

AAPL Newsletter

American Academy of Psychiatry and the Law



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Robert Sadoff, MD, Recipient of the Guttmacher Award

Renée Sorrentino MD



David Cash, Professional Risk Management Services, which endows the award, Thomas Gutheil, David Lowenthal, Richard Ciccone, Kenneth Weiss, Octavio Choi

The 2017 Manfred S. Guttmacher Award, co-sponsored by the American Academy of Psychiatry and the Law and the American Psychiatric Association, was given for the second time (1992 recipient) to Robert Sadoff, MD for his text, “The Evolution of Forensic Psychiatry” (published July 2015).

The Guttmacher Award recognizes an outstanding contribution to the field of forensic psychiatry. As many of you know, Dr. Sadoff died in April 2017 from complications following a two-year battle with pancreatic cancer. Drs. Choi, Ciccone, Gutheil, and Weiss gave the Guttmacher Lecture. In the tradition of the award lecture, the panelists presented chapters from the award winning text. But this year the lecture included a tribute to the author, Dr. Sadoff. And like the “Renaissance Man of Forensic Psychiatry,” as he was coined in the JAAPL article published in 2008, this year’s lecture was an intellectual revival.

To begin, the panelists shared Dr. Sadoff’s personal words of thanks. Dr. Sadoff asked the panel participants

to accept the award on his behalf, as he knew he would not be present. As pointed out by the panel, Dr. Sadoff’s humility was reflected in his gracious words, as he never forgot his teachers, peers, AAPL colleagues and students.

Dr. Weiss referred to Dr. Sadoff as one of the “pioneers in forensic medicine.” Dr. Weiss noted that in preparing for the award winning text, “Dr. Sadoff wanted to capture everything about early forensic psychiatry.”

Dr. Ciccone reviewed the “teaching roles of the forensic psychiatrist” as outlined in the textbook. He described Dr. Sadoff as “the embodiment of a great teacher and a key participant in the evolution of forensic psychiatry.” As the second president of AAPL, Dr. Sadoff was instrumental in the development of teaching and training in forensic psychiatry. His role in teaching and training is evidenced by his participation in the certification process for forensic psychiatrists, the establishment of the forensic review course and his many publications on the topic. In the text, the

teaching roles of forensic psychiatrists include teaching future physicians such as medical students, residents, and fellows. In addition the forensic psychiatrist is a teacher in the legal system. Dr. Ciccone concluded, “As we look to the future, the applications of the forensic psychiatrist as a teacher include social medical, telecommunications, apps, medical imaging and outcome-based measures.”

Dr. Gutheil, author of the chapter on the “The Program in Psychiatry and the Law,” reviewed his experience in the evolution of his Boston based forensic psychiatry-training program. Dr. Gutheil co-founded a forensic discussion group referred to as the “Think Tank.” This multidisciplinary, diverse team, now over thirty years old, meets every week to discuss forensic issues. The forum is open and occasionally invites guest speakers. In addition to providing education to attendees, the group has authored two amicus briefs. Dr. Gutheil remarked, this successful teaching model can be adapted anywhere.

In conclusion, Dr. Choi, a former fellow of Dr. Sadoff and author on topics related to the future of forensic psychiatry and neurolaw, described his formative training with Dr. Sadoff. He remarked that Dr. Sadoff was “a master of forensic psychiatry. He worked for social justice. He was a timeless educator.” Dr. Choi shared that Dr. Sadoff was respected for his wisdom but known for his kindness.

This year’s Guttmacher Award was a true celebration of an author’s work and his lifelong contributions to the field of forensic psychiatry. Even in his passing, Dr. Sadoff’s tradition of teaching and mentoring continue in his written words. ☪



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ALL ABOUT AAPL COMMITTEES

Staffing Forensic Hospital Units: A Burden on the Medical Director

James B. Reynolds MD, Forensic Hospital Services Committee

On July 13, 2002, I was unexpectedly promoted to Medical Director of my state-run forensic hospital. The responsibility was awesome, but my biggest worry was that I was now one provider short on my treatment units. My facility sits in a modest city, an hour's drive from a large metropolitan area. At first glance there seems little to offer young physicians if they desire nightlife and 5 star restaurants. I immediately scoured my list of colleagues who might be willing to relocate. No luck. I placed ads in all the psychiatric newsletters at considerable expense (given my "state" budget). I bought time on professional job search boards (1600 "hits," not a single call). I went to job fairs at local medical schools. I became increasingly nervous as my personal experience with the national psychiatrist shortage grew.

I did strike gold with a newsletter ad a few months later and hired a quality young doctor, though this "success" represented more luck than skill, as his family was moving to the area. I felt even more relieved as I contemplated a graduating forensic fellow who expressed a desire to stay on, only to be disappointed as a state hiring freeze hit in the post-9-11 economic slowdown.

Even my respite with my new hire was short-lived, unfortunately, as an unhappy employee departed with two weeks' notice just a few months later. That departure did teach me one valuable lesson, however. Being short an egg may spread the batter thin, but a rotten egg spoils the whole refrigerator. One is tempted to chance a physician whose best quality is a pulse of 80, but the headaches later may sadly outweigh the inconvenience you feel now.

So I was back on the recruiting trail, and in August, with training programs almost a year away from graduation. Due to the exigencies of my State personnel system, I am unable

to lock in candidates with a signing bonus, or even a binding contract. In a dilemma possibly familiar to other state hospital colleagues, I was faced with the risk of recruiting a candidate in August (to start next July), only to lose her (and nearly a year of recruiting time) to a better job in April, three months before her start date.

Locum tenens options were problematic in themselves, as it was difficult even finding providers willing to work in my locale, or facility. "Forensic" can sound scary, so care must be taken at the first call to properly describe your hospital, as many of us have an unfortunate picture of "state" or forensic facilities. The effort of explaining my needs in detail to multiple recruiters was demoralizing, as time after time, the initial boast "we have many qualified candidates interested in your position" morphed into a cheery "we'll get right on this." And that was often the last I would hear from them. The locums angle comes with its own problems as well. In the words of one colleague, "there's a reason some doctors choose to be locums." [No disrespect intended to the many outstanding locums, but beware the lemons]. Honest *word of mouth* is often invaluable in selecting a competent and motivated provider. Competence and motivation are not the only desirable attributes, either. Health issues, or even lack of computer savvy in this age of EMR's, have precluded several candidates.

As for permanent hires, working for a public facility adds several handicaps. I am unable to meaningfully negotiate salary or benefits. My salary is actually within the ballpark of reason, but by no means high end. [I can brag about a low cost of living, however]. Benefits are good, but again, not high end. We require on-call, a deal breaker for some applicants no matter how "light" the call. The fees recruiters charge are often above my state-imposed ceiling,

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"Many of the truths we cling to depend greatly on our own point of view"*

Susan Hatters Friedman MD

My son is working abroad in Japan. Excitedly, I was able to visit him in May, and he showed me around the temples of Kyoto and Nara. I also was able to spend time visiting the University of Kyoto, where I met some of our lovely Japanese counterparts. I learned more about Dr. Ryosaku Kawada's work looking into brains of pathological gamblers in Japan. After our discussions, I finally appreciated what the ubiquitous Pachinko signs were about. Japan has strict gambling laws; yet, one can play Pachinko (similar to pinball)—'pachin' refers to the sounds that the 'ko' (meaning 'ball') makes. While casinos are illegal in Japan, according to the BBC, pachinko goes through a legal loophole about how prizes are claimed. Winning balls are traded for alcohol or toys or 'special prize tokens.' The tokens then are taken outside the pachinko parlour to a nearby shop where they are exchanged for cash. Previously controlled by yakuza (mafia), this is now regulated by police.

The Japanese have words for concepts that we don't have in English. Within infanticide research, in specific, we know that Phillip Resnick coined the English word "neonaticide" (murder of the neonate in the first day of life) and that before 1969, there was no English word for this concept. In Japan, however, there existed two words for neonaticide—which describe different subtypes of the phenomenon. "Anomie" describes the neonaticide cases similar to those most common in the rest of the developed world—with characteristics such as hidden pregnancies in unmarried young women. "Mabiki" (which means pulling plants from a garden that is overcrowded; thinning out of population) alternatively describes neonaticide cases in which the parents kill the infant due to poverty, the lack of resources to raise the infant. While

the "mabiki" type was more common in generations past, now the "anomie" type is. Further, "shinju" is a culturally understood act of homicide-suicide. "Shinju" means "oneness of hearts." "Johshi Shinju", or lovers' suicide was previously the most common form of homicide-suicide. It has been surpassed now by "Oyako-Shinju" in which a parent kills the child and themselves—which often occurs in the Resnickian "altruistic filicide" manner. (For further details, the reader is referred to japanpsychiatrist.com)

It would be difficult to overstate the hard time I had understanding any Japanese words, and I would have been at a loss without my son to translate nearly everything for me outside of the University where my lecture and discussions occurred in English. So, I was relieved that *The Japan Times* was in English for travellers. Just in reading one day's worth of news, I found various forensic-related items. "Karoshi" is a Japanese term meaning that one has worked oneself to death. This was a finding by the Labour Standards Office, and working more than 100 hours of overtime in the previous month or 80 hours of overtime in 2 straight months lead to an increased likelihood of a finding of Karoshi. The same day's paper also held articles about determi-

nations of parental rights and child custody—with record numbers of custody suspensions to prevent child abuse. An important reminder of a different cultural belief occurred when reading an article about using donated eggs being unethical.

In sum, my trip to Japan helped consolidate my beliefs about the importance of understanding what various cultures bring to our field. It made me reflect further about the importance of AAPL being an international organization, and of our newsletter providing perspectives and information about international forensic issues.

In the current newsletter, you'll read about topics ranging from Canadian jurisprudence to the latest news from the APA and AMA to the recent (British) Royal College forensic meetings. You'll learn more about Dr. Sadoff's work. You'll learn more about upcoming AAPL resource documents, as well as the education of psychiatry trainees. Prepare to expand your mind on topics from the forensic search for truth to reading about the idea of no-lie MRIs. Committee articles in this issue include thought-provoking topics in staffing hospital units, geriatrics, trauma, suicidology, and substances of abuse. Special articles also include discussion of the Goldwater rule, boundary violations in corrections, and terrorism. You'll also meet the new Rapoport fellows, see the fellows' corner, and have some pesky forensic questions answered. Enjoy this issue of your *Newsletter*. Looking forward to seeing everyone at this year's AAPL meeting in Denver! ☯

*"Many of the truths we cling to...." - Obi-wan Kenobi, *Star Wars V*



The Search for Truth?

Michael A. Norko MD, MAR



Most AAPL members are accustomed to working within the adversarial system, with its premise that the zealous advocacy of each party and

the opportunity for vigorous cross-examination will, in the end, best inform the trier of fact. It is the common law methodology of serving justice. But it is not a methodology designed to seek truth as its *modus operandi*. For that task, the inquisitorial method is more purposefully designed.

Hans Crombag, a Dutch professor of law and psychology, notes that the two systems differ in their proximate goals, even though they have the same ultimate goal of serving justice. "In the adversarial tradition it is assumed that justice is done if the parties are treated equally in presenting their (side of the) case...Fair play is the proximate goal of the adversarial system." In the inquisitorial model, "truth itself is the proximate goal of the system." However, neither system is completely indifferent to the proximate goal of the other (Ref.¹, pp 23-24). This distinction has also been characterized as truth-seeking versus proof-making.² There is some empirical evidence that litigants perceive that the inquisitorial method produces more truth than the adversarial system, and the adversarial method more just outcomes.³

Law professor Carrie Menkel-Meadow (who will be our Friday luncheon speaker in Denver) has argued that, "Binary, oppositional presentations of facts in dispute is not the best way for us to learn the truth. Polarized debate distorts truth, leaves out important information, simplifies complexity and obfuscates where it should clarify" (Ref.4, p 50). Gutheil and colleagues have expressed a similar concern: "Testimony may be distorted or misquoted, important infor-

mation may be excluded, and pretrial motions may corrupt 'the whole truth'" (Ref.5, p 426). Menkel-Meadow has also argued that the reality that "lawyers seek to achieve their client's interests and 'win'" means that the adversary system lacks the important quality of the "genuine search for truth" (Ref. 4, p 54). Law professor Roger Park describes disincentives to truth-seeking in the adversarial process: "Any time that the cross-examiner fails to ask a relevant question because he fears backfire, or the direct examiner does not ask the question for the same reason (or because she knows the answer but doesn't like it) the adversarial climate has obstructed the search for the truth" (Ref.6, p 143). Park contrasts this with the "neutral interrogator" in the inquisitorial system who "need not fear embarrassment if the witness gives a surprising answer" (Ref.6, p 144).

Yale law professor and D.C. Circuit Court judge Thurman Arnold offered his critique of "trial by combat" in a 1935 text: "Mutual exaggeration is supposed to create a lack of exaggeration. Bitter partisanship in opposite directions is supposed to bring out the truth. Of course no rational human being would apply such a theory to his own affairs or to other departments of the government...mutual exaggeration of opposing claims violate(s) the whole theory of rational, scientific investigation. Yet in spite of this most obvious fact, the ordinary teacher of law will insist (1) that combat makes for clarity, (2) that heated arguments bring out the truth, and (3) that anyone who doesn't believe this is a loose thinker" (Ref.7, p 185).

I offer these brief critiques in preparation for our mock trial in Denver, which will reimagine the process of the trial of James Holmes (the Aurora, Colorado cinema shooter). On Thursday evening, we will be presenting an exercise exploring elements of the inquisitorial method and

the use of a consensus panel, as a demonstration to stimulate discussion of the potential strengths and weaknesses of these methodologies, particularly along the dimension of the search for truth in expert witness testimony. Drs. Jeffrey Metzner, William Reid and Phillip Resnick (who each participated in the death penalty trial of James Holmes) will serve as expert witnesses for the mock trial. Rich Orman, Senior Deputy DA in Denver (the prosecutor from the actual case) will participate in the mock trial, as will Denver attorney Phil Cherner as defense counsel, and the Hon. John L. Kane of the U.S. District Court of Colorado (our Thursday luncheon speaker) as the magistrate/inquisitor.

In the scenario prepared for the exercise, the three experts have been appointed by the court, charged with the task of attempting to achieve consensus on the medicolegal questions posed regarding diagnosis, ability to distinguish right from wrong, and the presence of psychiatric mitigating factors. They have conducted separate interviews and each reviewed available police reports and discovery information, followed by the opportunity to discuss the case among themselves to determine areas of consensus, majority and minority opinions. The inquisitor will elicit testimony from the experts about their consensus opinion and areas of disagreement, following which prosecution and defense attorneys will have the opportunity to question the experts.

In addition to the inquisitorial component, the consensus approach will be utilized in the mock trial as a further attempt to counter the tendency of court proceedings to emphasize differences in expert witness opinion (Ref.8, p 251). Consensus-seeking is also more natural to the methodology by which we approach our clinical work; when we encounter challenging cases, we seek consultation, hold case conferences, and engage in peer supervision. The resultant exchange raises questions and answers in a richer way than can be achieved by a clinician practicing in isolation. (Such a consultation/supervision process,

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AAPL Practice Resources

Jeffrey S. Janofsky MD



During AAPL's Semiannual meeting in May 2017 the AAPL Council voted unanimously to retire the terms Practice Guideline and

Resource Document, and instead use the term AAPL Practice Resource for all written AAPL educational products.

AAPL's first Practice Guideline, "AAPL Practice Guideline for Forensic Evaluation of Defendants Raising the Insanity Defense" was published in 2002¹ and revised in 2014.² AAPL has subsequently written practice guidelines about competence to stand trial³, evaluation of psychiatric disability⁴, and general forensic assessment.⁵ AAPL has also produced a task force report on video recording of forensic psychiatric evaluations.⁶ Revised versions of the competence to stand trial document and the disability document have been approved by Council and are being edited. Finally, a new educational resource for prescribing in corrections was recently approved by Council and is also being edited.

The Institute of Medicine (IOM) published *Clinical Practice Guidelines We Can Trust*⁷ in 2011. The authors explained that existing Practice Guidelines suffer from factors that undermine the trustworthiness of guideline recommendations including:

limitations in the scientific evidence on which CPGs [Clinical Practice Guidelines] are based; lack of transparency of development groups' methodologies, especially in deriving recommendations and determining their strength; conflicting guidelines; and challenges of conflict of interest (. . . tensions among guideline developers and users with respect to balancing desires for evidence-based rec-

ommendations with clinician desires for guidance on clinical situations in which great uncertainty exists. . . and Resource limitations . . .⁷

The remainder of the IOM document made multiple recommendations for improvement, including "adoption of systematic methods for rating quality of evidence and strength of recommendations"⁷, which require an assessment of the quality of each reference cited. The document makes many other recommendations and concludes "To be trustworthy, a clinical practice guide-

"[AAPL] can and should continue to produce educational resources that will expand knowledge in the field of forensic psychiatry."

line should comply with [all] proposed standards . . .⁷ There are 23 categories and sub-categories of summarized standards.

Unfortunately, in my opinion, the IOM document is a classic example of the perfect being the enemy of the good, and has led to significant problems. For example all but one of the APA's 23 practice guidelines developed between 1992 and 2011, "are more than 5 years old and have not yet been updated to ensure that they reflect current knowledge and practice. In accordance with national standards, including those of the Agency for Healthcare Research and Quality's National Guideline Clearinghouse, these guidelines can no longer be assumed to be current."¹¹ Since 2011 the APA has only been able to update the APA Practice Guidelines for the Psychiatric Evaluation of Adults, the

first set of practice guidelines developed under the new IOM process.¹² The APA has since completed a single new practice guideline, The American Psychiatric Association Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia.

Implementing all of the IOM's recommendations for Practice Guidelines is highly resource intensive, both from a financial and a human point of view. AAPL has neither the financial nor human capital to implement IOM recommendations. However our organization can and should continue to produce educational resources that will expand knowledge in the field of forensic psychiatry. Producing documents titled AAPL Practice Resources will allow AAPL to continue to produce such educational documents, without falsely portraying them as meeting IOM Practice Guideline standards.

The AAPL Council also voted that AAPL Practice Resources' authorship will be awarded to the current writers of the document. Current writers will acknowledge that the document they produce is the property of AAPL, but they will be listed as authors of the current document. In subsequent revisions of the document they will be listed in footnotes as prior contributors, but will not be listed as authors unless they contribute directly to the future revision.

AAPL Practice Resources will go through the same vetting process previously used for Practice Guidelines including:

- presentation at AAPL annual meetings for comments by AAPL members
- circulation of drafts to AAPL members for comment
- final approval by Council.

AAPL Practice Resources will be published as short abstracts in the paper JAAPL with a link to the online full version of the document, which would appear as a supplement to online JAAPL. This new process will apply to all new educational products and to current in-press and in-review

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Finding Your Seat

Jacquelyn T. Coleman, CAE



Thanks to all the word nerds who contacted me about my column in the last issue. I'm not surprised that there are at least a few of you in

AAPL. I am gathering material for another word rant, so please be sure to send me your most appalling examples.

So this time, with the AAPL Annual Meeting fast approaching, I'm thinking about logistics. I was musing recently about why people find construction projects so compelling. I had turned around from watching something going on, to find that there were lot of other people watching too. I will also say that if you want to see a nerd convention, sit with a few association executives while a function is taking place. Even when we are not responsible for it, we are counting empty chairs, checking on how fast the service is going, asking ourselves if the coffee is going to be served before the speaker starts to talk, and looking for the person who is supposed to be calling the proceedings to order. We just can't help ourselves.

I have been shushed by a few friends and family members after making an appropriate reference to meal service or other functions, and sometimes they haven't been very polite about it.

There are things that facilities can do, however, to make the lives of meeting planners and attendees easier. I imagine that there is a battle between the designers who want to make their hotel special and the frontline staff who would prefer not hearing the same questions over and over or wandering around lost.

A case in point: at the APA meeting in San Diego, we had our meetings in the lovely Bayside Hilton. There were 4 floors of meeting rooms. Each floor was named after a

different color of blue: cobalt, indigo, aqua, sapphire. That is a recipe for disaster. "What meeting room are we looking for?" "I don't know, something blue."

The massive Hyatt in Chicago, where the AMA has its Annual Meeting, labels its floors with metals: gold, bronze, silver, and then throws in a couple more colors, ... "Where is our meeting room?" "I don't know, some kind of metal?"

Many hotels seem to like dead Presidents for their actual room names. Others name rooms for local landmarks or surrounding areas that you have never heard of, or lakes or other bodies of water. I once had meetings on a floor that had a Michigan and a Minnesota room.

Life would be easier for all of us if we could just agree. How about A, B, C, D etc. starting with the lowest floor, and 1, 2, 3, 4 etc. for the room numbers. It's a system we all grew up with, and should be good enough.

We have gone from the hotel level, to the meeting rooms, so let's dive a little deeper – into the meeting groom itself. Did you know that a book has been written about seating arrangements? It's called: *Seating Matters: State of the Art Seating Arrangements* by Paul O. Radde, available on Amazon. I haven't read it but writing this column makes me think I need to before you start asking me questions. It was published in 2009, and I dare say nothing much has changed in seating arrangements since then. So we've got open square, u-shape, conference, theater, schoolroom, rounds and crescent rounds, and I am sure I have missed a few. But whichever one it is, most people prefer to be as far back as possible.

As if to make the point, this newsletter just appeared in my inbox: *Ponder Your Meeting Seating*. So I stopped writing and read the article. Two architects from Amsterdam spent 6 years researching the architectural layout of the legislative bodies in the United Nations member

states. (Parliament, by Max Cohen de Lara and David Mulder van der Vegt, October 28, 2016, self-published by their firm XML.)

They identified 5 styles that they claim have not changed since the 19th century. The most common is the semicircle, which they say "was used to foster consensus among a group of resident elites. Another style is opposing benches, which will be familiar to anyone who watches the British parliament. I don't think they even needed to tell us that "The setting of two sides that confront each other provokes a more heated debate than the single body..."

The horseshoe type is a hybrid of the other two, where the two sides bend toward each other on one side of the room.

Only nine parliaments in the world meet in a circle, among them the West German Parliament in Bonn, designed only in the 1980s by Gunther Behnisch but inspired by the Icelandic Althing of the 8th century.

And the classroom. The authors had some startling revelations about the classroom. They observed that the type is most prevalent in countries with a low rank on the Economist's Democracy Index.

And I found most interesting this quote from their story in the Washington post about their book (Washington Post, 3/4/17): "A comparison of the size of the assembly halls also reveals that - ironically - the scale of the assembly halls seems to be inversely proportional to the country's rank on the Democracy Index. Parliaments in the least democratic countries convene in the largest hall." Think about that the next time you watch the news.

Now you may ask what seating arrangement I prefer. It's a legitimate question. I prefer the seating arrangement where everyone has one. ☺

April newsletter correction:

In the April 2017 Newsletter, the authors of "Transgendered Patients and the Law: An Update" should have been listed as Anna Glezer, MD and Kelly L. Coffman, MD, MPH, Gender Issues Committee.

Ask the Experts 2017

Neil S. Kaye MD, DFAPA

Graham Glancy MB, ChB, FRC Psych, FRCP

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.

We begin by memorializing and celebrating the life of Robert Sadoff, MD, a founder of AAPL and its second President (1971-1973.) Bob co-authored this column from its inception in 2008 until the middle of 2015 when he stepped aside and Graham Glancy, MB, ChB, FRC Psych, FRCP took over for Bob who had pancreatic cancer. Bob authored, co-authored, or edited a dozen books about forensic psychiatry, and wrote more than 30 chapters in other texts. Legal and medical journals published at least 100 of his articles, and he lectured in every state in the U.S. and in 12 other countries. He somehow managed to find time for all, especially his family, who were extended AAPL family for all of us. He also was a Past-President of Magen David Adom, Israel's national EMS and blood services organization and through his work saved thousands of lives in Israel.

For anyone who had the honor and pleasure of knowing Bob, he will be sorely missed as a mentor, leader, teacher, and friend. The world is a dimmer place without his light, but we trust the knowledge he shared with so many of us will burn brightly and illuminate the path of truth and justice, for which he strived in all of his endeavors.

Q.: If expert #1 feels she is charging a fair rate for her type of work and the economy of her area, let's throw out \$300 per hour, and an expert on the other side of a case is

charging considerably more, say \$600 per hour, does that leave an impression with the lawyers, and potentially jury members, that expert #1 is worth less, or somehow less capable? When I was in Fellowship, I was cautioned about the tactic of trying to paint you as a hired gun by portraying your fees as "exorbitant." Twenty-five years later, I am actually wondering if the average juror might not see it the other way, that an expert who charges a lower fee does so because she cannot get work otherwise?

My question is timely because I am involved in a high stakes civil case outside of my own state. I live in a low cost of living, semi-rural area, and most of my local work is criminal cases, much from Public Defenders. It's safe to say some experts on the opposing side are charging two to three times my hourly rate. I am actually feeling self-conscious about it. I have been told I am a high quality testifier, but quality or not, in my local area I would not get the kinds of cases I like with a higher fee. If I had thought more before taking this current civil case, I could have quoted them a higher fee. But honestly, that doesn't ring well with me. I probably undercharge for my credentials and expertise, but to jack my price up because the traffic can bear it just strikes me as wrong.



A. Kaye: Rates and fees have always been a challenging area to discuss-along with sex and death, of course. You accurately point out the

competing arguments of risking being called a "bought opinion" if your fees are too high or being seen as less competent if your fees are "too cheap." There are many business models to guide one in establishing a fee schedule. One way is go with

what the market will bear, another is to determine the average price/rate and to act accordingly, a third is to always be the highest price (suggesting quality-think Rolls Royce.) and another is to think volume business by being the least expensive.

In discussions with colleagues, most seem more comfortable by being more centrist in rates and not being at either extreme. While there is a Federal prohibition to rate setting/fixing by a group, it is easy to find out what your colleagues usually charge.

Personally, I charge an hourly rate for all of my work, with the exception of depositions and trials. For that work, I charge for half or full-days, as my experience is lawyers and judges can't hold to any schedule and I don't want to lose that time. My rate is informed by my clinical charges, as I would be earning income from patients using that same time. But, my hourly forensic rate is higher, as it also reflects the increased value of my additional training, experience, and expertise in the field. I post my fee schedule and contract on my website, and I require payment in advance, barring special circumstances.

In Delaware, we have a joint committee of the Medical Society and the Bar Association and this Medico-Legal Committee has established a "guide" for expert witnesses that includes fees and covers conduct of both parties as well. I would be happy to share these documents with anyone who contacts me at nskaye@aol.com.



A. Glancy:

Thank you to the writer for raising this important issue. As forensic psychiatrists, we rarely discuss fees since we are somehow embar-

rassed or ashamed that we actually get paid for our work. A few years ago, when my knees were still intact, I used to run every morning with a

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The Search for Truth

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for example, can be practiced within a forensic training program.) In the courtroom context, the consensus panel method seems more disposed toward a fuller approximation of representing the whole truth, especially when the panel is permitted to deliver its narrative in a more open-ended manner.

I look forward to our discussions following the exercise, as well as those following Professor Menkel-Meadow's address on alternatives to adversarial legal processes. I trust they will be stimulating and encourage continued thought and investigation.

Let me also bring to your attention an intriguing step beyond non-adversarial justice. After many years of lawyering, Attorney James Kimmel concluded that the pursuit of justice and the pursuit of happiness were irreconcilable, producing profound suffering and violence. Seeking justice, he argues, is an excuse for acts of vengeance and retribution, and all violence is motivated by the pursuit of justice for some perceived wrong or another. This led him to develop the idea of "nonjustice," borrowing from Gandhi's nonviolence ideology.^{10,11} Nonjustice is a decision made by the victim, and taken solely for his or her benefit, to forego the pursuit of justice in order to achieve peace and happiness. The nine-step Nonjustice System is available online for use.¹² Pilot studies of the effectiveness of this methodology have been conducted by members of Yale's Program for Recovery and Community Health (PRCH), with encouraging early results. I look forward to the developments in these studies, and will be happy to point interested readers in the right direction when they are published.

Finally, one more coming attraction: in my Presidential address, I will be employing the theme of truth as an instrument to explore a spirituality of forensic psychiatry along several dimensions. I look forward to our

conversations on that topic as well, and to seeing many of you again next month.

Good journeys to all. ☯

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AAPL Resource

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documents, including the AAPL Competency and AAPL Disability Guideline revisions, and the new Practice Resource for Prescribing in Corrections.

I encourage all of you to consider helping write AAPL Practice Resources either by contributing to the Forensic Training in General Psychiatric Practice document that is being written, or by suggesting new AAPL educational products. ☯

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Battling the Opioid Epidemic Behind Bars

Anna Weissman MD



The opioid crisis in America has not only challenged the way physicians approach pain and prescribe controlled substances; it is com-

PELLING the adoption of new, evidence-based practices across diverse clinical settings. A robust body of evidence supports the superiority of medication-assisted treatment (MAT)—a combination of pharmacotherapy, counseling, and behavioral therapies—over abstinence-based treatment for substance use disorders. Opioid receptor agonists like methadone and buprenorphine, recognized to be among the most effective treatments for opioid use disorders, are now increasingly initiated outside of specialty clinics, in emergency rooms and primary care offices. Yet agonist therapy is rarely available in correctional settings, despite the fact that 65% of inmates suffer from active substance use disorders and correctional facilities are required to provide the community standard of care for treatment of medical illnesses.

Buprenorphine and methadone have been on The World Health Organization (WHO) list of essential medications since 2005. In 2006, the WHO and the United Nations Office on Drugs and Crime (UNODC) recommended that governments ensure access to MAT wherever it is available in the community, because of its effectiveness for treating addiction and its role in reducing drug injection and HIV transmission. Over the past decade, prison-based agonist therapy has been successfully implemented in Australia and most European countries. In Puerto Rico, buprenorphine initiated during incarceration reduced recidivism and drug use following release. In Canada, methadone main-

tenance programs have resulted in lower rates of re-incarceration.

Yet in the United States, only 11 percent of inmates with substance use disorders receive any treatment for those disorders while incarcerated. As a result, the majority of inmates with a history of heroin addiction will relapse within a month of release, leading to higher rates of overdose deaths, HIV and hepatitis infection, increased criminal activity and re-incarceration. For the small percentage of inmates who do receive help, treatment options are generally limited to psychoeducation and self-help groups favored by American correctional facilities. However, in those US correctional facilities where agonist therapy has been implemented, there has been success. For example, the methadone maintenance program at Riker's Island Jail in New York, in place for more than 20 years, has achieved high post-release treatment retention, reduced recidivism, overall health care cost savings, reduced HIV and hepatitis C transmission, and better than average rates of recovery from drug use. More recently, some correctional facilities in MD, PA, RI and CT have started to provide agonist therapy.

There are challenges to initiating agonist therapy in jails and prisons. These include the need for increased staffing and space, as well as navigating the level of regulation around methadone and buprenorphine, which is more extensive than the regulation of the painkillers that initially led to the opioid crisis. But some of the greatest barriers to implementing MAT are not logistics; they are the attitudes of corrections officials, staff, doctors and the general public. Within the law enforcement community, there is widespread stigma around using medications to treat addiction. Those who consider addiction a moral or spiritual failing, rather than a treatable brain disease, may see

medication as a “crutch” for those who lack the willpower for abstinence-only treatment. Many in the corrections community believe that pharmacotherapy means substituting one addiction for another. These beliefs contradict scientific facts. They conflate addiction (compulsive drug-seeking and use, despite harmful consequences) with dependence (requiring a substance to avoid withdrawal). Yet these convictions are widely held not just in law enforcement, but also in the 12-step community and among physicians.

Among the American correctional facilities that are beginning to offer pharmacotherapy, the vast majority prescribe only intramuscular naltrexone, a mu-opioid receptor antagonist that blocks the effects of opioids. There are multiple appealing aspects to using this medication in the criminal justice system. The drug can be given monthly and can be ordered by prescribing non-physicians like nurse practitioners. The lack of street value and absent potential for misuse make naltrexone particularly appealing. Additionally, mandating a shot of an opioid blocker may fit better with the mindset that prisons should provide punishment, rather than treatment.

But those aspects of intramuscular naltrexone are not solely responsible for its growing popularity in the penal system. Alkermes, the pharmaceutical company that manufactures the drug, has for the past several years been aggressively lobbying state and local lawmakers and law enforcement officials, including judges, to offer it to inmates and parolees. The heavy marketing of intramuscular naltrexone to the criminal justice system cost the company \$4.4 million in 2016, according to data collected by the Center for Responsive Politics. Their investment included large campaign contributions at the state level. This has been a worthwhile investment for the company; at about \$1000 per shot, the drug is lucrative, earning Alkermes \$209 million in 2016, up from just \$30 million in 2011, the year after it was approved to treat opioid addiction.

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Chief Justice of Canada Retiring: The End of an Era

Joel C. Watts MD, FRCPC

President, Canadian Academy of Psychiatry and the Law

Forensic psychiatrists have quite a profound understanding of the importance that jurists can have in the lives of the mentally ill and our work with them. On occasion, we even get to know some by name, particularly the ones whose contributions to landmark decisions are particularly memorable. In Canada, we recently learned that our longest serving (17 years), and first ever woman Chief Justice of the Supreme Court of Canada, the Right Honourable Justice Beverley McLachlin, will retire from the bench in December 2017. Having recently had the privilege to meet Chief Justice McLachlin and hear her speak about her views and the history of Canadian justice's treatment of the mentally ill, I thought it appropriate to briefly review her career and share some of her recent remarks.

Chief Justice McLachlin was appointed to the Supreme Court of Canada in 1989, only nine years after first being called to the bench as a County Court judge in Vancouver, BC. She has been Canada's Chief Justice since 2000. Described by some as having evolved "from a classical liberal determined to limit state intrusions on individual rights to a judge with an eye to the effects of laws on vulnerable people, and a leader in writing about issues involving mental illness"¹, others have described her as being "famously hard to pigeonhole politically, pleasing and annoying left and right by turns."² Although she has not personally authored many of the landmark case decisions for psychiatry in Canada, she contributed to numerous decisions given her long tenure as Chief Justice, often adopting positions that forensic psychiatrists would naturally champion. She has given speeches and written about the advances made in treatment of the mentally ill in medicine and the law's efforts to keep up with our science.

In early May 2017, Chief Justice McLachlin was invited to speak to an annual meeting of the Ontario Review Board (panels that decide the fate of individuals found Not Criminally Responsible or NCR). Inspired by Canada's 150th birthday as a nation this year, she reviewed the historical roots of our criminal forensic system and how far we have come since. She described how in 1800, the presiding judge in the James Hadfield case, Lloyd Kenyon, struggled with competing interests in this early insanity case. His ruling demonstrated concerns he had for Hadfield's mental health and the need to treat him humanely, but he also considered the need for public safety (Hadfield had after all attempted to assassinate the King). The British Parliament

"...now individuals found [Not Criminally Responsible] who represent an ongoing danger to society are subject to annual review by provincial Review Boards."

quickly adopted the Criminal Lunatics Act that year, not liking Lloyd Kenyon's reasoning. This allowed courts to commit individuals judged insane to "strict custody" until "his majesty's pleasure" was known, resulting in such individuals being held indefinitely in custody, often in prisons. The M'Naghten case (1843) further evolved the insanity criteria in Common Law, and although it helped "spare madmen from the noose", those found insane continued to be indefinitely incarcerated. For most of the 20th century, Canada followed 19th century practices of indefinite

custody for those found insane, with no judicial review. In the mid-1970's, a law reform commission in Canada began the work of questioning old assumptions about mental illness and dangerousness. The recent adoption of universal health care in Canada did not include funding for mental health, as attitudes about mental health being part of health care had yet to change. Insanity acquittees continued to be held under the Lieutenant Governor's Warrant system until Chief Justice McLachlin's court ruled it unconstitutional in the 1991.³ Our Parliament was then forced to make sweeping changes to the Criminal Code and now individuals found NCR who represent an ongoing danger to society are subject to annual review by provincial Review Boards. NCR accused are no longer presumed dangerous and automatically detained, and the Supreme Court explained that NCR accused "are entitled to sensitive care, rehabilitation and meaningful attempts to foster their participation in the community" in the landmark decision *Winko v. British Columbia (Forensic Psychiatric Institute)*.⁴

Chief Justice McLachlin told us that she believes the Canadian forensic system works quite well. It does a good job of ensuring public safety, providing appropriate medical care for NCR accused and only restricts liberties as appropriate to the individual's level of violence risk. She noted that recent data shows that NCR accused who were given an absolute discharge recidivate at a lower rate (22%) than general criminal recidivists (34%) and at a much lower rate than for inmates treated for a mental disorder (70%).⁵ Chief Justice McLachlin explained what she believes are some major problems that the forensic mental health system still faces. Firstly, there is a lack of standardization in how provincial Review Boards operate across the country and there is suboptimal coordination of efforts across the country. Secondly, there continues to be a lack of hospital bed availability for court-ordered assessments and the rehabili-

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Robert L. Sadoff MD, 1936–2017

Kenneth J. Weiss MD



In April 2017, the world of forensic psychiatry lost one of its giants, Bob Sadoff. During a 50-year career, he established himself as a premier

teacher and practitioner in the crossroads of psychiatry and the law. Having been inspired to learn about the law in the 1960s and to seek mentors in Los Angeles and Philadelphia, Bob joined the psychiatry faculty of the University of Pennsylvania in 1972. I was fortunate to be introduced to him in 1980, shortly after moving to Philadelphia from Massachusetts, at the dawn of shifting my practice into medicolegal matters. At first, I had no idea how Bob was revered in Philadelphia, let alone in America and abroad. He knew doctors, lawyers, judges, therapists; and he could mobilize people and convene groups of like-minded professionals to talk about how to address real issues in social justice. The more I knew Bob, the more astounding were his accomplishments and reach.

While I was a junior faculty member at Jefferson Medical College, my department chair, Paul Fink, generously permitted me to study with Bob, at his Program in Social and Legal Psychiatry, at Penn. It was a part-time apprenticeship during the 1982–83 academic year in a program that started in the 1970s. An amazing feature of being in this privileged group was to be part of Bob's entourage. He loved us to come with him and watch him work, whether at a jail or in the courtroom. His car was a classroom. That was a model I adopted when I have supervised psychiatric residents and fellows. But while he thrived on the real-life education experience, Bob retained humility and a firm grip on his standards of conduct. That is, he modeled the work for us, rather than putting on a bravura show (which he did any-

way). Bob also relished telling stories of how he took the moral high road with lawyers and opposing experts who tried to joust with or discredit him. We got the message: Don't mess with Bob! But with his students, he was always a gentleman. At the same time, he was fierce and formidable as a testifying expert witness. Bob loved to win, but for the right reason: not for winning's sake, but for the process of truth-seeking.

Bob Sadoff and books: a love affair. Over 40 years, Bob amassed a collection, consisting of thousands of books and pamphlets, spanning two centuries. He was famous among book dealers, collecting items in forensic psychiatry and legal medicine. Having been a fellow of the College of Physicians of Philadelphia, which has a fabulous historical medical library, Bob arranged with them in 2002 to house a specialized library in his name. It was a huge undertaking to catalog the collection, largely completed by the 2004 dedication.

Bob was fascinated by the intertwining of medicine and the law, especially how it shaped forensic psychiatry in the nineteenth century. To examine the whole arc of forensic psychiatry, Bob assembled over 40 colleagues and published, in 2015, *The Evolution of Forensic Psychiatry*. The book, published by Oxford University Press, received the APA's Guttmacher Award in 2017. Bob did not survive to receive it personally, but asked three colleagues, Drs. J. Richard Ciccone, Thomas G. Gutheil, and Octavio Choi, to join me on a panel. We talked about Bob's contributions to forensic psychiatry, his many accomplishments, and his generosity. I had not previously discussed the relationship between Bob and my studying the history of forensic psychiatry. While he was an avid collector, Bob left the documentation of the history of legal medicine to others. Little did I know that when the Sadoff Library opened, in 2004, that I would venture off into historical

work. Indeed, I was so inspired that, with Bob's help, I became a Fellow of the College of Physicians of Philadelphia the next year, and began researching Dr. Isaac Ray. Bob received the APA's Isaac Ray Award in 2006 and asked me to deliver the Sadoff Lecture at the College of Physicians in 2007. We both had friends and family in attendance. It was a proud moment for both of us. Giving the lecture was a benchmark in my career and personal growth, as I felt I was giving something back to Bob. In the following ten years, Bob and I arrived at a new plane of collegiality, wherein I helped to develop the fellowship program at Penn and we received eight classes of fellows. He derived intense pleasure from his role as mentor, which was reflected by my joy in seeing the master achieve his long-awaited goal of an accredited program. Sadly, Bob was unable to be on campus regularly, but he participated actively in program design and made a special visit to our three fellows this year.

This memoir represents a sliver of a richly lived life, told by one grateful colleague. Many persons and organizations, in many domains of life, were touched by Bob's wisdom and generosity. Over his long career, Bob received many awards and citations, and he donated time and money to improve social justice and education. For a fascinating account his life, please read Frank Dattilio and Tom Gutheil's 2008 article in the *AAPL Journal*. ☪

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RAPPEPORT FELLOWSHIP AWARDS, 2017-2018

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

The Rappeport Fellowship Committee is excited to announce the 2017-18 Rappeport Fellows: Dr. Lisa Anacker, Dr. Sarah Baker, Dr. Joseph Cheng, Dr. Joseph Dunlop, Dr. Matthew Hirschtritt, and Dr. Ryan Leahy. Congratulations!

The prestigious AAPL Rappeport Fellowship was named in honor of AAPL's founding president, Jonas Rappeport, MD. It offers the opportunity for outstanding senior residents with a dedicated career interest in forensic psychiatry to receive mentorship by senior forensic psychiatrists. In addition, fellows will receive a scholarship to attend the AAPL forensic psychiatry review course and the annual AAPL meeting in Denver, Colorado.



Lisa Anacker MD

Dr. Lisa Anacker is a Psychiatry Chief Resident at the University of Michigan, where she is also in her fourth year of residency. After graduating Summa Cum Laude from Miami University, she attended medical school on a full tuition scholarship at Wright State University Boonshoft School of Medicine. During her time in medical school, Dr. Anacker was inducted into both the Gold Humanism Honor Society as well as the Alpha Omega Alpha Honor Medical Society, where she served as president of her medical school chapter. She was awarded the Outstanding Graduating Student Award at her medical school matriculation. Dr. Anacker developed an interest in psychiatry and the law while in medical school, and cultivated that interest further in residency. While in residency, she has prepared and

delivered multiple presentations at both the local and national level on violence risk assessments as well as gun control laws and mental illness. Dr. Anacker has also co-authored a paper on the legal context and clinical approaches related to mental illness and firearms, as well as an article on lifelong GPS monitoring for sex offenders released from civil commitment. Her current projects include a data review on delusional disorder and its amenability to competence to stand trial restoration, as well as a policy paper on issues related to individuals with intellectual and developmental disabilities, with a focus on forensic and civil contexts where aggressive behavior may pose challenges. She plans to complete a Forensic Psychiatry Fellowship upon completion of her general residency in 2018. Dr. Anacker's Rappeport Fellow mentors are Dr. Jessica Ferranti and Dr. Britta Ostermeyer.



Sarah Baker MD

Dr. Sarah Baker is a fourth-year general psychiatry resident at UT Southwestern Medical Center in Dallas, Texas. She graduated from Rice University with a degree in history, and then she pursued an MD/MA dual-degree program at the University of Texas Medical Branch and its Institute for the Medical Humanities in Galveston, Texas. For her master's degree, she focused on the social sciences and their application to medical education. She designed a study for her master's thesis titled "Making Meaning of Empathy: A Qualitative Study of Medical Education at UTMB." Dr. Baker first became interested in forensic populations while in medical school, when she saw both incarcerated patients (in a correctional care hospital) and patients recently released from prison (in a student-run free clinic).

She has an interest in developing better community-based approaches to caring for patients who have contact with the legal system, particularly through the cultivation of empathy and collaboration across disciplines. While in medical school, Dr. Baker had the opportunity to be a Student Director for St. Vincent's Clinic, one of the largest student-run free clinics in the country. It was through this work that she developed an interest in advocacy, and she has recently been elected as Chair of the Resident-Fellow Section of the Texas Society of Psychiatric Physicians and appointed to the Texas Medical Association's Council on Science and Public Health as the Resident-Fellow Representative. She was also selected as a Group for the Advancement of Psychiatry Fellow, where she serves on the Community Psychiatry Committee. Dr. Baker plans to pursue a forensic psychiatry fellowship next year. Dr. Baker's Rappeport Fellow mentors are Dr. Susan Hatters Friedman and Dr. Alan Newman.



Joseph Cheng MD, PhD

Dr. Joseph Cheng is a fourth year psychiatry resident at the Medical University of South Carolina in Charleston, SC where he also graduated from the medical scientist training program. His interests broadly include trauma, psychopharmacology, sexual behaviors, and brain stimulation. He is completing a NIDA-sponsored Drug and Alcohol Research Training program fellowship at MUSC working with and researching law enforcement post-critical incident seminars with Dr. Gregg Dwyer. He is also working on a study of simultaneous functional imaging and phallometric assessment with Drs. Gregg Dwyer and Paul Fedoroff. Dr. Cheng has been the recipient of teaching and research awards, including the Gold Humanism Honor Society Excellence in Teaching Award and intramural Golden Apple. In AAPL, he is a member of three committees, presented poster and oral abstracts, and co-authored

AAPL newsletter articles with Dr. Ryan Hall. He plans to begin forensic psychiatry fellowship training in 2019. Dr. Cheng's Rappeport Fellow mentors are Dr. Ryan Hall and Dr. Renee Sorrentino.

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RAPPEPORT FELLOWSHIP AWARDS, 2017-2018



Jonathan Dunlop MD, JD

Dr. Jonathan Dunlop is a fourth-year psychiatry resident at the University of Michigan where he participates in the Clinical Scholars Track. He received his MD from the University of Illinois College of Medicine at Chicago. Prior to medical school, he was a practicing attorney and member of the Illinois State Bar Association. He received his JD at the University of Iowa, which he attended on a Merit Fellowship, as well as his BA in Spanish at Washington University in St. Louis. He has co-authored two articles in the Legal Digest of the Journal of AAPL and attended national and regional meetings of AAPL. He has served as a resident representative to the Michigan Psychiatric Society for three years.

Dr. Dunlop is currently developing a project examining the evaluation of individuals in law enforcement custody in psychiatric emergency rooms. He has an interest in systems of care and is looking forward to continuing to combine his legal background with the practice of forensic psychiatry. After graduation from general residency, he plans to continue his training in forensic psychiatry by completing a fellowship at the Center for Forensic Psychiatry in Saline, Michigan. Dr. Dunlop's Rappeport Fellow mentors are Dr. Cathy Lewis and Dr. Sara West.



Matthew Hirschtritt MD, MPH

Dr. Matthew Hirschtritt is a third-year trainee in the Adult Psychiatry Residency Training Program at the University of California, San Francisco (UCSF). Prior to residency, Dr. Hirschtritt received his undergraduate degree in psychology from Cornell University, then completed a two-year post-baccalaureate fellowship at the National Institute of Mental Health, a one-year pre-medical program at Johns Hopkins University, and served as a research associate at the Yale Child Study Center. He went on to complete his MD and MPH degrees from the Cleveland Clinic Lerner College of Medicine and Case Western Reserve University, respectively. During medical school, a Doris Duke Clinical Research Fellowship brought him to UCSF, where he stayed for residency training. His research interests

include access to care, implementation science, quality of mental-health care in correctional settings, prevention of criminal behavior and recidivism, and psychiatric epidemiology. He co-led a workshop addressing forensic issues in emergency psychiatric settings for the 2015 AAPL Annual Meeting and wrote a Perspective regarding the criminalization of mental illness, which appeared in JAMA. He has lead- or co-authored several other peer-reviewed reports. In the summer of 2018, following residency training, he will begin the forensic psychiatry fellowship at UCSF. Dr. Hirschtritt's Rappeport Fellow mentors are Dr. Vivek Datta and Dr. Brian Holoyda.



Ryan Leahy MD

Dr. Ryan Leahy is in the second year of a child and adolescent psychiatry fellowship at the University of Miami/Jackson Memorial Health System. He currently serves as co-chief fellow for the program and is also completing a two-year psychodynamic psychotherapy training program through the Florida Psychoanalytic Institute. Dr. Leahy completed his training in adult psychiatry at the University of Tennessee where he served as chief resident and was also able to complete a yearlong certificate course in clinical research methodology to help strengthen and expand his research skills. While at the University of Tennessee, Dr. Leahy was given the opportunity to consult with the Memphis police department's Crisis Intervention Training Program, working with police officers on de-escalation skills and ways of

dealing with persons in distress. Prior to medical school Dr. Leahy was a Chicago police officer where he worked in uniform patrol as well as gang tactical and city-wide anti-crime units. In Chicago, he also earned a Master of Science degree in Financial Markets from the Illinois Institute of Technology. This is Dr. Leahy's fourth AAPL conference in a row. He is a current committee member of Child and Adolescent Psychiatry, Law Enforcement Liaison and Sex Offenders. His interests include violence risk assessment, law enforcement stress management, psychopathy, working with juveniles and working with sex offenders. Dr. Leahy has presented on topics that include malingering, psychopathy, conduct disorder, and antisocial personality disorder. He presented posters at the APA 2016 IPS meeting and the European Congress of Psychiatry. Next year, he will begin a forensic psychiatry fellowship at the Medical University of South Carolina and is looking forward to establishing a career in this field. Dr. Leahy's Rappeport Fellow mentors are Dr. Jacqueline Landess and Dr. Robindra Paul. ☎

AAPL is pleased to announce the 31st Annual Rappeport Fellowship competition. PGY-3 residents in a general program, or PGY-4 in a child or geriatric subspecialty training program, who will begin their final year of training in July 2018, are eligible. Canadian PGY-5 general psychiatry and PGY-6 child residents are also eligible. Registration to the Forensic Review Course and Annual Meeting in Austin, TX (October 22-28, 2018) along with travel, lodging, and educational expenses are provided to the winners. Contact the AAPL Executive Office for more information.

No Lie MRI? So Far, Courts Say, "No Way!"

Joseph Simpson MD PhD

A recent episode of the popular daytime television show *The Dr. Oz Show*¹ featured the case of Gary Smith, who was convicted of murdering his roommate and fellow former Army Ranger, Michael McQueen. Smith's defense contended that Mr. McQueen committed suicide. After his original conviction was overturned, he sought, at his second trial, to introduce evidence from a functional magnetic resonance imaging (fMRI) lie-detection test to support his argument that he was being truthful when he denied killing Mr. McQueen.

It has been over 15 years since articles first began appearing in cognitive neuroscience and bioethics journals exploring the possibility of using advanced brain imaging techniques like fMRI to identify when a person engages in deception, and the potential implications of such technology for the legal system^{2,3}. By the middle of the 2000's, two companies, No Lie MRI, Inc. and the Cephos Corporation, were offering commercial lie-detection services using fMRI. Suggested applications included civil and criminal legal cases, as well as employment-related uses for the government sector.

To date, few courts have been asked to opine on the admissibility of fMRI lie detection evidence. Those which have all found such evidence to be inadmissible. In a 2010 New York civil case, *Wilson v. Corestaff*⁴, and also in the second murder trial of Gary Smith in 2012, the trial courts did not allow the proffered evidence to be presented. The most extensive judicial analysis of fMRI lie detection evidence published thus far stems from another criminal case, the federal Medicare fraud trial of psychologist Dr. Lorne Semrau in 2010.

At Dr. Semrau's trial the district court Magistrate Judge, Tu Pham, conducted an extensive hearing,

including testimony from Dr. Steven Laken, the founder of Cephos Corporation. After the hearing he issued a 43-page Report and Recommendation⁵ setting forth his reasoning for excluding the proffered lie detection evidence. Dr. Semrau was subsequently convicted of three counts of healthcare fraud and sentenced to 18 months in prison.

Dr. Semrau appealed his conviction to the Sixth Circuit Court of Appeals. A three-judge panel reviewed the trial court's decision to exclude the fMRI lie detection evidence (as well as other unrelated arguments for reversing his conviction) in a lengthy opinion⁶. They upheld the ruling that the evidence was inadmissible and affirmed Dr. Semrau's conviction. Both Judge Pham's original report and the Sixth Circuit opinion (which relied heavily on Judge Pham's report) are well worth reading for anyone interested in this area, as they are very instructive and demonstrate a number of obstacles that are likely to confront any expert witness who may seek to present this type of evidence in the future.

The grounds for excluding the fMRI lie detection included the fact that all published laboratory studies involved mock scenarios, that they had used subjects between the ages of 18 and 50 (Dr. Semrau was 63 when he was given the test), a high false-positive rate in the studies (i.e., incorrectly classifying truth-tellers as liars), and perhaps most critically in terms of application in a criminal trial, the fact that the test could only provide a general conclusion as to whether the test subject had been truthful during the test, rather than rendering a specific assessment of the truthfulness of Dr. Semrau's responses to individual questions during the test.

A group of neuroscientists and legal experts recently published an

article reviewing the status of fMRI lie detection in the legal arena⁷. The article describes several factors working against the adoption of the technique for real-world applications in court, including the difficulty in defining what is meant by a "lie," the difficulty in identifying the role of a given brain region in specific cognitive processes, confounds such as variations in the richness and detail of a given memory, the length of time between the test and the events being asked about, and the dearth of research into possible countermeasures.

Humans have sought answers to the problem of deception for thousands of years. The complexity of the brain has not yet yielded to our most advanced technology when it comes to accurately and reliably distinguishing lies from truth in high-stakes situations where large sums of money, a prison sentence or even a death sentence may hang in the balance. For now, it seems safe to say, the finder of fact will retain the ultimate responsibility for determining who is lying and who is telling the truth in court, without any assistance from the advanced technology and sophisticated statistical analysis that create fMRI images. ☞

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Middle Ground: An Update on Terrorism and Mental Illness

Kavita Khajuria MD

Terrorist events in England this year remind us of this unfortunate phenomena which doesn't seem to go away. A van plowed into worshippers near a London mosque in June, injuring 11 people (1). This took place just a few weeks after a trio ploughed into pedestrians on London Bridge and stabbed people in pubs and bars, killing eight and injuring 48 (3). A suicide attack killed 22 people after a pop concert at Britain's Manchester arena in May (2), and in March, a man drove a car into pedestrians on Westminster Bridge and stabbed a policeman to death (8).

Research on the relationship between terrorist involvement and mental disorders extends for over 40 years. Many early studies assumed specific mental disorders as causal, but these were later rejected by other studies, which downplayed the presence of mental illness (4). More recent research has found a *middle ground* where mental disorders are just one factor among many, but not for all terrorists everywhere (4).

Many assumptions and incorrect interpretations of earlier work permeate the current day. Gill and Corner cite 4 generations of paradigms that differ in terms of their empirical evidence, the specific mental disorders studied, and their conceptualizations of terrorist involvement (4). The first "*Psychopathy as Key*" offered psychopathy as a cause of terrorist involvement, and characterized this as a yes/no dichotomy (either the person was a terrorist, or not). The second "*Personality as Key*" subsequently focused away from psychopathy toward specific personality types, wherein psychoanalytic perspectives took over and focused on motives spanning from childhood maltreatment (4). Various aspects of personality were analyzed, especially narcissism, with narcissistic rage directed toward other targets held to be responsible (4). This theory lacked

empirical strength, however. The third paradigm "*Synthesizing the Evidence*", argued that the first 2 paradigms suffered from the fundamental attribution error, and focused too much on the actions of the terrorist, rather than the processes through which he/she became one. Psychopathy and personality disorders were both found to be unsupported empirically. These reviews were not arguing that people with pathological disorders do not join terrorist groups. Instead, they argued that the prevalence rates of various mental disorders are *no different* to those found in general society, and that previous studies had been misinterpreted (4). The 4th paradigm "*Pathways, Disaggregation and Continuums*" embraces the *complexity* of terrorist involvement, which includes the experience of 'being' a terrorist, its lifestyle, associated risks, group conflict, and the need for consideration of the circumstances of arrest and detention.

The avalanche of literature on terrorism since 9/11 led many to understand terrorists as if they were all similar. Terrorism and psychopathology are more complex, as a wide range of behaviors, members and functions comprise terrorist groups, and radicalization is a process that can vary from case to case (4). Research demonstrates that those with mental disorders have been just as likely to engage in rational pre-attack behaviors. They are more likely to express violent desires, seek legitimization for their intended actions, stockpile weapons, train, carry out a successful attack, kill, injure, discriminate in their targeting, and claim responsibility (4).

Subgroup comparisons have demonstrated that some terrorist types are more likely to suffer from mental disorders than others (4). Lone-actor offenders were 13.5 times more likely to have a history of mental illness than group-based actors (6), and men-

tally disordered lone-actor terrorists were significantly more likely to experience a recent stressor prior to planning their terrorist attack (4). They exhibited a higher prevalence of schizophrenia (most noteworthy) (5), delusional disorder and autism spectrum disorder than the general population (4). Those diagnosed with schizophrenia were the only diagnostic group to be significantly associated with previous violent behavior. Lone actors had a high preponderance of single issue ideologies with highly personal grievances linked to political aims, and often fostered intense online relationships (5). Meloy *et al* described 70% of their adolescent mass murderers as loners and outcasts.

The suicide bomber group received significantly more diagnoses of avoidant-dependent personality disorder, depressive symptoms, and more readily displayed suicidal tendencies, while a control group was more likely to contain members with psychopathic tendencies (4). Studies have also concluded there to be a causal relationship between the impact of stressors on the onset of depression, noting that those predisposed to depression place themselves into high risk environments (6). Anecdotal evidence from a sample of 'coerced' and 'escapist' suicide terrorists suggest they suffered from significant depression, anxiety, stress and trauma (7). Individuals with a spouse or partner involved in terror were 22 times more likely to have a diagnosis of schizophrenia and 250 times more likely to be diagnosed with a mood disorder (6). Suicide bomber organizers scored higher in ego-strength, impulsivity and emotional instability than would-be suicide bombers (4).

The likelihood of detection of mental health problems and suicidal motives among would-be terrorists by researchers and clinicians seems small, as many remain at large. Doctor avoidance may be particularly common in the young, male, or those struggling financially (7). The World Health Organization has also drawn attention to the under-diagnosis of

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Boundary Violations in Correctional Psychiatry

Susan Hatters Friedman MD; Ryan C. W. Hall MD; Brian Cooke MD; Abhishek Jain MD; Ryan Wagoner MD; Renée M. Sorrentino MD

At the San Diego APA meeting we presented a workshop on Boundary Violations in Corrections that focused on education and prevention. Recent news headlines, such as “Four female prison guards impregnated by same inmate,” “Prison tailor used food to help killers escape,” and “Expert: Escaped California inmates must have had inside help,” describe boundary violations and transference issues between corrections staff and inmates which negatively impact the safety and security of correctional facilities. Often these relationships seem counter-intuitive, because research on the guard-prisoner dynamic suggests authority figures will devalue inmates, rather than form close relationships, due to concerns that inmates will escape or break safety rules. In a behavioral study on obedience, Milgram showed obedience could lead normal individuals to engage in destructive and harmful behavior when encouraged to do so by an authority figure. Likewise, in the famous Stanford prison experiment, Zimbardo proposed that individuals took on specific roles and characteristics of those roles, such as prisoner or guard, when placed into a correctional setting. Moreover, some correctional relationships mirror classic therapy transference/counter-transference dynamics (e.g. erotic transference) resulting in such activity occurring.

Sexual boundary violations are a risk in corrections in general, as well as correctional psychiatry. Much like in a therapy setting, where there is a power imbalance, a shift may occur in the relationship that may be rationalized as consensual. “Orange is the New Black” and its (seemingly) romantic relationships may affect how many (including trainees) view ‘relationships’ between staff and inmates as innocent and consensual. In addition, there are

unique vulnerabilities found in correctional work (e.g., being undervalued as a law enforcement officer; having close, frequent, and often physical contact with inmates; being in geographically-isolated areas) that further explain the potential for boundary violations to occur. These relationships also present a risk to the prison—because they may be a means to an end—such as prisoners obtaining contraband. Therefore, it may be beneficial to apply lessons taught in psychiatric training regarding transference and boundaries, to correctional situations.

“...minor violations in prisons by providers (e.g. bending a rule) can be a slippery slope towards behavior that may eventually lead to ethics concerns...”

Understanding how the complexities of boundary violations are taught to medical students and psychiatry residents helps explain gaps in knowledge and how they might lead to professional misconduct. Gabbard and Nadelson wrote, “Professional boundaries in medical practice are not well defined. In general, they are the parameters that describe the limits of a fiduciary relationship in which one person (a patient) entrusts his or her welfare to another (a physician), to whom a fee is paid for the provision of a service.”

Boundary crossings are distinct from violations, as the former are typically benign, may be helpful, occur in isolation, and are minor. Boundary concerns may arise in categories of gifts and services, self-disclosure,

physical contact, and dual roles. Furthermore, minor violations in prisons by providers (e.g. bending a rule) can be a slippery slope towards behavior that may eventually lead to ethics concerns from a professional organization, such as the APA, disciplinary actions from a state medical board, or lawsuits. Psychiatrists may also consider the ethical duties of reporting colleagues, as well as specific legal standards in correctional settings, such as mandated reporting under the Prison Rape Elimination Act (PREA) of 2003.

It is important to discuss professional boundaries with trainees, because it promotes high quality treatment and minimizes liability, in addition to promoting integrity and professionalism. Although there are opportunities to teach these topics in different learning environments, students may have negative responses. Several model curricula for students and psychiatry residents are publically available that emphasize teaching boundary violations and professionalism.

Most psychiatry residency programs do not provide training in correctional settings. Forensic psychiatry fellowship programs have a treatment rotation in a correctional setting. To date the opportunities for specialized training include resident electives, through a forensic fellowship, and/or “on the job” training. Prevention of boundary violations includes self-awareness of when one is at risk (e.g. isolation or relationship breakdown or over-identification with an inmate), maintaining a healthy work-life balance, supervision as needed, and appropriate boundaries and limit setting. ⁽⁴⁾

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American Medical Association 2017 Annual Meeting Highlights

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

The American Medical Association's (AMA) June 2017 Annual Meeting in Chicago focused on policy related to the Opioid Epidemic, Health Reform and Practice, Health Initiatives, Science and Technology as well as elections for leadership positions. David O. Barbe, MD, MHA a family practice physician, from Missouri and, who is Vice President of Regional Operations at Mercy Clinic, was inaugurated as President of the AMA. In his inaugural address, Dr. Barbe spoke of "the AMA's unwavering goal of affordable health insurance coverage for all" as well as three areas where physician leadership is critical: advocating for health reform in today's political environment, describing and shaping the future of health care, and in mentoring those who will enter our profession.

Barbara L. McAneny, MD, a board-certified medical oncologist/hematologist from Albuquerque, New Mexico, was elected to the position of President-Elect. In addition, Patrice A. Harris, M.D., MA, a child and forensic psychiatrist, who is a member of AAPL, has moved into the role of Immediate Past Chair of the Board of Trustees; she continues to serve as the Chair of the AMA Opioid Task Force which has been a major initiative for the AMA.

Resolutions addressing the Opioid Crisis include expanding access to buprenorphine for individuals with an opioid use disorder, safe storage and disposal of controlled substances, improving pain care. The AMA has organized a Taskforce to address this public health crisis to involve medical specialties who are providing pain care and treatment. Multiple courses regarding this topic were offered to physicians attending the meeting.

The AMA Committee on Constitution and Bylaws heard passionate tes-

timony and debate on topics involving Women and Children in Family Immigration Detention Facilities, the unmet needs of this population and the improvement of medical and mental health care in these facilities. Resolutions referencing this serious situation included "Increasing Access to Healthcare Insurance for Refugee Populations," "Healthcare as a Human Right" and multiple resolutions on "Care of Women and Children in Family Immigration Detention" as well as "Improving Medical Care in Immigrant Detention Centers" and "Consideration of the Health and Welfare of U.S. Minor Children" Unanimous testimony was heard by the Constitution and Bylaws Committee on "Patient and Physician Rights Regarding Immigration Status" which prohibits U.S. Immigration and Customs Enforcement or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.


There was also broad, positive and robust testimony on "No Compromise on Anti-Female Genitalia Mutilation Policy" and the resolution was adopted. The AMA's Council for Ethical and Judicial Affairs (CEJA) report on "Professionalism in the Social Media" was also adopted, while "Competence, Self-assessment, and Self-awareness" recommended that ethical responsibility of competence guidelines be adopted for physicians in practice and physicians in training, as phases of a physician's medical career vary in what a physician should know and have the ability to practice safely. This resolution was recommended for referral due concerns about the language within the reports recommendation that could have unforeseen legal consequences. CEJA resolution on "Ethical Physi-

cian Conduct in the Media" was recommended for referral, as the role of the physician must be distinct from other roles. The resolution "Who Owns Our Patient Data," which asks AMA to study the use and misuse of patient information by hospitals, corporations, insurance companies or Pharma when the patient data is withheld from the physician and the impact on safety, quality and access to care, was adopted with report back at the 2018 Annual Meeting.

Other relevant topics in forensic psychiatry including "Access to Basic Human Services for Transgender Individuals," "Commercial Exploitation and Human Trafficking of Minors," "Consideration of Health and Welfare of U.S. Minor Children in Deportation Proceedings Against their Undocumented Parents," "Increasing Access to Healthcare Insurance for Refugee Populations" and "Improving Physicians' Ability to Discuss Firearm Safety" were adopted. "Appropriate Placement of Transgender Prisoners" was recommended for referral.

"Mandatory Public Health Reporting of Law-Enforcement-Related Injuries and Death" regarding the AMA to encourage the CDC and state departments of health to make law-enforcement-related deaths a notifiable condition, were recommended for referral for decision.

AAPL Delegate, Barry Wall, MD and Rebecca Brendel, JD, MD served on the Constitution and Bylaws Reference Committee. They actively took a lead role during deliberations. Dr. Wall also continued to serve as Co-vice-chair for the psychiatric caucus. Young Physician Delegate Jennifer Piel, JD, MD was honored with the Excellence in Medicine Leadership Award and also continued to serve as the Chair for the Young Physicians Section's Internal Reference Committee.

For information on the actions of the AMA House of Delegates at the 2017 Annual Meeting, please visit <https://www.ama-assn.org/about/house-delegates-hod>. 

The APA Assembly Report

Cheryl D. Wills MD, AAPL Representative to the APA Assembly

The APA May 2017 Annual Meeting in San Diego, California offered more than 450 sessions, 30 in-depth courses and four master courses to attendees. The theme for the meeting was “Prevention Through Partnerships” and there were 104 invited sessions that were related to President Maria Oquendo’s, MD, PhD theme and charge to diversify the program. At the end of the meeting, Anita Everett, MD, who is the Chief Medical Officer at the Substance Abuse and Mental Health Services Administration (SAMHSA), became the President of the APA and Altha Stewart, MD became President-elect.

The APA continues to be involved in meeting the practice needs of psychiatrists and the clinical needs of our patients. The organization collaborates with other healthcare advocacy organizations to surveil proposed healthcare legislation with the goal of advancing mental health parity. The disparity in mental healthcare reimbursement is important to members and the APA is working to address this. The organization continues to use secret shopper data to inform national and local discussions with insurance commissioners and state attorneys about reimbursement rates and patient outcomes. Educational webinars for APA District Branches will occur in the future. The goal is to obtain guidance from the federal government regarding what constitutes parity and what violates parity requirements. The Centers for Medicaid and Medicare Services, CMS, has issued mental health parity compliance grants to 20 states and the APA has been working closely with affected District Branches to interface with state insurance administrators as the project evolves.

Scope of practice concerns are important and APA continues to assist District Branches that are trying to prevent psychologist prescribing bills from being passed. The APA has developed an Unsafe Prescribing Toolkit that is being used in collabora-

tion with several District Branches, to “coordinate lobbying, communications, and partnership strategies, as well as promoting alternatives to psychologist prescribing, including telepsychiatry utilization and integrated care.” Also, the APA is providing input on the rulemaking process for psychologist prescribing education, certification and practice in Illinois, Iowa and Idaho, which became the fifth state to have a psychologist prescribing law in June 2017. The APA also is working with District Branches in 10 states to weigh in on Advance Practice Registered Nurses’ scope of practice proposals.

In the past year, two well-attended briefings on Capitol Hill were cosponsored by The APA. “Suicide in America: Trends, Prevention and New Approaches” was cosponsored with the American Foundation for Suicide Prevention and “The Opioid Crisis in America: Addiction, Access and Treatment” was cosponsored with the American Society of Addiction Medicine. Positive feedback from attendees suggests that future educational briefings should be planned.

More than 1200 psychiatrists have been trained on the collaborative care model (CCM) in the past eighteen months. The APA is offering 12-week online learning collaboratives for psychiatrists who have completed CCM training. The organization recently conducted a webinar for primary care providers that showed how CCM can enhance their clinical productivity. Online training modules are now available for primary care physicians to receive CCM education. The APA will offer joint training for physicians and primary care providers for District Branches who request such programs. Reimbursement is available for collaborative care mental health providers through Medicare Behavioral Health Intervention codes which are used by primary care practices that hire behavioral healthcare managers and establish a

working relationship with a consulting psychiatrist.

The APA’s video-based “Telepsychiatry Toolkit” has been updated for the second time and contains 12 pages of new content. The organization is collaborating with the American Telemedicine Association to craft a telepsychiatry practice guideline. Information may be found at psychiatry.org/Telepsychiatry.

When the American Board of Psychiatry and Neurology (ABPN) introduced Maintenance of Certification (MOC) for board certified psychiatrists it was controversial. Some psychiatrists believed that if the medical profession did not police itself, legislators would do it. Despite the challenge of navigating a sometimes obfuscating process, many of us complied. Some psychiatrists who refused to do so suffered professionally as some insurance panels and healthcare agencies would only work with board certified physicians who completed MOC.

More than 20 years later, the tide may be changing direction. This may be related to a physician shortage in some states, concerns about how possible changes in US immigration policy will affect the availability of physicians and access to medical care for Americans or other concerns. In 2017 legislators in 10 states have crafted MOC waiver bills that prohibit medical licensure boards, insurance companies, and/or healthcare facilities from denying practice privileges to physicians who do not meet MOC requirements for board certification. Despite strong objections from the American Board of Medical Specialties, the ABPN and other agencies and individuals, three of those states – Maryland, Oklahoma and Texas – now have laws. The vote in Oklahoma was unanimous.

Despite these changes, MOC remains a reality for most of us and the APA has crafted a resource that is available online to help members understand changes that are occurring in the ABPN MOC program. The APA continues to communicate members concerns about MOC to the

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Trajectories of Post-Traumatic Response and Implications for Assessment of Damages

Stuart B. Kleinman MD, Trauma and Stress Committee

Determination of prognosis is a central component of forensic psychiatric assessment of emotional distress damages. Too frequently, non-evidence based conjecture is offered as an opinion.

Evaluation of the prognosis of a Post-Traumatic Stress Disorder (PTSD) is particularly challenging. Multiple psychosocial, and probably not yet well identified biological, variables influence prognosis. That greatly varying experiences may produce the same diagnostic entity, i.e., PTSD, markedly complicates both research and rendering a forensic opinion regarding the outcome, especially long-term outcome, of traumatic events.

Recent research increasingly supports that the response to traumatic events follows various trajectories.

Bonanno, Galea, Bucciarelli, et al., (1) importantly contributed to the concept of response trajectories, identifying and describing four types:

1. Resilience: Those who follow this trajectory never experience a significant disruption of functioning.
2. Recovery: Those who follow this trajectory experience initial, acute reactions which gradually diminish.
3. Chronic: Those who follow this trajectory experience an initial, severe response which persists, to a varying severe extent, for months to years.
4. Delayed: Those who follow this trajectory experience sub-syndromal symptoms for six months, which then abruptly increase in magnitude.

Illuminating the trajectory of PTSD across decades, Solomon, Horesh, and Ein-Dor, *et al.*, (2) identified the following four trajectories amongst 164 Israeli soldiers who were taken captive in the 1973 'Yom Kippur War', and subsequently

assessed in 1991, 2003, and 2008:

1. Delayed: 67.0% of former POWs suffered delayed onset of PTSD. 59.1% of those with no PTSD in 1991, were found to be suffering from PTSD in 2003, and 38.5% of those with no PTSD in 2003 were found to have PTSD in 2008. Moreover, 60.2% of former POWs had PTSD in 2008, as opposed to 12.3% in 1991.
2. Chronic: 5.1% of former POWs were in this group.
3. Recovered: Only 1.3% of former POWs were in this group.

An exceptionally high number of individuals manifested a delayed PTSD. Methodological factors, including the lengthy periods between assessments, may have artificially inflated the study's rate of such.

The trajectory of PTSD differed significantly between former POWs, and the control group composed of war veterans. Amongst the latter, 4.8% displayed a delayed trajectory, and 88% were in the resilient group.

Significant to forensic psychiatric assessment, the subjective experience of captivity most strongly distinguished between the resilient and PTSD groups. Also significant for forensic psychiatric consideration, being a prisoner of war involves chronic, prolonged, as opposed to acute, significantly circumscribed, exposure to trauma.

A 2015 study (3) of Vietnam war-zone veterans who were assessed 40 years post-combat exposure revealed the following regarding the prevalence and course of DSM-V defined PTSD:

1. Current prevalence: PTSD- 4.5%. PTSD, and sub-syndromal symptoms- 10.2%.
The high rate of sub-syndromal symptoms is important to consider in forensic psychiatric assessment.
2. Lifetime prevalence: PTSD- 17.0%.

PTSD, and sub-syndromal symptoms- 26.2%.

Importantly illustrating that PTSD suffered by combat veterans may be prone to worsen over extended periods, 16% of war theater veterans demonstrated an increase of more than 20 M-PTSD (Mississippi Scale For Combat-Related PTSD) points, while 7.66% demonstrated a decrease of this magnitude. Significant to interpreting such, the study's design, specifically the limited number of points of measurement, may have prevented detection of waxing and waning of symptoms.

Further significant for forensic psychiatric assessment, 31.7% of those with current PTSD, and 30.9% of those with current sub-threshold symptoms, concomitantly suffered from Major Depression. Most combat veterans did not, however, suffer from alcohol or drug abuse.

The course of PTSD amongst those who have suffered civilian traumas does not necessarily resemble that of the above veterans.

Notably, litigation regarding emotional distress damages primarily involves civilian injury. A study (4) which followed 1022 individuals consecutively admitted to an emergency room helps to illuminate the trajectories of such. These individuals were evaluated 10 days, and 7 and 15 months, following admission. Approximately 84% of those studied had suffered motor vehicle accidents, approximately 9% terrorist attacks, and approximately 4% work accidents. The following trajectories were identified:

1. Remitting: The symptoms of those who followed this trajectory precipitously decreased from one to five months (per a calculated, negative symptom slope). 56% of individuals followed this course.
2. Slow Remitting: The symptoms of the 27% in this trajectory declined at a relatively consistent rate over 15 months.
3. Non-Remitting: The symptoms of the 17% belonging to this group remained persistently elevated.

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Free (to) Love?

Sherif Soliman MD, Geriatric Psychiatry Committee

In January 2015 Henry Rayhons was a respected Iowa State Legislator and retired farmer. In April 2015, he was a criminal defendant, charged with third degree felony sexual abuse for allegedly having sexual contact with his wife, Donna Lou Rayhons, on May 23, 2014. In a first of its kind case, Mr. Rayhons was charged with having sexual contact with his wife after she lost the capacity to consent due to advanced Alzheimer's Disease. Concord Care Center, the nursing home where Ms. Rayhons resided, held a family meeting with her adult daughters (from a prior marriage) and determined that she lacked capacity to consent to sexual activity. Mr. Rayhons agreed not to have sexual contact with his wife at that time.

Henry and Donna Rayhons, both widowed, had met in church approximately four years earlier and had married. Shortly after, Ms. Rayhons developed Alzheimer's Disease. As the disease progressed, she required nursing home placement. Her husband continued to visit her daily and often sat and prayed at her bedside. Nursing home staff testified that she was always pleased to see her husband. Mr. Rayhons told investigators that they had continued to have sexual contact and that his wife often initiated the contact. Mr. Rayhons initially denied having sexual contact with his wife on May 23. After an investigator implied that the security camera had recorded the contact, Mr. Rayhons acknowledged having sexual contact with his wife on May 23 but subsequently testified that the investigator had confused him and reiterated his initial denial. The evidence against him included a report from her roommate that she heard "noises" after Mr. Rayhons had closed the curtain, semen stains of unknown age on her sheets, as well as security camera footage showing him putting her undergarments in a hamper, which he said he did because she had left them in a common bathroom.

Dr. John Brady, who was employed by the nursing home, had been asked beforehand if she had the capacity to consent to sexual contact and opined that she did not. Dr. Brady was asked by the defense whether the fact that Ms. Rayhons smiled and expressed affection towards her husband indicated that she had capacity to determine whether or not to be in an intimate relationship with him. He stated that she did not and that her responses were "primal" in nature and did not indicate capacity. Essentially, the jury was tasked with deciding (1) whether sexual contact occurred on May 23, 2014 and (2) if so, whether Ms. Rayhons had the capacity to consent. The jury ultimately found Mr. Rayhons Not Guilty.

This case challenges our preconceptions about sexuality in later life and the nebulous space between protection and paternalism. Nursing home staff and family members are often uncomfortable with the idea of elders engaging in sex. Sexual health is an important part of physical and psychological health and continued sexual activity contributes to the elder's overall well being. On the other hand, elder abuse, including sexual abuse, is a serious and growing problem and the duty to protect vulnerable elders is paramount.

Assessing capacity to consent to an intimate relationship or to sexual activity can be challenging. Of course, the mere presence of dementia does not indicate the presence of incapacity. Patients with dementia often retain certain capacities during the early and sometimes into the middle stages. In 1990, Lichtenberg and Strzepek proposed a semi-structured interview for capacity to engage in sexual activity for elders with dementia based on the components of specific capacity described by Appelbaum and Grisso. It requires an MMSE of 14 or greater and focuses on three areas of inquiry: (1) awareness of the relationship, (2) ability to

avoid potential exploitation, and (3) awareness of the potential risks of the relationship. Specific areas of inquiry include awareness of the identity of the partner (ie, not mistaking the partner for one's spouse), the level of intimacy involved, the nature of the relationship, the ability to set limits and say "no" when the person does not desire contact, and how one might react when the relationship ends. But, how strict should the test be? Appelbaum has discussed the concept of "sliding scale" capacity assessments in the context of medical decision-making. Under this model, less capacity would be required to make a decision that is low risk with significant benefits. Using the same logic here, it would make sense to evaluate the extent to which the intimate contact is consistent with the person's values, prior behaviors, and stated wishes.

If a standard assessment were adopted, who would be subject to it? It would be discriminatory to apply it based on age alone. The need for long-term care is an imprecise measure because many are admitted to nursing homes for purely physical disabilities. The most logical threshold would be based on mental state including acquired cognitive impairment, intellectual disability, or serious mental illness.

The Rayhons case raised difficult questions which remain unanswered two years later. It is not clear what the standard for capacity to consent to intimate contact should be in an impaired elder, how strictly the "test" should be applied, and to whom it would be applied. What is crystal clear, however, is that we can no longer ignore these issues. Family members need to have frank discussions with each other and with the treatment team about the elder's preferences, values, and capacity. Nursing home staff need additional training about sexual health in the elderly and decisional capacity. Court appointed guardians should proactively discuss with their wards and family members the possibility of intimate relationships and agree upon

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Current Quandaries in Suicide Risk Assessment

Hal S. Wortzel MD and David B. Arciniegas MD, *Suicidology Committee*

The last few years have yielded interesting, and at times alarming, developments in the world of suicide risk assessment. Recent case law appears to direct expansion of suicide risk assessment and raise expectations for its effectiveness. At the same time, scientific and mass media publications indicate that clinicians' ability to predict death by suicide is actually quite poor. Concurrent efforts to set the bar for suicide prevention at 'zero suicide' have garnered substantial attention and, in Colorado, legislative action.¹ These developments present quandaries – and, at times, irresolvable clinical and administrative paradoxes – for clinicians engaged in suicide risk assessment and management. These conflicting perspectives on suicide risk assessment and management also provide a foundation for, and will give rise inevitably, to a broad spectrum of opinions from forensic evaluators.

Dr. Janofsky, in a recent newsletter article,² described the "Tarasoff Pendulum" as swinging back toward an expanded duty to protect third parties. The court's opinion in *Volk v. DeMeerleer*³, and the expanded duty it created, appears to largely be based on expert opinions regarding suicide risk assessment and what it ought to accomplish. The court's opinion judged the defendant's suicide risk assessment as inadequate, referencing the plaintiff's expert opinion and the argument that the defendant "breached the standard of care for psychiatrists in Washington by failing to inquire into DeMeerleer's suicidal thoughts and instead relying on DeMeerleer's self-reporting... inquiry into DeMeerleer's mental state, including an adequate suicide assessment, may have revealed the threat so that further action could have been taken to prevent harm to Schiering and her sons." The treating psychiatrist's final note, three months prior to the murder-suicide, expressly notes

that DeMeerleer "states when depressed he can get intrusive suicidal ideation, not that he would act on it but it bothers him." That same psychiatrist's initial treatment note, from about nine years prior, notes a two-week hospitalization due to suicidal ideation. Based then apparently on nearly a decade's-worth of a therapeutic relationship, the treating psychiatrist determined and documented: "At this point it's [suicidality] not a real clinical problem but will keep an eye on it." The apparent implication is that the suicide risk assessment should not have only been able to identify DeMeerleer's risk for suicide in the months ahead, but should have also discerned otherwise unnamed potential victims of future harm.

This opinion and the clinical practice it appears to mandate is without any evidentiary support in the medical literature, and has created a practice standard that clinicians cannot reasonably be expected to meet. Should suicide risk assessment now involve efforts to identify anyone the patient might act violently towards in the event of a possible future emotional crisis? Should clinicians be inquiring routinely about bad break-ups, mean bosses, and obnoxious neighbors? How are we to balance the competing needs of creating therapeutic relationships with the expectation that we deeply probe everyone about potential objects of scorn, derision, and aggression?

Scientific American, within just a few months of the above-described ruling, published an article entitled *Suicide Risk Assessment Doesn't Work*,⁴ suggesting that even the most rudimentary goal of suicide risk assessment is beyond our grasp. "New research suggests it doesn't help, – and it may hurt – to rely on a formula to predict the risk of suicide." Murray and Devitt assert that our ability to predict an individual's level of suicide risk is "not very good

at all."

Murray and Devitt support their position with the results from a recent meta-analysis by Large et al.⁵ reporting that:

"The pooled estimate from a large and representative body of research conducted over 40 years suggests a statistically strong association between high-risk strata and completed suicide. However the meta-analysis of the sensitivity of suicide risk categorization found that about half of all suicides are likely to occur in the lower-risk groups and the meta-analysis of PPV (positive predictive value) suggests that 95% of high-risk patients will not suicide." (p.12)

They report the psychometric properties of optimal suicide risk categorization are uncertain and qualify the degree of that uncertainty as "profound." They also cite a systematic review by Chan et al.⁶ that evaluated prospective studies of persons with history of self-harm in order to determine the predictive value of various risk factors and risk assessment scales. In that systematic review, all of the scales and tools studied were reported to carry poor predictive value, prompting Cahn *et al.* to conclude:

"In our collective quest to reduce the risk of suicide following self-harm by building highly structured assessment tools from risk factors, rather than encouraging a real engagement with the individual, we may be putting our own professional anxieties above the needs of service users and, paradoxically, increasing the risk of suicide following self-harm." (p.282)

Given this conclusion, Murray and Devitt suggest that clinicians should not be dedicating clinical time and energy to such assessments. They

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A Practice Resource on Forensic Training for General Psychiatry Trainees

Cathleen Cerny MD and Jessica Ferranti MD

Forensic Training in General Psychiatry Residency Programs Committee

Over the last few years, the primary activity of the Committee on Forensic Training in General Psychiatry Residency Programs has been to create a practice resource for general psychiatry trainees. Jessica Ferranti initiated this project at the APA meeting in 2015 with the recognition that many training programs have limited access to fellowship trained forensic experts and other forensic educational resources.

A workgroup have contributed to the effort and the document now moves into the next phase of development in which we will seek public feedback from AAPL membership.

The Accreditation Council for Graduate Medical Education (ACGME) does provide forensic requirements for general training programs. ACGME expects all residents have “experience” in forensic psychiatry inclusive of “evaluating patients’ potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability and competency.” The ACGME allows programs flexibility in how to accomplish those objectives. There are also ACGME milestones that fall into the forensic psychiatry realm. Milestones are knowledge, skills, attitudes and other attributes for each of the six ACGME core competencies organized into a developmental framework. The *Medical Knowledge 2 Psychopathology B* thread of the general milestones focuses on “knowledge to assess risk and determine level of care.” *Medical Knowledge 4.1/B* is attained when residents can describe the “influence of acquisition and loss of specific capacities in the expression of psychopathology across the lifecycle.” Decisional capacity is the focus of the *Systems Based Practice 4* milestone. Although forensic psychiatry does not seem to be prioritized for general training by our ACGME, our Committee takes

the position that forensic psychiatry and the daily clinical practice of general psychiatry are inseparable. A resident cannot be a competent practicing psychiatrist without some forensic training.

The initial steps in the development of the practice resource were primarily organizational. After an open committee discussion on content for the document, Dr. Ferranti solicited commitments from nine committee members interested in being part of the practice resource work group. We established that the draft document would be available to work group members via Google Drive. In that way, each member would be able to keep track of the latest draft and make contributions to the “live” document. The next step was division of labor. Work group members volunteered to cover specific topics. A flexible deadline was set to return drafts of the various sections to Dr. Ferranti with sufficient time for editing prior to the 2016 APA meeting. Dr. Ferranti planned to keep the AAPL Executive Committee informed of our endeavors and she sought the input of AAPL Medical Director Dr. Jeffrey Janofsky who also attended several of our committee meetings

Between October 2015 and October 2016, work group members worked hard on their topic sessions. We encountered several challenges. We struggled with how inclusive and specific to be. Were we writing general suggestions in an outline format or covering each topic in a comprehensive way? Initial drafts of the document included some landmark legal cases. The work group also wondered what resources to recommend. Was it best to just recommend things that were freely available online in the public sphere or should we recommend paid content? Were there any ethical issues to considering when

recommending paid content resources created by AAPL members? The biggest challenge of all was simply how to organize the practice resource and this task fell to Dr. Ferranti who put together the initial draft document for review at the Portland meeting. Dr. Cerny, the new chair of the committee (appointed in 2016), used SurveyMonkey to help gain consensus on some of the other questions raised during drafting of the resources.

The practice resource was initially organized into five main sections: background, ACGME Requirements, Basic Forensic Training for General Psychiatrists, Other Free Online Resources and References. A section on key legal landmark cases was added later in the process.

The bulk of the document comes in the Basic Forensic Training section which is further subdivided into Clinical Rotations, General Clinical Experiences, and Enriched Forensic Experiences for General Psychiatry Residents, Innovative Experiences, Clinical Rotation General Recommendations, Didactics and Forensic Didactic Recommendations. The work group settled on 12 Essential Forensic Topics for General Psychiatry Residents. We later expanded the topic list to 13 with the suggested inclusion of a basic law section.

At present, the committee work group is preparing to share the practice resource with a larger audience. We will present a panel presentation on the Practice Resource in progress at the 2017 Denver Meeting. We also plan to submit the practice resource to the AAPL membership for review and feedback, then finally the Executive Council.

We look forward to important contributions from organization members and we hope that the finished product will serve as a helpful resource for general psychiatry residency programs for years to come. ☯

What was Old is New Again: Ketamine in 21st Century

Robert A. Ellis MD, JD, MA; Joseph C. Cheng MD, PhD;
Ryan C. W. Hall MD, Psychopharmacology Committee

55 years after ketamine was first synthesized, with its primary clinical use being a non-barbiturate dissociative anesthetic agent, it is again being clinically investigated this time as a treatment for psychiatric conditions. Traditionally forensic psychiatrists are more familiar with the compound as a psychedelic substance of abuse (street names: Special K; Jet; Super Acid; K; or Cat valium) than as an anesthetic or mental health treatment.³ In the past several years there has been increasing interest in using ketamine as a psychopharmacological treatment for severe and/or refractory depression. What follows is a brief review of ketamine's history, potential for abuse, side effects and expanding role in clinical application.

Ketamine was developed in 1962 at Park Davis Laboratories as a replacement for phencyclidine (PCP) given that it has a lower potency as an anesthetic, a faster onset of action, and shorter duration of action than PCP.³ Ketamine received Food and Drug Administration (FDA) approval in 1970 for human use as an analgesic and sedative.² Ketamine produces analgesia, amnesia, and sedation while keeping the protective airway reflex and cardiopulmonary function stable. As an anesthetic it can also be administered by multiple routes (e.g. IV, IM, orally, rectally or intranasally). It was a popular choice for veterinary medicine since it could be delivered intramuscular in a dart. The anesthetic properties of ketamine are based on its direct action on the cortex and limbic system. It is a non-competitive N-methyl-D-aspartate (NMDA) receptor antagonist that blocks glutamate. The blockage sets off a cascade of changes that are not yet completely understood. Ketamine may also directly or indirectly increase norepinephrine, dopamine, and serotonin in the brain. In addition ketamine also binds to mu opi-

oid receptors.³ Low doses produce analgesia and modulate central sensitization, hyperalgesia, and opioid tolerance.⁶ Clinical dosage in humans is often limited due to potential hallucinogenic side effects. Ketamine was classified as a schedule III controlled substance in 1999.³ Its most common legal use today is in pediatric and veterinary anesthesia.

Ketamine has been used as a recreational street drug and potential date rape drug due to its psychedelic, amnestic, and euphoric properties.¹⁰ Routes of administration for recreational use often occur through snorting, shooting, smoke inhalation, or mixing in a drink.³ Recreational users often describe ketamine as resulting in one of the following states: "k-land" – referring to a mellow and colorful experience; "k-hole" – refers to an out-of-body experience; "baby food" – referring to a blissful, infantile inertia; and "God" – users are convinced that they have met their maker.³ It has also been theorized that some individuals that chronically abuse ketamine are self-medicating to treat depression. Ketamine's popularity as a substance of abuse may be on the decline. For example The *Monitoring the Future Study* found that the prevalence rate in Twelfth graders' ketamine use was 1.2% in 2016 compared to 2.5% in 2000.⁵

Although death from direct pharmacologic effects of ketamine appears rare, the disinhibition and altered sensory perceptions caused by ketamine puts the user at risk of environmental harm. Acute toxic adverse effects of ketamine include: impaired memory; delirium; amnesia, hyperthermia; impaired motor function; tachycardia; increased muscle tone and cardiac output; hypertension; change in respiration; increased bronchial secretions; bronchodilator; increased cerebral blood flow and intracranial pressure; blurred vision;

insensitivity to pain; nausea and vomiting; and dizziness. Chronic toxicity may lead to gastrointestinal complications including: epigastric pain; gall bladder complications; hepatic toxicity; and nephrotic toxicity.⁴

Ketamine has been studied in off-label and experimental settings as a treatment for severe depression. The first published article about the use of ketamine for treatment of depression that the authors are aware of published in 2000.¹ Ketamine has been reported to have rapid onset of therapeutic effects, with some reporting alleviation of suicidal thoughts within four hours of administration. The controlled use of ketamine infusion offers tantalizing prospects for the treatment of suicidality.^{7,8} It has led some to postulate that certain Ketamine protocols could be used in much the same way as ECT to treat severe and refractory depression. Most recently, esketamine, the single isomer formulation of ketamine, has received breakthrough therapy designations from the FDA as a treatment for both major depression with imminent risk for suicide and treatment-resistant depression. Although there is little doubt of ketamine's efficacy for alleviating depression, even if just for a brief period of time, generalized standardization of dosing, monitoring, and follow up protocols need further development and refinement. With that being said the APA has recently published an official advisory outlining a dose protocol.⁹

In closing it should be noted that in 2014, Dr. Thomas Insel, then Director of the National Institute of Mental Health, declared that ketamine might be "the most important breakthrough in antidepressant treatment in decades." Although forensic psychiatrists interest in ketamine has traditional been in its recreational misuse, its burgeoning use as a treatment for suicidality raises new and interesting questions for forensic psychiatry in terms of ketamine's clinical use, what are the standards of care, and what is the liability of ketamine. (P)

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Royal College of Psychiatrists Forensic Faculty Annual Conference Madrid 2017

*Dr. John Baird; Carolina A Klein MD; Dr. Nicola Swinson;
Dr. Laurence Tuddenham; Dr. Mary Whittle; Sara O'Connor,
International Relations Committee*

The 2017 annual conference of the Forensic Faculty of the Royal College of Psychiatrists was held from 29 February to 2 March 2017 in Madrid, Spain. The Faculty has alternated between a venue in continental Europe and a venue in the UK, and this has become a popular arrangement.

Madrid's population it is the third largest in Western Europe after London and Berlin. Visitors to Madrid are usually impressed by its elegance, its tree-lined boulevards, parks and galleries and the conference hotel was well located to allow delegates to explore these attractions for themselves.

It was though of course not always thus as Spain, in common with other Western European cities has a rich, complex and diverse history and in more recent times during the Spanish civil war in the 1930's Madrid saw some of the bloodiest fighting of the whole conflict, with huge loss of life among combatants and civilians. By the end of the civil war, General Francisco Franco had seized power and he was the country's leader until his death about forty years later. Western Europe has been peaceful and has enjoyed steadily increasing prosperity over more than half a century now, but this was preceded by an era when tyrants were dominant and their rule caused unimaginable suffering, misery and death. Some of these individuals such as Franco seized power by force while others such as Hitler gained office by democratic means but then proceeded to dismantle the democracy beneath them, crush any opposition and assume absolute power. It is possible to speculate that the memories of these dark days motivated the countries of Europe and their leaders to commit

themselves to living and working together and respecting their neighbours, and throughout all of this the U.S. was always a valued ally held in high regard. But human nature can endure and memories fade. The delegate reflecting on this history of a couple of generations ago now might well start to consider what may happen in the time to come. Is it possible that the western world is moving towards another era of isolationism, division and conflict? Another aspiring tyrant may be waiting for their chance as we write these words. Will the pillars of democracy and constitution be sufficient to withstand new attack? Where, and indeed whether, this happens depends upon those who have an awareness of the recent past doing what must be done to control such malignant individuals.

As if inspired by these considerations, the programme on the first day of the conference began with a session on various aspects of modern day terrorism, extremism and radicalisation. The scene was set by the first speaker, an officer from the Metropolitan Police in London who described that the terrorist threat to modern western society arose by three main routes. International threat from a foreign country, domestic acts and activity online, with the last of these becoming ever more sophisticated and difficult for law enforcement agencies to monitor. It was clarified that radicalisation of an individual is not an event but is a process and so-called lone agents who have been recruited are very likely to have been vulnerable because of factors such as social isolation, immaturity and social instability and in many cases, mental health problems. This leads to a need for law enforcement and mental health to collaborate and

initiatives to achieve this are now well established. Next two academic sociologists presented the results of sophisticated studies into the area. They described how many of the assumptions about the perpetrators of terrorist acts were no more than that. What has emerged now has found that there are differences between lone actors and terrorists who are part of a group, with the former more likely to have been subjected to stress and trauma in their lives and to have mental health issues, particularly schizophrenia, personality disorder, post-traumatic stress disorder and autism. Further insights into the whole process of extremist ideology was provided by the next speaker who argued that the spread of radicalisation within a group could be compared in some ways to the spread of a disease. Individuals were in contact with one another. Normal procedures and precautions were not always followed and 'infected' individuals contaminated those around them. Also, and as is well recognised, extremist groups share many features with a criminal or delinquent gang, appealing to individuals who were disaffected, felt excluded from wider society, for whom membership brought status and excitement. Furthermore, leaving or detaching from the group was not an easy process for vulnerable individuals who had few other options. Recruitment in prisons was also seen as a particular problem. Related to this process was the concept of 'meme', defined as an idea or style that spreads from person to person within a culture. The final speaker discussed the challenges of family therapy and adolescent mental health care within cultures where there was a risk of radicalisation, and described how many of the most bitter conflicts arose not between different societies but within the same often marginalised ethnic group. It was also important to recognise that 'white' terrorism and racism were another manifestation of the same problems within society and that whatever the obstacles may be, it was always important to challenge extreme

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views, work to avoid division and isolation and aspire to a society which was as inclusive as possible. Some contemporary politicians take note!

The public protection and extremist theme continued with a debate, a format which has become a popular and successful aspect of the conference programme. The proposal on this occasion was that 'this house believes that psychiatric co-operation with 'prevent' arrangements is in the interests of our patients'. What is meant by 'prevent' arrangements is that individuals who have come to the attention of law enforcement because of threats or other behaviour which raises concerns that they may be preparing to cause harm, are referred to a multi-disciplinary mental health team who seek out their medical records, assess the individual and discuss the conclusions with law enforcement. There are established services for undertaking this liaison work and it is again emphasised that lone individuals who attract attention to themselves in this way have a high incidence of various mental health issues. It was clear that an increasing number of the delegates had been persuaded during the debate that medical confidentiality was being compromised.

The importance of formulation in the assessment of offenders who have personality disorder was discussed next. The final presentation of the day was a keynote address by a senior practitioner who throughout his career has had extensive experience of malingering, factitious disorders and factitious induced illness. The frequency of factitious disorders was discussed, with PTSD, chronic pain and whiplash injury following a road traffic accident being particularly common. Malingering was seen in many respects as being a term synonymous with a factitious disorder but was complex and disabling. The presentation may begin with deception but once the deception becomes established the 'sufferer' can lose

insight and their pathology - real or imagined - becomes established and entrenched.

The second day of the conference began with a series of research and update presentations on a range of topics. Regarding the prison population, we learned that while rates of imprisonment vary considerably from country to country, with the U.S. having one of the highest rates of imprisonment in the world, crime rates internationally are falling and crime rates do not appear to be linked to rates of imprisonment. Recidivism rates, however, particularly repeat violent offences among those who are released, was staying constant with an overall rate of around 20%. This also did not appear to vary from country to country. Among violent offenders who re-offend following release, mental health psychiatric issues in the broadest sense were associated with increased risk of re-offending. Somewhat surprisingly, and when there was co-morbidity, the more mental health pathology which was present, the more the likelihood of re-offending and it did not appear to matter which mental health conditions were present in that there were no stronger links with substance misuse or personality disorder than with other conditions. Completing a series of rather thought provoking academic findings was a report that participation in an offence focused programme was associated with a slight increase in the rate of violent re-offending.

A session on mild traumatic brain injury described research had found that subjects themselves tended to under-report head injury, for example, not considering that an episode of concussion indicated that there had been brain injury. Amongst offenders the long term sequelae of TBI, particularly in relation to emotional, cognitive and behavioural problems was a significant cause of offending and re-offending and one of the clinical implications of this was that treatment of these conditions in association with TBI had to be modified. Medication should be used only in low dosage and polypharmacy was to be avoided.

In a quick-fire succession of important topics next to be discussed was suicide, where figures consistently show that the rates amongst men are three times greater than amongst women with a particular increase in suicide rate amongst men in 2008 following the financial crash. Regarding self-harm, this is commoner in women than men and there has in particular been a significant increase in self-harm amongst young women in the years since 2000.

The final research presentation dealt with the link between inflammation and mental disorder, particularly depression. Research in this area is complex but we were alerted to expect that in the future a simple blood test could determine whether a patient suffering from depression would be likely to have a good outcome and to respond to conventional antidepressants, or whether their illness was likely to be refractory and to require much more intensive polypharmacy. If such assessment were to be possible then effective treatment for these patients could be commenced at a much earlier stage.

Dr. Reena Kapoor discussed the emotive topic of solitary confinement within correctional institutions. Studies have found that there are currently almost 70,000 prisoners held in solitary confinement in American prisons and among them prisoners who are young, male, African or Latino, of low IQ and mentally ill are over-represented. While solitary confinement is a practice which no clinician would support, research evidence demonstrating harmful effects of long-term solitary confinement is hard to come by. Initiatives to limit its use have been pursued in recent years.

It is a feature every year to sponsor medical students from the UK to attend the whole conference, with applications linked to an annual essay prize. This year one of the students, Sarah O'Connor from Cardiff University Medical School, wrote a short account of her experience of the conference in Madrid and we conclude this year's conference report with her words. (4)

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The Goldwater Rule and Presidential Mental Health: Pros and Cons APA Symposium on May 21, 2017

Karen B. Rosenbaum MD; Claire Pouncey MD, PhD

The first speaker of the symposium was Dr. Paul Appelbaum on “Reflections on the Goldwater Rule.” In 1964, Fact Magazine publisher Ralph Ginzburg created a “poll” about Republican candidate Barry Goldwater’s mental state and mailed it to 12,356 psychiatrists, and over 1000 responded. Many described Goldwater as having Personality Disorder or psychosis. 1189 psychiatrists concluded that Mr. Goldwater was psychologically unfit to be president.

Goldwater filed a suit in the Federal District Court for Libel and won a \$75,000 judgment that was upheld on appeal to the U.S Supreme Court and Fact magazine went out of business. The professional aftermath was that it was a “major embarrassment for psychiatry.” As a response, in 1973, the APA adopted a rule designed to prevent a recurrence.

The Rule stated that occasionally a psychiatrist may be asked to give an opinion on someone in the public arena. In that regard, a psychiatrist may share with the public his or her expertise about psychiatry in general. However, it is unethical for a psychiatrist to offer a professional opinion unless that person has given consent and submitted to a psychiatric examination by the psychiatrist providing the opinion.

The reasons for the rule that Dr. Appelbaum outlined were to (1) Protect the integrity of the profession from members who are willing to draw judgments on the basis of insufficient information, (2) Protect persons who may be harmed by speculative statements by psychiatrists about their mental health, (3) Avoid discouraging persons in need of psychiatric treatment from seeking care. He concluded that the Goldwater Rule (GR) remains valuable, although it may need modification, and that it is not meant to cover analysis for the

FBI, CIA or for other government purposes.

Dr. Jerrold Post, a psychiatrist longer than two decades in the CIA, was the next speaker. He pointed out that the APA includes other ethical principles such “Psychiatrists are encouraged to improve society, community and should share with the public their expertise...”

Dr. Post contributed to a psychological profile of Saddam Hussein. An article was published in the New York Times about his work in which he was complimented for his contribution to policy. However, he was criticized by the APA for violating the GR. The New York Times article indicated he profiled Hussein without evaluating him. Dr. Post cited the Tarasoff principle, as policy decisions were being made which could have lead to significant loss of life. He believed it would have been unethical to not speak and that he had a duty to warn.

He asked the question, “How could something which is deemed helpful to community welfare also be thought of as violating an ethical principle?”

He said that the rule did not make a distinction between giving an opinion to the public vs. political professionals and suddenly Dr. Post’s work in the CIA was subject to an ethical violation of the APA rule.

The APA appointed a task force which then made an exception for psychological profiles prepared for use of government. This was considered not only ethical but praise worthy.

Dr. Post discussed how he felt constrained at times by the ethical rule in his work. He was often reluctant to offer his professional opinion because of ethics. He sought an audience from the APA ethics committee asking about psychological profiles based on

careful research. They answered that a psychological profile of historical figures does not conflict as long as it does not give a diagnosis and is based on careful research, peer review, etc.

He explained that within the ranks of political psychology, there have been serious questions raised about the emotional suitability of the current president. He again sited that there is also an ethical responsibility to improve society. The APA leadership however issued a statement that making observations about the president would “not only be unethical it would be irresponsible.”

Dr. Post feels that the rule as stated above is too restrictive. He asked for the APA to convene a commission to reconsider the GR and examine more flexible ways to deal with the dilemma where a public figure is of such concern.

The third speaker was Dr. Claire Pouncey, who asked the question, “Is the Goldwater Rule a viable Moral Dictum?” She explained that philosophy plays a role here. She explained how in order to reinforce the GR, the APA addressed and dismissed several concerns including the Freedom of Speech argument which “confuses the personal and professional roles of the psychiatrists.” Dr. Pouncey explained that even in the clinical setting, formal diagnoses are often made based on incomplete information and without the full consent of the person being evaluated especially in the emergency room setting.

The APA objection is that public assessments of public figures risk the reputation of the profession of psychiatry and the APA and can subject us to criticism.

She expanded on her 2016 JAAPL paper by Kroll and Pouncey, “The ethics of APA’s Goldwater Rule.” She argued that there is a redundancy in the principles of medical ethics, that the rule provides no direction for action, that individual physicians must balance personal and professional concerns, and that conflicts among an individual’s various social commitments and roles make the GR better considered as “a guideline or

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point of etiquette than an enforceable moral dictum.”

She said that it is important to be respectful of how we conduct ourselves as professionals and that when the GR functions as a gag rule, it is itself unethical. In a profession, members see one another as peers or colleagues who abide by the same standards of professional practice and conduct and members of the same moral community with explicit expectations of conduct.

Dr. Pouncey asked the question, “Do professional obligations supersede general social and moral obligations and rules of conduct?” She explained that we make moral choices about how we act toward one another. We can be members of multiple subsets of moral communities. Not all of the communities overlap all of the time and we all have to struggle with that. In professional ethics, the moral code changes over time. Ethical codes are always being changed.

Dr. Pouncey said that the GR suggests that a professional code of ethics should override personal conscientious balances of values. She explained how the GR denies the full moral agency of psychiatrists.

Dr. Pouncey advocated for eliminating the GR, not reinforcing it. She suggested adequately teaching trainees how to conduct themselves professionally and how to talk to the media. She said it could help eliminate stigma to patients by clarifying what we mean by mental illness and that we do not think all are mental illnesses are identical.

Nassir Ghaemi, MD, MPH, the fourth speaker, wrote a book about how a number of historical political leaders have bipolar disorder. He critiqued the GR by pointing out that emphasis for consent and direct examination does not reflect current psychiatric diagnostic practice, and that it might be good practice to update guidelines every fifty years or so. He reiterated that the majority of polled psychiatrists did not diagnose

Goldwater.

He also explained that diagnoses have shifted over the years. We used to misdiagnose Schizophrenia and gave that label to anyone who had any disordered thinking. He said that the DSM system is mostly unscientific. If diagnoses are not scientifically valid, then that is a rationale for saying we should not be diagnosing these public figures. If we are saying our diagnoses are falsely applied or are false, the ethics of science is that we are supposed to put out ideas that are false (hypotheses) and that truth is corrected error. He claimed it is an antiscientific ethic to not say anything because it might be false.

In the March 2017 extension of the GR, saying someone does not have mental illness also violates the rule.

He elucidated two general assumptions underlying the GR: (1) Psychiatry is a liberal profession and psychiatrists tend to be liberal in social attitudes. Any expression will express a political opinion. Applying this to every psychiatrist is heavy handed. (2) In 1964 and 1973 psychiatry was different. It was largely psychoanalytic. In this community, it was important to have a patient’s consent and direct examination. This was extended to diagnosis.

He explained that clinically, we do not always take what the patient says at face value when we examine them. The standard of diagnosis is not only history taking from the patient, it is taking history from collateral sources. He also argued that the mental status examination is crude and not usually diagnostically specific. For example, there is no equivalent of the Babinski sign in psychiatry.

Regarding stigma, he said that the main problem with saying that GR would increase stigma is that implies that having a psychiatric diagnosis is a negative prospect. In his research, he found that there are positive aspects to having depression and mania. People with depression are more empathic and more realistic than “normal” people. People with mania are more creative and more resilient to PTSD. These are good

traits for leaders.

He said that it is an assumption that we would cause stigma if we break the GR. We are sending the message that it is stigmatizing to be labeled as having psychiatric illness.

The media is also concerned about the consequences of diagnosing the president. Dr. Ghaemi said that the current president has directly said he has a decreased need for sleep. In fact he boasts about it. He talked about being distractible and having a high sexual drive. He also said that his brother died at age 42 of alcoholism. He has an elevated self-esteem and possible impulsivity. Some of these are positive traits, and others may be negative such as impulsivity.

Dr. Ghaemi advocated for the radical revision of the GR that would include using scientifically valid diagnoses, and the absence of stigmatizing intent.

The final speaker was Paul Summergrad, MD, recent past president of the APA. Dr. Summergrad suggested that we think about issues implicit in the GR and how governments and political entities deal with issues of illness in political leadership. He said he disagrees with Dr. Alan Stone who views this as a first amendment issue. He said that no one is obligated to be a member of the APA and reminded us that the GR only binds individuals who voluntarily join APA. He disagreed with Dr. Ghaemi that most psychiatrists get collateral information. He did not disagree that there are other leaders who have had conditions and who have done “quite well.”

He explained that the constitution allows for the creation of a group of medical and mental health professionals to examine the physical and mental health of the president should there be a question of his capacity to serve. He said there needs to be a process to advise on dealing with issues that may come up with presidential disability. ☞

Ask the Experts

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neighbor who was a computer consultant. When I discussed fees with him, he was shocked and amused to hear my attitude to billing. He helped me realize that it was not unreasonable to get paid reasonable fees, commensurate with my expertise and experience. So, to all of you forensic psychiatrists, welcome to the real world, in which forensic psychiatrists are hardworking, highly qualified, ethical people who do very difficult work, and deserve fair compensation for that work.

For those of us who are not in salaried positions, setting fee schedules is very difficult. In certain cases, such as competency to stand trial, fee schedules are set by the state, and there is no room for argument. In other cases, it is important to establish a reasonable fee schedule. This should be set out in your retainer letter to the retaining party. This letter should include a clear statement of charges, not only for examining the evaluatee and writing a report, but for reviewing material, making phone calls, handling emails, and any traveling incurred by the case. If there is not prior agreement upon these issues, you may find yourself submitting an invoice at the end of the case and receiving a phone call from an outraged lawyer, who may claim (likely hypocritically) how surprised they are that you billed for all these other services.

It is advisable to stick to this fee schedule in all cases. It would raise eyebrows, and questions of ethical behavior, if you raise your fee simply because you know the evaluatee can afford it. In some cases, you may decide to decrease the fee, if you feel that it is a worthy case, and the evaluatee cannot pay your full fee, or in some cases where there is an important psycholegal issue to be litigated, which may set a precedent or enter into the law at a later date.

In general, it is my belief that we should charge at least equivalent to what lawyers bill. Generally speak-

ing, your fee depends on years of experience and qualifications. If you are five years out of Fellowship and have not published anything, a reasonable fee would be equivalent to the rate that lawyers charge in similar circumstances. If, on the other hand, you are 25 years out, are widely published, and the president of AAPL, then you may likely double the aforementioned fee, again equivalent to the way that lawyers will bill their clients in similar situations. In my experience lawyers rarely quarrel with an established fee schedule. This is because they are aware of what similarly qualified lawyers charge in similar circumstances. Another point to bear in mind is that our involvement in the case may involve only a few hours, sometimes as few as two hours to review some materials, whereas the lawyer is maybe billing one or 200 hours, due to their extended involvement with the case. This should be taken into account when setting fee schedules.

As has been mentioned previously in this column, charging contingency fees, even if the lawyer is working on contingency, is not ethical for the forensic psychiatrists, since this introduces a bias in that we may give an opinion that is not objective and almost but is rather designed to win the case and to get paid. Do not succumb to pressure from lawyers who may try to put you in this situation. You will not regret refusing the case, in favor of retaining your ethical values. Retainer fees are ethical and may actually decrease bias, in that they deliberate the reality of an expert providing an opinion that the lawyer may not want to hear, without the concern that the lawyer may not pay you if you provide an opinion that they do not want.

Take Home Points:

There is no shame in charging an appropriate amount for your time. Fee schedules and written contracts are strongly encouraged to keep things honest. Retainer agreements are common and help to protect all parties. To quote our dearly departed

Bob Sadoff, MD, "a cleared check is the admission ticket to my entering the courtroom." ☞

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As a medical student attending the conference I knew very little about forensic psychiatry and the work that forensic psychiatrists do. I was nervous because I feared that I would stick out as being 'different' and 'not belonging' as I did not know anyone else there. However I soon realised that I had nothing to be nervous about. I felt very welcomed by all of the organisers and other attendees who offered to help me find the other medical students at the event. I felt that I was valued as an attendee at the conference, particularly over the conference dinner when I was sat with the other medical students we were introduced to everyone. Before attending I was concerned that I wouldn't be able to understand the talks and discussions in the programme. Again, I was pleasantly surprised that although I didn't know a great deal about forensic psychiatry before I attended, I learned vast amounts while I was there. Not only has the conference given me an insight into what a career in forensic psychiatry might involve, it has also given me the opportunity to listen to debates around the current 'hot topics' and about how forensic psychiatrists work around the world, particularly in America, Canada and Spain. Having attended the conference and having listened to discussions ranging from solitary confinement in American prisons to violence among the at-risk individuals with learning disabilities, I am sure now that I want to gain more experience in this area of psychiatry. I was touched by how warmly I was welcomed to this event by everyone and I feel enriched with knowledge after being able to attend such a diverse programme. I am truly grateful for being invited to attend this conference as I have gained knowledge, experience, friends and an idea about how my career may progress in the future.

Current Quandaries

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assert that mental health services are best directed at treating mental illness and alleviating the pain of patients and families, rather than “expending energy and resources on futile efforts at risk assessment.” While many, including us, would argue that this assertion goes too far by dismissing the importance of suicide risk assessment, their point is well taken: there is only very modest evidence supporting the accurate prediction of suicide through currently established risk assessments. Accordingly, it is impossible to reconcile the state of the science surrounding suicide risk assessment with the claims and expectations established by the court’s judgment and written opinion in *Volk v. DeMeerleer*.

Adding to the quandaries in suicide risk assessment is the sudden popularity of “Zero Suicide,” an approach to suicide risk assessment and management developed at the Henry Ford Health System. As the name suggests, the ostensible goal of this approach, coupled with that institution’s Perfect Depression Care⁷ program, is to eradicate death by suicide – an admirable, if not overly ambitious, goal, to be sure. The program has received considerable praise, as exemplified by a JAMA article⁸ claiming “depression care effort brings dramatic drop in large HMO population’s suicide rate.” The astute reader might wonder how any program could achieve dramatic decreases in suicide rates given the previously described evidence in support of our collective (in)ability to even accurately determine suicide risk.

Dr. James Coyne sheds light on these remarkable claims in a PLOS blog entitled *An Open-Minded, Skeptical Look at the Success of “Zero Suicides”*: *Any Evidence Beyond the Rhetoric?*⁹ Coyne offers a compelling analysis of the actual data, and concludes that:

“The claims came up short... any persuasiveness to these

details quickly dissipated when they were scrutinized. Lesson: Abstract numbers and graphs are not necessarily quality evidence and dazzling ones can obscure a lack of evidence.”

He cogently observes that the subject of suicide engenders powerful emotions, and that it is difficult to take a stand against the idea that we can eliminate suicide.

“Clever sloganeering can stifle criticism and suppress embarrassing evidence to the contrary. Yet, we should not be bullied, nor distracted by slogans from our usual, skeptical insistence on those who make strong claims having the burden to provide strong evidence.”

Most importantly, Coyne points out that efforts to advance zero suicide may carry unintended, negative consequences, not unlike some of the concerns raised by Murray and Devitt. He writes:

“If taken literally and seriously, a lofty, but abstract goal like Zero Suicide becomes a threat to any ‘just culture’ in healthcare organizations. If the slogan is taken seriously as resources are inevitably withdrawn, a culture of blame will emerge and pressures to distort easily manipulated statistics. Patients posing threats to the goal of zero suicide will be excluded from the system with an unknown, but negative consequences for their morbidity and mortality.”

The above described events and circumstances might leave clinicians working with individuals at risk for suicide feeling as though somebody split the baby and threw it out with the bathwater. The notion that risk assessment should identify not only everyone who is at risk for suicide but also anyone that might fall in harm’s way is obviously untenable, as

is the goal of “zero suicide.” At the same time, the suggestion that clinicians should abandon suicide risk assessment and management altogether given the limited success of such efforts to-date seems reactionary and impractical, as this suggestion fails to recognize the therapeutic benefits – independent of its effects, or not, on suicide rates – entailed by a suicide risk assessment process that thoughtfully facilitates discussion of challenging issues, fosters a more robust mental health assessment, and engages patients in treatment more generally.

Between the poles of these opinions is an enormous middle ground that providers must navigate as they endeavor to match suicide risk assessment practices to patient (and risk management) needs and to scientific realities. More research and expert guidance is needed to guide clinicians faced with these challenges, and less hyperbole that distracts from what is realistically achievable. AAPL’s Suicide Committee will endeavor to consider these important questions moving ahead, and invites members to join us in this effort. ☺

Disclaimer: The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of any agency of the U.S. government, agency of the State of Colorado, academic institution, or the institutions and organizations with which the authors are affiliated.

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(continued on page 31)

Trajectories

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Whether an inciting event was intentional or non-intentional is further important to determining the likelihood of development, and prognosis for PTSD. A study (5) differentiating trajectories over the course of a year amongst those exposed to these trauma types, revealed the following:

1. The median prevalence of PTSD increased over time, from 11.8%, at one month, to 23%, at 12 months, for intentional, but not non-intentional events.

In contrast, the median prevalence of PTSD amongst those exposed to non-intentional events diminished from 31%, at one month, to 14%, at 12 months.

2. Amongst those exposed to intentional events, approximately one third developed PTSD in the first year.
 - A. One third of cases of PTSD remitted within three months.
 - B. 39% of those with PTSD followed a chronic course.

Further, amongst those exposed to intentional events, only 3.5% developed PTSD after three months, i.e., only a small number of individuals demonstrated a delayed expression of PTSD.

Intentional acts studied included assault and terrorist attacks. The nature of the assaults, an important prognostic factor, was not identified.

Importantly demonstrating that there are not yet universally identified, or, more likely, universal trajectories of responses to traumatic events, a study (6) of 635 United States peacekeeping soldiers who had served in Kosovo, and were assessed: 1) pre-deployment, 2) late deployment (time not specified), 3) three to four months post-deployment, and 4) eight to nine months post-deployment, described the following trajectories:

1. Resilience: Approximately 84% of the peacekeeper sample followed this trajectory.

2. Delayed: Approximately 3% followed this trajectory. Those who did so suffered moderate to severe PTSD symptoms at times one and two, and a steady increase in symptoms at times three and four (as assessed via the PCL).

3. Realized Anxiety: The approximate 9% who followed this trajectory had relatively high magnitude symptoms pre-deployment, which greatly decreased at time two, and were of low severity at times three and four.

Potentially significant to forensic psychiatric assessment, if forensically reliable modalities for measuring such become available, stress reactivity was highest amongst those in the Realized Anxiety group.

4. Recovery: Amongst the 4% who followed this trajectory, symptoms were low in severity pre-deployment, were high in severity at times two and three, and returned to baseline at time four.

Notably, there was no chronic trajectory amongst the peacekeepers studied.

Reliably knowing how PTSD evolves, i.e., trajectories of trauma response, would importantly facilitate assessment of prognosis. More than knowledge of such, is however, necessary for significantly improving prognostic acumen. Crucial to such is reliably being able to ascertain which individuals are likely to follow which trajectory. Multiple variables, known and yet unknown, determine the risk for developing a PTSD, and the likelihood of the course it will follow. These include, or may include:

1. Peritraumatic dissociation.
2. Peritraumatic elevated heart rate.
3. Actual and perceived post-traumatic social support.
4. Prior history of trauma, and adaptation to such.
5. Pre-existing anxiety, and, potentially, extent of stress reactivity.
6. Personality make-up.
7. Traumatic brain injury.
8. Qualitative nature of a traumatic event, e.g., intentional versus non-

intentional.

9. Duration of a traumatic event.
10. Magnitude of a traumatic event, e.g., extent to which life is threatened, nature of a sexual assault.
11. Presence of particular, co-morbid disorders.

How to weigh the contribution of each of these factors, and, especially, determining how they interact in producing outcome, is particularly complex, and not yet generally, reliably known.

Another factor often not sufficiently assessed in forensic psychiatric evaluation is the nature and efficacy of the type of treatment provided.

The prognosis of a PTSD, and trauma-related entities, is a function of multiple individual and circumstance specific variables. Group data regarding outcome, including post-traumatic trajectories, help inform, but do not in and of themselves determine, prognosis. Forensic psychiatric conclusion regarding prognosis is always an individual-specific determination. ☹

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Staffing

continued from page 2

requiring negotiation to lower it, and probably lowering their incentive accordingly. And there is the above mentioned shortage, often magnified by factors beyond my control (hint: location, location, location).

Is it hopeless? Well, it requires resourcefulness when you face an average search time of 19 months for a single position. I have personally cultivated affiliations with multiple medical schools and residency programs, including programs for nurse practitioners and physician-assistants. To date those have directly led to one part-time psychiatrist hire, some much needed but temporary help, and two solid allied health providers. I have also been an active supporter of physicians who return to practice after addressing a personal challenge. I urge anyone in my position to explore a relationship with their state program for impaired providers (most states have one). Being open-minded and willing to give a second chance has landed me two outstanding long-term physicians, and two others who moved on but provided solid support when needed. Such hires might require accommodations that add to your own workload, but the benefit may well outweigh the extra effort. Relationships made at AAPL, both national and chapter meetings, and local medical societies have been valuable as well, landing me at least one psychiatrist and word of mouth on others. I also direct attention to my desirable factors (i.e. no managed care pressures, reasonable pace of work, quality performance on surveys, etc.).

Competition for providers will continue, forcing us to be even more imaginative to fill the gaps. AAPL, and the new Forensic Hospital Committee, provides a forum for dialog among institutional colleagues to share ideas and strategies as we search for good people to join us in this worthwhile career. ☯

Current Quandaries

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Free to Love

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an approach should such relationships develop. Much pain can be avoided by addressing these issues in the consultation room rather than the courtroom. ☯

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Ketamine

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Fellows Corner

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Despite the fact that it is being written into legislation across the country, there are downsides to the choice of intramuscular naltrexone. It is two to three times more expensive than buprenorphine and far more expensive than methadone, which is available in generic form. The opioid antagonist is also problematic for patients with acute or chronic pain and is not recommended for pregnant women. Even more concerning is the fact that there have been no studies published to date comparing intramuscular naltrexone with buprenorphine or methadone. Given this lack of evidence, intramuscular naltrexone, unlike buprenorphine and methadone, does not appear on the WHO list of essential medications. Fortunately, results from the first study comparing outcomes of treatment with intramuscular naltrexone and buprenorphine are expected to be published this fall.

The tide is turning for pharmacotherapy for addiction in America. In the past year, two pieces of bipartisan federal legislation, the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act, have been enacted that direct states to prioritize medication-assisted treatment. The latter law actually requires treatment providers to offer or provide referrals for all F.D.A.-approved medications for opioid use disorder. Yet despite this mandate, the path forward is not simple. There are competing ideas and interests that challenge the delivery of patient-centered, evidence-based care for addiction within the criminal justice system. The time has come for the corrections community to embrace the data and provide this essential treatment. ☉

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MUSE & VIEWS

Thought: Why does man kill? He kills for food. And not only food: frequently there must be a beverage.

Woody Allen (1935 -)

Middle Ground

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mental illness. Those who claim to be motivated by radical ideologies may also be particularly silenced by cultural stigmas against mental illness and suicide (7).

In sum, there is no common psychological profile, yet evidence suggests that some types of terrorists possess certain traits at higher rates than the general population. Mental disorders may be just one factor among many, and may also be a by-product of terrorist activity and/or later disengagement from a terrorist group (4). The relationship between mental illness and criminal behavior is complex, and terrorism will continue to be a contentious issue. ☉

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Chief Justice

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tation of NCR accused or those found Unfit to Stand Trial. She encouraged us to be leaders in championing the lessons we have learned from history. She encouraged further work in combatting negative stereotypes that individuals with serious and persistent mental illness are dangerous or evil and incapable of rehabilitation. She noted that this continues to be fed by negative media reporting of high profile cases, such as in the notorious case of Vincent Li, who was found NCR for the killing and beheading of a stranger on a Greyhound bus in 2008 and was subsequently discharged absolutely in February 2017. She observed that despite the public outcry from this case, the criminal justice and forensic systems worked well. She encouraged more research to be done in the area of Review Board performance, given the paucity of good data currently available. She lamented the lack of funding and resources available for mental health in the justice system, resulting for example, in the “warehousing” of mentally ill individuals in segregation in jail. She lauded the implementation of Mental Health Courts with their multidisciplinary approach to delivering justice with this population and their potential to save the system money over all.

Chief Justice McLachlin finished her remarks by telling us that the justice system can better deal with victims’ desire for revenge and she counselled that if we don’t do this better, victims will remain dissatisfied and public support for just and humane ways of managing mentally ill accused will continue to be difficult. She is convinced that the answer is public education. She encouraged the justice system to provide more support to victims rather than simply a venue to express how bad they think an offender is.

As we prepare to wish our current Chief Justice a well-deserved retirement from public service, I think retired Ontario Court of Appeal Jus-

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tice Robert Armstrong offered a fitting quote in a recent interview: “Beverley McLachlin will be remembered as a great Chief Justice. She has a fine legal mind, which is combined with common sense and humanity.”¹ 

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APA Assembly

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ABPN and to discuss ways to make the process more salient to psychiatric practice. The APA also has advocated for ABPN fees that reflect the cost of administering the MOC program and reforming the MOC 10-year examination process. Additionally, the APA’s Division of Education is beta testing a smartphone app which will offer members an opportunity to receive one self-assessment question per day along with feedback and peer comparisons based on each response. The program should be available to all members in mid to late-2017. Regarding alternative paths to MOC, the APA has reserved judgement until it has a better appreciation for the programs, including their strengths and weaknesses. By so doing, the APA is fulfilling its fiduciary obligation to members to provide timely, well-informed information about an important part of psychiatric practice. 

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AAPL members who are interested in serving on committees for a three-year term are invited to send a letter to the President, Christopher Thompson, MD through the Executive Office by November 15, 2017. Committee members must be full voting members of AAPL.

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

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The agenda will consist of reports and election of officers and councilor. The slate as approved at the Semiannual Business Meeting is as follows:

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