.

Other clusters reported as logically linked to neurocognitive deficits are affect regulation, hyperactivity and cognitive inflexibility. Similar clustering was proposed and is now used to diagnose those with PAE: neurocognition, adaptive and self-regulation. (9) Improved outcomes are therefore based on rational pharmacotherapy for domain-specific ligands including adrenergic agents such as clonidine and guanfacine in managing hyperarousal, stimulants for hyperactivity and antipsychotics for cognitive inflexibility - important target clusters in ND-PAE/FASD.

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Moon Rocks

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Trauma & Stress

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out/trauma. Guille et al. (12) demonstrated that a web-based cognitive behavioral therapy program delivered prior to the start of intern year reduced the development of suicidal ideation among interns at Yale University and the University of Southern California. The CBT program, "Mood Gym," consisted of four 30-minute weekly modules designed to explore the relationship between mood, thought, and behavior. Other programs encourage physicians to balance personal and work commitments as well as to process and reduce stressors. Stanford University has instituted an innovative "time banking" program, allowing physicians to exchange time spent doing nonclinical work (mentorship, serving on committees, etc.) for services, such as laundry/dry cleaning, meal delivery, car maintenance, etc. (13) By aiding doctors in completing mundane tasks, this frees up time to be spent on self-care, family, patients, or documentation.

While it is obvious that physician well-being is important in and of itself, studies have also demonstrated the economic benefits of improved physician general and mental health. Wright and Katz (14) estimated that replacing a physician who has left due to burnout or mental health issues (including expenses for loss of revenue, training/onboarding, and recruitment), can cost an organization $500,000 to $1 million. Panagioti et al (15) reported that physicians experiencing burnout are more likely to have made a major medical error in the prior three months and receive lower scores with regards to patient satisfaction. The Mayo Clinic found that physician burnout/dissatisfaction was associated with an increased likelihood that physicians would reduce their professional work effort over the following 24 months. (16) This data indicates that improving physician well-being improves healthcare for all.

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Legislative Update

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include expanding Services, Training, Officers and Prosecutors (STOP) VAWA grants to include additional community resources for response to incidents of domestic violence and increasing grant funding to support youth violence prevention education programs; combating violent crimes on campuses; and supporting training in early childhood programs on domestic violence, sexual assault and stalking.

AAPL was also informed by our CFSO legislative liaison that the American Bar Association is considering developing ethical standards for the practice of forensic science, including forensic psychiatry. More details on this will be forthcoming in the near future.

In addition to these federal bills, the committee also actively monitored relevant legislative and judicial actions related to not guilty by reason of insanity (NGRI) pleas. The U.S. Supreme Court has recently granted a writ of certiorari in the case of *Kahler v. Kansas,* raising the question of whether citizens have a constitutional right to raise the insanity defense (See the Medical Director's Column in this issue.) The state of Utah had a bill proposed in their legislative session to reinstate the NGRI defense. However, as of March 2019, this bill had not been passed by the Utah legislature. The current plan is to further study the issue and revisit the bill at the 2019 interim session.

Forensic Training

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a good understanding of forensic psychiatry makes all psychiatrists better clinicians. In addition, as Dr. Magalotti indicated, trainee members bring energy and passion to our organization. They can revitalize committees, share in the work of scholarly projects, and help shape the vision of our organization. Recruitment of bright, motivated, and interested trainees insures that AAPL will be a thriving organization for years to come.

Technology

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it will likely adopt ML. The role of clinical judgment in risk assessments, i.e. structured professional judgment, has more recently taken the focus off purely actuarial analysis. What has yet to be established is the role our professional judgment will play in the training and implementation of ML agents in future assessments.

"Algorithmic discrimination" is a relatively new phrase for an older idea. Discrimination from a ML algorithm, even if entirely open source, is frequently not apparent. This is in part due to the "black box," and in part due to training data that contains undiscovered biases. The unintended blunders from deployed AI are voluminous, but a few examples will illustrate: In 2015, Facebook's automatic translation algorithm changed "good morning," written in Arabic, to "attack them," written in Hebrew, resulting in a prompt but erroneous arrest. (9) In 2017, Amazon abandoned a ML algorithm that unduly penalized women applicants after they were unable to make the algorithm fair. (10) Later in 2017, Facebook's algorithm allowed ProPublica to purchase ads targeted towards anti-Semitic phrases. (11) In 2018, a commercially available IBM facial recognition algorithm correctly identified gender 99% of the time for white men, but only 35% for dark-skinned women. (12) It bears stating that these companies may be the most skilled in the utilization of machine learning, and they are very invested in avoiding newsworthy PR blunders. Still, these examples are illustrative of the unforeseen outcomes from learning algorithms that reflect biased input.

This author's opinion is that the most critical step that we can take is to ensure a focus on fairness in the selection of training data and performance evaluation as this methodology finds its way into our field. Somewhere between the extremes of a) terror of our AI overlords and b) dismissal of a fad for young people and techies, we will benefit from increased awareness and fluency on the topic.

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