

# AAPL Newsletter

## American Academy of Psychiatry and the Law



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2013 Presidential Address

### Debra Pinals MD: Forensic Prevention through Policy and Financing

Simha Ravven MD



On Thursday, October 24, 2013, Debra A. Pinals, MD addressed the audience as the 39th president of the American Academy of

Psychiatry and Law. She was given a warm welcome and introduction by AAPL past president, Dr. Charles Scott, who highlighted her broad experience and many accomplishments.

Dr. Pinals began by outlining her own professional trajectory – from forensic psychiatric fellowship director to acting State Medical Director for the Department of Mental Health to her current position as the Assistant Commissioner of Forensic Services for the Department of Mental Health of Massachusetts. These multiple administrative leadership perspectives informed Dr. Pinals' view of forensic psychiatry as interacting with multiple overlapping systems.

At the beginning of the address, Dr. Pinals posed the following questions: 1) should forensic psychiatrists be taking a broader view? 2) How will justice-related mental health services be funded and how will funding determine services? 3) Where are forensic psychiatrists in emerging "justice related program designs?" 4) How do we train forensic leaders of the future to help chart the best course?

She then gave a case example to illustrate the difficulties persons with mental illness who are also forensically-involved might have and the systems with which they might interact.

Dr. Pinals highlighted the issue of community treatment for the forensically-involved people with mental illness: access to a high standard of treatment in

the community, and funding for treatment. She explained that forensic psychiatry is at the crossroads of behavioral health, criminal justice, and multiple forensic settings, and then proceeded to outline the significant overlap of the mental illness and criminal justice systems - there is an over-representation of persons with a criminal history in the mental health system, and an over-representation of people with mental illness in the criminal justice system. She called individuals with mental illness and forensic involvement as the "crossover population," and described how care for them is delivered across correctional, psychiatric hospital, and community settings. She observed that these individuals are high healthcare utilizers and they often have poor health outcomes.

Dr. Pinals reflected on the growth of this crossover population and highlighted several reasons for their growth: lower community crime tolerance that led to more severe drug policies beginning in the 1970s, determinate sentencing and consequent increase in the number of people in prisons and jails, civil commitment laws, and the closure of state hospitals have all been implicated in shifting landscape of where care is delivered.

The more recent emphasis on providing care in community settings has resulted in the placement of more people with justice-histories out of institutional settings. For example, Dr. Pinals noted the increase in community placement of mentally ill individuals following the 1999 United States Supreme Court Decision of *Olmsted v. L.C.*, and the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA), both of which emphasize the right of individuals with mental disabilities to live in the community when appropriate. In addi-

tion, the United States Supreme Court decision of *Brown v. Plata* of 2011 spurred the release of 40,000 inmates from California prisons into the community. The movement for self-determination of people with mental illness has provided an impetus for individuals to pursue community treatment as opposed to institutional care - a social justice issue embodied in the rights of all persons to live meaningful and productive lives in the community. Individuals with mental illness and correctional inmates have been participants in conversations that have helped shape public policy.

In discussing financing for the treatment of the population at the crossroads of criminal justice and mental health systems, Dr. Pinals noted that the largest payer of mental health services is Medicaid. This is a change from the 1990s when state and local governments were the largest payers. Within state expenditures, overall bed costs have decreased with the closure of many facilities. However, within state mental health costs, there has been a rising percentage attributed to forensic beds. Additionally, state expenditures for prisons have increased. Dr. Pinals highlighted that around five million people are supervised on probation or parole, many with mental illness. These people are largely

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Incoming President Robert Weinstock with Awards Committee Chair Renée Binder



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## COVER STORY

### Presidential Address

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receiving their care in community mental health settings.

With regard to how healthcare reform and the Affordable Care Act (ACA) would affect those with both mental illness and forensic involvement, Dr. Pinals noted that Medicaid expansion will likely encompass many in this crossover population. Some of the pros of the ACA are the mandate for parity, and payment methodologies that may work differently than traditional fee for service models. There is the hope that improved care coordination under new healthcare delivery schemes will lead to improved health outcomes. Dr. Pinals noted that measures assessing quality of care are still evolving as are integrated care delivery models, which will be especially important for this population that suffers significant psychiatric and medical illnesses. Some of the weaknesses of the ACA may be increased overall expenses because of a larger group of people who will receive healthcare coverage. There will be need for cost containment.

Dr. Pinals next addressed the issue of transition from incarceration to community care, and continuity of health benefits and coverage. She explained that healthcare of the incarcerated population is state funded. When incarcerated people are discharged into the community it can take months to re-enroll in publicly funded healthcare coverage such as Medicaid and the VA, and to connect to community services. She emphasized the importance of improved continuity between incarceration and community care through continuous enrollment in public health coverage. She spoke about the importance of suspension, rather than termination of benefits while an individual is incarcerated so that the time to re-enroll upon release would be diminished and healthcare coverage would be continuous.

In closing, Dr. Pinals gave a message of hope to the future. She described steps that could improve the outcome of justice involved individuals with mental illness, and emphasized the importance of screening for mental illness, including early pre-trial screening, and referral to appropriate services. She stressed the

importance of minimizing disruption in health coverage entitlements so that individuals being released from correctional and forensic settings do not have periods of time where they lack access to covered healthcare. She also emphasized the importance of integrating care with partners in criminal justice and probation.

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*“Some of the weaknesses of the ACA may be increased overall expenses because of a larger group of people who will receive health-care coverage.”*

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Dr. Pinals outlined important areas for training forensic mental health professionals in the future. This includes training in trauma, criminogenic risk and recidivism factors, as well as models of integrated behavioral and physical healthcare, and specialized justice and mental health collaborative services. Future forensic mental health professionals need to be familiar with the larger systems in which forensic treatment and evaluation take place and be conversant in forensic, correctional, and public mental health financing and administration, disability, and other entitlements. They should understand access to and barriers to benefits across systems.

In conclusion, Dr. Pinals answered the questions she had posed. She opined that forensic psychiatrists should take a broader view relating to community forensic services, that they should utilize clinical and legal knowledge to inform forensic evaluations and practice, and that forensic psychiatrist should gain experience with newer program models. She also noted that forensic psychiatry training should include education on healthcare and justice systems and their interaction with policy and financing, as well as innovations in this area. ☯

## FROM THE EDITOR

# Children Reading Violent Books

Charles C. Dike MD, MPH, FRCPsych



Debate about the influence of violent video games and violent media on aggressive behavior has been raging for years, but got

louder and shriller following the Newtown tragedy. Certain groups fought hard to defend their right to own guns, and pointed accusatory fingers at the mentally ill ("guns don't kill, people do") and at violent video games and movies. I wondered about the impact of movies and dwelt on it for a while. Are violent movies associated with real life violence? A casual review of the literature indicates that media violence has not just increased in quantity; it has also become more graphic, sexual, and sadistic.<sup>1</sup> Surveys have found that 82 percent of the American public consider movies too violent.<sup>2</sup> A study by James B. Weaver III and Dolf Zillman, showed that prolonged exposure to gratuitously violent films is capable of escalating hostile behavior in both men and women and of instigating such behavior in unprovoked research participants.<sup>3</sup> 1000 studies - including a Surgeon General's special report in 1972 and a National Institute of Mental Health report 10 years later - attest to a causal connection between media violence and aggressive behavior in some children. Studies show that the more "real-life" the violence portrayed, the greater the likelihood that it will be "learned."<sup>4</sup>

According to the American Academy of Pediatrics, media violence may cause aggressive and antisocial behavior, desensitize viewers to future violence and increase perceptions that they are living "in a mean and dangerous world." Children younger than 8 "cannot uniformly discriminate between real life and fantasy/entertainment... They quickly learn that violence is an acceptable solution to resolving even complex

problems, particularly if the aggressor is the hero." Witnessing repeated violent acts can lead to desensitization and a lack of empathy for human suffering.

The American Psychiatric Association summarized the above findings and concluded, "The debate is over... For the last three decades, the one predominant finding in research on the mass media is that exposure to media portrayals of violence increases aggressive behavior in children."

As these conclusions settled in my mind, I wondered about the recent trend of bringing books to life on screen. Marvel and DC Comic heroes such as the Avengers, Spiderman, Superman, Spiderman, Iron Man, X-Men, and so on, have been hugely successful. There is no doubt that as in past generations, children and teenagers make up a large and predictable base of comic book readers. The movies involving these characters mostly attract a rating of PG-13.

In terms of books, the Harry Potter and Hunger Games series (authors - JK Rowling and Susan Collins respectively) have hit the screen and now, the Divergent series (author - Veronica Roth) are hovering the horizon and will make landfall (movie appearance) in early 2014. These books have been credited with getting kids to read. Most attract movie ratings of PG 13, denoting the presence of violence, sex, profanity or other risky behavior at the level supposedly appropriate for someone 13 years old and over, if such behaviors could ever be seen as appropriate for that age group. However, a lot of children less than 13 are reading these books, and now that they have been made into movies, are clamoring to see the movies. I know of precocious 8-year-olds who have finished reading the Hunger Games series (three books), and the Divergent, Insurgent and Allegiant series. As evident in the two Hunger Games movies that came out to much aplomb and acclaim, the central theme of the books is survival

through brutal killing and elimination of strangers thrown together in an arena and watched by fictional country folks on big screens across the country. In fact, in the first movie, one of the victims was an adorable 12 year old girl specifically targeted and killed by the other much older contestants! The only way to advance and stay alive is to kill, and all methods of achieving that goal are acceptable. In the most recent Hunger Games movie released around Thanksgiving 2013, a nine year old watching the movie with her parents stated that she knew when to close her eyes so as to not witness the violent acts that she knew were coming from having read the book! Interestingly, a movie rating site for kids, Kids in Mind, rated the Harry Potter and the Deathly Hallows (part 2) movie released in 2011 as 7/10 for Violence and Gore, with 10 being the most violence rating.

Several questions come to mind: does reading books that describe violence, physical or sexual, in graphic details also lead to desensitization of violence and subsequent increase in violent behavior in real life? Should children be banned from reading these books? If not, does it make sense to encourage them to read these books but then prohibit them from watching the movies made from the books? Once exceptions are made for children to watch these PG-13 movies, can parents subsequently prohibit the watching of other PG-13 movies? These are interesting conundrums indeed.

Researchers at the Annenberg Public Policy Center and University of Pennsylvania looked at 390 popular movies released from 1985-2010 in order to gauge the number of times violent characters participate in other risky behaviors, and concluded that there was very little statistical difference between PG-13 and R-rated films with regards to the characteristics of violence. A similar study published in Pediatrics journal in November 2013 indicated that the amount of gun violence in PG-13 movies more than tripled since 1985, and last year,

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## PRESIDENT'S REPORT

# Forensic Consultation on Legal Regulation of Clinical Practice

Robert Weinstock MD



I am honored to write my first column as your 40th President of AAPL. This organization and its members have meant a great deal to me

throughout my career. We are in strong shape, and I follow in the line of many outstanding presidents including Debra Pinals, MD and Charles Scott, MD who will be a challenge to follow. I plan to continue the work they and others have begun and develop some new initiatives. Jeffrey Janofsky, MD, is our very capable new AAPL Medical Director, and I look forward to working with him. We are fortunate to have the assistance of Jackie Coleman and her staff who provide invaluable assistance and a fountain of knowledge about our organization. Please attend the exciting annual meeting we are planning for Chicago in October. Christopher Thompson, MD, and Gregory Sokolov, MD, are program chairs.

Joining and attending committees is the best way for new members to become involved. I plan to use these columns to highlight some aspects of our practice that in my view do not get the attention they deserve. I start with consultation to general psychiatrists.

Forensic psychiatrists often are asked by other clinicians to consult about legal aspects of psychiatric practice. It is important we are clear to others and to ourselves that we are not attorneys and cannot substitute for a lawyer or give legal advice. It is necessary to include an attorney whenever there are legal complexities and/or a threat of a legal challenge including a law suit. But, having said that, the forensic psychiatrist can provide an important alternative perspective for the general psychiatrist and

attorney to consider.

Attorneys who work for hospitals and for governmental agencies or even an organization consider as their primary obligation the protection of the clinician and the hospital or agency or organization from liability. The attorney who works for a malpractice carrier or the risk management advisor also has liability avoidance the primary goal. Some such advisors, but not all, will also consider the welfare of the patient and society. Others though will need to be encouraged by a clinician to do so. Forensic psychiatrists can be helpful in alerting other clinicians of the need to tell the attorneys and risk management advisors that they would like to balance self-protection against the actions they believe most helpful to patients and society. These other considerations sometimes even can protect against other types of liability. The "right" thing may even end up being more protective to the psychiatrist since juries likely will be more sympathetic to clinicians who strive to do the best thing as opposed to engaging in extreme self-protection to the detriment of others.

In the case of a hospital or government agency, there also is a risk that there can be a conflict of interest in the event of a law suit. Protecting the agency that has a "deep pocket" with much more money at risk may be a higher priority than protecting the individual clinician who may risk getting reported to a data bank. If that is suspected in a potential law suit or effort to settle the case, it can be advisable to hire a private attorney who will have the protection of the clinician as their primary concern even when less or even not protective of the agency.

Protection from liability of course is likely to be the primary consideration of the clinician as well and should therefore be for the forensic psychiatric consultant also. But on

their own, attorneys do not necessarily give significant consideration to the welfare of the patient and society, except insofar as it is clearly more protective of liability. But the clinician may well consider patient and societal welfare as an independent goal over and above liability concerns. Doing the "right" thing clinically and ethically is likely to be a significant concern by most clinicians, especially if any additional liability risk is minimal. Unlike some attorneys, clinicians might often be willing to put themselves at a small liability risk to do what is clinically and ethically right and can pursue this discussion with the attorney.

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*"Forensic psychiatrists can introduce the perspective of considering patient and societal welfare in addition to solely narrow views of liability protection"*

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It is important in the consultative role to be sure that the other psychiatrist is aware of whatever small liability risks may exist so as to be able to make an informed decision what to do. Clinicians should not act contrary to legal advice. The attorney may be needed to assist in the future if there is an adverse outcome and can be more aware of liability risks than the clinician or forensic consultant. But the treating psychiatrist or administrator can be assisted to explore with an attorney whether there is a legal way to accomplish the clinical and ethical goals the clinician desires. Some psychiatrists may have liability protection as their only significant concern. If so, then they could consult with their attorney or risk management advisor and just follow that advice. They most likely will want sometimes at least to balance those

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## MEDICAL DIRECTOR'S REPORT

### AAPL: Retrospect and Prospect

Jeffrey Janofsky MD



It is a real honor and privilege for me to be beginning work as AAPL's third Medical Director since our organization's founding in 1969. I had the

opportunity to work with both of AAPL's two prior Medical Directors, Jonas Rappeport and Howard Zonana. Although Jonas and Howard had very different leadership styles, both had an equally strong commitment to AAPL's growth into the premier organization for forensic psychiatry in North America. I hope to bring my own commitment to our field and organization to help continue AAPL's success.

As many of you may know, AAPL was founded primarily as an educational organization to further excellence in practice, teaching, and research in forensic psychiatry. That educational focus was initially carried out primarily through our Annual Meeting and Journal (originally named the Bulletin). In Volume 1 Number 1 of the Bulletin, AAPL's second President Bob Sadoff wrote that over 50 members attended the Annual Meeting in Ann Arbor, Michigan and that, "... the opportunity to meet with each other and share our ideas and discuss new issues in forensic psychiatry is invaluable ...". Such collegiality has been a core component of AAPL Annual Meetings since.

I attended my first AAPL meeting in 1985 in Albuquerque as a member of AAPL's first class of Rappeport Fellows. I not only learned a great deal, but I also began to establish new friendships that have continued and expanded as I have gotten to know other AAPL members through the years. AAPL is still a small enough organization so that members who come to just a few meetings begin to be recognized by other members. This recognition and collegiality accelerates once a member joins a

committee or authors a presentation. Our last meeting in San Diego had 753 participants and 134 presentations. Although impressive, such numbers do not fully reflect the additional networking opportunities provided by AAPL committee meetings and informal conversations with colleagues generating ideas for future professional endeavors.

AAPL's education mission has expanded over the years through a Board Exam in Forensic Psychiatry, first through AAPL, and later as an official American Board of Medical Specialties Board through the American Board of Psychiatry and Neurology. AAPL began sponsoring a review course, first under the auspices of Richard Ciccone and now under Phil Resnick, that provides an intensive three day overview of key issues in forensic psychiatry. Both the Course and our Annual Meeting receive high marks from participants for educational quality.

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*"AAPL has chosen to attempt to influence the policy positions of the AMA and APA through our formal liaisons, and informally through the many AAPL members who are active in both organizations."*

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As our membership grew, our educational products expanded, and administrative challenges to provide CME for educational activities became more difficult. It became clear that professional management was required. Jackie Coleman has ably filled the role of AAPL's Executive Director since 1993 to provide such services. It would simply not be

possible for AAPL to exist in its present form without Jackie and her staff.

Maintaining Forensic Psychiatry Board Certification has become even more complex with expanding Maintenance of Certification (MOC) requirements. AAPL has responded by providing new educational products spearheaded by our Education Committee, such as an online CME self assessment exam and Performance in Practice (PIP) modules required under the new MOC requirements.

Under the guidance of Howard Zonana, AAPL began writing Practice Guidelines for critical areas in forensic psychiatry. Guidelines are produced by a workgroup, presented to the membership and Council for vetting and then published in the Journal. AAPL has now produced Practice Guidelines on the Insanity Defense, Video Recording of Forensic Evaluations, Competency to Stand Trial, and Psychiatric Disability. A revision of the Insanity Defense Guideline and Video Guidelines has been completed and revisions of our other Guidelines, as well as potential new Guidelines, are in the works.

During his 1998 to 1999 AAPL Presidential term, Larry Faulkner identified the importance of a strong research foundation in forensic psychiatry and the difficulties in funding such a research enterprise. Based on his recommendations and initiative, AAPL established the AAPL Institute for Education and Research (AIER) in 2004. AIER has received funding both directly from AAPL and from AAPL members. Lead grantees, who must be AAPL members, have received over \$163,000.00 funding fifteen projects to date in both research and education. More importantly, grantees have been able to use AIER grants as stepping stones to larger grants and research, a key underlying purpose of the Institute.

More recently in its history, AAPL has created formal liaisons with other organizations to make AAPL's voice heard when those other organizations made policy that could affect forensic

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## PRESIDENT'S REPORT CONTINUED

### Forensic Consultation

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concerns with other factors and should be encouraged to negotiate with the attorney or risk management professional to try to find a way to accomplish the clinical and ethical goals with minimal liability risk if possible. They would not want to defer the clinical decision to an attorney. However, if the law clearly requires something that is not best clinically and ethically, there generally is no reasonable choice but to follow the law unless a way consistent with the law can be found to accomplish the desired goal.

In most areas of forensic practice our job is to accept the law as is and, as forensic psychiatrists, apply our data to the current legal criteria. However, sometimes if the criteria are ambiguous, it can be appropriate with the attorney to test transparently the possibility of an alternative interpretation that seems better able to address the salient considerations that can be appealed and potentially establish new precedent. Additionally, in appellate cases that will set precedent when there are issues that have psychiatric implications, as part of an organization, we may want to file amicus briefs to try to establish a legal precedent that will extend far beyond the case at hand. On rare occasions, there are times the psychiatric or forensic psychiatric profession may even want to make efforts to change the law by legislation when there are laws, or interpretations at the state or federal level, that significantly impact clinical or forensic practice. Some such efforts can be successful. So on rare occasions, attempts to change precedent or the law might be appropriate either as professionals or privately as citizens.

In California, because of confusion caused by an ambiguous poorly worded immunity statute, it became necessary to clarify by statute that the Tarasoff duty was a duty to protect and not a duty to warn. Warning potential victims and the police is the way to obtain immunity from liability. But in situations in which warning

would exacerbate the risk to a potential victim, it can be desirable to do something other than warning, and not automatically be liable for failure to warn as a California appellate court had earlier interpreted. As a result of a subsequent legislative change to the statute, clinicians desiring liability immunity can still get it by the "safe harbor" of warning the potential victim and the police. But alternatives again are possible. In order to be liable for an alternative action, that choice and action would need to be proven negligent. This change permitting flexibility when the therapist desires it was accomplished by modifying the existing statute.

Another complex area is pressure to use statutes designed for involuntary psychiatric treatment in order to keep involuntarily medical patients who are incompetent to consent to medical treatment in a medical unit when they try to leave despite lacking the capacity to understand and appreciate the reason for needing to stay there. If there is also a psychiatric problem needing involuntary treatment, then psychiatric holds or civil commitment are appropriate and necessary to treat the psychiatric problem. If the psychiatric problem is stable or there is an illness such as major neurocognitive disorder that will not respond to treatment, the psychiatric holds are not appropriate or desirable. Their use unnecessarily grafts heavily rights-driven cumbersome systems designed for psychiatric treatment on to the medical arena that historically never required such careful monitoring of rights. It can create logistical problems such as a need to transport a severely medically ill unstable patient to a court a distance away for a writ or civil commitment hearing or be required to discharge the patient unless he agrees to stay. But some attorneys or administrators accustomed to using the procedures for involuntary psychiatric patients trying to leave the hospital think it is the only way to keep a patient from leaving the hospital.

A useful role forensic psychiatrists can undertake in consulting in such

situations is to try to help persuade attorneys and administrators to interpret silence or even ambiguities in the law in ways to help patients in the treatment setting. Rather than interpret the ambiguities and silence in the law to require things like inappropriate psychiatric holds just because they are familiar, it would likely be best for everyone to assist the hospital to develop policies and procedures in these situations to benefit patients in addition to avoiding liability. If there is too much resistance in many such facilities, it might necessitate efforts to create something like a new alternative capacity-based system to detain patients lacking decisional capacity to consent to urgent medical treatment including the need to stay in a medical hospital. In situations qualifying for emergency exceptions, that offers a solution.

In conclusion, the forensic psychiatrist often can provide an important perspective when consulting to general psychiatrists about treatment. Although not a substitute for consultation with an attorney, forensic psychiatrists can introduce the perspective of considering patient and societal welfare in addition to solely narrow views of liability protection. Being familiar with clinical issues as well as having some familiarity with the law, forensic psychiatrists in this role may be uniquely qualified to help other psychiatrists intimidated by both the law and attorneys to find ways to balance competing considerations. ☞

### MUSE & VIEWS

"I do not suffer from insanity, I enjoy every minute of it." -Edgar Allan Poe

#### *Pro se Trial Performance*

A man accused of stealing a woman's purse decides to represent himself and asks the following question of the robbed victim:

"Did you get a good look at my face when I took your purse?"

The defendant was found guilty and sentenced to ten years in jail.

*Submitted by Charles L. Scott MD*



## 2013 ANNUAL MEETING - Luncheon Speaker

### Kenneth Feinberg, Esq.: Unconventional Responses to Unique Catastrophes: Tailoring the Law to Meet the Challenges

Joseph Chien DO



Luncheon attendees on the opening day of the 2013 Annual AAPL Meeting were treated to a fascinating glimpse into the life's work of

attorney and mediator Kenneth Feinberg. A graduate of the NYU School of Law, Mr. Feinberg worked in the 1970s as an assistant, and then later as the chief-of-staff for Senator Edward Kennedy of Massachusetts. Later in his career, he was assigned as a special master overseeing the allocation of billions of dollars of funds after several major American tragedies, including the September 11, 2001 Victim Compensation Fund and the BP Oil Spill Fund. Most recently, he was appointed to oversee One Fund Boston, which was set up to compensate victims of the Boston Marathon bomb attack. Mr. Feinberg, as he playfully reminded the audience, is also the author of two books: *Who Gets What: Fair Compensation after Tragedy and Financial Upheaval*, and *What is Life Worth?: The Inside Story of the 9/11 Fund and Its Effort to Compensate the Victims of September 11th*.

In his role as a special master, Mr. Feinberg has repeatedly been handed the unenviable task of determining the extent of financial compensation to be awarded to the victims of horrible tragedies. Attuned to the profound grief often felt by surviving family members, and the need for some to have their stories personally heard, Mr. Feinberg insists on affording every victim the opportunity to meet with him face-to-face.

Mr. Feinberg opened his lecture with the observation that the most difficult part of his job consists of being confronted with the intensity and range of emotions harbored by people who have suffered tragic loss. To more skillfully

deal with these emotions, he opined that he would have been better served by a degree in divinity or psychiatry rather than law.

His speech consisted of a free-flowing series of narratives about tragedy victims, some amusing, most devastatingly sad. There was the story of the man who lost a leg in the Boston Marathon bombing, who responded to an offer of compensation by stating, "how about you give me my leg back." A woman, whose husband died in the 9/11 attacks, asserted that instead of money she wished she could die in his place. Collectively, these stories underscored the inadequacy of monetary compensation alone in being able to heal these individuals, and make them whole again. But alas, the dispensing of this type of compensation is what Mr. Feinberg has been charged to do time and time again, sometimes at the behest of the President of the United States.

*"Mr. Feinberg surmised that arguments over compensation often take the form of who is more 'deserving' of it."*

And how does one go about determining the amount of money each victim should be entitled to receive? The process, Mr. Feinberg explained, can be quite arbitrary. There is a finite amount of money, and he tries to be as fair as possible, but inevitably there are comparisons and accusations of bias and mistreatment. "Everyone," he surmised, "counts other people's money."

Mr. Feinberg surmised that arguments over compensation often take the form of who is more "deserving" of it. He cited the example of parents

of a lost son, who after his death in 9/11 argued that his fiancée was not entitled to financial compensation. In an interpretation worthy of a psychiatrist, Mr. Feinberg opined that such disagreements were not evidence of greed as much an expression of denial—to acknowledge the legitimacy of the fiancée would also mean having to acknowledge a lost future (the possibility of grandchildren, etc.). Some painful things, it seems, are better kept underground.

Nearing his conclusion, Mr. Feinberg thanked the audience and remarked, "I've learned over the past 25 years, the important work you do." Judging by the exuberant roar of applause after his speech, AAPL members likewise acquired an appreciation of the important work Mr. Feinberg has done and continues to do. ☞

#### AAPL Awards Committee Seeks Nominations for 2014

The AAPL Awards Committee would like your help. We would be interested in receiving nominations by June 1 for the following awards:

**Red AAPL** - For AAPL members who have provided outstanding service to AAPL, e.g., through committee membership.

**Golden AAPL** - For AAPL members over the age of 60 who have made significant contributions to the field of forensic psychiatry.

**Seymour Pollack Award** - For APA members (who may not be AAPL members), who have made distinguished contributions to the teaching and educational functions of forensic psychiatry.

**Amicus Award** - For non-AAPL members who have contributed to AAPL.

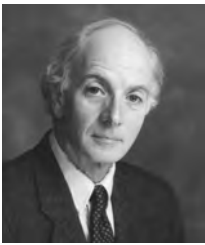
**Best Teacher in Forensic Fellowship Award** - For outstanding faculty member in fellowship program.

Please send your nominations to Renée Binder, MD, Chair of the Awards committee at [reneeb@lppi.ucsf.edu](mailto:reneeb@lppi.ucsf.edu).

## 2013 ANNUAL MEETING - Luncheon Speaker

### Howard Zonana, MD: *Reflections of a Medical Director*

Brian Cooke MD



On the second day of AAPL's Annual Meeting, attendees were honored to listen to Dr. Howard Zonana provide his "Reflections

of a Medical Director." Before I get started, I must disclose that Dr. Zonana has been one of my mentors since I had the privilege of training under him at Yale's forensic fellowship. Like many he has trained, he has imprinted on me a permanent impression of the ideal standard for a forensic psychiatrist. He has made a difference in the personal and professional lives of so many in our field. In fact, on April 22 and 23, 2010, the Law and Psychiatry Division of Yale School of Medicine Department of Psychiatry hosted a Festschrift to honor and pay tribute to his contributions to forensic psychiatry. Forensic scholars, faculty, and former fellows acknowledged his influence. Much of the Festschrift and his contributions are captured in the December 2010 issue of the *Journal of American Academy of Psychiatry and the Law* (Volume 38, Number 4). This newsletter article can hardly do justice to adequately reflect Dr. Zonana's career and accomplishments.

For those unfamiliar, a description from the Annual Meeting Program summarizes his numerous accomplishments: "Howard Zonana, MD has been Medical Director of AAPL since 1995. He is only the second Medical Director in AAPL's history and has seen many changes in his 18 years of service to AAPL. Since 1968 he has been on the faculty at Yale University School of Medicine and is Professor of Psychiatry and an Adjunct Clinical Professor of Law at the Yale Law School. Since 1969 he has been the forensic psychiatry residency-training director at Yale with approximately 75 graduates from the

program. He has also been active in the American Psychiatric Association as Chair of the Committee on Judicial Action and Chair of the Council of Psychiatry and Law. He also has served as a federal court monitor at the York prison for women in CT, regarding standards of mental health care from 1987 to the present. He was a member of the ABPN group writing the Board exam for Forensic Psychiatry for 15 years, including services as Chair. He is a recipient of AAPL's Golden Apple, Red Apple, and Seymour Pollack Awards. In 2012 he won the Isaac Ray award of the APA-AAPL."

Now back to the AAPL luncheon... In the style of Bravo TV's "Inside the Actor's Studio," Drs. Stuart Anfang and Barry Wall, Co-Chairs of the Program Committee, invoked the spirit of James Lipton as they interviewed Dr. Zonana for a luncheon version of "Inside the Medical Director's Office." The interview was filled with playful moments that mimicked Lipton's style of questioning (e.g., "What is your favorite word?") and more serious reflections of Dr. Zonana's experiences with AAPL, the APA, and the AMA.

First, some humorous insights delivered in response to questions that James Lipton would have asked had he conducted this interview. When Dr. Zonana was five, he wanted to be an archeologist, and he would never want to be a boxer. His favorite sound is Mendelsohn's violin concerto, while he despises the clanging noises of children's toys. If he had to have a mental illness, he would want to have hypomania. Things that turn him on emotionally and spiritually include hiking, music, and sailing. Slapstick comedy, however, is a turn-off. When asked, "If heaven exists, what would you like to hear God say as you crossed the pearly gates?" he responded, "I've got an evaluation for you to do."

Now, some serious reflections

about Dr. Zonana's career. His work was captured by themes of dedication, service, justice, and perseverance. He worked alongside other physicians to improve the professionalization of our organization and "enhance the stature of our subspecialty." While training at Massachusetts Mental Health Center in Boston many years ago, he realized that forensics, at that time, was a "wasteland" with dubious ethical and legal practices. He worked for two years of service in the training branch of NIMH. He joined the faculty at Yale and soon worked with APA to revise the civil commitment laws. When the NIH offered grants for seed programs, he started a forensic psychiatry fellowship in 1979. He had an instrumental role in developing ethics guidelines for AAPL, receiving the approval of forensic psychiatry as a specialty, and later the creation of a Board. He brought Jackie Coleman to AAPL. He worked for three years with Drs. Ken Hoge, Paul Appelbaum, and Bob Phillips to get a meeting with the AMA's Council on Ethical and Judicial Affairs (CEJA), because he realized that CEJA ethics opinions have a huge effect on the practice of forensic psychiatry. Dr. Zonana knew that AAPL needed to have a voice within the AMA and play a more active role.

It would be an understatement to simply state that Dr. Zonana's tireless service to our field has had a lasting impact. His work has shaped our practice, our profession, statutes, and policy.

For those fortunate enough to have been trained or taught by him, Dr. Zonana's dedication to education also has had permanent effects. He has led the efforts to improve the position of forensic psychiatrists, clinicians, patients, and defendants alike on both a local and a national level. Quite simply, the entire profession is grateful for his tireless work and dedication. The next Medical Director for AAPL will certainly have big shoes to fill. If those shoes are anything similar to Dr. Zonana's, they should be hiking boots ready to lead the way up the nearest mountain. ☪



## 2013 ANNUAL MEETING - Luncheon Speaker

### Danalynn Recer, JD: Capital Defense and Forensic Psychiatry: One Capital Defender's View

*Sylvester Smarty MD*

The 44th Annual Meeting of the American Academy of Psychiatry and the Law (AAPL) was held at the opulent Hotel Coronado, in San Diego, California from October 24 to 27, 2013. I attended the Saturday luncheon talk during which the topic of discussion was capital defense and how it applied to forensic psychiatry. The scheduled guest speaker was Judy Clarke, a nationally renowned death penalty defense attorney. However, she could not fulfill that obligation because of an unforeseen conflict. In her place, the discussion was moderated by Danalynn Recer, a defense attorney against the death penalty based in Texas.

Ms. Recer was introduced to the audience by Stuart Anfang. He told the audience that she holds a BA, MA and JD from the University of Texas. Initially, she worked as a Mitigation Investigator, before working as an attorney for the Texas Resources Center, an organization that is committed to the repeal of the death penalty in Texas. In 2002, she founded the Gulf Region Advocacy Center (GRACE) an organization that has played an important role in the establishment of current standards for the mitigation of death penalty cases.

Ms. Recer started her talk by apologizing for not being Judy Clarke, but promised to do her best to emphasize important death penalty issues and how they applied to the forensic psychiatrist. She suggested that although mental health does play a very important role in the adjudication of death penalty cases, forensic psychiatry was often "misused" by the state to highlight negative aspects of the defendant's history, which will be favorable towards imposition of the death penalty. She promised to try to guide the audience through the rigorous process involved in the mitigation of death penalty cases so as to help forensic psychiatrists have a better



understanding of their role in the process.

Ms. Recer informed the audience that the death penalty was abolished by the

United States Supreme court in 1972 because it was "arbitrarily administered." At that time, there was no "rational way" of predicting who would get the death penalty following a capital conviction. This was evident from the fact that some individuals who had been convicted of very heinous capital offenses were not sentenced to die, while others who committed less heinous capital crimes were executed. There was the belief that race played an important role in the imposition of the death penalty as evident from the fact that minorities were more likely to be sentenced to die than whites. When the Supreme Court reinstated the death penalty in 1976, it was against the argument that race was an important factor in the determination of who gets the death penalty. As a result of "the race argument," they rejected the death penalty statutes of states with "mandatory death penalty statutes." The reasoning was that mandatory sentences did not take into account the "individual features of the defendant." They also introduced the idea of "guided discretion" in the administration of the death penalty.

Ms. Recer explained that the principle of "guided discretion" involved two broad concepts. One was the "objective criteria" which granted courts "unlimited power to impose the death penalty." The other was "subjective discretion" which granted the courts "unlimited power to dispense mercy and justice." The role of a competent mitigation expert was to present evidence that would allow the courts to exercise its power to show

mercy to the defendant.

According to Ms. Recer, the United States Supreme Court in lifting the ban on the death penalty stipulated that there has to be a narrowing process amongst individuals suspected of committing the most heinous capital crimes. Such a process would allow the death penalty to be fairly applied. In order to help with the narrowing process, the defense should not try to counter the prosecution's portrait of the defendant as "all bad" with a picture of "all good." Rather, the defendant should be presented as a human being with flaws like anybody else, so that the jury can develop some form of emotional connection to the defendant, thereby making it easier for them to justify sparing his/ her life. She described this sense of emotional connection and identification with the defendant as "neighborliness." The more neighborliness a jury has for a particular defendant, the less likely they would recommend the death penalty.

Ms. Recer gave some examples of the role of neighborliness in every day human interaction. She recalled the witch trials of the seventeenth century, noting that those that were killed were more likely to be those who did not fit into the mainstream of society. They included foreigners, people with uncommon accents and those who lived outside the city limits. Based on the same principles, she surmised that jurors in death penalty case would reach out and show mercy to defendants that they connect with emotionally. The job of the mitigation specialist is to help the jurors see the defendant in a more positive way and help them develop more neighborliness with the defendant.

Ms. Recer referenced the results of the "Capital Jury Project," a collection of research studies on the decision-making of jurors involved in death penalty cases in the United States. The results suggest that the two most important factors in death penalty jury decisions is remorse and the capacity for redemption. The jury would often spare a defendant if they

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## 2013 ANNUAL MEETING - Luncheon Speaker

### Capital Defense

*continued from page 9*

perceive that he/she has the capacity to love and if they perceive that he/she is loved. The higher the level of neighborliness, the greater the likelihood that the jury will dispense mercy.

Ms. Recer informed the audience that while the defense tries to increase the degree of neighborliness of the defendant for the jury, the prosecution often tries to present the defendant as very bad. To this end, the prosecution will often call upon a forensic psychiatric expert to attempt to run around the 8th amendment. She gave the example of the case of *Estelle v. Smith* (United States Supreme Court, 1984) in which the issue of future dangerousness was raised as an objective requirement for imposing the death penalty. For years, the prosecution focused their death penalty phase strategy on highlighting the most aggressive aspects of the crime as well as suggesting the defendant could not be trusted not to engage in similar behaviors in the future. To support their argument, the prosecution would often seek the services of a forensic psychiatrist. They would often “goad” the psychiatrist into disregarding the “humanity” of the defendant, with the aim of using them to avoid the requirements of the 8th amendment of the constitution. Most psychiatric experts are often oblivious to the way their testimonies are used to “run around” the 8th amendment. She opined that it was fundamentally wrong for any expert to focus on only the material aspects of the crime without considering other individual factors of the defendant before predicting that the individual is not capable of ever changing.

Ms. Recer then discussed the American Bar Association (ABA) standards for capital representation. She indicated that per case law, capital punishment defense must begin with a culturally competent bio psychosocial history through multicenter, multigenerational and multisystem life history investigation. Lawyers

cannot choose to do a thorough life history investigation and clients cannot waive their rights to have this done. One area of frequent conflict is often the “Sell” issue involving competency to be executed and forced medication to ensure competency. She admitted that this was often a difficult scenario and there was no clear case law for reference. Her recommendation was that mitigation investigation should still proceed even if the defendant is not competent.

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*“The jury would often spare a defendant if they perceive that he/she has the “capacity to love” and if they perceive that he/she “is loved.”*

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Ms. Recer expressed an observation that there is often the assumption in the forensic psychiatric community that people facing the death penalty are always malingering. However, based on her experience, most people facing the death penalty are often ashamed of their crimes and are terrified of the trial process exposing them as weak. For this reasons they would often chose the death penalty rather than spend the rest of their life in prison. As such, they would often fight to prevent the revelation of humanitarian information about them during the death penalty phase of their trial. To this end, they might fire their attorneys and go pro se during the death penalty phase of their trial.

Ms. Recer cautioned that the biggest mistake the defense can make is to bring in a forensic psychiatrist during the mitigation phase prior to obtaining a detailed life history. This is because in forensic settings, the only source of information is often the defendant. However, investigators trained to gather a detailed life histo-

ry would often talk to several individuals including members of the defendant’s family, friends, acquaintances, neighbors, classmates, teachers and others that have been involved with them at any time in their lives. She gave the example of a young black male who was convicted of murder in Louisiana. During the sentencing phase, she presented testimony from several people from the defendant’s church and neighborhood and was able to avoid the death penalty without any mental health testimony. Avoiding extensive mental health testimony is important because mitigation is not to explain the crime, but to present the other side. A detailed life history is usually made up of several little stories that helps to change the context of the crime. The forensic psychiatrist who has access to a detailed life history will be an asset to the defense as they will utilize the available information to better conceptualize the background of the crime to the jury since mitigation investigators themselves are not testifying experts. In specific cases involving individuals suffering from certain mental health conditions, detailed mental health testimony becomes important. An example will be that of an individual suffering from a developmental disability.

Ms. Recer rounded out her discussion by taking questions from the audience. To a question about the nature of life history investigations, she suggested that such investigations have to be “culturally competent.” By this, she meant that the investigator does not have to live in the defendant’s culture, but must “figure out ways to better understand the defendant’s culture so that they can be able to help them.” Another individual wanted a better explanation of the term “neighborliness.” She explained that every case was different. The job of the defense is to help the jury see the human qualities of the defendant. This approach to mitigation was arrived at after the Capital Jury Project showed that traditional mitigation was not effective because it “over pathologizes the defendant.”

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## CHILD COLUMN

## I Have Two Mommies

Stephen P. Herman MD



The US Census of 2000 revealed that two million gay and lesbian people were considering adoption. At least 65,000 adopted children were living with a gay or lesbian parent. California reported more than 16,000 children raised by gay or lesbian parents. At the time of the census, California was the state with the highest rate of gay and lesbian parents in the country. Over four percent of all adopted children in the United States are raised by gay and lesbian parents. One can only assume that in the census of 2010 these statistics would be higher. With 16 states plus the District of Columbia now allowing same-sex marriages, more married gay and lesbian couples are looking to adopt children. Hawaii's law – the most recent – took effect on December 2. According to some statistics, slightly more than fifty percent of all Americans favor gay and lesbian marriage. For most people, finally, the idea that being gay or lesbian means one is also a pedophile has, fortunately, all but disappeared from the landscape.

For gay men, whether married or not, one or both of the couple must adopt to have children of their own. With lesbian couples of child-bearing age, it is common for one of the couple to be the biological mother. We know the children of lesbian couples grow up with psychological issues at the same rate as children with heterosexual parents. They are not at risk simply because their parents are gay. But couples break up, marriages fail, and, for a small percentage of couples, custody and visitation conflicts arise just as they do with heterosexual parents.

Some years ago, I was asked to become involved in a lesbian breakup (before same-sex marriages were allowed anywhere) in which the biological mother refused to allow her

ex-partner to see their child. The child spoke of having two mommies and was clearly and deeply attached to both of her parents. The biological mother's position was that she was the "real" mother and her ex-partner was not. The non-biological parent had not adopted the child and was accused by the mother of having no standing in court. I testified that the child was equally attached to both of her mommies and it would be detrimental to cut off all contact with her non-biological mother. The judge agreed and the non-biological mother was given extensive parenting time with her child.

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*"But for forensic child psychiatrists, same-sex marriage will bring same-sex divorces and custody battles."*

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But what if the non-biological parent adopts the child and the couple breaks up? Both parents then have equal status in the eyes of the court – definitely in New York State and elsewhere. That is when it becomes complicated. That is when a custody battle may begin.

I had such a case a few years ago. Once again, the child, who was seven years old, was equally attached to both of her parents. There was no "psychological parent." This child was used to having two mommies. This was her life, and she loved both of them. How does the judge come to a custody decision in this situation? It is not easy. In my case, the judge ordered joint custody over the objection of the biological mother. This arrangement was bound to fail. The parents had no interest in co-parenting. Unfortunately, the case was lost to follow-up. One can only assume that the child was headed for trouble,

either by acting in and becoming depressed (as is common in girls in this situation) or by aggressive behavior (more common in boys.)

This past fall, a mother donated an egg to her female partner and, when the child was nine years old, the relationship ended. The Florida Supreme Court ruled unconstitutional a state law which significantly limited parental rights of the donor in such a situation. The egg donor was found to have no rights in a lower court. After that ruling, the recipient mother moved to Australia. But the Florida Supreme Court overturned that decision and found, in a 4-3 ruling, that the donor mother had as much right to her child as the recipient. The court wrote:

"It would indeed be anomalous if, under Florida law, an unwed biological father would have more constitutionally protected rights to parent a child after a one-night stand than an unwed biological mother who, with a committed partner and as part of a loving relationship, planned for the birth of the child and remains committed to supporting and raising her own daughter."

The Florida Supreme court invoked the equal protection provisions of both the state and federal constitutions.

Also this past fall, the Nevada Supreme Court declared a child born in that state can have two legal mothers. The Court overturned a lower court ruling that held a co-parenting agreement signed by both parents was unenforceable under state law. The child was a product of insemination in one parent with sperm from an unidentified donor. There was disagreement between the parents about the motivation behind the original co-parenting agreement. The sperm

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## FELLOWS CORNER

### A Surprising Bias

Michael Gower, MD



As part of the AAPL forensic review course this past October, I had the opportunity to attend Dr. Phil Resnick's excellent seminar "Insanity Report

Writing Exercise." Dr. Resnick presented excerpts from a videotaped insanity evaluation of a defendant charged with making terroristic threats and extortion. Participants were asked to generate and share their opinions on the defendant's sanity with the group. It turned out that the room was fairly evenly split "sane" vs. "insane," with both experienced forensic psychiatrists and greenhorn fellows falling in either camp. Asked to present my opinion as a representative for the "sane" side, I was the subject of a mini-deposition before the audience. Yes, the defendant recognized the wrongfulness of his actions—he admitted that his actions were against the law and he expected to be prosecuted if caught. No, I was not impressed by his statements that he felt divinely ordained to wage war against the government (after all, that's not a defense allowed for religious extremist groups). I took my seat and listened as another fellow explained how she arrived at the opposite conclusion. The defendant heard the voice of God commanding him to commit the acts for which he was being prosecuted. The bizarre specifics of his crime lent credence to the idea that his actions were driven by delusions. Clearly he had a mental illness which caused him not to know the wrongfulness of his acts.

Perhaps unsurprisingly, a repeat polling of the room revealed that our testimony had swayed approximately no one from their previous position. The fifty-fifty split remained. Dr. Resnick resumed the floor and explained that he had selected this case precisely for its nuance and ambiguity, and that it offered an opportunity to examine the issue of

individual bias. Some of us, he explained, tended to be more "law-and-order types," placing more emphasis on individual responsibility and showing less willingness to let a defendant "off the hook" with an insanity defense. Likely this focus on personal responsibility would manifest in other legal scenarios as well, with perhaps a tendency in favor of defendants vs. plaintiffs in civil suits or towards finding defendants competent. Others held opposite biases, Dr. Resnick continued. As mental health professionals, we work to develop

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*"Throughout my fellowship, mentors have emphasized to me many times the benefit of working with multiple faculty members on evaluations in order to get a sense of each one's individual style and strengths and ultimately to assemble parts of each into an effective and eclectic personal style."*

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empathy as a professional skill. We advocate for the mentally ill in matters of public policy. In dealing with mentally ill defendants, our professionally developed compassion and sense of beneficence can produce a bias towards findings of insanity. One of the benefits of working with other fellows and attendings in a fellowship is that when multiple evaluators come to different opinions about the same cases, we have the opportunity to map out where our own individual set of biases places us in the

spectrum of professional opinions. Just as in psychotherapeutic situations, we cannot eliminate our personal biases, but by being aware of them we guard against their leading us to inappropriate decisions.

All this makes sense, I thought to myself, but when did I become a "law-and-order type"? In college, I volunteered with Amnesty International, participating in demonstrations against the death penalty and writing letters to governments demanding freedom for prisoners of conscience. I was an avid reader of Noam Chomsky. At a dinner party last year, I argued with a friend that it was wrong to see the movie *Zero Dark Thirty* because I had heard that it justified torture for the sake of the War on Terror. Since I of late work in correctional psychiatry, I feel compelled to chide family members and acquaintances who remark that our government spends too much to provide services to inmates in jails and prisons. Surely I'm as compassionate as anyone else; just look at my Facebook news feed! Yet I felt that this particular mentally ill defendant should be held criminally responsible for his acts, when half of my colleagues did not.

Of course bias can arise not only from personal values, but is also determined by our experiences. We may unconsciously reflect the collective biases of our communities. I was raised and educated in Alabama and moved to the University of Florida for my psychiatric training and my current fellowship. I have always made my home in the deep south, an area which has a well-deserved reputation for a more punitive "law-and-order" style of justice. Since 1976, states in the southern U.S. have executed 1108 people, roughly four times as many as the rest of the nation.<sup>1</sup> My current home state, Florida, is second nationwide in number of executions in 2013 to date,<sup>2</sup> and also achieved national prominence (or notoriety) for the "Stand Your Ground" self-defense statute employed as a defense by George Zimmerman. Though I am

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## FACES OF AAPL

### Cheryl Wills MD

Philip J. Candilis MD



Brooklyn-born Cheryl Wills, MD, caught the forensic bug when she picked up one of Robert Simon's books. Simon, a former

AAPL president and long-time educator, "thought exactly like I think," she recalls. She completed a combined residency in general and child psychiatry at the University of Pittsburgh then made her way to the eminent forensic program at Case Western where she honed her child forensic skills with Phillip Resnick and Katherine Quinn.

Back in New York to work with underserved groups in Buffalo, Dr. Wills conducted her early work in a local jail, a juvenile detention center, and a long-term inpatient psychiatric unit for children and adolescents. Each setting permitted her to develop different aspects of her forensic skillset. She conducted competency and criminal responsibility assessments for adults and children, and fostered rehabilitation of youths with mental disorders and intellectual disability. She also began to introduce forensic psychiatry to residents in an effort to promote safe and competent clinical practice.

Returning to Ohio to work more extensively in corrections, Dr. Wills spent two formative years in a women's prison. The capacity to understand how this vulnerable group managed conflict in a more "relational" manner reinforced Dr. Wills' appreciation for the gender differences among inmates. The extent of trauma and the penchant for delayed rather than reactive aggression among women underscored the lack of guidance in correctional manuals that were written largely for male prisoners. She also observed the difficulties young women experienced when they were transferred from juvenile to adult corrections facilities. "Their immaturity impeded their capacity to

adapt and they were at least six months behind their same-aged peers who entered the criminal justice system directly from the community," she observes.

Dr. Wills' child psychiatry perspective was useful here as the threads of risk assessment, developmental maturation, and adult presentation of childhood disorders came together to inform her increasingly nuanced view of mental health in correctional settings. The diagnosis of ADHD was a case in point. The need to uncover co-morbid illness and develop behavioral coping skills allowed for less reliance on medication – a safer and more cogent approach for correctional health. "I never prescribed stimulants as this presents a security risk in corrections facilities. Yet, comprehensive assessment and treatment resulted in significant improvement in the emotional stability and well-being of patients," Dr. Wills says. "Women often struggle with their roles as mothers, daughters, and partners, and with rejection and trauma." Sensitivity to these concerns was critical to fostering therapeutic alliances in the correctional setting. These concerns and a higher prevalence of self-injury among women combined to underscore the unique nature of the female inmate's experience.

Dr. Wills' forensic mentor, Kathryn Burns, who also trained at Case Western, ultimately recommended that she take on a leadership position in juvenile justice in Louisiana in 2001. At a time when advocacy for youths in Louisiana's juvenile corrections facilities was being reinforced by a settlement agreement, Dr. Wills brought a clinical and administrative approach to a system that generally addressed problems by warehousing youths without providing rehabilitation. With a greater emphasis on assessment, treatment, re-training, family involvement, and team-building, Dr. Wills was able to influence the juvenile corrections system to decrease self-injurious behavior and physical

aggression, and raised the quality of psychiatric services above the standard of care. Although the system could be quixotic, it remained important to emphasize high standards of assessment and treatment.

When Hurricane Katrina hit, Dr. Wills was there. "I was supposed to work in the Superdome," she recalls, "but the communication system broke down, so I was in my home for five days." She witnessed pain, suffering, and trauma of unconscionable proportions, yet "the crisis brought out the best in many people who made sacrifices to help others." It was a lesson in overcoming obstacles that Dr. Wills would take to heart, applying it to challenges in her own life and career.

Now back at Case Western as director of child and adolescent forensic psychiatric services, Dr. Wills works to integrate child, family, and community forensic services within the university. She is particularly proud of a two-year-old clinic at the juvenile courthouse. Multi-agency collaboration facilitates treatment, while community support engages parents in ways that ensure greater attention to justice-involved and at-risk children in the community and in juvenile detention and corrections facilities.

Service to the professional organizations has been an important part of Dr. Wills' experience. Within AAPL, she has chaired the Criminal Behavior Committee, co-chaired the Education Committee, and served on the Executive Council. She is book review editor of the *AAPL Journal*, and is an alternate AAPL representative to the APA Assembly.

As a former member of the APA Council on Psychiatry and Law she has advised the DSM-5 workgroups on forensic matters related to mental disorders in children and adolescents. Throughout her service to the professional organizations she has endorsed the importance of systems building, especially in the form of extending forensic expertise into the community. She is confident this can only improve assessment, care and rehabilitation at every level. ☯

## ALL ABOUT AAPL

### AAPL

*continued from page 5*

psychiatry. From its beginning, AAPL had an unofficial liaison with the APA, primarily through the APA's Council on Psychiatry and the Law, with many AAPL members serving on the Council or its Committees. I had the privilege to be AAPL's first formal liaison to the American Psychiatric Association Assembly when AAPL was asked, along with seven other psychiatric organizations, to pilot such a program. AAPL first only had a voice in the Assembly, but was later granted voting membership in the Assembly's Allied Organization Group. AAPL's current Assembly representatives Deb Pinals and Cheryl Wills, provide critical guidance during Assembly debates over issues critical to forensic psychiatry. Most recently, Deb and Cheryl worked tirelessly to shepherd the APA's Firearms Position Statement through the Assembly. That Position Statement was approved by the APA Board of Trustees in December 2012.

Somewhat later AAPL obtained formal representation in the American Medical Association. This required that AAPL ensure that at least 35% of AAPL members also belong to the AMA. After a several-year effort, AAPL was able to join the AMA is now part of the American Psychiatric Association's delegation. AAPL has been ably represented in the AMA by Bob Phillips, Barry Wall, Ryan Hall and Howard Zonana. They were just joined by Jennifer Piel. AAPL's representation in the AMA most recently helped provide testimony and policy reaffirmation on violence and mental illness. We helped the AMA convey the message that as many patients as possible should have treatment, and that physicians should address gun violence in their practices and reduce stigma surrounding mental illness.

Throughout the years, the AAPL Council has deliberately chosen not to take formal policy positions on issues relevant to forensic psychiatry. The sole exception was a 2001 call for a moratorium on the death penalty, a position that was retired this year.

Instead, AAPL has chosen to attempt to influence the policy positions of the AMA and APA through our formal liaisons, and informally through the many AAPL members who are active in both organizations.

How AAPL should proceed in policy areas remains an open question. Should AAPL begin a process to form its own policy statements? Should AAPL attempt more formal liaisons and relationships with other organizations such as the Residency Review Committee (RRC) that sets requirements for forensic fellowships, or the National Commission on Correctional Health Care (NCCCHC), the organization that attempts to improve health-care in jails and prisons? At the October 2013 Council meeting, AAPL created a work group to look into these future policy questions.

Please feel free to e-mail me your thoughts on these or any other AAPL issue you feel is important at [jjanofsky@gmail.com](mailto:jjanofsky@gmail.com), please put AAPL in the subject line. If we have not met, please introduce yourself to me at our next meeting. I look forward to working with all of you as Medical Director in the coming years. ☎

### Capital Defense

*continued from page 10*

This causes confusion in jurors and engenders negative emotions. They start to think, "He so different from us" there by causing them not to have any difficulty with imposing the death penalty.

Ms. Recer ended her discussion by thanking the audience. She hoped that she had provided them with enough information that will help them better understand their role in the death penalty process. ☎

### Child Column

*continued from page 11*

recipient claimed she had an equal right to parent the child as her ex-partner in view of the co-parenting agreement. The ex-partner's argument was that the agreement was merely

written to satisfy the adoption agency and to provide insurance for the child.

Confusing? Absolutely. But for forensic child psychiatrists, same-sex marriage will bring same-sex divorces and custody battles. Physicians should understand the laws of their state and use that knowledge as a foundation for the custody evaluation. The same protocols published for child custody evaluations by all the major behavioral organizations should be followed.

Finally, the evaluator should know that a child can have two mommies and be healthy and well-adjusted. New laws make complicated cases. ☎

## YALE UNIVERSITY DEPARTMENT OF PSYCHIATRY

The Department of Psychiatry, Yale School of Medicine, is recruiting an academic psychiatrist for appointment at the Associate/ Assistant Professor level, for a position as a consulting forensic psychiatrist. Candidates must have a minimum of 5 years experience in forensic psychiatry, preferably in an academic setting, be licensed to practice medicine in Connecticut and be legally employable. The primary clinical work assignment will be the state mental health authority and teaching of fellows in forensic psychiatry. Interested candidates send CV and list of references no later than February 15th to: Howard Zonana, MD, Yale University/CMHC, 34 Park Street, New Haven, CT 06519. Yale University is an Equal Opportunity/ Affirmative Action Employer. Qualified women and members of under-represented minority groups are encouraged to apply.



## ASK THE EXPERTS

### Ask The Experts

Robert Sadoff MD  
Neil S. Kaye MD

Neil S. Kaye, MD, and Bob Sadoff, MD will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send questions to [nskaye@aol.com](mailto:nskaye@aol.com).

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

**Q.** I am asked by a lawyer to evaluate a man for a not guilty by reason of mental disease or defect (NGRI) or guilty but mentally ill (GBMI) defense, but the charges are pretty minor. Any advice on how to proceed would be appreciated.



**Sadoff:** It is important to stay within one's area of expertise. We are called upon to advise the attorney with respect to the mental state of his/her

client. In criminal cases we evaluate the client's state of mind at several junctions in the criminal procedure: at the time of the alleged offense, at the time of arrest, at the time of trial and subsequent to trial with respect to disposition. Depending on the diagnosis, we advise with respect to treatment. If the client has a chronic mental illness that requires treatment, we emphasize the medical needs; if the client had an acute psychotic disorder at the time of the alleged offense that rendered him/her legally insane in our opinion, but the psychosis has remitted and the defendant is currently competent to stand trial and is not psychotic and does not need medical treatment, we can emphasize the legal issues.

The lawyer and client need to make their decisions based on a number of factors, one of which is our examina-

tion, evaluation and consultation. We can be very helpful in such cases depending on the diagnosis and recommendation for treatment.

Sometimes we have no control of the matter. In one similar case, I examined for the prosecution an elderly man charged with a relatively minor offense and found him to meet the legal criteria for insanity in that jurisdiction. Normally, the defense counsel would be pleased with such an opinion about his client, but defense counsel knew if he were found to be legally insane, he would likely spend more time in the hospital than he would spend in jail for the same offense. Without consulting me, the prosecutor and the defense counsel worked out a negotiated plea that allowed the defendant to receive probation with treatment. The prosecutor got his conviction and the defendant got a reasonable disposition. It all worked without my testimony.

Our input may be very helpful in such cases in order for the lawyer to make the best decision for the client. We do so by maintaining our role as medical expert and consultant.

**Kaye:** This is not an uncommon situation. Lawyers generally will focus on the ability to get a not guilty verdict, often missing that if the charges are of a "low level," the client may end up spending more time "locked up" in a mental hospital than would be spent under a plea bargain or even under sentencing guidelines if found guilty of the original charges. In most states, NGRI acquittees are now given the equivalent of an "indefinite" sentence where the law prohibits release from a secure mental facility until the treatment team certifies that the person no longer poses a danger to the public.

GBMI was conceived in the aftermath of the Hinckley case with the idea that mental illness could be taken into consideration without it being exculpatory and with the belief that treatment would be more readily



available in prison for the person. In fact, there is little evidence that a GBMI verdict results in treatment any different from a guilty plea itself. A person so labeled might get additional treatment in prison but might also face discrimination and taunting by other inmates. There remains a possibility that down the road when a prisoner applies for parole or pardon, that the GBMI finding might afford some leniency. This has yet to be shown and many experts question the value of the GBMI defense.

**Sadoff/Kaye:** Take home point: Forensic psychiatrists often have more experience with a mental health defense than the attorney for whom they are working. Sharing your professional opinion and advice is appropriate, but remember, you are a doctor and not a lawyer. If the lawyer seems open to being educated about this dilemma i.e., civil liberty vs. a not guilty finding, proceed cautiously and deferentially.

### Nominations Sought

The Nominating Committee of AAPL will be presenting a slate of Officers and Council candidates at the Semiannual Business Meeting in May, 2014.

Any regular AAPL member who would like to be considered for a position should send a letter to the AAPL Office with a statement regarding his/her interest in serving and a brief summary of activities within AAPL.

Open officer positions are: President-elect (one year); Vice-President (one year); Secretary (one year). Councilors serve for three years. Attendance at both the Annual and Semiannual Council Meetings is expected of all officers and councilors.

Please send statements of interest and activity to Robert Weinstock, MD, Chair, Nominating Committee, AAPL, P.O. Box 30, Bloomfield, CT 06002 by March 31, 2014.



# PHOTO GALLERY



The Program Chairs, Drs. Wall and Anfang, enjoy movie night.



Dr. Renée Binder (right), with Dr. Ken Busch, recipient of the Service to AAPL Award.



Dr. Binder with Dr. Richard Martinez, recipient of the award for Outstanding Teacher in a Forensic Fellowship Program.



Getting together at the committee dinner.



Lunch head table with (left-right) Drs. Janofsky, Weinstock and Anfang.



Dr. Andrew Kaufman (right) presents the Young Investigator Award to Dr. Jennifer Piel.







# PHOTO GALLERY



Drs. Wall and Anfang set the tone for the meeting.



Dr. Pinals thanks the AAPL committee members.



Dr. Pinals and Zonana. Dr. Zonana holds his award of appreciation for his years served as AAPL Medical Director.



Rappeport Fellows with Committee Co-Chairs Drs. Britta Ostermeyer (top left) and Susan Hatters Friedman (bottom left).



Colligiaty during a poster session.



Dr. Andrew Kaufman presents the 2012 Poster Award to Dr. Bryan Shelby.





## ALL ABOUT AAPL - Committees

# Overseeing Psychotropic Medications for Youth in State Custody

Loretta A. Sonnier MD, Cory Jacques MD, and Christopher Thompson MD  
Child and Adolescent Committee

The local, state, and national media often relay concerns that youth in the child welfare system (a.k.a. “foster youth”) are being “over medicated” or inappropriately medicated. Given the disruption in family bonds and high rates of traumatic exposures, it is not surprising that youth in foster care and juvenile detention facilities commonly experience social, emotional, and behavioral problems. Ideally, psychotropic medications are prescribed after a thorough assessment and, if appropriate, trials of psychotherapeutic or behavioral interventions. Such medications should decrease the frequency and severity of significant psychiatric symptoms and allow for the youth to engage more fully in much needed psychotherapeutic treatment. For foster and detained youth (i.e., youth detained in juvenile justice facilities), however, information often is difficult to access and stepwise, algorithmic treatment may be neither pragmatic nor available. In these circumstances, government oversight (typically via an independent consultation with another psychiatrist) can be helpful and important.

Most studies on the use of medications in foster youth utilize data from Medicaid claims. In its 2008 report, which surveyed Medicaid claims from Florida, Maryland, Massachusetts, Oregon, and Texas, the General Accounting Office showed that 21% to 39% of foster youth received a prescription for a psychotropic medication compared to 5% to 10% of children not in foster care.<sup>1</sup> The Agency for Healthcare Research and Quality (an agency within the United States Department of Health and Human Services) funded a study of antipsychotic prescribing based on Medicaid claims from 13 states which found that utilization of antipsychotics in 2007 was much higher among foster youth than among non-foster youth—

12.4% versus 1.4%, respectively.<sup>2</sup> Although Medicaid data provide abundant information about the use of psychotropic medications in foster youth, little data exist about the use of psychotropic medications among detained youth who are generally not Medicaid-eligible while detained. Existing studies analyze data from a particular state or local jurisdiction, and knowledge of general national trends in “juvenile justice” psychotropic prescribing is lacking.

Another important issue is the increase in Medicaid spending on psychotropic medications over the past decade. For example, Minnesota’s Medicaid spending on antipsychotic medications for children surged from \$402,000 in 2000 to \$6.8 million in 2006. Interestingly and perhaps of concern, primary care doctors wrote many of these prescriptions. Recognizing that the primary care doctor is often the first to see the patient, the Mayo Clinic established a consultation service so child and adolescent psychiatrists could provide guidance to primary care physicians.<sup>3</sup>

Critics of child and adolescent psychiatry have offered several hypotheses to explain the increase in psychotropic prescriptions in youth, and foster youth in particular. These include: utilizing flawed diagnostic methods, pathologizing normal behavior, succumbing to the influence of the pharmaceutical industry, failing to provide alternate psychosocial treatments, and not resisting financial incentives to medicate. Other possible contributing factors include: poor access to therapists trained in evidence-based treatments, lack of coordination of available services, overall shortage of child psychiatrists, and insufficient state oversight of psychotropic prescribing to youth in state custody (i.e., foster youth and detained youth). Conversely, many foster youth have unmet mental

health needs and may not be receiving pharmacotherapy, although they could benefit from it.

The United States legislature recognized and addressed some of these concerns in passing the Child and Family Services Improvement and Innovation Act of 2011. This act mandated that states use both training and technical assistance to oversee psychotropic prescribing and that these efforts be documented in the states’ strategic child welfare systems’ plans. In these plans, each state must include an outline of: (1) procedures to monitor and treat “emotional trauma” associated with a child’s maltreatment and removal from his or her home; and (2) protocols for the appropriate use and monitoring of psychotropic medications. The Children’s Bureau instructed states to address the following areas: (1) Comprehensive and coordinated screening, assessment, and treatment planning; (2) informed and shared decision-making and methods for ongoing communication between the prescriber, the child, his/her caregivers, and all other service providers; (3) effective medication monitoring; (4) availability of consultation by a board-certified or board-eligible child and adolescent psychiatrist; and (5) mechanisms for accessing and sharing accurate and up-to-date information and educational materials related to mental health and trauma-related interventions. In April 2012, the Administration on Children and Families (ACF) released the Information Memoranda on “Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medications for Children in Foster Care.” To help states create and implement oversight protocols, ACF convened a summit in August 2012: “Because Minds Matter: Collaborating to Strengthen Management of Psychotropic Medications for Children and Youth in Foster Care.” This summit brought together representatives/leaders from the child welfare, Medicaid, and mental health systems from all fifty states, the District of Columbia, and Puerto Rico.

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## ALL ABOUT AAPL - Committees

### **Franco-Gonzalez v. Holder: The Promise of Gideon for Immigrants with Serious Mental Disorders**

*Kristen Ochoa MD, MPH, Human Rights and National Security Committee*

In their 1954 decision in *Massey v. Moore*, the Supreme Court held that it would be a denial of due process to require an insane man to stand trial in a state court without counsel. The opinion read, “No trial can be fair that leaves the defense to a man who is insane, unaided by counsel, and who by reason of his mental condition stands helpless and alone before the court.” As we close 2013, the year that marked the 50<sup>th</sup> anniversary of *Gideon v. Wainwright*, the historical Supreme Court decision holding that criminal defendants have a right to counsel at state expense, we do so with the news that the promise of *Gideon* has been extended to non-citizens with serious mental disorders facing deportation who no longer must stand hopeless or alone before the court.

In 2010, the American Civil Liberties Union, Public Counsel, and a coalition of organizations filed *Franco-Gonzalez v. Holder*, a class action lawsuit brought to ensure counsel for noncitizens with serious mental disorders that render them incompetent to represent themselves in removal (deportation) proceedings. The class members made up a compelling group of immigrants, many of whom were permanent legal residents of the United States, who because of psychotic disorders or intellectual disabilities were incapable of advocating for themselves in a system where they had no right to counsel.

Before *Franco-Gonzalez v. Holder*, Immigration and Customs Enforcement, the largest arm of the United States Department of Homeland Security, deported most noncitizens with mental disorders who remained unidentified in the system and removed in proceedings that they could not understand or participate in. Others were held for years because immigration judges were unwilling to proceed against them. One such case

was Mr. Franco-Gonzalez himself, a man with moderate intellectual disability who was detained for four and a half years without an opportunity to ask a judge for bond despite the fact that his case was administratively closed and there were no open removal proceedings pending against him. About two months into detention, Mr. Franco’s removal proceedings were administratively closed because of a competency evaluation which stated “he had no clue as to what type of court Your Honor presided over, what the possible outcomes might be, or how to defend himself at trial.”

How can an incompetent person remain in detention for four and a half years with no procedures in place to evaluate his restorability or release him? How we got to such a place is the result of two aspects of our immigration removal system: A mandatory detention statute passed in 1996, requires that many people, including those with certain minor criminal convictions, be detained throughout their removal proceedings without the opportunity to seek release on bond before a judge. Because proceedings may take months or years, this has contributed to a significant increase in the number of immigrants detained on any given day. Because of mandatory detention, the immigration detention system has grown exponentially, with 9,011 detainees per day in federal immigration custody in 1996 and 33,330 detainees per day in 2011.

The other aspect of our immigration removal system that led us to this place is the lack of a right to counsel at government expense, the same right that millions of criminal defendants in our country receive. The majority (about 86%) of immigrants in detention have no lawyer. They often do not have the resources to hire a lawyer or are held in locations

where access to lawyers is extremely limited. In Mr. Franco’s case, because he had no attorney and the Government did not provide him one, there was no one to seek redress for his detention. Though there was an active legal orientation program in at least one of the facilities in which he was held, he had never signed up and could not even write his full name.

Mr. Franco has been one of many. On any given day, thousands of immigrants with serious mental disorders are held in immigration detention, most of them without access to a lawyer. As we so often see, untreated or under-treated chronic serious mental disorders lead to encounters with law enforcement and in turn Immigration and Customs Enforcement custody via cooperation between federal and local authorities. In the same way that persons with mental disorders are over-represented in the criminal context, they are also over-represented in removal proceedings and immigration detention.

*Franco-Gonzalez v. Holder*, however, has brought change to the horizon. In April of 2013, the Federal District Court ordered legal representation for immigrant detainees with mental disorders and Judge Dolly M. Gee issued a permanent injunction holding that the Rehabilitation Act requires the government to provide class members with a Qualified Representative in their immigration proceedings, the first opinion recognizing the right to appointed counsel in immigration proceedings for a group of immigrants. The permanent injunction also requires the government to provide bond redetermination hearings for class members who have been detained for more than 180 days. Although this ruling is not yet published, the district court did publish one of its preliminary injunction rulings at *Franco-Gonzales v. Holder*, 727 F. Supp. 2d 1034 (C.D. Cal. 2010)

In anticipation of the Court’s injunction, the Government announced that it will develop policies nationwide that address the three

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## ALL ABOUT AAPL - Committees

### American Medical Association: 2013 Annual Meeting Highlights

*Robert T.M. Phillips MD, PhD, Delegate; Barry Wall MD, Alternate Delegate; Ryan Hall MD and Jennifer Piel MD, JD Young Physician Delegates; Howard Zonana MD, Medical Director*

The American Medical Association's (AMA) Interim Meeting focuses on advocacy issues. A chief AMA focus over the past decade has been finding a permanent solution for the Sustainable Growth Rate (SGR) formula, part of a complicated mechanism that determines physicians' Medicare payments. This year's Interim meeting included robust discussion on the SGR because of news from Capitol Hill that a legislative proposal is in play to end it, but with significant cost offsets, including a ten-year freeze on future physician payment increases to help pay for the accumulated debt from postponing SGR cuts in the past. Ultimately, there was collaboration and consensus within the House of Delegates to allow the Board to negotiate for the best possible outcome. That said, the House of Delegates added language to resolutions still calling for private contracting and for the AMA to continue to advocate for future physician payment increases. At the time of this report deadline a Congressional bipartisan proposal is still a work in progress, but comments offered by physician groups appear to be under serious consideration as SGR repeal legislation is being seriously considered and prepared for mark-up in early December.

Psychiatric highlights of the Interim meeting include the following:

**AMA Code of Ethics modernization progress:** For the first time since 1957, the AMA Code of Medical Ethics will be comprehensively updated for clarity, consistency, relevancy and ease of use. The AMA Council on Ethical and Judicial Affairs (CEJA) leads this project, which involves reorganizing the Code and reformatting nearly every ethical opinion. The old code consisted of nine mixed chapters, and the new code is divided into eleven intuitively-divided chapters arranged around

core topics. Each ethical opinion will identify the foundational ethical values of the opinion, define the general context of the guideline, and set out explicit ethical responsibilities by providing specific guidance. This process has been in the works for five years, and APA and AAPL have had preliminary input. What remain are two public comment periods, posting of an online draft and, ultimately, a final draft for action by the AMA House of Delegates in November 2014.

*“The report calls for research to determine the consequences of long-term cannabis use and supports the modification of state and federal laws to emphasize public-health strategies to reduce cannabis use.”*

**Ethical Opinions on Gifts to Physicians from Industry:** The House of Delegates approved a CEJA report on gifts to physicians from industry. It includes statements that physicians should decline cash gifts in any amount from an entity that has a direct interest in physician treatment recommendations and to decline any gifts for which reciprocity is expected or implied. The report does not address accepting drug samples, which can be of significant value; CEJA will address this later in a separate report.

**Call for national policy on drug abuse:** The House of Delegates approved a report by the AMA's

Council on Science and Public Health urging the formation of a comprehensive national policy on drug abuse. It specifically advised that the federal government and the public should acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective. The report calls for research to determine the consequences of long-term cannabis use and supports the modification of state and federal laws to emphasize public-health strategies to reduce cannabis use.

**Reproductive parity and right of physician conscience:** The House of Delegates passed a number of resolutions ensuring that hospital mergers and acquisitions do not lead to restrictions on women's reproductive health care services. CEJA is working on a report addressing the implications for patients when a physician's personal moral beliefs are in conflict with patient choices, especially regarding abortion.

Other subjects addressed at the meeting related to gun-safety counseling in undergraduate medical education, a call for Congress to support further research into gun violence epidemiology, promoting health awareness and preventive screenings for individuals with disabilities, and providing culturally-competent mental health care for at-risk communities.

This was Dr. Zonana's last AMA meeting, as he has retired as AAPL's Medical Director. AAPL hosted a reception at the AMA for his years of service to AAPL as Medical Director and past President, and for his years in AMA as Alternate Delegate and AAPL Medical Director. The current AMA President and Immediate Past President, as well as members of the AMA Board, attended the reception. The large number of attendees and dignitaries attest to the high esteem in which Dr. Zonana is held, and to the importance of AAPL's role in the AMA House of Medicine. In addition, APA hosted a separate reception for James Scully, M.D., for his years of service to the AMA as the Medical Director and CEO of APA. ☪



## ALL ABOUT AAPL - Committees

### Gender Oriented Changes in DSM-5

Anna Glezer MD, Aimee Kaempf MD, Susan Chlebowki MD,  
Gender Issues Committee

The Diagnostic and Statistical Manual, now updated to the 5th edition, has numerous changes that impact gender related issues. In this article, the Gender Issues Committee will attempt to clarify these changes and help readers understand the impact of these modifications. We will specifically address the new elements in the diagnosis of eating disorders, paraphilic disorders, and gender dysphoria (previously called gender identity disorder), and the addition of premenstrual dysphoric disorder.

#### *Feeding and Eating Disorders*

The DSM-5 includes several changes to the chapter devoted to Eating Disorders. The most considerable changes include the addition of Binge Eating Disorder and revisions to the diagnostic criteria for Bulimia Nervosa and Anorexia Nervosa. In the DSM-IV, Binge Eating Disorder was diagnosable only as Eating Disorder Not Otherwise Specified (NOS). Prompted by studies suggesting that many individuals diagnosed with Eating Disorder NOS actually have Binge Eating Disorder, the DSM-5 now recognizes Binge Eating Disorder as its own diagnostic entity. Binge Eating Disorder is characterized by recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control. Persons with Binge Eating Disorder may eat too quickly, even when not hungry, and may eat alone to hide binge-eating behaviors which are often accompanied by feelings of guilt, embarrassment or remorse. The disorder is associated with marked distress, and episodes occur, on average, at least once a week over the course of at least three months. Binge Eating Disorder is distinguished from mere overeating in that it is more severe, less common, and associated with more significant psychological and

physical problems.

The criteria for Bulimia Nervosa and Anorexia Nervosa have several small but important changes. For Bulimia Nervosa, the frequency of binge eating and compensatory behaviors required for diagnosis has been reduced from twice weekly (as proscribed by the DSM-IV) to once weekly. The most notable change for Anorexia Nervosa is the deletion of the DSM-IV requirement of amenorrhea which could not be applied to certain patient groups including males, pre-menarchal females, females taking oral contraceptives and post-menopausal females. A stated goal of the above changes is to provide diagnoses that more accurately describe the signs and symptoms exhibited by individuals with eating disorders. With these changes, fewer patients will be diagnosed as Eating Disorder Not Otherwise Specified, and more will have a specific diagnosis to help guide treatment.

#### *Gender Dysphoria*

*“There continues to be a debate in the LGBTQ community regarding the inclusion of this in a manual of mental disorders at all, not dissimilar from the debate years ago that led to the removal of homosexuality from the DSM.”*

The DSM-IV described Gender Identity Disorder as: a strong and persistent cross-gender identification coupled with a persistent discomfort with his/her sex or sense of inappro-

priateness in the gender role of that sex. In making the changes for DSM-5, one of the driving forces of the change was the sense of stigma associated with the term, Gender Identity Disorder. The rationale was that focusing on the dysphoria is more clinically appropriate than the gender identity per se, moving towards a more dynamic view of gender rather than the binary, and a move away from a focus on gender nonconformity. Even so, there continues to be a debate in the LGBTQ community regarding the inclusion of this in a manual of mental disorders at all, not dissimilar from the debate years ago that led to the removal of homosexuality from the DSM. The World Professional Association for Transgender Health, an internationally recognized authority on the treatment, education, and research related to transgender health, positively notes also the inclusion of an “exit clause,” whereby an individual who has resolved his or her incongruence no longer meets criteria for the disorder. Removed is the sexual orientation specifier, which acknowledges that sexual orientation and gender identity are two separate features.

Gender Dysphoria was also given its own chapter, separate from sexual disorders and paraphilias. Finally, there were changes made in how to diagnose the condition in children, who may not be able to verbalize their discomfort or desires as an adolescent or adult.

#### *Paraphilic Disorder and Sexual Dysfunctions*

There have been a number of changes in these chapters, including its separation from issues of gender identity, as discussed previously, and the creation of two separate chapters for sexual disorder and paraphilic disorders. With respect to sexual disorders, sexual aversion disorder has been eliminated due to rare use and minimal research. Vaginismus and dyspareunia have been integrated into one disorder, called genito-pelvic pain/penetration disorder due to the high comorbidity of the two and the

*(continued on page 24)*

## ALL ABOUT AAPL - Committees

### Report of the APA Assembly

*Debra A. Pinals MD, AAPL Assembly Representative and Cheryl Wills MD, AAPL Assembly Alternate Representative*

The APA Assembly took place in Washington, D.C. from Nov 8-10, 2013. Of note, one major issue overshadowing the meeting was the passage during the week of the meeting of the Final Rule related to parity. There was a great deal of excitement about this development.

In addition, Saul Levin, MD, MPA, attended the Assembly meeting as his first one in his role as CEO/Medical Director of the APA. Dr. Levin described many priorities, including his strong interest in “bringing allied organizations under the tent” of the APA as a way to be more productive.

Dr. Levin is also working with staff to do an environmental scan of how the APA is doing in terms of communication with members, media presence and internal organization. He feels that the current healthcare reform agenda should be one where APA, as the psychiatrists within the House of Medicine, is a key resource to general practitioners and others and he is hopeful that the subspecialty organizations will contribute to the APAs thinking about this. Dr. Levin attended a meeting of the Allied Organizations at the Assembly, of which AAPL is a member, and spoke directly to the group and heard from each of the organizations represented. Drs. Wills and Pinals were present to help represent AAPL at this meeting.

In addition, former Congressman Kennedy gave an inspiring speech about his advocacy in getting the Mental Health Parity and Addiction Equity Act passed. He also spoke about his personal story of recovery and his foundation of One Mind for Research, which he is hoping will fund a significant amount of neuroscience research. Mr. Kennedy also spoke of the importance of setting up appropriate processes to help facilitate true implementation of parity rules especially in the context of the Final Rule issued by the Departments of Treasury, Labor, and Health and

Human Services.

Dr. Howard Goldman spoke of a workgroup looking to develop informational products for members in relation to healthcare reform. One of the sections of this work group examines public sector impact. A comment was made on the Assembly floor from AAPL representation regarding the importance of considering justice involved youth and adults in developing recommendations.

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*“APA should urge federal policy makers and responsible agency officials to ensure that detained individuals with mental disorders receive appropriate mental health treatment”*

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Of interest to AAPL was also the *Position Statement on Detained Immigrants with Mental Illness*: This position statement was crafted by the Council on Minority Mental Health and Health Disparities and the Council on Psychiatry and the Law and states that the APA should urge federal policy makers and responsible agency officials to ensure that detained individuals with mental disorders receive appropriate mental health treatment. Background information is included in this paper related to challenges in mental health services for those detained through Immigration and Customs Enforcement (ICE).

This position statement went to the Joint Reference Committee and some modifications were made. These changes may be returned to the Coun-

cil on Psychiatry and the Law for one more review, after which it will be reviewed by the Board of Trustees for final approval. This paper will be a helpful resource to AAPL members who are working on matters pertaining to immigrants and mental illness.

Another interesting Action Paper, entitled “Unsafe and Uncontrolled Access to Mental Health Records Affecting 21.5 Million Veterans” was passed on the Assembly Floor. This paper asks the APA to petition the VA to halt online disclosure of mental health notes in the absence of clinical oversight.

There was a further resolution in this action paper asking that the Committee on Electronic Health Records, the Council on Psychiatry and the Law, the Ethics Committee and the Caucus of VA Psychiatrists to come together to develop a position statement and training for members on documentation and access to documentation by patients. The issue raised interesting forensic issues not only relevant to confidentiality and potential misuse of information, but also to concerns that documentation about sensitive issues (e.g., violent thoughts) might not be documented accurately for fear of patient retaliation.

Arguments in favor of online access for patients included the importance that mental health records be treated similarly to medical records and that paternalism toward patients may not be appropriate. After the debate within the Assembly, the Action Paper passed as it appeared that the request to petition for a halt might allow more time for position statements to be developed regarding direct patient access to one’s own sensitive medical information.

AAPL representation continues to monitor actions at the APA through the Assembly and reports regularly to AAPL Council about these activities. If AAPL members have any questions or comments, please feel free to contact us through the AAPL office. ☎

## ALL ABOUT AAPL - Committees

### Silence is Not Always Privileged

*Paul O'Leary MD, Chair of the Law Enforcement Liaison Committee*

United States Supreme Court has ruled in multiple cases (*Minnesota v. Murphy*, 465 U. S. 420, 427; *Roberts v. United States*, 445 U. S. 552, 560; *Berghuis v. Thompkins*, 560 U. S. 370) that silence does not invoke a privilege that must be claimed. In *Salinas v. Texas*, the Supreme Court upheld the Texas Courts' ruling that Mr. Genovevo Salinas' Fifth-Amendment rights were not violated when the prosecution used the fact that he did not answer a policeman's question during an interrogation as evidence of his guilt.

On December 18, 1992, two brothers were shot and killed in their Houston home. The only witness was a neighbor who heard gunshots, saw someone run out of the brothers' home and speed away in a dark-colored car. The investigation led police to Mr. Salinas, who had been a guest at a party the victims hosted the night before they were killed. When Police visited Mr. Salinas' parents' home, his mother agreed the police could come in, his father agreed they could take his shotgun for ballistics testing and Mr. Salinas agreed to accompany

police to the station for finger printing, "to be used for exclusionary purposes."

As Mr. Salinas was voluntary, he was not placed in custody and not read his Miranda rights. While there he participated in an hour-long interview, answering most of the officer's questions. However, when he was asked if his shotgun "would match the shells recovered at the scene of the murder," he declined to answer. The officer waited, then asked other questions which Mr. Salinas answered. At the end of the interview Mr. Salinas was detained for outstanding traffic warrants. However, he was soon released after the prosecution thought there was insufficient evidence to charge him with the murders.

A few days later, a friend of Mr. Salinas, Damien Cuellar, stated he had heard Mr. Salinas confess to the killings. With this statement, the prosecutors decided to charge Mr. Salinas. It took police 15 years to once again locate Mr. Salinas, who was living in the Houston area under an assumed name when they arrested

him in 2007.

During the first trial, prosecutors focused on the ballistic evidence, his friend's statement, and his attending the party at the brothers' home. The trial ended in a mistrial. During the second trial, prosecution emphasized the pre-arrest silence during the police interview in their closing statements, highlighting the fact Mr. Salinas failed to answer the police's question about the shotgun, instead he "[l]ooked down at the floor, shuffled his feet, bit his bottom lip, cl[e]nched his hands in his lap, [and] began to tighten up."

The jury returned a guilty verdict and sentenced him to 20 years imprisonment. Mr. Salinas appealed. Both Texas courts affirmed the verdict. The Supreme Court reportedly "granted certiorari to resolve a division of authority in the lower courts over whether the prosecution may use a defendant's assertion of the privilege against self-incrimination during a noncustodial police interview as part of its case in chief." However, the Court found it unnecessary to answer that question, as "petitioner did not invoke the privilege during his interview." Instead the Supreme

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### Overseeing Psychotropic Medications

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In order to meet the new statutory requirements set forth in the Child and Family Services Improvement and Innovation Act of 2011, state agencies have employed different approaches. One approach is to devise and implement parameters that automatically trigger a "prior authorization" process or require expert consultation before a prescription can be filled. Most states also developed psychiatric consultation hotlines to assist primary care physicians in making their treatment decisions. Some states will not reimburse doctors who do not follow the recommendations of the psychiatric consultant. Another approach is to keep Medicaid prescription registries in

order to analyze the prescribing patterns of physicians and determine the "top prescribers" of antipsychotic medications. The states with the most comprehensive and collaborative plans appear to be Florida, Maryland, Massachusetts, Minnesota, and Texas, where detailed websites guide the oversight of prescribing psychotropic medications to children and adolescents.<sup>4</sup>

Essentially, the Child and Family Services Act of 2011 is the federal government's response to concerns about the prevalence of psychotropic medication use by foster youth. This Act mandated that states evaluate, modify, and monitor the mental health treatment they provide for children and adolescents. The impact of these government interventions is yet to be determined and likely will have impacts other than the reduction of

psychotropic medication use. Hopefully, it will improve the quality of care for youth in state custody.Ⓢ

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## ALL ABOUT AAPL - Committees

### Gender Oriented Changes

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difficulty in differentiating one from the other. In recognition of the possibly artificial separation of desire and arousal in women, sexual desire and arousal disorders have also been combined into one illness – female sexual interest/arousal disorder.

The chapter previously entitled Paraphilias is now called Paraphilic Disorders in order to emphasize that to meet the criteria for a mental illness, an individual needs to suffer distress or impairment. It also acknowledges the fact that certain individuals may have non-mainstream sexual practices and this does not constitute a mental disorder. For example, an individual who engages in transvestitism does not necessarily suffer from a mental illness unless that activity causes distress and functional impairment for that individual. There had been discussion in the committee about the inclusion of Coercive Paraphilia. It was decided that this would not be included in the DSM-5, that rape is not a mental illness, but a criminal act. This decision has significant implications for involuntary sexual predator commitment statutes. Finally, specifiers of “in remission” or “in a controlled environment” were added to the paraphilic disorders in recognition of those whose symptoms may be difficult to assess in a restricted environment.

#### *Premenstrual Dysphoric Disorder (PMDD)*

The initial diagnostic criteria for “late luteal phase dysphoric disorder” appeared in Appendix A of the DSM-III. In DSM-IV, late luteal phase dysphoric disorder was renamed “premenstrual dysphoric disorder” (May 1993) and the diagnostic criteria were modified slightly. However, PMDD was not yet recognized as a disorder and was noted in appendix B under “Criteria Sets and Axes Provided for Further Study.” According to the DSM-IV the essential features are

symptoms such as markedly depressed mood, marked anxiety, marked affective lability, and decreased interest in activities. These symptoms regularly occur during the last week of the luteal phase in most menstrual cycles during the past year. The DSM-5 requires at least 5 symptoms in the majority of the cycles. The symptoms begin must *improve*, not remit, within a few days of the onset of menses and *become minimal*, not absent in the week following menses.

The DSM-5 placed PMDD under Depressive Disorders in the main text. Recognition of PMDD as a disorder and placing in the main text will facilitate diagnosis, treatment, and future research directions into the etiology and management of this illness. Those concerned about pathologizing normal female reproduction may be shown that this condition affects only a small minority of women, with prevalence rates 2-5% in the general population.

#### *Concluding Comments*

These primarily gender oriented issues were selected for purposes of this article, but it is not an all-inclusive description of all the changes in this newest edition of the DSM that may relate to gender differences. The changes are noteworthy as they signify more research initiative and thoughtfulness being placed on issues related to gender differences. It will be valuable to see how these changes are incorporated into clinical practice and the impact on treatment. ☯

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### Silence is Not Always Privileged

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Court reaffirmed in a 5-4 ruling that the privilege to remain silent is not invoked by remaining silent during noncustodial police interrogation, with two exceptions; a person need not testify at trial to invoke the fifth, and if the government involuntarily coerced forfeiture.

The Court decision was down its conservative/liberal split, with Alito’s judgment joined by Chief Justice John Roberts and Justices Anthony Kennedy, Clarence Thomas and Antonin Scalia. Though the Court did not find it necessary to address the question of privilege against self-incrimination during a noncustodial interview, Thomas, joined by Scalia, concluded that precustodial silence, even if claimed, was not a privilege, as it did not compel one to give self-incriminating testimony.

As the question of whether claimed precustodial silence is privileged has yet to be answered, simply claiming the fifth while talking with police would appear insufficient to ensure protection. On the other hand not claiming the fifth ensures one’s silence may be used as proof of guilt. Reemphasizing the importance of knowing when to shut up. ☯

## ALL ABOUT AAPL - Committees

### The Human Rights and National Security Committee Wants You

*Emily A. Keram MD, Human Rights and National Security Committee*

The Human Rights and National Security committee invites interested AAPL members to join our committee. Although members may feel they lack the knowledge and experience to contribute meaningfully to our work, it is our belief that the most helpful asset for prospective members is a desire to bring consensus to a variety of opinions regarding the expanding role of the forensic psychiatrist in the area, within an ethical framework.

The committee focuses on identifying and exploring ethical issues that arise in the context of human rights and/or national security cases and policy, evaluating available subject matter for evidence of soundness and bias, and providing collegial support

to prevent and manage role diffusion, secondary trauma, and burnout.

Committee members participate in discussions, training, and cases regarding evaluation of asylum applicants, child soldiers, political detainees, and accused terrorists. Examples of consultation and training include policy development regarding institutional management of hunger strikes, psychiatrist participation in national security investigations and interviews, and the ethical challenges faced by military psychiatrists.

We base our explorations on historical and current advancements in the field of human rights and international humanitarian law. Various international agreements guide our discus-

sions, such as the Geneva Conventions (treatment of POW's), the Convention on the Rights of the Child (involvement of children in armed conflict), and the World Medical Association's Declaration of Malta on Hunger Strikers.

Through our work, we've become familiar with the complex history of the interplay between human rights and national security. We've appreciated learning this history as we've observed earlier professionals struggling with the tensions between these two, sometimes competing, priorities.

We emphasize a pragmatic and open-minded exploration of the role of forensic psychiatry in these matters. We place value on opposing viewpoints, using them as a starting point from which to achieve consensus within an ethical framework.

If you are interested in joining the committee, please contact Emily Keram, MD at [emilykeram@hotmail.com](mailto:emilykeram@hotmail.com).

### AAPL Chief Photographer Signs Off

*Steven Berger MD*

As you know, I am retiring as the Chief APPL Photographer. The photographs are used only for the newsletter. Perhaps there will be more uses for these photos as time goes on. Eugene Lee from Arkansas will be replacing me as chief of the "Photography Committee" His email is [elee4n6@gmail.com](mailto:elee4n6@gmail.com).

The 3 continuing photographers are

Roni Seltzberg in Chicago  
[roniseltzberg@yahoo.com](mailto:roniseltzberg@yahoo.com)

James Wolfson in Missouri  
[jwolfson@bop.gov](mailto:jwolfson@bop.gov)

Alan Newman in D.C.  
[alanneuman@mac.com](mailto:alanneuman@mac.com)

And a new additional photographer is Alyson Kuroski-Mazzei in North Carolina  
[Akuroski@med.unc.edu](mailto:Akuroski@med.unc.edu)

Eugene will make assignments as needed. The Editor of the AAPL Newsletter, Charles Dike, will let Eugene know if particular photos are needed. So far, his only specific request is photos of the lunch time

speakers. Charles' email is [cd244@email.med.yale.edu](mailto:cd244@email.med.yale.edu).

For the lunches, the "photography committee" is given 1 ticket for each lunch. Eugene will decide who gets each ticket. With the ticket comes, of course, the obligation to take the photos of the lunch speaker and head table guests. I think a good idea is to include the name placards in the photos of the head table guests. In general, the photos turn out better if the subjects are asked to smile and look at the camera.

In the current system, each photographer hands in his or her photos to Jackie, Kristin, or Marie on Saturday or Sunday. The easiest way is to put the photographer's sandisk into Kristin's computer and upload the photos to her computer. Perhaps Eugene or Alan knows how to transfer photos from an iPhone to Kristin's computer as a batch, rather than 1 photo at a time. That might be an even easier system.

At times, people have asked me for a copy of a photo. My practice has been to email the photo to them the same day or next day. They like that.

Eugene is now in charge. I greatly appreciate the help of Roni, James, and Charles during the last 15-20 years, or whatever it's been. Thanks to all of you.



## ALL ABOUT AAPL - Committees

### Violent Books

*continued from page 3*

exceeded the amount of gun violence in top-grossing R-rated movies.

While it is quite impressive to watch little children reading and enjoying books 500 pages and over, should parents be worried about how the violent content in the books will affect their children? Does the violence in the books translate to real life violence as has been suggested for violence in movies? It seems research intended to answer these questions would be greatly appreciated by parents trying to avoid raising the next Columbine, Aurora or Newtown shooters. ☹

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### Fellows Corner

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far from uncritical in my feelings about these issues, perhaps my sense of a “neutral” position is different compared to that of a native of Boston, California, or Iowa.

Another profound and potentially unrecognized influence on our biases is made by our teachers and professional mentors. During that seminar, I realized that I had chosen to emphasize the defendant’s admission that he expected criminal prosecution, rather than the statements from the mouth of God justifying his actions, because I was hearing the voice of a particular attending! In all of the unsuccessful insanity defenses I remembered from my work in the fellowship, we have emphasized statements or actions of the defendant in which they recognized the legal wrongfulness of their act, either implicitly or explicitly. The defendant in Dr. Resnick’s case recalled these examples for me. The countervailing evidence in this case, arguing for the defendant’s insanity, simply didn’t speak as loudly to me, because in the insanity cases when we have determined the defendant was insane there were no examples in which we emphasized moral versus legal wrongfulness. Throughout my fellowship, mentors have emphasized to me many times the benefit of working with multiple faculty members on evaluations in order to get a sense of each one’s individual style and strengths and ultimately to assemble parts of each into an effective and eclectic personal style. How right they are!

Without recognition of our personal biases, we are subject to errors in judgment because of them. And it is only by confrontation with others with dissimilar views, those with experiences different from our own, that we are able to recognize these biases. My experience at AAPL allowed me to appreciate a certain degree of personal bias that I would not have recognized working only within my fellowship. Obviously this highlights the benefits of participating in national professional organizations

and interacting with others in our profession. In a larger sense, it speaks to the need for us as forensic psychiatrists to engage with other disciplines, including creative arts, history, and the humanities. As forensic psychiatrists it is our professional obligation to continuously strive for truth and objectivity. If we never venture from our own intellectual comfort zones, we miss out on vital opportunities for growth. ☹

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*Michael Gower, MD is a Fellow in Forensic Psychiatry, University of Florida, Department of Psychiatry*

### Franco-Gonzalez v. Holder

*continued from page 19*

major aspects of the lawsuit: Screening and competency evaluations for certain detainees, legal representation for incompetent detainees, and bond hearings after six months of detention. Whether this comes to fruition remains to be seen, but the progress is undeniable. As Robert F. Kennedy said in 1963, if not for Mr. Gideon’s triumph, “the vast machinery of American law would have gone on functioning undisturbed. But... the Court did look into his case ... and the whole course of American legal history has been changed.” The Franco litigation carries on that promise of Gideon. And as its efforts proceed, there is real hope that the due process rights of noncitizens will not only be affirmed, but extended. ☹

*Dr. Ochoa serves as a pro-bono expert in Franco-Gonzales v. Holder and is an Assistant Clinical Professor in the Department of Psychiatry and Biobehavioral Sciences at the David Geffen School of Medicine at UCLA.*



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### FORENSIC PSYCHIATRIST

The Department of Psychiatry at the University of Florida College of Medicine-Jacksonville is pleased to announce an opening for an experienced forensic psychiatrist. This position is for a full time faculty member at the non-tenure accruing level of Assistant/Associate Professor. Candidates must possess a MD degree or equivalent and be qualified for an unrestricted physician license in Florida. Successful candidates must also be board eligible/board certified in forensic psychiatry. Must have completed a subspecialty fellowship in forensic psychiatry; possess excellent diagnostic skills and have a strong interest and commitment to teaching, service and research. Salary and academic appointment commensurate with experience and training. The position will advertise until an applicant pool is established and will continue until the position is filled.

Qualified applicants should submit a letter of interest which includes a discussion on their goals for resident education, a *curriculum vitae* and three letters of recommendation to: P. Nicole Taylor, MD Committee Chair, Department of Psychiatry, UF College of Medicine – Jacksonville, 580 West 8<sup>th</sup> Street, Box T-11 Jacksonville, FL 32209, or apply on line at [www.jobs.ufl.edu](http://www.jobs.ufl.edu) by referencing requisition number 0904244 position number 00028387 or email [rosetta.payne@jax.ufl.edu](mailto:rosetta.payne@jax.ufl.edu).

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