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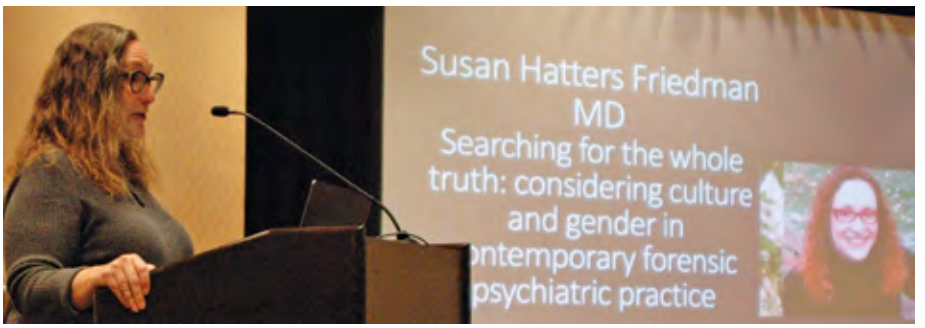
2022 AAPL Presidential Address

Dr. Susan Hatters Friedman, MD, DFAPA: Considering the Whole Truth in Forensics

Britta K. Ostermeyer, MD, MBA, DFAPA



Dr. Susan Hatters Friedman, MD, DFAPA, is AAPL's 48th President and the Phillip J. Resnick Professor of Forensic Psychiatry; Professor of Reproductive Biology and of Pediatrics; and Adjunct Professor of Law at Case Western Reserve University. During AAPL's opening ceremony, she was introduced by her close friend and colleague, Dr. Renee Sorrentino, MD, DFAPA as well as her daughter Ms. Elise Friedman.

This year's AAPL presidential theme was entitled "Searching for the Whole Truth: Considering Culture and Gender in Contemporary Forensic Psychiatric Practice." Dr. Hatters Friedman started by reminding the audience that AAPL Past Presidents Drs. Charles Scott and Michael Norko also focused on the search for truth. Dr. Scott emphasized the importance of utilizing objective scientific methodologies in forensic evaluations, while Dr. Norko discussed forensic psychiatry as a spiritual practice. In addition, AAPL Past President Dr. Ezra Griffith added the cultural component to forensic examinations in 1998, outlining that forensic psychiatrists have "a duty to be culturally connected." Dr. Hatters Friedman emphasized that she is "referring to truth as the whole experience," inclusive of culture and gender.

Dr. Hatters Friedman identified the need to consider the gender and culture of both forensic evaluators and forensic evaluees and patients during the evaluation process. She added, "Misunderstandings of culture and gender are a global problem as well as a problem in our field." She acknowledged that while we can never know the whole truth, we have to be aware of biases, including biases based on our own culture and gender, and how these can impact our evaluations. She reminded us that AAPL's 2007 Practice Guidelines regarding competency to stand trial stated, "psychiatrists must strive to feel comfortable with and accepting of an evaluee's cultural identity." AAPL's Forensic Evaluation Guidelines include a section about culture in forensic evaluations, which was initially drafted by Drs. Eraka Bath and Hatters Friedman, contextualizing culture, race, and ethnicity, disparities in diagnosis, language issues, and more. These practice guidelines also outline the need for forensic examiners to exercise "self-assessment to guard against cultural biases." Dr. Hatters Friedman stated that forensic examinations are often "cross-cultural" because cultural and racial minorities are overrepresented in the legal system, whereas forensic examiners tend to be of the dominant white race. She implored, "Not recognizing this obscures our search for truth." Potential biases are infinite and "our goal should be equitable care."

Dr. Hatters Friedman pointed out that cultural competence starts with "self-awareness," which refers to "a core knowledge of other groups, recognizing our own knowledge limitations, and using our unique forensic skills in a culturally appropriate way to understand the individual in front of us." Forensic examiners must first seek to understand traditions, beliefs, values, and cultural norms of the evaluee that are relevant to the forensic evaluation at hand. She referenced the "observer effect" explaining that although we ought to be neutral observers, we are after all "also products of the culture from which we observe." Finally, she cautioned that our dominant culture's view of the criminal justice system being fair may not be shared by other cultures.

Dr. Hatters Friedman spoke about "intersectionality," which acknowledges the overlap and interdependence of different disadvantages and discrimination at multiple levels. Intersectionality offers a framework of understanding as to why persons of different races, genders, sexual orientations, or socioeconomic backgrounds may experience racism or sexism differently.

Next, Dr. Hatters Friedman spoke about gender and remarked that "contemporary forensic psychiatry needs to understand women as aggressors, not just presume them to be victims." The legal system remains inundated with many gender biases, examples include underreporting

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Presidential Address

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of female sexual offenders; misperceptions that women are rather harmless; misperceptions that intimate partner violence is perpetrated exclusively by men; lower arrest rates and lower sentences for female offenders in comparison to their male counterparts; and the fact that mothers are more likely than fathers to be found insane in child murder, although both sexes may kill their children for rational motives. She remarked that gender-based inaccuracies and disparities clearly exist in many areas of forensic psychiatry. "The relevant question is whether these differences are correct or whether they are inaccurate and translate into a distorted understanding of forensic issues."

Dr. Hatters Friedman added that "with both culture and gender there is a risk of misguided beneficence" in forensic evaluations. The concern is that blindness to culture and/or gender would not allow us to objectively understand the full situation of our evaluees or patients. "When we don't seek true understanding" and "keep coming back with biased views and perceptions," we end up with unconsciously compromised evaluations conducive to poor, incorrect opinions, recommendations, or treatment plans. "An approach that does not consider culture oversimplifies life experiences and meanings, and risks incomplete explanations to the court."

Dr. Hatters Friedman concluded with a discussion of our roles as forensic psychiatrists and stated that the search for the whole truth requires "humility" and "curiosity." She noted that we have "larger roles in society as educators and as a force for positive change." As an example, "#metoo is a grassroots social movement aimed at drawing attention to the current climate in this country that seems to support rape culture, and the staggering number of women who have experienced sexual harassment and sexual assault. It is imperative that we, as forensic psychiatrists, confront the many misconceptions about sexual assault held by the public, who often distrust victims thereby allowing these crimes to continue. Common myths accepted by the public and law enforcement include that rapists are strangers, rapists always use weapons, false rape reports are common, most victims report rapes right away, and that certain victims are not credible. Finally, Dr. Hatters Friedman encouraged all of us to "be more visible" as practicing forensic psychiatrists. We must educate the public, jurors, judges, law enforcement, and attorneys on cultural and gender issues to promote and work towards fairness in our legal system.

Of note, Dr. Hatters Friedman appointed the AAPL task force, "Understanding Disparities in Evaluations and Addressing Our Biases in Forensic Practice," led by Drs. Sandy Simpson and Gary Chaimowitz, during her presidency.

AWARD WINNERS

- 2023 GUTTMACHER AWARD:
  Textbook of Antisocial Personality Disorder
  Edited by Donald W. Black, MD and Nathan J. Kolla, MD, PhD, FRCPC
- 2023 ISAAC RAY AWARD: Dr. Steven Hoge

CONGRATULATIONS!

Balance & Change in Forensic Psychiatry: Teamwork, Technology & Touchstone

James L. Knoll, IV, M.D.

An inflection point refers to a radical event that changes the course of reality. (1) The reality affected may initially be social, technological, or economic, but quickly extends to all areas of life. Two powerful recent examples are the advent of the Internet and smartphones. (2) These creations produced both intentional and unintentional changes to our existence. When a significant inflection point occurs, it is usually necessary to adapt while maintaining balance. Since balance will be the theme of the 2023 AAPL Meeting, I would like to elaborate a bit on its meanings. Balance is an understated value with multiple connotations including stability, as well as a means of discerning and judging. Balanced judgment requires an awareness of differing viewpoints while maintaining objective rationality. AAPL has stressed the virtue of balance in the preamble of our ethical guidelines, noting the importance of *balancing* competing obligations to individual and society. The forensic psychiatrist confronts balance routinely and in a variety of areas. (3) In expert work, thoroughness must be balanced with conciseness. In daily work, personal life must be balanced with career. Because information now flows too fast for a single individual to keep pace, leveraging certain skills and approaches might be considered. Here, I propose adaptation and stability may be promoted via the use of teamwork, technology, and returning to a balancing touchstone when necessary.

Teamwork

In 2011, neurosurgeon and writer Dr. Atul Gawande gave a well-received graduation lecture to Harvard Medical School. (4) Titled "Cowboys and Pit Crews," it presents a practicality that is difficult, but necessary to hear – "medicine's complexity has exceeded our individual capabilities as doctors." Fortunately, he proposes a solution that applies well to our field. He suggests the future of medicine (and thus forensic psychiatry) shall rely heavily on *teamwork*. There is reason to be hopeful and optimistic about this strategy as Gawande notes, "nothing says teams cannot be daring or creative or that your work with others will not require hard thinking and wise judgment."

Working in forensic or correctional treatment settings quickly makes one a believer in the importance of teamwork. Forensic psychiatrists have long recognized the necessity of the correctional officer as a vital member of the mental health team. (5, 6) The importance of teamwork can be found in many other areas of forensic psychiatry. I have been extremely impressed with the efficiency, thoroughness and reliability of the forensic team interview style when performing astronaut fitness evaluations for NASA. Team members brought their own area of expertise and unique contributions, which resulted in an evaluation that was more comprehensive, inclusive, and balanced. Expanding on this notion, it makes sense to conceive of forensic psychiatric investigative teams that consist of a variety of specialists who are true experts in their area. For example, a case may require a team consisting of an addictions specialist, a psychopharmacology expert, a consulting expert with relevant socio-cultural knowledge, and so forth. In this manner, the team becomes a collaborative group of highly trained experts working in concert towards the same mission and goal.

There remain many areas in forensic psychiatry where guidelines or standardized approaches do not yet exist. Very little has been written about approaches to fundamental methods such as crime scene visitation (7) or analyzing specific types of behavioral evidence left by a defendant. (8) Such important standardization methods are well-suited for forensic psychiatry investigative teams and will decrease the likelihood of important evidence being neglected. Forensic psychiatry interview teams hold promise not only for enhancing thoroughness, but also for improving interview style and objectivity. After several decades of conducting team evaluations, it has occurred to me that one may not fully grasp one's limitations until one has had two or three other trained forensic psychiatrists in the same evaluation constructively critique one's opinion or style, or notice key evaluee responses that may have slipped past one's perception. In this age of accredited forensic psychiatry training programs, the notion of group/team consultation and supervision should be familiar and easy to implement. (9, 10)

Not only does information now flow more rapidly, but we have come to live in an electronic version of Bentham's panopticon, wherein all behaviors are automatically tracked via real-time digital surveillance. How can forensic psychiatrists best function in this new landscape which produces an abundance of real-time behavioral evidence to consider?

Technology

In his 2018 AAPL Presidential Address, Dr. Christopher Thompson stressed the "life-changing technological innovations related to the practice of forensic psychiatry" that have the potential to "render our society almost unrecognizable in the near future." (11) It will be clear to any practicing forensic psychiatrist in 2023 that technology has taken root as a major source of evidence that must be carefully analyzed and used for opinions, decision-making and practice improvements. Google, Facebook, smartphones, and related platforms continuously gather data about behavior, location and commu-

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The *Dobbs* Decision and Forensic Psychiatry

Jeffrey S. Janofsky, MD

The *Dobbs* decision (1) of the US Supreme Court (USSC), overturning *Roe v. Wade's* (2) holding that the right to abortion was guaranteed by the US Constitution, and stating that *Roe* was "egregiously wrong from the start," also puts the whole notion of a Constitutional right to privacy based on substantive due process in jeopardy. As Justice Thomas stated in his concurring opinion: "substantive due process" is an oxymoron that "lack[s] any basis in the Constitution." [citations omitted]. Justice Thomas continues that, "in future cases, we should reconsider all of this Court's substantive due process precedents, including *Griswold* (3), *Lawrence* (4), and *Obergefell* (5)." Thus, to Justice Thomas the right of married persons to obtain contraceptives; the right to engage in private, consensual sexual acts; and the right to same-sex marriage should also be rejected as rights guaranteed by the US Constitution. Interestingly, Justice Thomas did not mention *Loving v. Virginia* (6), where the USSC found unconstitutional state laws that prevented marriage based solely on race under substantive due process theory.

Since 1962, the American Psychiatric Association (APA) has joined or written multiple amicus briefs in multiple areas. (7, 8) AAPL's first step into advocacy began when the AAPL Council authorized AAPL's participation in amicus briefs in 1985. Since that time, AAPL, after careful Council review, has signed onto twenty-four amicus briefs, of which eighteen have been with the APA. The briefs AAPL has signed on to have been restricted to traditional forensic psychiatry issues like the insanity defense, the death penalty, confidentiality, correctional mental health care, testimonial privilege, and forced medication. While AAPL has never written an amicus brief on its own, AAPL has had significant content input into the briefs in which we have participated. This was perhaps especially true in our brief in *Kahler v. Kansas* (9), a USSC case argued over whether the insanity defense is required under the Constitution's Due Process Clause. AAPL has not signed on to what had been considered briefs that have not directly affected forensic issues, like abortion rights or gender-affirming care. In contrast, the APA has signed onto multiple such briefs.

"The Dobbs decision will have far-reaching consequences for us as citizens, as general psychiatrists, and as forensic psychiatrists."

As AAPL's Medical Director, I sit on the APA's Committee on Judicial Action (CJA). That Committee is tasked by the APA Board with reviewing and writing amicus brief significant to general psychiatric practice. During the past two to three years CJA has been asked to vet for the APA Board many amicus briefs written by other organizations, with a very short turnaround time. From 2021-2022, twenty-one such briefs involved abortion or gender-affirming care. Such a rapid turnaround time has not only allowed little participation by the CJA, but has also made it impossible for me to send such briefs to AAPL Council for review. The APA's amicus brief in *Dobbs* was such a quick turnaround brief.

The *Dobbs* decision will have far-reaching consequences for us as citizens, as general psychiatrists, and as forensic psychiatrists. It will open a whole new chapter in criminal and civil contexts for women who obtain abortions and for physicians who offer abortions. Additionally, *Dobbs* may also reopen an old chapter for psychiatrists who examine people who request abortions. Before *Roe*, all states made exceptions to allow abortion to preserve a person's life. Frequently, this exception included a psychiatric condition that could, along with pregnancy, cause a woman harm. For example, Rovinsky and Gusberg reported the experience at Mount Sinai Hospital from 1953 to 1964, a period when 406 therapeutic abortions were performed. Of those, 205 were for psychiatric reasons. The authors also found that the incidence of psychiatric indications for abortion rose markedly during the study period. (10)

If Justice Thomas's position on substantive due process becomes the position of the Supreme Court majority, the very basis of what we believe to be settled law in much of general and forensic psychiatric practice could be ended.

Given the above, I believe AAPL may need to consider a much broader range of issues for the amicus briefs that we participate in in the future.

References:

(1) Dobbs v. Jackson Women's Health Organization, 597 U.S. ___ (2022)
(2) Roe v. Wade, 410 U.S. 113 (1973)
(3) Griswold v. Connecticut, 381 U.S. 479 (1965)
(4) Lawrence v. Texas, 539 U.S. 558 (2003)
(5) Obergefell v. Hodges, 576 U.S. 644 (2015)
(6) Loving v. Virginia, 388 U.S. 1 (1967)
(7) American Psychiatric Association Amicus Briefs for 1962-2012. (https://fpamed.com/american-psychiatric-association-amicus-briefs/ (accessed 11/4/2022)
(8) American Psychiatric Association Amicus Briefs 2012-2022 (https://www.psychiatry.org/psychiatrists/search-directories-databases/amicus-briefs) (accessed 11/4/22)
(9) (http://www.supremecourt.gov/DocketPDF/18/18-6135/102319/20190607122435025_18-6135tsacAPA%20et%20al.pdf) accessed 11/4/22)
(10) Rovinsky JJ and Gusberg SB: Current Trends in Therapeutic Termination of Pregnancy. Amer .J. Obstet. Gynec 98:11-17.1967

Witness to the Evolution

Joseph R. Simpson, MD, PhD

The field of psychiatry is inextricably intertwined with government and with the laws, policies and procedures created at various levels of government. More than nearly any other medical specialty, psychiatry needs experts who understand the complexities of working in such a heavily-regulated field, to help other practitioners, as well as patients and their families, navigate. We also need advocates to assist lawmakers, to avoid outcomes that are detrimental to our practice or to our patients.

The impact of a new piece of legislation can be dramatic. Many legislative bodies take a very active interest in the regulation of mental health care, and practice-altering changes are frequent. They might even occur every few years. Often, the "law of unforeseen consequences" makes its presence known.

The evolution of California's procedures relating to competency to stand trial illustrates the impact of the state legislature on forensic and correctional psychiatry. Until the 1990's, defendants adjudicated as incompetent to stand trial (IST) were typically remanded to a state hospital, even if their most serious charge was a misdemeanor. It is not difficult to make the argument that this represents a mismatch of resources, considering the extremely expensive nature of secure forensic hospital services as compared to other services. This reality was likely in the minds of state legislators when they changed the law so those accused of misdemeanors found IST no longer went to state hospitals. The usual location for restoration-to-competency efforts for those defendants then became county jail, with all of the issues and problems that such a process entails (a subject that has been debated in quite a few articles in the AAPL *Journal* in recent years).

In any event, county correctional mental health providers, particularly in larger counties, now had to develop robust competency restoration programs. Over the next decade and a half, the number of IST misdemeanor defendants in custody on a given day in, for example, Los Angeles County, grew to over two hundred – a small but significant percentage of the entire jail mental health caseload. The reasons for the massive growth in the number of misdemeanor IST defendants in California jails in the 21st century are not entirely clear. Reductions in community inpatient and outpatient mental health services and increasing rates of methamphetamine-induced psychosis are two likely contributors. A third is the worsening shortage of long-term Institution for Mental Disease (IMD) beds. This has necessitated "stepping down" severely ill patients on conservatorship from locked facilities to open board-and-care settings, where many unfortunately begin a cycle of medication nonadherence or substance abuse, followed by psychiatric decompensation, departure from the board-and-care, homelessness, termination of conservatorship due to inability to locate the conservatee, and finally, arrest on misdemeanor charges, sometimes called "crimes of homelessness" (indecent exposure due to public urination, criminal threats or simple battery driven by psychosis, shoplifting, etc.).

In 2015, Los Angeles County began a concerted effort to divert misdemeanor IST patients to community restoration programs. Despite truly remarkable work by County providers and contractors and hundreds of patients successfully diverted, the size of the in-jail population of misdemeanor IST defendants was not significantly reduced. Again, the reasons are unclear, but public defenders choosing to request more competency evaluations in misdemeanor cases in the hopes that their client would receive needed treatment via diversion to a restoration program may have been one reason. Finally, in 2022, a new law went into effect, abolishing in-jail restoration programs for misdemeanor IST defendants, including the elimination of involuntary medication orders for the purpose of competency restoration in misdemeanor cases.

Meanwhile, for felony IST defendants, two significant legal changes have occurred recently. One reduced the maximum commitment for restoration from three years to two. I won't discuss the literature on this topic here, but the change likely produced significant cost savings, without increasing the number of defendants found unrestorable: few patients who cannot be restored to competency within two years become competent in a third year of treatment. The other was the creation of a process to re-evaluate competency status while the defendant was still in jail custody. Prior to this change, essentially all felony defendants adjudicated IST had to be transported to a state hospital. Since, as in many states, the waiting period for transfer could be three to six months or even longer, many defendants regained competency before transfer. Until the new law went into effect there was no mechanism for avoiding the costly and time-consuming transfer of a psychiatrically stabilized defendant from jail to the state hospital.

The anticipated and unanticipated results of legislative changes are instructive to observe. Many of you will be able to think of examples from the jurisdictions where you practice. Legal regulation of psychiatry is far from static and unchanging. There is a strong case to made for psychiatrists, and forensic psychiatrists especially, to reserve time to keep track of what is going on legislatively. Some may wish to go further and engage in advocacy, with the goal of improving the legislative changes that emerge, for the benefit of our field, the public, and our patients.

Ask the Experts

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

Neil S. Kaye and Graham Glancy will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send questions to nskaye@aol.com.

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

Q: I was asked to do a record review for a custody case involving a 16-year old (turning 17 in two months.) I'm board-certified in forensic and adult psychiatry, but not child/adolescent. In my private practice I do treat a few 15- to 17-year-olds. Would you say to take the case or not?

A. Kaye:

Thanks for a great question. If you are comfortable doing the evaluation and you feel competent and expert to do so, the board certification means nothing. I take cases from newborn to 110 if I feel I am appropriately knowledgeable and experienced regarding the specific issue.

That being said, child custody is often a cesspool and a nightmare. I never get into those cases unless I am guaranteed unfettered access to all parties for as long as I feel is needed. Of course, get a retainer and make certain that billing and payments are kept up to date. Rarely will anyone like your opinion or report, and the desire to use experts to club the other parent is all too common (okay, call me cynical, but I was in one case where each side spent ten million dollars to try to destroy the other side, and they had the money to do so...) Remember, you might need to see mom, dad, the child, the *guardian ad litem*, teachers, grandparents, significant others; and do site/home/school visits, etc.

As to the less obvious question you raise: I think it would be extremely difficult to render a custody decision based solely on a record review. If the question is simply "capacity to parent" you might be able to pare it down, but you should anticipate that the lawyers or court might try to change the questions later to things you never really assessed.

This is a civil case, and presumably the parties involved are available to be evaluated. The AAPL Ethics Guidelines address a similar issue in Section IV, noting that honesty and striving for objectivity require an earnest effort to examine the defendant. (1) Of course, that reference is to a criminal case and custody is a civil matter. So, it may not be unethical, but at a minimum it would be necessary to note the limits of the evaluation. I would qualify my opinion and indicate in any reports that there was no personal examination conducted, and consequently the opinion is limited by the absence of a personal evaluation.

A. Glancy:

I agree with Dr. Kaye that family law can be as vitriolic as, or more so, than other types of law. In custody cases, emotions are high and this is transmitted to respective counsel and consequently it is not unusual for there to be a bare-knuckle brawl. I believe I have read that there are more complaints against forensic mental health professionals in custody cases than in any other type of case. If the case comes to court, you should also expect rigorous cross-examination.

The AAPL Ethics Guidelines state, "Expertise in the practice of forensic psychiatry should be claimed only in areas of actual knowledge, skills, training, and experience." (1) Although board certification or subspecialty status does not necessarily reflect actual knowledge, skills, training, and experience, the absence of this qualification may render one vulnerable to a claim of lack of expertise. Once this issue has been raised, unless you can definitively provide your training and experience proving that you are qualified, I would say that this is an area that you should avoid.

Assessing one or both parents for any issues that may bear upon parenting capacity would likely be within the expertise of a forensic psychiatrist who does not have qualifications in child and adolescent psychiatry. I would recommend including a caveat that this assessment does not represent a full custody assessment but is limited to the stated purpose. A full custody assessment, however, requires evaluations that go well beyond a forensic assessment of one or both adult parties. In my opinion, a full custody assessment is best left to those who routinely perform them.

A forensic assessment generally involves a full psychiatric and forensic interview, mental status examination, and in particular perusal of any significant collateral information. According to the AAPL Ethics Guidelines, "Honesty, objectivity and the adequacy of the clinical evaluation may be called into question when an expert opinion is offered without a personal examination." (1) This is followed by advice to make every effort to interview the evaluee in person. In this case, I would urge the member to follow this advice. I would call counsel and discuss the above with them. It may well be that counsel is retaining you merely to do a paper review in order to clarify the issues, with a view to making a decision as to whether a full assessment is warranted. For instance, if the question is whether a documented diagnosis of adjustment disorder in one parent disqualifies them from joint custody, you may well be able to advise counsel that a full assessment would be unlikely to

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Ask the Experts

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come to this conclusion, and counsel may want to divert their energy to other facets of the case. The expert should clarify that this is a preliminary assessment, and this may often be offered in verbal form.

Another point pertains to an experience that I have had various times. This involves a lawyer retaining you to do a preliminary report or a paper review that emerges much later,and you find yourself on the witness stand being cross-examined on this inadequate report. Sometimes, in this situation, the lawyer may have said that they only need a short report because some sort of quick resolution is imminent. When this resolution did not work out, often months or years later, you are left trying to remember why your assessment was inadequate. The solution is that the report should be clearly labelled as a preliminary opinion that may be modified by further information or assessment.

Take-Home Points:

Knowing what you know is knowledge; knowing what you don't know is wisdom. Act wisely.

Reference:

(1) American Academy of Psychiatry and the Law. (2005). *Ethics Guidelines for the Practice of Forensic Psychiatry*.

2022 AWARD RECIPIENTS

Red Apple Outstanding Service Award

This award is presented for service to the American Academy of Psychiatry and the Law.

Stuart A. Anfang, MD
Renée M. Sorrentino, MD

Golden Apple Award

This award is presented in recognition of AAPL members who are over 60 and who have made significant contributions to the field of forensic psychiatry.

Patricia R. Recupero, JD, MD

Award for Outstanding Teaching in a Forensic Fellowship Program

This award is selected by the AAPL Awards Committee from nominations submitted by individuals familiar with the nominee's qualities as a teacher.

Tobias D. Wasser, MD

Seymour Pollack Award

To recognize distinguished contributions to the teaching and educational functions of forensic psychiatry.

Richard P. Martinez, MD

President's Column

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nications. (12) This has stimulated a rapidly evolving field known as Digital Forensic Science, defined as: the use of scientifically derived and proven methods towards the preservation, collection, validation, identification, analysis, interpretation and presentation of digital evidence for the purpose of facilitating reconstruction of criminal events. (13) New technologies are developing rapidly and are being used in mental health care. So far, such technologies have involved passive monitoring and machine learning, which capture behaviors and provide objective data regarding mental states. (14)

Forensic analysis of an evaluee's texts and social media postings may be relied on to provide real-time data which can increase accuracy of inferences about mental state, motive, or knowledge of wrongfulness at the time of an offense. (15) Application of these technologies to the clinical forensic population, as well as criminal and civil forensic evaluations, warrants careful consideration. Here is an area in which AAPL and its membership can help guide the proper acquisition and use of digital information. (16) Although the courts will ultimately need to define the limits of "digital discovery," (17) forensic psychiatrists should assist with research and outlining best practices.

Touchstone

"Touchstone" refers to a specific type of siliceous stone used for centuries to test the purity of precious metals. Metals of unknown purity are rubbed on the touchstone to create a mark which is compared to marks on the touchstone made by rubbing a sample of a metal of known purity. Because of the touchstone's long-standing dependability, its meaning has transcended the literal and is used as a metaphor to refer to a measure of the validity or reality of a concept. In

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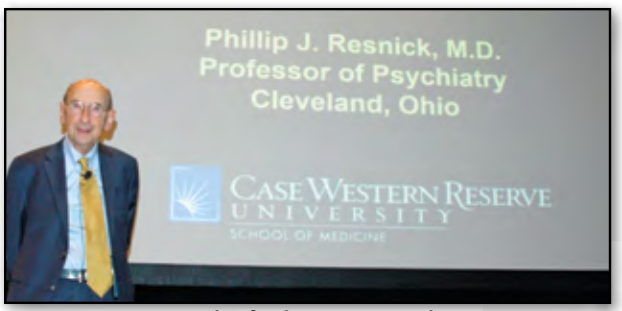
Program Chairs Drs. Hall and Rosenbaum

Dr. Resnick's final year as review course chair

Dr. Resnick addresses opening ceremony



Dr. Resnick's final review course lecture

Dr. Dike with the first Charles Dike Scholars

AAPL members enjoyed an in-person meeting for the first time since 2019

NYU reunion

Halloween 2022

Bryan Stevenson, JD: American Injustice: Mercy, Humanity and Making a Difference

Karen B. Rosenbaum, MD

We were honored to have Professor Bryan Stevenson as the first lunch speaker at the Fifty-third AAPL Annual Meeting. An attorney and founder and executive director of the Equal Justice Initiative, he spoke about his work confronting abuse and injustice in the criminal justice system. He illustrated his message about being proximate with clients by sharing his own personal journey. His experiences helped him navigate disadvantaged clients through the criminal justice system after it had failed them at least once.

He began his dynamic and compelling presentation by differentiating between a "person" and a "crime," and said that forensic psychiatry can help illustrate the difference between the person being evaluated and the crime that was committed.

As background, he reminded us that the country has changed a lot over the last century, and that in the last fifty years there has been a huge investment in incarceration. The population of incarcerated people has grown from about 300,000 in the 1970's to 2.2 million today. There are five million people on probation and 75 million with arrest histories. There has been a shift in gender, with an increase in incarcerated women of whom 80 percent are parents of minor children, impacting the next generation. Professor Stevenson gave many other grim statistics including that in 2009 one in three black male babies was expected to go to prison, and one in six Latino male babies. He said that unlike with the COVID-19 pandemic, there was no "pandemic-like response" to these forecasts. No task force, no emergency response team; and that this was due to acculturation. He said that we cannot understand how to think of this human behavior without thinking of the broader context, and we need to focus on possible solutions, not problems. He emphasized how important it is that we do not make judgments without knowing the whole story. To help those we serve, we need to focus on getting closer. When we are disconnected, we miss things we need to see and hear. He drew the analogy of a "drive-by," where someone makes assessments and conclusions by just looking at an accident from afar, but a 'drive-by' does not facilitate the kind of proximity necessary in our work.

Professor Stevenson said he helps poor, neglected, traumatized, severely mentally ill people and if he's not close enough to them, he cannot be effective in evaluating who they are. He intimated that people underestimate the value of proximity, of being in the space and looking at the whole person. In the context of a proximate evaluation, he can see the things that allow him to understand what is important. Ultimately, it is about understanding.

A philosophy major in college, he decided to attend law school at Harvard where Dr. Alan Stone was one of his professors. He ended up leaving law school to pursue a degree in public policy, but did not like that either. He said that he learned to maximize benefits and minimize costs, but felt disconnected and that it didn't matter whose costs and whose benefits. He eventually went to Georgia to work with lawyers representing people on death row. There he found people animated and excited by their work. He recalled the first time he met a condemned man and how moving the interaction was for both of them. At the end of the long meeting, while being forcefully chained back up by guards, the condemned man sang a hymn. Professor Stevenson recalled how this experience made him a different kind of lawyer.

Professor Stevenson clarified that the secret is not only to work hard but to become proximate, and hear his clients sing. Understanding human capacity is really important to the work that he does. Being proximate gets us closer to the challenging and affirming work that we do and is important when making proclamations about mental illness, incarceration, etc. He said that we need to change the narratives that block the research from being understood. People begin to accept things they would not otherwise tolerate. Without understanding fear and anger, we cannot understand the Holocaust, the Rwandan genocide, etc. Fear and anger are the essential ingredients of injustice, oppression and abuse; people at the individual level are also operating with fear and anger.

He lamented how mental health experts once argued that some kids act like kids but are not kids, they are "superpredators." These kids happened to be mostly black and brown; around this time, every state lowered the minimum age to try a child as an adult.

He said that he has represented nine- and ten-year-olds facing 60 years in adult facilities. These children sometimes spend 20 years in solitary confinement because it is not safe to put them with adults. They grow up never touching another human. Until recently, we were executing kids and sentencing them to life without parole. This has changed by explaining adolescent development and by slowly changing the narrative about children. He gave an example

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Dr. Ann Burgess: A Killer by Design - The FBI's "Mindhunters" and Profiling Killers

Joel Watts, MD

Dr. Burgess is a Professor of Psychiatric Mental Health Nursing at Boston College Connell School of Nursing and Professor Emerita from the University of Pennsylvania. She began her extremely well-attended and highly anticipated remarks by commenting that the AAPL audience was a far more sophisticated one then she was used to given that during her career she was used to teaching undergraduates. She explained early in her career at Boston College, the ideology of fantasy sparked her interest in studying individuals who commit rape. She was also hired to interview rape victims early in her career. She then received a cold call from the FBI asking if she was interested in teaching agents about interviewing rape victims so that they might better learn the patterns of behaviors exhibited by perpetrators. They were hoping that this would help them develop tools to catch them. She expanded her teaching of FBI agents on the subject of rape victimology. Dr. Burgess informed the rapt AAPL audience that as she began to get to know the agents she was teaching better, they would invite her to socialize with them in pubs after her talks. Several agents shared with her that they had never received any teaching in how to interview suspects accused of murder, and this led to a broader conversation about how she could help them gather information from murderers that would help their investigative techniques.

Dr. Burgess explained that it was during this period that the FBI created their Behavioral Science Unit. The goal of this small unit was to teach agents how to improve their interviewing techniques. At the time, this team was comprised mostly of men and there were very few women. Eventually, some agents requested permission from their superiors to conduct a study of convicted murderers with the goal of interviewing and collecting data about convicted murderers' offending behaviors and fantasies. Eventually, with Dr. Burgess' assistance, their research team developed a 57-page interview protocol. Dr. Burgess jokingly remarked that everyone involved in the study, including herself, had to sign a waiver releasing the FBI from responsibility if any of them were to be held hostage during their interviews with murderers in custodial settings. It clearly indicated that they understood that during such a circumstance, the FBI would not negotiate for their release and would not be responsible if such actions resulted in an agent being killed by the hostage-taker.

Dr. Burgess explained that initially, it was very difficult to convince FBI leadership to approve the study, but eventually their research team and agents received the go ahead and $63,000 to conduct their analysis. They eventually interviewed 36 killers from 20 prisons across the country. This represented well over 100 victims. There were only eight members of the original research team. They also obtained all official records including legal, medical and psychiatric documents for the offenders between 1979 and 1983. From this they conceptualized and obtained detailed information from the offenders about their childhood histories, attributes, environment and formative events during their early lives. They obtained information about academic, occupational and military performance. The FBI agents conceptualized this information as how offenders "grow up to murder". They also asked detailed questions regarding the offenders' preoccupations with their murderous behaviors. This included the role of fantasy and an exploration of all data they could obtain about the types of images, videos or pornography that the offenders were known to view in relation to their fantasies and behaviors. They asked detailed questions about the content of the offenders' violent fantasies including their intensity and whether or not substance use during, prior to, or after their offending contributed to their acts. From this study, the concept and study of victimology, and crime scene behavioral pattern analysis accelerated, contributing directly to improving knowledge about sexual homicide. Many of the offenders interviewed admitted that they would kill again if they were released, causing the team to better understand just how difficult it was for them to "extinguish deadly sexual fantasies."

Dr. Burgess commented candidly that during the study period, some of the offenders seemed to derive pleasure from toying with the interviewing agents, suggesting that they (the offenders) were corresponding with each other between prisons and encouraging each other to give false reports. This caused the research team some concern that perhaps the validity of the information they were receiving was false. However, after some further investigation, it turned out that this was not true, and the offenders were simply toying with the interviewers for fun.

During her talk, Dr. Burgess played several video clips from the well-known Netflix series *Mindhunter* that portrayed not only the agents' meetings with her early in the development of the FBI research study, but several

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"One Giant Leap is Not Enough"

Ryan Hall, MD

The 2022 Annual Meeting's Saturday lunchtime speaker was Gary E. Beven, MD, who discussed the unique field of aerospace psychiatry and the behavioral elements of long duration spaceflight and the International Space Station (ISS). Dr. Beven is the Space Medicine Operations Division Chief at the NASA Johnson Space Center and is a forensic psychiatrist by training. Although working at NASA is his full-time job, he still moonlights with the Texas Department of Criminal Justice and feels that his forensic background has provided him with additional skills and insights, which help with his job at NASA.

Dr. Beven focused on three primary topics: selection of NASA astronaut candidates; mental health components of long duration space flight onboard space stations (missions longer than 30 days); and preparation for human space flights in the future, including the Artemis Program and NASA's return to the lunar surface in preparation for an eventual human mission to Mars. (Of note, the Artemis I launch occurred on November 16, 2022).

The first part of the lecture discussed the astronaut selection process for the most recent class of astronaut candidates. Dr. Beven noted that over twelve thousand people applied, with the application pool eventually whittled down to 30 finalist applicants, of whom ten were selected. The 30 finalists underwent detailed psychiatric and psychologic screening and testing. For proprietary reasons Dr. Beven could not discuss the specific psychologic test battery performed. However, he noted that as part of the screening process the candidates underwent psychiatric interviews, which have been performed by several AAPL members, including Dr. Charles Scott, Dr. James Knoll, and Dr. Joseph Penn. Besides being interviewed and undergoing a battery of psychological testing, the applicants also partake in live exercises, which assess leadership and followership abilities including completing tasks and mock spaceflight drills with a high cognitive load under time pressure.

Dr. Beven noted that the NASA Astronaut Corps uses similar selection methods and processes to those used by NASA's international partners including the European, Canadian and Japanese space agencies. The current NASA astronaut candidate class is approximately 1:1 male to female, while the Russian space program still has an almost exclusively male cosmonaut corps. In general, though, Dr. Beven believes that the quality of astronauts and cosmonauts, no matter their national origin or space agency, is very similar, and they are often some of the best and the brightest individuals that humanity has to offer. He joked that during astronaut applicant selection interviews, one often feels like a gross underachiever who hasn't achieved their full potential in comparison… even as an accomplished physician. Dr. Beven also noted that although there may be geopolitical conflict or strife on the ground, including between the US and Russia, their space agencies cooperate very well, and the respective personnel work closely together for a common higher purpose.

Dr. Beven next spoke about the history of the space program, focusing on aspects of mental health concerns. A significant amount of spaceflight-related psychological research has emanated from astronauts and cosmonauts during space station missions. To highlight this, Dr. Beven quoted Valery Ryumin (Cosmonaut who served on Soviet space station Salyut 6, dates of operation 1977-1982): "All the conditions necessary for murder are met if you shut two men in a cabin measuring 18 by 20 feet and leave them together for two months." The Russian psychological support program began after Salyut 6, due to many of the cosmonauts showing signs of stress during the missions. During a mission on the Salyut 7 space station, there was the possibility of crew members experiencing visual hallucinations—an episode that lacks a clear explanation to this date. It was also noted that cosmonauts involved in the Soyuz T14-Salyut 7 mission had to abort the mission due to possible depression in a crewmember.

There were two general terms that Dr. Beven discussed, "space fog" and "spaceflight asthenia." Space fog is a condition that many astronauts report experiencing when they first enter low Earth orbit onboard the International Space Station. It is transitory, with individuals reporting that they feel they are not quite as cognitively sharp. Dr. Beven noted that this condition has not been objectively measured, and may be a common subjective aspect of transition to the new environment of life in zero gravity. The term space asthenia originated from Salyut space station missions. This condition presents with symptoms such as physical and emotional fatigue or weakness, hypoactivity, irritability, tension, emotional lability, appetite and sleep problems, attention and memory deficits, withdrawal from others, and territorial behavior. Dr. Beven noted that, fortunately, space asthenia has not been observed in ISS crew members. He attributes this to the psychological countermeasures undertaken to support astronauts' emotional and physical needs in current-day space exploration by NASA's behavioral health and performance group.

Dr. Beven then transitioned to discuss future long-duration human spaceflight missions. We are on the verge of the next major project with

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House Call: Finding an Ethical Home in Forensic Psychiatry

J. Alexander Scott, MD

As I started my fellowship, I wondered if I was leaving behind the bedside manner I'd developed in residency. Patients, it seemed, were in short supply having been replaced by "defendants" and "evaluees." I began interviews by explaining, and reminding myself, that I was "not acting as a treating psychiatrist." Many people had little interest in talking with me. The adversarial nature of the legal process seemed to turn the conversation into a minefield where I was unable to comfortably align with those I interviewed. Although I had been lied to before in my training, the specter of deceit loomed large over every forensic interaction. Instead of dealing with that deceit (or loneliness, or anger, or hopelessness), my job was to note it carefully and move on. I took in symptoms but shared nothing–no insight, no interpretation. What mattered was answering the forensic question.

Several ethical systems of forensic psychiatry have been formulated. Glancy and colleagues recently published a helpful review of these systems in which they discuss ideas of empathy and detached concern (1). Empathy, or the ability to share feelings with another, was viewed by Alan Stone as problematic in forensic settings where it might adulterate the examiner's objective opinion. D.W. Shuman was concerned that empathy and therapeutic alliance could cause an evaluee to unwittingly disclose legally damaging information. Paul Appelbaum's "respect for persons" and "truth-telling" precepts attempted to balance the dignity of a person with an objective opinion of their circumstances. Later, Ezra Griffith and Michael Norko emphasized compassion and insisted that sociocultural power imbalances must be acknowledged within an ethical framework. The authors end with a discussion of "forensic empathy" and detached concern, concluding that an examiner's ability to modulate their own empathy will promote the best balance of truth and compassion.

I thought about these discourses on empathy while driving to the home of an elderly man whom I'd been asked to forensically evaluate. It was in this rather dispassionate and decidedly non-clinical context that I was taking part in the antiquated medical tradition of the house call for the first time in my career. I found the man on his couch–soft-spoken, incontinent, and terminally ill. The house was cluttered. Next to him, a sheet of phone numbers and names scrawled in large, shaky handwriting sat atop a stack of magazines. We talked for a while. I then tried to review the legal guidelines and form a preliminary opinion. I found that all I could do was sit with him in silence for a few minutes. Before I left, I told him that I had enjoyed talking with him and acknowledged how difficult things seemed to have become. He looked me in the eyes, thanked me, and shook my hand.

Standing there in his living room, I certainly wanted to help this man. I wasn't yet sure if my opinion would do so. But I realized what could matter to him, definitively and if only in a small way, was that I had listened to him. Griffith and colleagues wrote that "the psychiatrist writes to explain a complex life" (2). I think this is where empathy is found. Even if I did not construe the facts as favorable to this man's legal situation, I could still acknowledge him and his complexity. What was and what could have been were always going to be two different things, and whether the opinion of the forensic psychiatrist "helps or hurts," it will do so incompletely and incidentally. Bearing witness is intentional, and at times is as much as we can do for each other.

It is important for fellows to receive deliberate instruction in the forms of "forensic empathy." Trainees have been asked to set aside–albeit thoughtfully and carefully–the "unconditional positive regard" which they began cultivating toward patients in the first days of medical school. This deliberate instruction might include a review of introductory statements that do not promise assistance, but instead appeal to truth and an honest account of the subject's life. Useful answers to questions from subjects about one's opinion (i.e., "so is your report gonna help me out?") should also be explored. Finally, interview techniques in which the examiner simply validates the gravity and the stressful nature of the legal situation should be addressed with the trainee. Forensic empathy may not appear fully formed on the first day of fellowship, but if it is discussed and nurtured throughout the year, our future work, our souls, and those we interview will all be better for it.

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Bryan Stevenson

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of a 14-year-old boy he helped who had been the target of domestic violence and later committed a crime by shooting a man who hurt his mother. The prosecutor insisted that the child be tried as an adult. The child didn't speak to Professor Stevenson at first, until he gently put his hand on the child's back and then the child cried and cried, making him wonder who is responsible for the narrative that some children are not children.

Similarly, politicians have criminalized drug addiction, leading to a high rate of incarceration instead of health care intervention. Professor Stevenson

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Driving Under the Influence of Cannabis: Forensic Issues

Laurence M. Westreich, MD; Gregory L. Iannuzzi, MD; Neil S. Kaye, MD
Addictions Committee

Cannabis laws in the United States are rapidly changing. Differences in regulatory status between states are creating a confusing patchwork of laws with few legal precedents. Law surrounding driving under the influence of cannabis is especially convoluted. In states with legal use, law enforcement must balance keeping roads safe with respecting the rights of adults to use cannabis. In this discussion, we will highlight several issues related to the effects of cannabis on driving and legislative approaches to these issues.

State policies with respect to cannabis and driving vary widely. (1) The Insurance Institute for Public Safety maintains a listing of state marijuana laws. (2) A similar compilation focused on marijuana-impaired driving laws can be found at the National Alliance to Stop Impaired Driving. (3) The most draconian "zero-tolerance" states (Arizona, Delaware, Georgia, Indiana, Iowa, Michigan, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Utah, and Wisconsin) consider any positive drug test, including delta-9 tetrahydrocannabinol (THC), to be evidence of intoxication. Five states have *per se* laws, which establish a legal THC limit of between 2 and 5 ng/mL, and automatically define any person who tests above that level as intoxicated. Colorado has a "reasonable inference" law, which allows drivers who are above the 5 ng/mL limit to present an affirmative defense that, despite the level of THC in their body, they were not in fact intoxicated. The Massachusetts legislature considered a bill – named after a state trooper killed by an allegedly marijuana-intoxicated driver – which would have equalized alcohol and marijuana impairment cases, suspended the license of any driver who declines a requested chemical test, and explicitly allowed the testimony of Drug Recognition Experts (DREs). (4) However, the bill stalled after lawmakers complained that there is no reliable method to assess cannabis intoxication. (5)

Toxicologic determination of THC levels has been stymied by the lack of reliable roadside testing. Although 24 states have statutes authorizing the use of oral fluid specimens for roadside testing, only a few have actual programs in place. (6) Alabama and Indiana regularly conduct these tests; Michigan has a program in five counties; and Colorado ran an oral testing program during the years 2015-2018. Furthermore, there is no clear, agreed-upon toxicological standard for driving while under the influence of cannabis. This contrasts with the nationally accepted standard for alcohol intoxication of 0.8 mg/dL.

Cannabis differs from alcohol in several important ways, which has impeded development of toxicologic measures of intoxication. Cannabis contains multiple different compounds which may modulate the level of intoxication in the user. These substances include THC, cannabidiol (CBD), and other substances which are less well studied. (7) Cannabinoids remain detectable long after the effects of acute intoxication have resolved. These nuances in pharmacology make roadside toxicological testing substantially less useful for identifying impaired drivers than roadside tests for alcohol. Toxicologists testifying regarding accusations of cannabis-impaired driving can expect questions on the practical meaning of measured THC levels. One judge (8) suggested that these questions would include, among others:

1. Is there a set THC blood concentration that equates to marijuana driving impairment?
2. Do Standard Field Sobriety Tests (SFSTs) apply to marijuana driving impairment?
3. What was the potency of the marijuana used?
4. How do age, gender, weight, dosage, use, tolerance, metabolism, ingested food, absorption, distribution, and excretion rate of THC affect impairment?

Although the techniques for law enforcement officers recognizing and documenting drug intoxication are nowhere near as codified as those for identifying alcohol intoxication, a substantial body of knowledge does exist. For instance, the certification of Drug Recognition Experts (DREs) is under the aegis of the International Association of Chiefs of Police (IACP), with support from the National Highway Traffic Safety Administration and the U. S. Department of Transportation. (9) Certification is earned in three phases, including a "pre-school" of 16 hours, the DRE School lasting 56 hours, and field certification requiring 40 hours. This rather substantial process allows the expert – usually a police officer – to deliver an expert opinion as to 1. whether a particular examinee was so impaired that he or she should not operate a motor vehicle, 2. if the impairment was due to drug use, an injury, or a medical problem, and 3. which drug or category of drugs would be most likely to cause the impairment. The DRE arrives at those opinions by performing a breath alcohol test, an interview and directed physical examination of the individual involved, and sometimes requests further toxicological testing. Although the physical examination results for the use of stimulants or opioids are arguably more distinct than those for cannabinoids, the DRE is instructed to look for a lack of eye convergence and an inability to shift attention by the person intoxicated with cannabinoids.

Laboratory studies clearly demonstrate that cannabis use impairs behaviors necessary for good driving, including psychomotor skills, divided attention, lane tracking, and various cognitive functions. (10) It is less clear to what extent these behaviors

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Cannabis

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are impaired in habitual cannabis users versus cannabis-naïve individuals. (11) The net effect of cannabis-induced behavior changes on driving safety is also uncertain. Studies using driving simulator tests "have shown that drivers who are high on marijuana react more slowly, find it harder to pay attention, have more difficulty maintaining their car's position in the lane and make more errors when something goes wrong than they do when they're sober. But such tests have also shown marijuana-impaired drivers are likely to drive at lower speeds, make fewer attempts to overtake and keep more distance between their vehicle and the one ahead of them" (Ref. 12, para. 6). This demonstrates that cannabis intoxication may result in a variety of changes in driving behavior.

Other data suggests that cannabis has a negative impact on highway safety. One insurance industry study examined the effect of cannabis legalization in four states through 2019 and found that cannabis legalization was associated with a statistically significant 3.8% increase in collision claim frequency, as well as injuries to people. (13) In another study, analysis of drug tests done on the drivers involved in Washington fatal car crashes from 2008 to 2019 showed that the proportion of drivers positive for THC approximately doubled after the legalization of recreational cannabis in December 2012. (14) Although the authors found that the proportion of drivers with high THC levels also increased, they acknowledged that the base rate of cannabis use had increased, and that the heavier cannabis use was statistically *associated* with fatal car crashes, rather than necessarily *causative* of those crashes. Several reviews of large data sets suggest that the combination of alcohol and cannabis intoxication confers greater risk than driving under the influence of either substance alone (15,16), an important consideration given the frequent combined use of these substances. (17)

Many key issues remain to be determined in the evolving landscape of cannabis law. Medicine has yet to reach a consensus on several basic principles regarding cannabis use and intoxication, such as how to reliably correlate the presence of cannabinoids with changes in cognition and motor activity, how these psychological changes affect driving behavior, and how these changes in driver behavior affect safety. Scientists in other disciplines similarly continue to clarify the net impact of cannabis use on road safety. Regardless of the state of the science, lawmakers are tasked with enacting laws to protect citizens in the context of mounting public pressure to decriminalize cannabis use. Forensic psychiatrists bridge the divide between these disparate entities, and it is our hope that this article will encourage them to participate in the discussion.

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Forensic Hospital Staffing in the Pandemic Era

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Forensic Hospital Services Committee

The COVID-19 pandemic led to a nationwide healthcare staffing crisis. The effects were compounded by the concurrent increase in mental health distress, leading to a critical shortage of psychiatric beds (1). The effects of the pandemic hit state hospitals especially hard, causing states to take drastic measures. For example, Oregon State Hospital called for National Guard to staff the hospital (2), and the Virginia Commissioner closed five of eight state hospitals to new admissions (3). In Missouri, "Assistant Physicians"—medical school graduates who have not completed residency programs—were employed, with hospital leadership scrambling to update bylaws and figure out how to utilize this new type of practitioner as effectively and safely as possible (4).

Multiple pandemic-related issues contributed to this staffing crisis. As the public was instructed to avoid large congregate gatherings and adhere to public health prevention measures, staff were understandably fearful to continue working in state hospitals, where basic health measures were difficult to implement (5). As a result, many decided to retire early. Others took time off due to the need to home-school children, the desire to avoid bringing the virus home to medically fragile family members, or requirements for isolation and quarantine. With staff urgently needed, states turned to temporary staffing agencies, often onboarding healthcare professionals with minimal or no experience working in psychiatric settings, which contributed to increased workplace violence (6-8).

The nationwide increase in use of agency staff heightened the demand for such contractors. Many seasoned professionals left their positions to join the ranks of agency employees, receiving significantly higher salaries. In some cases, staff who took agency jobs were assigned back to their previous workplace, furthering the hemorrhage of personnel when they compared notes with their former co-workers. Severe staffing shortages led to mandated overtime. The mandates led to burnout and poor morale, resulting in yet more staff leaving. This contributed to even more dangerous working conditions, creating a vicious cycle that has been very difficult to break (2, 3).

Several factors made state hospitals particularly vulnerable to staffing shortages. First, chronic shortages already existed. Some states struggled due to low salaries. For example, direct-care staff such as psychiatric technicians often work under very stressful and dangerous conditions, yet receive less pay than they would at fast-food restaurants or retail stores (6). Second, many state hospitals utilize large congregate settings as part of their milieu-based treatment approach. These large gatherings added stress to the workplace, especially early on when personal protective equipment shortages were common and vaccines not yet available. Thirdly, many state hospital patients have difficulty following infection control measures (5). Finally, once shortages began, state psychiatric facilities were at a competitive disadvantage because most could not quickly adjust salaries, implement bonuses, or speed up hiring processes. In a state system, the state government controls the budget and human resources, rather than the hospital (2). Some states also have laws prohibiting incentives such as signing and retention bonuses, making recruitment and retention even more challenging.

There are many consequences of this staffing shortage. Bellman et al. (7) described how in multiple studies staff have reported increases in violence, which the authors attribute primarily to the lack of nursing staff. This increased violence, in turn, contributed to work dissatisfaction and further loss of nursing staff, creating a cycle of staffing turnover and violence. Puzzo et al. (8) found that, since the pandemic's beginning, there has been an increase in physical assaults, self-harm, suicidal ideation, forced medications, and restrictive interventions on forensic units. As forensic hospitals increasingly rely on agency staff and inexperienced new graduates, and detail non-clinical staff (e.g., clerical employees, housekeepers, nurses working in administrative roles) to fill clinical roles, they introduce additional safety risks. Some hospitals have been so severely short-staffed that they have asked the chief operating officer, medical director, social workers, and physicians to serve as psychiatric technicians on evening and night shifts. Although generally overqualified, many of these individuals required basic competency training on patient lifts, environmental rounds, and the like, placing additional burdens on the already-overworked staff development personnel.

Many state hospitals closed beds due to staffing shortages, decreasing their ability to serve their community and lengthening the wait for admission for civil and forensic patients (3, 9, 10). The wait for a bed for those deemed incompetent to stand trial, already a crisis in many states, was lengthened by pandemic-related effects. Simultaneously, alternative community resources and housing settings were also struggling with their own staffing problems and limitations due to infection control concerns (11). These challenges forced state facilities to practice flexibility and learn how to be nimble. For example, they learned the importance of regularly updating disaster privileging requirements in bylaws. When a crisis hits, it is essential for these processes to be functional, given the lead time required to write and obtain approval for amendments. Some state hospitals also learned how helpful it is to identify military veteran employees, and tap into their expertise in areas such as improvisation, decontamination, and field hygiene.

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Challenges in Supervision of Advanced Practice Providers: How to Improve Collaborative Supervision

Gloria Osuruaka, MD and William Walsh, Esq.
Early Career Development Committee

The provision of mental health services exists within a consumer-driven model, where the demand for psychiatric services exceeds the availability of psychiatrists. To fill this void, most states and insurers have increased the scope of practice of nurse practitioners (NP's) and physician assistants (PA's) in an effort to increase access to mental health and behavioral medicine services. Some states have gone even further by enabling psychologists to obtain prescribing privileges.

More than 150 million people live in federally designated mental health professional shortage areas. (1) According to a population analysis assessing the projected workforce of psychiatrists, within a few years the US will be short between 14,280 and 31,091 psychiatrists, which will increase the burden on other mental health care professionals to fill the gap. (2) While the American Medical Association and American Psychiatric Association have fought against scope of practice incursions, this battle appears to have been lost.

Seasoned psychiatrists may have little if any experience in working with NP's or PA's. Further, there are a plethora of potential medicolegal potholes into which the unwary psychiatrist can fall. While the law generally holds all practitioners, regardless of credentials, to the same standard of care when treating the same medical condition, the law regarding supervision is not as clear. Prior to embarking on any type of professional relationship with a NP or PA it is imperative for the psychiatrist to get proper legal counsel as well as confirmation/approval from their medical malpractice carrier.

As AAPL members know, there are 51 sets of laws in the US. While most states require PA's to have a supervisory relationship with a physician, many states allow NP's to practice independently without such supervision. Prior to agreeing to a supervisory role, the physician must learn the risk and decide if it is worthwhile.

Absent a formal written contract, a psychiatrist should be wary of engaging in something that could be construed as a supervisory relationship. The legal doctrine of *Respondeat Superior*, commonly applied in the context of tort law to hold a principal vicariously liable for the actions of an agent, raises liability concerns for supervising psychiatrists. Most psychiatrists are not trained to be supervisors of non-MD's. They may work together in teams, especially in institutional or community/public sector settings, but still be unaware of the legal standards, risks, or hierarchical structure that enables such care delivery. Collaborative care is an emerging model in health care, but many of the medicolegal risks have yet to be decided by appellate level courts or codified into state or federal laws.

The path to becoming a psychiatric physician assistant or psychiatric nurse practitioner consists of six or seven years of higher education, followed by on-the-job training where the practitioner begins to develop their professional niche in the field of psychiatry. On the other hand, a psychiatrist may receive 12 or 13 years of higher education, including residency and fellowship training. In residency, psychiatrists undergo rigorous training under the guidance of attending physicians in a heavily academic and clinical curriculum. Senior residents are trained conceptually to respond to pattern recognition and to "teach it back" to their junior residents to enhance their professional development and learn to be independent clinicians. At the same time, residents are under the supervision of an attending psychiatrist who must have thorough knowledge of their patient care and attest to the trainee's medical decision-making. According to the Center for Medicare & Medicaid Services (CMS) guidelines, teaching physicians must document that they were part of the patient management, either providing the service themselves or being physically present for critical treatment provided by residents. As such, the attending psychiatrist plays an active role in the care of all patients treated by a resident, and is generally liable for acts or omission and/or commission by the resident. Institutional liability may also be incurred.

Early career psychiatrists may not be prepared to supervise a NP or PA. The psychiatrist may lack sufficient time or availability to provide supervision that meets both a legal and ethical standard. There may be issues around appropriate compensation for such an activity, and the early career psychiatrist may not be interested in signing on to more risk while trying to master the demands of a new career.

At a minimum, collaborative supervisory relationships require mutual respect, clear boundaries, an understanding of the differences in respective training, and recognize the common goal of providing high-quality care. There must be a clear understanding of the scope of practice of the supervisee. Without this, there is no measure to gauge the level of supervision and oversight necessary to improve the competency of the provider and aid in their professional development. Both parties must understand that a psychiatrist's role in collaborative supervision of NP/PA is inherently different from an attending physician's active supervision of treatment provided by residents. While state law governs the bulk of these relationships, CMS guidelines pertaining to the collaboration process for nurse practitioners provide:

> In the absence of State law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with

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Forensic Assessment of Asylum Seekers: Cultural Competence and Forensic Training of Psychiatry Residents

Joel Barrett, MD; Micah Park, MD; Sanya Virani, MD, MPH; Astik Joshi, MD, FAPA
Forensic Training of Psychiatry Residents Committee

An estimated 65.6 million individuals were displaced by persecution, conflict, violence, or human rights violations before 2017, and the number of displaced individuals is increasing daily. (1) An asylum seeker is an individual who applies for asylum in the United States due to persecution or a well-founded fear of persecution. (2) The Immigration and Nationality Act defines a refugee as "any person unable or unwilling to avail himself or herself of the protection of that country on account of race, religion, nationality, membership in a particular social group, or political opinion." (3) People from Mexico and Central America account for 52% of the asylum applications in the US, including culturally diverse children, adolescents, and their families. (1)

As the burden of proof of persecution is on the asylum seeker, a forensic assessment can inform fact-finders on the credibility and eligibility of applicants. A forensic assessment includes psychiatric symptoms, mental health treatments, medical care, and educational or occupational needs. (4) Of 746 asylum applications which received medical evaluations, 89% of cases were granted asylum in a 2008 study. Of the total, 37.5% did not have medical evaluations. (5)

Although forensic assessments can help fact finders adjudicate asylum applications, evaluators must practice cultural competence. (6) Hatters Friedman reviewed how cultural differences in communication and belief systems may lead to errors in forensic assessments. (7) Forensic assessments must be culturally informed and thorough to avoid errors.

The Quality Development Standard of the World Federation for Medication Quality Development recommends that programs prepare trainees to interact appropriately with gender, cultural, and religious influences. (8) The US Accreditation Council for Graduate Medical Education's Common Program Requirements for Graduate Medical Education in Psychiatry further requires residents to formulate plans using cultural background, identity, and values. (9) In order to prepare residents for evaluations of asylum seekers, we propose that psychiatry residency programs take specific measures to address cultural competence in general psychiatry residents, including didactic and applied activities addressing: Psychiatric Diagnosis (10-12), Cultural Identity (10-13) and Dangerousness. (14-16)

Culture and Psychiatric Diagnosis

It is often a condition for granting asylum that an asylum seeker's statements be consistent with other evidence and records, but mental disorders or traumatic experiences may affect the coherence of the narrative. (2) Therefore, reliable, and credible mental health testimony require cultural as well as clinical competence. (10-12) Knowledge of how trauma and cultural views affect refugee reports requires that residents integrate trauma and sociocultural context in clinical diagnosis, starting with the DSM's Cultural Formulation Interview. (12)

Similarly, residents should learn about disparities in the rates of psychiatric diagnoses. (10-12) The systemic factors that contribute to these disparities include clinician bias, distrust of the medical system due to a history of maltreatment, or limited access to care. (10-12) Residents should also acknowledge how such systemic factors explain why subjects display affect differently in front of strangers. (12) The DSM-5-TR chapter on Culture and Psychiatric Diagnosis provides clear examples of cultural concepts of distress. (12)

Cultural Identity

The evaluee's cultural context matters. (10-11) In addition to the subject's Cultural Formulation Interview, residents should consult with other colleagues to expand awareness of an evaluee's culture. (10-11) Collateral sources of information, such as the evaluee's family members, may provide context. A modified Cultural Formulation Interview for informants is available for this purpose. (12) Additionally, a resident's self-awareness of cultural biases is important. (11) Residents may have culturally related implicit associations, namely, unconscious attitudes, automatic preferences, or hidden biases. Harvard University provides free self-assessments of implicit associations through Project Implicit. (13) Self-assessments available online assess implicit associations residents may have with race or ethnicity, sexual orientation, gender, age, and religion. Finally, it is important to recognize that individual variants of cultural expression and practice will affect both the evaluator and the evaluee.

Dangerousness

Alongside any risk of violence posed by an asylum seeker, credible and reliable mental health testimony may help fact finders understand the risks to asylum seekers if they are repatriated. (14, 15) The US and Canadian governments use the Risk Classification Assessment and the National Risk Assessment for Detention, respectively, to assess risks, including criminal dangerousness. (15) In *Ewert v. Canada*, the Canadian Supreme Court ruled that the use of risk assessment tools without cross-cultural validity violated statute 24(1) of the Canadian Conditional Release Act. (16) Despite this important affirmation of cultural context, more research is needed regarding the widespread lack of cross-cultural validity of risk assessment tools.

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Responding to Violence: Insights from Uvalde

Micah Park, MD; Mariama Poquiz, MS3; Link Blevins, LMHC; Omaira Garcia, LMHC; Michelle Saenz, LMHC; Natalie Scanlon, PhD
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Mass shooting is defined as a multiple homicide incident in which four or more victims are murdered with firearms in one event, excluding the shooter, without a commonplace cause (i.e., arguments or criminal activities). It can occur in a variety of settings, but less common are those in K-12 school settings. (1) One of the more recent occurrences was on May 24th, 2022, at Robb Elementary School in Uvalde, Texas. In its aftermath, organizations sent volunteers to help coordinate with local mental health authorities to administer disaster relief and provide psychological counseling. As these events are rare, there are variable factors that may affect each community's response. In this article, the authors outline the currently available resources for responding to mass shootings, the response of the Texas Child Mental Health Care Consortium (TCMHCC) to the event in Uvalde, and the observations we can make from it.

Resiliency Center

UnitedOnGuns is a multidisciplinary nonpartisan initiative launched by the Public Health Advocacy Institute to reduce gun violence. (2, 3) It has released a 200-page resource guide to help mayors, city managers, and staff to prepare and respond to mass shooting, with case summaries of mass shootings responses from six cities in the US, as well as a tabletop exercise template. This guide details preparation, response, and recovery phases to mass shooting. Specialized centers—Family Reunification Center, Family Assistance Center, and Resiliency Center—are recommended for the response and recovery phases. (2)

Within days of the event in Uvalde, local and national organizations gathered to create the components of what would later become the Uvalde Community Resiliency Center. (4) Organizations, such as the Red Cross, Hill Country Mental Health, the Mexican Consulate, the Ecumenical Center, Bluebonnet Child Advocacy Center, Attorney General's Office, National Organization for Victim Assistance, and Office of Eligibility Services of Texas Health and Human Services, offered services in education support, insurance claims, childcare, healthcare, and other expenses. The first team of volunteers from the TCMHCC arrived in Uvalde two weeks after the initial event. (5)

In the Uvalde Community Resiliency Center, organizations were allocated workspace. As different organizations arrived at the Resiliency Center at different times, there was an adjustment period where one organization may have been uncertain of the services offered by another organization. The Red Cross provided patient navigators at the entrance of the Resiliency Center so that each community member who sought help would be accurately directed to the organization that would best serve their needs. In order to protect the privacy of community members, the press was not allowed to enter the Resiliency Center. Knowledge of the Resiliency Center appeared to spread primarily by word-of-mouth. It was not uncommon to see some members visit the Resiliency Center multiple times throughout the week. As time passed, visits became less frequent, and the volunteers at the Resilience Center went into the community to actively engage community members. (5)

There were formal processing sessions for the organizations at the Resiliency Center during which statistical information was presented. The processing of individual experiences by volunteers was left up to the discretion of each organization and its leadership. (5)

Trauma-Informed Response and Psychological First Aid

Supportive services offered by the Resiliency Center included play therapy, childcare, and language interpretation services. Volunteers from TCMHCC provided Psychological First Aid (PFA), which can be provided by any mental health provider or first responder. The American Psychological Association provides a list of resources for PFA which are publicly available, including a mobile app by the Substance Abuse and Mental Health Services Administration (SAMHSA), a guide by the World Health Organization (WHO), as well as information by the Minnesota Department of Health PFA and by Johns Hopkins University. (6) One of the most detailed guides is the Psychological First Aid for Schools Field Operations Guide, published by the National Child Traumatic Stress Network (NCTSN). (7) It provides specific directions for interactions with victims in a trauma-informed way, but is not meant to replace individual training. The initial volunteers from TCMHCC, while not all trained specifically through NCTSN's program, had been trained in trauma-informed care, varying from a military first responder, community-based crisis response, to trauma-focused CBT training. They were all experienced in evaluating and assessing school-aged children with acute mental illnesses in a city with a significant Hispanic/Latino population. (5, 8)

The guide provides instructions such as *"respect the person's privacy and give him/her a few minutes before you intervene"* and *"remain calm, quiet, and present [to avoid] cognitive/emotional overload."* (7) There were times during which community members appeared to be overwhelmed with information they were presented when they first arrived at the Resiliency Center. (5) It may also have been the significant cultural differences between the volunteers and the Uvalde community, which is primarily Hispanic/Latinx. (9) There were community members who were primarily Spanish-speaking and who required

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Improv-ing the Forensic Interview

Karen B. Rosenbaum, MD; Nina Ross, MD; Jeff Guina, MD; Charles Scott, MD
Media and Public Relations Committee

A workshop on using improvisation techniques in the forensic psychiatric interview was given at the 53rd annual AAPL meeting by Nina Ross, MD, Karen Rosenbaum, MD, Charles Scott MD, Gayden Day, Kendall Genre, MD, and Jeff Guina, MD. A brief demonstration of improvisation, or "improv," in the form of an improvised town hall meeting, kicked off this fun and informative workshop.

To provide an evidence base for the workshop, we reviewed some basics about improvisation, including the existing evidence-based literature regarding improvisation in medical education. Improvisational theater involves collaborative storytelling. It is created spontaneously and unscripted and was initially developed in the 1940s or 1950s as an educational method using games to teach drama to children. (1) Improvisation often consists of exercises, known as improv "games," and tasks participants to creating scenarios through these exercises. There are five main rules of improvisation that are important. (2) The first is perhaps the most fundamental rule of improv: "Yes, And." This statement refers to acknowledging others' contributions and building on these statements to create a collaborative reality. Another rule is to not ask open-ended questions, which can put excessive pressure on scene partners to create the work themselves, rather than building collaboratively to create an improv game. Other helpful improv rules include not trying to be funny because while humor can result, the goal is collaborative story-building. Finally, it is important to work to make others in your group look good, again emphasizing the collaborative nature of improvisation, and to work together to tell a story.

Improvisational techniques have been used in educating health professionals. Gao et al. conducted a literature search in 2018 (1) and found that improvisational curricula had been used to help improvement in the following healthcare roles: the Medical Expert; Leader in Team Management; Scholar; Communicator; and Professional. When improv was used, it was also shown to improve interprofessional team development, leadership, wellness and resiliency.

Regarding the role of medical expert, improvisation was found to help with increased comfort with uncertainty, adapting quickly to new situations, improved thinking in front of an audience and the ability to deal with the unexpected, among other things. For the communicator role, it improved empathy, listening, and being more attuned to nonverbal as well as verbal communication. Improvisation also improved collaboration through promoting an environment that facilitated working in a team (3) and helped reduce hierarchical issues. (4)

According to Boesin et al., (5) improvisation helped with leadership roles through improving team management and the ability to speak in front of a group. Improvisation was helpful in the role of 'scholar' by helping people to receive feedback better, (3) to self-reflect more, and the perception of learning as play rather than work. Finally, it improved professionalism by giving people confidence about their knowledge and resiliency through self-esteem building. (3)

The workshop, led by Gayden Day (a professional improvisational comedian from Dallas and also the sister of Dr. Charles Scott), explored a variety of improvisation exercises, with the goal of illustrating how improvisation may be used to improve forensic evaluation skills. Although improvisation exercises, often referred to as improv "games," may appear to be trivial exercises, they in fact rely upon valuable skills, including mental flexibility, the ability to be present in the moment, collaborative work with others, and active listening, all of which are skills that can be valuable for a number of tasks within forensic psychiatry.

The first exercise was an improv game where participants were instructed to present two truthful statements and one false statement to a group, who then had to guess which statement was a falsehood. This exercise was designed to demonstrate improvisation as a technique that can be used to promote mental flexibility and the need to think on one's feet. In the next exercise, participants were asked to stand in a circle and throw and accept imaginary balls of all sizes and colors and weight to and from other people in the circle. This exercise was intended to demonstrate the need for mental flexibility, being in the moment, as well as collaboration.

The next exercise relied on the fundamental rule of improv: Yes, And. In this exercise, people were tasked with standing in a circle and saying one sentence at a time, with the intention of building a cohesive story. In the first part of this exercise, participants were to start each sentence with "Yes, but." In the second part of this exercise, participants were asked to start each sentence with "Yes, and." Participants reflected that even a small change in these phrases significantly impacted their ability to meaningfully build upon their group's shared story. The phrase "Yes, and" allowed for collaboration with relative ease, in contrast with the phrase "Yes, but," which worked to the detriment of the group's goal.

In the final exercise, participants were also asked to build a cohesive story within their groups, each member saying a sentence at a time. In this exercise, however, each sentence had to begin with the last word or last phrase of the previous sentence. This exercise was intended to illustrate the importance of listening actively and being in the moment, because a person's sentence could not even begin until the prior sentence was completed.

Overall, the feedback from this unusual creative workshop was extremely positive. Attendees noted

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Pharmacy Records as an Important Source of Collateral Information for Forensic Evaluations

Ana Natasha Cervantes, MD; Celestine de Trana, MD
Private Practice Committee

Medical records have always been critical sources of information for forensic evaluations. Widespread adoption of electronic medical records, however, has resulted in records that are often voluminous, redundant, not updated, and not always easy to interpret. There may also be a significant wait to obtain them, which can be a limiting step in forming opinions and completing reports.

Pharmacy records can be enormously helpful in forensic cases, bringing clarity and efficiency to the otherwise arduous task of organizing a prescription history. Pharmacy records can often be obtained within minutes (as opposed to days or weeks for medical records), can provide years' worth of prescription history, and can reveal new information and trends not previously known, even when all medical records have been reviewed. Pharmacy records are most valuable when an evaluee fills all prescriptions at the same location or on one online platform; however, as with any health record, the information may be in more than one location.

While pharmacy records cannot replace a medical record, they can provide a useful and quick starting point if not all medical records are yet available. They contain concise information that is often not in the medical records at all, and accurately summarize an individual's prescription history in a few sheets rather than interspersed across potentially hundreds of pages. Pharmacy reports can also provide information about all prescriptions filled, even when patients use cash. Many believe that prescriptions paid with cash are invisible to such inquiries, but this is not the case.

Examples of information a pharmacy record can provide that a medical record might not include: compliance history, by showing the dates prescriptions were actually refilled; time periods when medications were not filled; and the precise quantity of medication dispensed and exact instructions. The prescriber information, such as name and credentials, can also be useful to verify the type of settings and time of treatment (e.g., ER, Urgent Care, hospital). Pharmacy records may also provide information about prescribers and medications not previously known or disclosed.

Some real-life examples:

- In the course of evaluating a plaintiff reporting unremitting symptoms of PTSD, it was discovered that a medication which, according to the medical record had been prescribed and titrated for several months, was never actually filled. While it is possible that this one medication was filled at another pharmacy, this was not supported by other sources of information.
- An employee referred for a fitness-for-duty evaluation for, among other issues, sleeping on the job, reported using only a fraction of the prescribed amount of sedating controlled substances. However, the pharmacy history showed that the employee consistently filled the medication on the date the previous prescription would run out if used daily at maximum prescribed doses. Because this was in a state that does not allow pharmacies to provide automatic refills of these medications, refills would have had to have been requested each time. While pharmacy records cannot provide information as to how exactly someone uses medications once filled, it was deemed most likely that the medications were being taken at higher doses than the employee reported, explaining the impairments.
- An evaluee's prescription history revealed a number of prescribers not previously disclosed, writing concurrent prescriptions for medications which were duplicative or with significant interactions, many of which were controlled substances.

A release of information should accompany these requests (since forensic evaluators are not providing treatment, pharmacies should not release protected health information without a release), but compared to medical records, pharmacy records are easy to obtain rapidly.

Another type of pharmacy record exists which, unfortunately, is not readily available to forensic evaluators (nor treating physicians) but is made available exclusively to insurance companies with a legitimate reason to access comprehensive prescription histories. One such company providing these reports is Milliman IntelliScript. While primarily used for underwriting, insurance companies (and the forensic evaluators providing consultation for them) may also receive these reports when asked to conduct disability or personal injury evaluations, where a claimant has allowed the insurance company to access their medical, and by extension, their prescription history.

Such reports include extensive prescription histories across all states, prescribers and institutions. The information in this unified report is obtained not only from pharmacies, but from insurance company and Pharmacy Benefits Manager databases. These thorough reports are usually cross-referenced by medication type, prescriber, and date, among other criteria. These reports are available only to insurance companies, but it is worth knowing they exist. An evaluator who is asked to perform an evaluation where the insurance company can access such a report would be well-served to request that the insurance company obtain it if they have not already. It has the potential to not only save a significant amount of time for

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Fostering Recovery and a Life Worth Living

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Recovery Committee

In just one moment a person's life trajectory can change. This is true for many insanity acquittees who have committed crimes while experiencing severe symptoms of mental illness. They are left with a long road to recovery, fraught with uncertainties and challenges, clinically, legally, and spiritually. At the 2022 AAPL Annual Meeting, the Recovery Committee sponsored a panel entitled, "The Recovery Challenge: Identity, Culture, and the Life Worth Living."

Sandy Simpson, MBChB started off by speaking about the meaning of recovery while exploring the literature on what makes a "life worth living" for acquittees. When an acquittee enters the forensic setting, they are tasked with trying to understand an unfamiliar system. Additionally, they are trying to gain insight into their mental illness and are just beginning to come to terms with their offense. While staff are focused on assessing the individual's violence risk, that same individual is trying to assess their own sense of safety and trust in their new environment. Dr. Simpson highlighted how a sense of safety and security is a necessary base for recovery, (1) followed by recovery goals which may involve helping individuals find a sense of identity, meaning, responsibility, and hope. Dr. Simpson discussed innovative opportunities for forensic systems to assist individuals with their recovery process. He suggested developing modes of interaction that allow acquittees to be involved in shared decision-making (2); clinical application of recovery-oriented risk assessment tools; inclusion of cultural formulations in clinical assessments; and integration of individuals with lived experiences working as peer support specialists into clinical teams.

John W. Thompson Jr., MD provided an overview of recovery-oriented forensic services in Louisiana, emphasizing that acquittees "do not need to be locked up for the rest of their lives." He invited two guest speakers to reflect on their journey through the forensic system while developing "a life worth living." The first individual titled her talk, "A Story of Hope and Success." She has been in the forensic system for 12 years and over time has learned about her psychiatric diagnosis and her identity. Her story of success involved unwavering love and support from family which helped her navigate some of her most challenging times. She was able to pursue higher education and become a peer support specialist in addition to nourishing meaningful relationships. In her concluding remarks, she poignantly stated, "I don't want to be a diagnosis, I want to be like anybody else." She uses her narrative to instill hope in others living with a mental illness that they too can create a meaningful life.

The second story was a father's emotional account of his son's journey. He detailed the initial shock of being informed that his son was in jail and all the tribulations that followed. He recalled the difficulties of navigating the legal system without any prior knowledge, the 600-mile round-trip drives to visit his son in a secure forensic hospital, and the struggles of maintaining a connection as the world shut down during the COVID-19 pandemic. When his son was granted community release, the challenges did not stop. During a medication change, his son had an episode of decompensation requiring hospitalization. Through all the trying times, he remained hopeful and grateful that his son got a second chance at living a meaningful life; his son is currently attending school and working at the family's business. Despite immense challenges, what remained steadfast was the family's support, devotion, and advocacy for their son.

Both inspirational stories highlight the importance of having support from family. Not everyone is lucky enough to have such resources. For some, their mental illness has caused tension in relationships with loved ones, leaving them with a very limited support system. Giving these vulnerable individuals the right resources through a recovery-oriented model can help them gain agency while navigating complex legal, medical, and social systems.

Darren L. Lish, MD shared his experiences with forensic community-based services (FCBS) in Colorado. He pointed out that management of risk in acquittees is an essential part of recovery, but biases related to an individual's offense and fears of reoffense can hinder the recovery process. He suggested addressing safety and risk concurrently with helping individuals restore a meaningful life. In the FCBS acquittees work with an interdisciplinary team comprised of psychiatrists, psychologists, case managers, conditional release coordinators, benefits specialists, and legal assistants, who become their support network through interpersonal connectedness. Utilizing the Risk-Need-Responsivity (RNR) Model, staff assess an individual's criminogenic needs and tailor interventions and programming to address those needs. (3)

Ultimately, the process of recovery requires recognition of the importance of instilling hope while shifting from focusing too much on pathology and placing greater emphasis on an individual's strengths and wellbeing. By fostering acquittees' sense of empowerment, positive personal identity and community, they can be given a second chance at a life worth living.

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Not Guilty by Reason of Werewolf: Lycanthropy, Zoanthropy, and Forensic Psychiatry

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Criminal Behavior Committee

During the 2022 AAPL Annual Meeting, Dr. Phillip Resnick and the authors presented a workshop on lycanthropy, the cultural and clinical phenomenon in which one has the delusional belief that he has morphed into a wolf. What better time to present a workshop on werewolves than the day before Halloween in one of America's "Most Haunted" cities?

References to lycanthropic transformation date back to antiquity. The earliest mention is in Ovid's *Metamorphosis* about Lycaon, King of Arcadia, turned into a wolf as punishment by Zeus. Lycanthropic transformations are referenced in the Epic of Gilgamesh, by the Greek historian Herodotus, and in Norse mythology. Depending on the cultural and historical context, these transformations have been viewed as conferring special powers or skills, divine punishment, or demonic possession.

Although these phenomena have been written about for millennia, lycanthropy and zoanthropy (the belief of being any animal) are rare clinically and their incidence remains unclear. In one study only 56 cases of zoanthropic delusions were identified in the reviewed literature spanning over 150 years. (1)

Lycanthropic delusions have been observed in psychotic and mood disorders and in neurologic conditions like seizures and brain lesions. (2) Individuals experience aberrant sensations, or cenesthopathies, about body shape and appearance. Perhaps the most widely accepted explanation of lycanthropic delusions is the "two-factor" theory. Abnormal sensations (Factor 1), like the feeling of excessive hair growth or other wolf-like changes to appearance, coupled with an impaired belief system (Factor 2), cause individuals to attribute these sensations to transformation. Thus, lycanthropic delusions can perhaps be viewed as belonging to the category of delusional misidentification syndromes, like Capgras (belief that a duplicate replaced a familiar person) and Fregoli Syndromes (belief that a stranger is a familiar person in disguise). (2)

Fictional lycanthropy has been portrayed in various ways. Movies in the latter part of the 20th century such as an *American Werewolf in London* portrayed werewolves sympathetically, as victims of supernatural forces beyond their control. Later in the 1980's films like *Teen Wolf* painted them in a comical light. In the 21st century, werewolves have morphed into beings with sex appeal, such as Jacob from the *Twilight* series of movies. Being familiar with cinematic portrayals of lycanthropic delusions may aid forensic psychiatrists in understanding how their patients perceive their own delusional transformations, since lycanthropy is likely a culture-bound phenomenon.

There have also been reports in recent centuries of wolf-like beings. In 1860's India, Dina Sanichar was pulled from a den of wolves as a young boy. When placed in an orphanage, he walked on all fours, refused to eat cooked food, and never learned to read or write. Dina's story may have served as the inspiration for Rudyard Kipling's *Jungle Book* protagonist, Mowgli. More recently, in the 1970's, approximately 50 reports were made to local authorities in Mobile, Alabama about a "wolf woman" who was described as "pretty and hairy." Several medical conditions such as hypertrichosis, cutaneous porphyria, Cushing's Syndrome, and rabies could contribute to appearing or acting like a wolf.

It is interesting to note two recent cases involving werewolf delusions. In 2015, Mark Andrews, a California man with a history of schizophrenia, believed he was a werewolf and, following God's instructions, killed his neighbor because she was a vampire emitting evil. He unsuccessfully pled NGRI and was sentenced to 50 years to life. In 2019, Pankaj Bhasink was found NGRI for murder after believing his victim, whom he stabbed over 50 times, was a werewolf. He was hospitalized at the Northern Virginia Mental Health Institute for three years prior to discharge on conditional release.

For the workshop portion, Dr. Resnick presented a composite case involving zoanthropic delusions. A man in his early twenties developed manic and psychotic symptoms over a period of several weeks, culminating in killing two strangers. He had grandiose beliefs that he would be the next great civil rights leader, that he was Jesus, Gandhi, and Martin Luther King, Jr., and that he had the power to sterilize water by blessing it. He shifted between believing he was a dog and believing he was half-horse, half-man in the days before the alleged offense. On the day of the alleged offense, he crawled into the back of a hatchback vehicle, where a dog might sit. He had periods where he would talk less "because horses don't talk." He was paranoid regarding evil in the dark and feared a dark spirit would kill him in his sleep. He wore sunglasses and an emerald cross for protection. He killed his victims in apparent misperceived self-defense and chewed on one of the victim's bodies; shortly after, he demanded to be killed by police, stating he deserved to die. Dr. Saxton led audience members in formulating an insanity opinion using a *McNaughten* test, and volunteers participated in mock testimony and cross-examination.

It was the hope of the presenters that audience members become acquainted with the rare clinical phenomenon of lycanthropy and understand how it might be relevant in the medicolegal setting.

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Douglas Mossman, M.D.: A Gold Standard for Forensic Psychiatry

Christopher Marett, MD, MPH

"It is not your responsibility to finish the work, but neither are you free to desist from it." (1) This advice remained foremost in the mind and practice of our beloved colleague, Douglas Mossman, M.D., and it continues to inspire the office he once shared. Simultaneously, it encapsulates Dr. Mossman's commitment, principles, and deep-rooted faith. Though his life was cut short in 2018, his work, character, and legacy live on.

Known among colleagues for his wit, sartorial style (particularly his trademark bowtie), and generous spirit, Dr. Mossman's professional contributions to psychiatry and forensic psychiatry are immense. He authored over 140 articles and 20 book chapters, and made key contributions to the AAPL Practice Guidelines on Competency to Stand Trial (2) and the Insanity Defense. (3) Dr. Mossman was a keynote speaker at forensic psychiatric conferences around the world and the 2017 recipient of AAPL's Golden Apple Award recognizing members who have made significant contributions to the field. Further, he served AAPL through his participation in the Research Committee and the AAPL Journal editorial board, as councilor between 2004-2007 and treasurer from 2011-2017, and as president of the Midwest AAPL chapter in 2003-2004. He was a master teacher, adored mentor, (4) and long-time fellowship director at the University of Cincinnati.

Dr. Mossman's route to a distinguished career is clear. At his core, he was a healer who cared deeply about relieving the suffering of fellow human beings. Discussing his desire to become a psychiatrist, he recalled, "It seemed like the perfect occupation for a Jewish boy with my kinds of interests … psychiatry was a specialty where you listened to people, talked with them, and helped them get better. As a psychiatrist, I could be a doctor … but I'd be doing something that I thought was intriguing." (5) Indeed, Dr. Mossman was a gifted clinician well-loved by his patients. Despite managed care pressures, he maintained an active psychotherapy practice until his passing.

His path to forensic psychiatry was rooted largely in his love of philosophy. Having studied philosophy during undergraduate studies at Oberlin College and graduate studies at the University of Michigan, he later reflected on this influence: "When I practice forensic psychiatry, I get to exercise my philosophical interests and education in a practical way."[5] Dr. Mossman's scholarship reflects this, relying on figures like Kant, Locke, and Rawls to address ethical and legal issues. For example, he believed that psychiatrists could participate ethically in evaluations that others found problematic, (6) most notably assessments of competence to be executed. (7) Implicit entrance into a social contract necessitated that, as ends unto themselves, people who committed crimes would be punished. As he put it, "One's humanity establishes a right to experience the logical consequences of one's acts, including the act of promising to obey the law and punish the disobedient." (8)

Gifted with genius, Dr. Mossman advanced the field in many ways. A primary focus of his scholarship was the application of mathematical principles to advance the scientific base of the field. He believed firmly that mathematics is a language to interpret and solve the world's problems. Dr. Mossman applied principles of Bayes' theorem and decision theory both to clinical and forensic issues, including malingering, the interpretation of psychological tests, and civil commitment. His application of receiver operating characteristic (ROC) analysis advanced knowledge and interpretation of violence risk assessment. He also applied mathematical theory to attempts to solve a conundrum that troubles many areas of forensic assessment: how to determine accuracy when there is no gold standard. For example, while statutory criteria for competency to stand trial (CST) are clear, the fact-finder's decision regarding competency relies heavily on the mental health professional's opinion. If CST is viewed as an ability on a continuum rather than categorically as yes or no, evaluators can use available data (e.g., verbal incoherence, impaired processing speed and retention) to make reasonably informed opinions and provide ratings of their own confidence in the opinion. With that data, researchers can use latent class modeling and ROC analysis to quantify the accuracy of evaluations.

Another avenue of Dr. Mossman's work addressed how psychiatrists should respond to *Tarasoff* duties. His 2008 Guttmacher Award-winning work (9) and other scholarship (10) outline a beautiful, human-centered approach to individual risk assessment that satisfied both legal and ethical duties. Although courts in some regards have expected psychiatrists to predict violence risk, it is a practice fraught with difficulty. Each person poses some level of violence risk, but as his research showed, the threshold for acceptable intervention to mitigate this risk varies widely. Dr. Mossman suggested we treat our patients, then, as humans rather than statistics. His faith and philosophy guided him to the conclusion that when presented with a patient who poses an imminent risk, psychiatrists have a moral obligation to intervene as any good neighbor would.

Dr. Mossman cared deeply about the standard of the profession. In an article with perhaps the most provocative title among his writings, he analyzed the legal profession's propensity to view psychiatric witnesses as "whores" and "hired guns." (11) This work was prompted by his

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Douglas Mossman

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experience that, "when I testified in some of the more high-profile cases, I was very aware of the smirks and eyebrow-raising of television reporters who reported on the cases."(12) He believed that psychiatric expertise must be grounded in objectivity and, to the extent possible, science.

Throughout his career, Dr. Mossman completed hundreds of forensic evaluations involving an array of issues. His reports and testimony serve as a model of clear and effective communication educating courts on psychiatric matters. Occasionally, his testimony helped set precedent. One fascinating instance is his testimony in the matter of *State v. Stringham*.(13) Ohio courts had previously barred psychiatric expert testimony regarding false confession. The appellate court found error in this prohibition, given that Dr. Mossman proffered testimony that could help the jury address the *reliability* of the confession rather than *voluntariness* or *truthfulness*. Essentially, his testimony cleared the way for psychiatric experts to use available science to assist the jury in understanding vulnerabilities predisposing individuals to incriminate themselves in crimes they did not commit.

Among his countless gifts was his musical talent. Dr. Mossman appreciated the relationship between musical composition, mathematics, and the beauty of the natural world. He composed and sang liturgical music, and sometimes served as cantor at his synagogue. He arranged music for the choir at high holiday services, and even composed music for his own funeral. On the lighter side, he was known for his clever and at times raucous musical parodies at professional conferences. Upon accepting the 2008 APA Guttmacher Award, he performed the following, to the tune of "Danny Boy:"

Though many lawyers thought
the threat of suing
Would save the world from patients'
violent minds,
What all us psychotherapists
have been doing
Is finding ways to cover our behinds.
If we were fortunetellers,
we'd be better off,
But what the future holds
we cannot know.
That's why we long to say,
"Good riddance, Tarasoff,"
Though many courts and plaintiff's
lawyers love you so. (14)

Alas, nothing golden shines forever. In 2017, Dr. Mossman was diagnosed with pancreatic cancer. He battled it valiantly with a sense of humor until his passing. In a way only Dr. Mossman could, he chuckled heartily to the lyrics of the Weird Al Yankovic parody, "Pancreas:"

My pancreas attracts every other
Pancreas in the universe
With a force proportional
To the product of their masses
And inversely proportional
To the distance between them
Insulin, glucagon
(Wont'cha flow flow flow,
pancreatic juice)
Comin' from the islets
of Langerhans…
(Flow flow, into the duodenum)
Lipase, amylase, and trypsin
They gonna help with our digestion
(15)

Most importantly, Dr. Mossman maintained a strong sense of duty to the very end. Perhaps the publication that brought him the most pride, was his article guiding responsible approaches to ending one's practice in the face of terminal illness.(16) Here, he examined the psychotherapeutic relationship, considered the impact of impending death on both patient and psychiatrist, and outlined steps to prepare responsibly for the rupture.

At the end of his own journey, Dr. Mossman took similar steps with those he loved. Family was always first for him. In an indelible moment shortly before his death, Dr. Mossman and his wife, Dr. Kathleen Hart, invited former fellows to gather in their home to celebrate his life. During this moment, he glowed with pride and awe at the career and personal accomplishments of his cherished pupils. To him, this meant the world.

In a 2014 interview,(5) Dr. Mossman remarked, "I am a very lucky guy who gets to do a lot of great things by virtue of many people's kindnesses." His collegial and collaborative spirit cannot be overstated. Dr. Mossman had an uncanny ability to recognize the talent and impact of every member of the team and to bring out the best in them. He viewed AAPL and our field as a community of colleagues, not a competition. AAPL was truly lucky to count Dr. Mossman among its members and leaders. We hope that his warmth, spirit, and guiding principles will echo on, much like the notes of his music. He was the gold standard for an outstanding career and life.

To submit columns for this feature please contact philip.candilis@dc.gov

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Vicarious Trauma in Forensic Psychiatry

Ren Belcher, MD; Renee Sorrentino, MD; Joel Watts, MD; Susan Hatters Friedman, MD

As electronic evidence becomes more common in criminal proceedings, forensic psychiatrists are increasingly exposed to potentially traumatic media. From body camera footage of violent crimes to digitally-distributed child pornography, electronic evidence is ubiquitous, permanent, easily distributable, and may offer new dimensions of insight into contemporaneous mental status for certain types of forensic evaluations. To date, little is known about the traumatic potential of viewing graphic media in the line of duty. Are we putting ourselves at risk?

At the 2022 AAPL Annual Meeting, our group presented a Panel Discussion titled "To See or Not to See? Danger vs. Duty When Viewing Evidence." (1) At this Panel, we polled 44 attendees on their attitudes regarding viewing traumatic material in the line of duty. 28 respondents were board-eligible or board-certified forensic psychiatrists (64%); 4 were fellows (9%); eight were residents or non-forensic fellows (18%) and four were other participants (9%). Their responses to questions about vicarious trauma (VT) are outlined in Figures 1-3.

Starting the Panel, Dr. Renée Sorrentino outlined the professional duty of forensic psychiatrists to view all the available forensic evidence in a case, as outlined in the AAPL Practice Guideline for the Forensic Assessment. (2) "As forensic psychiatrists, it is our professional duty to strive for objectivity in the pursuit of the truth. Reviewing all of the available evidence including collateral sources of information facilitates such objectivity," said Dr. Sorrentino. She emphasized that today's technological advances have expanded the scope of collateral data to include the digital footprints of an evaluee as well as real-time videorecording of criminal behaviors, and stressed that forensic opinions should be informed by the totality of such information regardless of their graphic nature.

The literature on sexual offenders, in particular, outlines the importance of such collateral data in formulating paraphilia diagnoses as well as risk assessments. For example, in cases involving child pornography it may be necessary for the evaluator to view the child pornography in evidence in order to appropriately score risk assessment tools such as the C-PORT (Child Pornography Offender Risk Tool) (3).

Additionally, real-time video recordings and other digital footprints can provide a contemporaneous mental status examination important for sanity and mitigation evaluations. This collateral data helps to minimize bias, supplementing a defendant's memory and witness accounts in an effort to facilitate an accurate understanding of a defendant's thinking and behavior. As such, Dr. Sorrentino advises: "the relevant question is not whether to view but how to mitigate potential risk."

Common misperceptions identified by evaluators who choose not to view graphic material include beliefs that written reports by other forensic experts or medical colleagues are sufficient; that audio recordings (without video) of forensic evidence are sufficient; that viewing such evidence could confer undue bias; and that viewing such evidence is not relevant to the referral question. Forensic psychiatrists should be cautious in taking this approach, especially if an opposing expert has viewed the material in question, or if the material provides diagnostic information such as a mental status that is relevant to the reason for the evaluation.

Dr. Joel Watts discussed how the privileged and confidential nature of many forensic assessments often limits an expert's ability to share or process content of an assessment with supportive peers. He warned, "one should be wary of potential personal biases that could distort one's opinion, such as identification with the victim or having negative views towards an aggressor." According to Dr. Watts, it is unclear whether forensic psychiatrists are at similar risk to other professionals of developing symptoms from traumatic evidence. Medical and psychiatric training, with anatomy labs and surgical training, may better prepare forensic psychiatrists for graphic imagery. One study indicated that trauma exposure led to more VT among lawyers than mental health professionals. (4) Personality and individual factors that increase propensity to developing VT or PTSD are nonetheless still relevant in a psychiatrist's risk. These trauma-related symptoms may include having a more cynical and pessimistic world view, a tendency to be more suspicious and less trusting of an evaluee's self-report, burnout, emotional exhaustion, compassion fatigue and PTSD.

Forensic psychiatrists can mitigate risks to themselves by first obtaining any details about potentially traumatogenic material they are being asked to view. This can include asking for a detailed list of disclosure materials to review and details about the format (photographic, audio, or video) and their quantity, duration, and quality. Psychiatrists should be aware of their own personal risk factors and what subject matter might amplify or trigger difficult memories or experiences. Other ways to mitigate risk of trauma can include arousal, stress, and sleep management at the time of reviewing the materials, or obtaining an agreed statement of fact (with the caveat, as above, that one must consider possible effects on the quality of the expert's analysis and opinion). Ultimately, an expert can refuse to get involved in a particular case they view as posing too high a risk of trauma to themselves.

Dr. Susan Hatters Friedman spoke about VT in forensic psychiatrists. She noted that secondary stress, compassion fatigue, VT, and burnout are convergent concepts. VT from graphic or traumatic material involves harmful changes in views of ourselves

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Vicarious Trauma

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and the world. Our beliefs in our own invulnerability are challenged, as are our beliefs about justice. This can lead to decreased empathy and productivity at work, as well as physical and emotional symptoms, and difficulties in relationships.

Strategies to mitigate traumatic potential include vigilance regarding our work-life balance, especially when working on potentially traumatic cases; spirituality; psychotherapy to explore our own past traumas as well as our countertransference feelings; reduction in the number of traumatic cases and not viewing highly traumatic material when under other stress; and seeking supervision.

Peer supervision is more commonly used in Australia and New Zealand, where it is part of continued licensing requirements by the Royal Australian and New Zealand College of Psychiatrists. Peer supervision allows us to debrief, to receive support from our colleagues, to connect, and to examine our counter-transference.

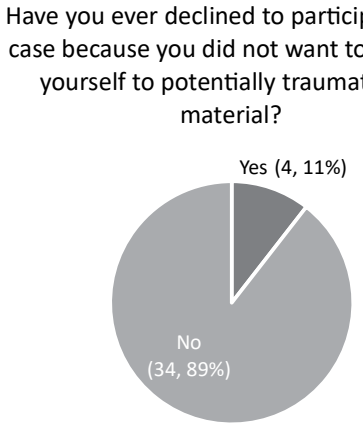

FIGURE 1

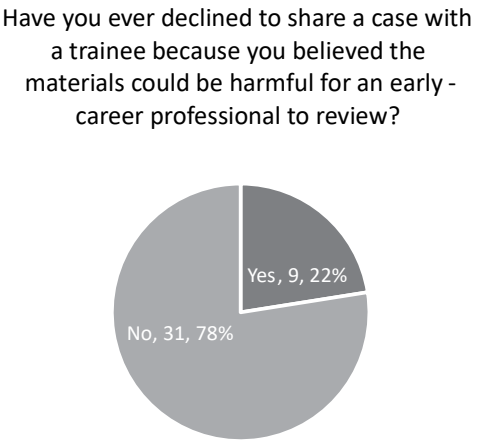

FIGURE 2

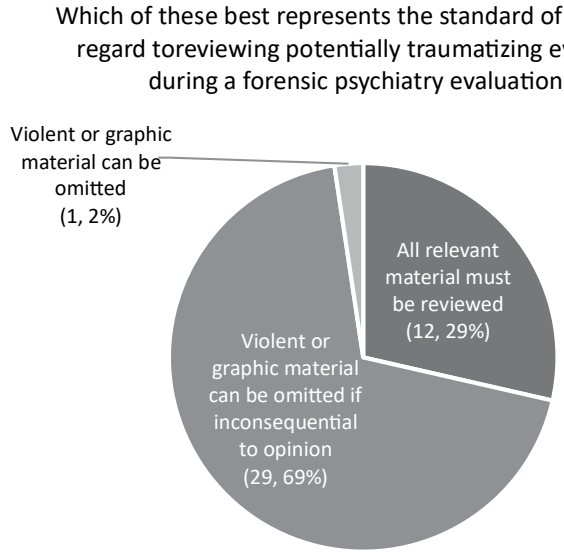

FIGURE 3

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RIP: Rest in Peace or Retire in Productivity? Part I

This article is dedicated to the memory of the late Brian Crowley MD, long-time AAPL member, who had offered to be one of the authors.

William Reid, MD:

I'll set aside the physical and mental infirmities of aging and assume financial security is the norm for psychiatrists. We're very fortunate in that regard, but we've *earned* it. Don't apologize for success.

Retiring is tough, even if it doesn't always feel tough. I see mine coming in decisions like whether to cancel licenses, hospital privileges and memberships, going to fewer meetings, reducing malpractice coverage to part-time, and when I don't entertain choice job feelers that come along, or cases I would have jumped at a few years ago.

At night, I may dream of searching and loss, attributable, at least partially, to losing parts of my career—of my *life*—and realizing they won't be found again. Recently, one was about searching through a crowded hotel for an AAPL committee meeting, finding it, and realizing I no longer knew the members. The next morning, I reversed an earlier decision and registered for this year's Annual Meeting.

For me, the process has been gradual. I love the freedom from 7:00 AM or PM commitments, not accepting cases that don't interest me and being a senior professor who can ignore faculty bickering or p.c. disputes.

On the other hand, I want the phone to ring. I renew hospital privileges, though a cognitive exam is required to keep them (a good rule). I renew my controlled substance license, though I haven't prescribed any in years. It took a long time to give up unused medical licenses. I still belong to most of the professional societies. Younger people don't truly understand the pain of feeling irrelevant, but it's so common among the elderly.

The young lions of medicine want respect, but they're often blind to reciprocal courtesy. I deal with that by trying to be very good at what I still do, and seeking out those who benefit from it. Ask me about my 10-year-old guitar student.

A medical career cannot be replaced, but we can substitute other good things. I tell young physicians to cultivate family and nonmedical ways of being productive and fulfilled. It helps when medicine and its trappings are put away, or are beyond our waning energies and abilities. I have a wonderful wife, a bit of family, and ways to feel *productive* and *useful*, a *contributor* to the world. Teaching is great, so long as there are willing trainees. My guitar has been an unconditional friend all my life. Writing non-professional books has been a new way to produce. A large close family would create different priorities; those without that blessing must deal with what is.

At the end of life, will you wish you'd taken one more case or one more patient? Or think back on balanced and rewarding senior years, with family and contribution and not so many "wishes?" My late friend and colleague Brian Crowley had his devotion not only to a fine career but to a close family, a lesson for all of us.

Carla Rodgers, MD

AAPL has a great policy of helping early career doctors, but what of late careerists? How to handle the challenges that come at the end of one's career? I am surprised to be in my 70's, given the short lifespans in my family, but I'm still here, and a physician as well.

Articles have recently been written about aging physicians, and whether we should even be allowed to work. What do we have to offer? (1, 2) The consensus is, wisdom and experience.

My slow-down plan started at 60 with the decision not to do work that did not give me personal satisfaction or some feeling of enjoyment. My spouse and I discussed this fully. Though it hasn't always worked out, it has been a good roadmap.

My specific goal was to go from a full-time forensic and clinical psychiatrist, with occasional athletics and art classes thrown in, to reversing that balance, and also continuing to teach. I was enjoying the transition when Mother Nature struck, as commonly happens in the elderly. Surprise!

A large spinal cord tumor was found in 2020, fortunately benign, resulting in complicated neurosurgery, and a year-long, and continuing, recovery. A problem that a healthy lifestyle cannot prevent, which is most annoying. I also do not recommend neurosurgery in the middle of a pandemic.

This stopped my plan in its tracks. So, what to do? After treatment, I am still navigating my new normal, whatever that is. Fortunately, I was able to ramp up my forensic practice again. My current work has been a true gift, showing me that I remain productive, but some days I just have to work from bed. I've put even more emphasis on lifestyle issues to protect my brain if I can. I am finding working on this senior challenge surprisingly satisfying. As Bob Dylan sang, "I was so much older then. I'm younger than that now."(3)

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Improv-ing

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appreciation of this teaching format and consideration for use of improvisation principles in their own forensic work.

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Report of the American Psychiatric Association Assembly

Danielle B. Kushner, MD

The American Psychiatric Association (APA) Assembly met virtually on November 5th and 6th, 2022 with all committees and area meetings convening virtually prior to the meeting. Similar to the spring meeting, the fall meeting opened with an Assembly pledge emphasizing respect and inclusion during the meeting.

In the Executive Director's Report, Saul Levin, MD, MPA, started by discussing APA's response to recent national and international human rights issues and discrimination. He also provided legislative updates on key APA issues awaiting the midterm elections, including collaborative care, parity enforcement, extension of telehealth flexibility, and funding for mental health programs. He emphasized the importance of supporting the APA Political Action Committee, along with encouraging more physician involvement through such events as the APA State Advocacy Conference that took place in Minneapolis in October.

Other notable updates included the launch of LaSaludMental.org, an APA website dedicated to hosting Spanish-language information and resources on mental health and substance use disorders. The nationwide mental health crisis and suicide hotline, 988, also launched in July. Additionally, the APA has continued to provide robust online resources, including new mental health explainer videos, resources for veterans' mental health, and "The Looking Beyond Series" with recent Mental Health Fireside Chats on LGBTQ issues, Climate Change, and Collaborative Care, among others. The APA has also recently received grant funding to promote education and awareness regarding eating disorders and perinatal mental health, along with supporting diversity leadership fellowships and school mental health.

Current APA President, forensic psychiatrist Rebecca Brendel, MD, JD, summarized the ongoing work the APA has accomplished and is continuing in support of Diversity, Equity and Inclusion (DEI) and combating structural racism. These ongoing efforts are accessible to members on an online dashboard. Dr. Brendel also discussed the current Minority and Underrepresented (MUR) Definition Workgroup that will present their ideas to the APA Board in December. Dr. Brendel also reported on the work supporting her Presidential Theme, "Roadmap for the Future." The three key components are Access/Equity in Mental Health Care (patient/public-facing), Resources for Mental Health and Workforce Development (profession-facing), and Strategic Partnerships & Leadership (policy-facing).

Key Action Papers of forensic interest presented at the recent meeting included two Action Papers focusing on gun violence. The first, *APA Champions Firearm Safety*, passed on consent calendar and aims to reaffirm APA focus on firearm safety by coordinating with organizations for a strategy on firearm policy and developing a targeted media campaign. The second, *APA Advocates for Raising Minimum Age for Firearms Purchases*, advocates to increase the age requirement to 21 years and eventually was approved after a lengthy debate. Other passed Action Papers included *Assisted Suicide and Inability to Determine Mental Illness Irremediability* that requests development of a Position Statement on this issue and *Advocating for Financial Equity and Responsibility in ABPN Certification* that advocates for ABPN fee decreases and the price of certification to be commensurate specifically with the cost of certification without subsidizing other professional activities of ABPN.

Approved Position Statements include a new statement on *Engaging Law Enforcement Personnel and Correctional Staff to Address Mental Health and Racial Inequities in Jails and Prisons,* which advocates that education and training of law enforcement personnel and correctional officers should include effective mental health collaboration, implicit bias training, and de-escalation techniques. Additionally, it states that these agencies should publicly report use of force data and the impact of anti-racist initiatives, implicit bias training, and diversity in the workforce on injuries and deaths.

Other updated Position Statements include *Misuse of Psychiatric Examinations and Disclosure of Psychiatric Records in Harassment Litigation*; *Use of Jails to Hold Persons Without Criminal Charges Who Are Awaiting Civil Psychiatric Hospital Beds; Affirmative Action; Intimate Partner Violence; and Discrimination Against International Medical Graduates.* The Assembly also voted to wait to vote on an Action Paper regarding replacing the MUR terminology, pending an update from the taskforce.

The 2023 APA Annual Meeting is scheduled for May 20-24, 2023 in San Francisco, California and the APA Assembly meeting will be in person prior to the meeting. The theme of the meeting is "Innovate, Collaborate, Motivate: Charting the Future of Mental Health."

Improv-ing

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President's Column

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his classic paper "The quest for excellence in forensic psychiatry," Dietz invokes the touchstone metaphor:

> …the proper role of the forensic psychiatrist is the same as that of any other forensic scientist. My touchstone for grappling with apparent moral conflicts has always been to ask myself what the ideal forensic pathologist would do in a similar situation…. My conception of our role is that it is the same as that for any other group of forensic scientists who are called upon to give evidence about technical matters. (18)

I have observed that *the touchstone of the ideal forensic pathologist* resonates well with trainees, legal professionals, and the courts. One of the benefits of reflecting upon the forensic touchstone is that it centers our attention on foundational issues for forensic psychiatry – what do the courts most need from us and how can we best provide it in an effective, objective manner? Reflecting on this touchstone may also help AAPL navigate the terrain in this age of historical socio-cultural change. Which social advocacy positions would AAPL be wise to embrace? Which will be better addressed by other organizations like the American Psychiatric Association? There may be some social advocacy positions for which AAPL is well suited, while others may have too tenuous a link to AAPL's goals and mission. Let us look forward to AAPL adapting and responding to the many post-inflection-point changes in a virtuous and balanced way that strengthens AAPL and its reputation.

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emphasized that narrative work is vital and that psychiatrists are powerful at constructing narratives that help people understand what is happening in a broader cultural context. He said that racial injustices created toxins in the air, and there has been a long history of racial injustice that we have never really talked about and is not acknowledged or addressed. We have to change the narrative in medicine, science, law, and every sector of society.

Professor Stevenson discussed how he has experienced firsthand that you can be a well-respected psychiatrist, lecturer, lawyer, or preacher, but if you are black or brown, you will still have to navigate a presumption of dangerousness and guilt, and it is exhausting. He explained that even though he had won a landmark case banning life sentencing for children, he was still angrily questioned by a judge in the Midwest about why he was sitting at the defense counsel table. He had to explain to the judge that he was the lawyer, and then he had to make himself laugh when the judge laughed, so as to not disadvantage his clients.

We need to be willing to tell the truth of how our history has reduced our ability to see biases. He compared the US to the city of Berlin, where they have owned their history of the Holocaust, and that the Jews who were taken are honored everywhere and there are no monuments to the perpetrators of the Holocaust. Commitment to truth-telling is key. There has not been a profession in this country that has not been compromised by this issue. Just as people will not accept treatment without a proper diagnosis, we need to recognize that there are biases in order to find and accept treatment for it.

He said that the introduction of synthetic drugs has flooded prisons, and two-thirds of inmates have a drug dependency problem, which leads to violence over not being able to pay, and that there is severe trauma in the

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system that is untreated. We have not really engaged in interventions to help the most vulnerable populations, and therefore jails and prisons have become an alternative to mental health care.

However, we must stay hopeful about our capacity to make a difference, our ability to heal, help, shelter, aid. We can treat trauma and provide interventions to help people deal with mental illness and cope and manage stressors that trigger problematic behaviors we wish to avoid. Hopelessness is the enemy of justice; we need to identify the greatest threat and fight against it.

He realizes that people who came before him did so much more with so much less. He respects the right to vote and to be treated fairly and not get beaten while praying. He realizes how easy it is to become hopeless. When he went to Harvard, he did not tell people that he started his education in a colored school or that he was descended from slaves. He thought these things would diminish him, and he had given in to the hopelessness. Not only was this the wrong choice, but talking about history helps him. Now, he tells everyone. Anti-literacy laws made it illegal for his great-grandfather to learn to read, but he learned anyway, believing he would one day be free. When emancipation came, his grandfather taught others, including his grandmother. His grandmother was powerful because she was tough and strong, but kind and loving. She was a reader, and her ten children, and their children, had to prove that they loved to read. He saw this as an act of hope. His mother went into debt buying them encyclopedias. Because of this, he saw the world through those books, and did not think it was "crazy" to want to become a lawyer.

Hopelessness about what we can do constrains our appetite for improving health, but hope is our superpower. The 14-year-old boy who was the victim of domestic violence whom

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One Giant Leap

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the Artemis Program and NASA's return to the moon as a stepping stone to future Mars missions. The short-term plans are to return to the lunar surface with establishment of a permanent lunar base, utilizing the experience and technology during these lunar missions to plan and eventually undertake the first human mission to Mars. Dr. Beven indicated that one of the long-term goals is to determine how best to select crewmembers, prepare them for the mission, and maintain their behavioral health and physical well-being. Two major limitations he discussed were the lack of in-person/real-time communication due to the distance between Earth and Mars, as well as how to best protect astronauts from the adverse effects of space radiation.

Dr. Beven discussed the current behavioral support mechanisms in place on the International Space Station, including scheduled private psychological conferences (PPCs) with Dr. Beven and his NASA colleagues; once-a-week private family video conferences; internet protocol phone calls where astronauts may contact family or friends any time of the day; and private crew discretionary events including video conferences with celebrities and famous persons selected by the astronaut to boost crew morale and optimize performance. Such conferences may also permit astronauts to meet with influential persons or institutions that had an impact on the crewmember's career, such as military academy departments or other groups that had a hand in their education. Care packages are also sent to the ISS via uncrewed cargo vehicles, which may include culinary treats or other special items, including gifts from family members. NASA also encourages space crews to celebrate important events such as holidays to break up the monotony of working and living in space for up to a year. Astronauts also have access to recreational items, including musical instruments, and the ability to have television shows, miniseries, movies or news digitized for them.

Dr. Beven concluded his presentation on a hopeful note of continued international cooperation, respect for the work NASA and the astronaut crews are performing, and acknowledgment that there will be continued challenges going forward, especially with missions beyond low earth orbit and eventually into deep space. Dr. Beven noted that space exploration is something that remains fulfilling and exhilarating and that many prominent individuals in medicine find it an honor and a privilege to be able to work for or consult with NASA. He remains very optimistic regarding the future of the space agency and for ongoing international cooperation in the realm of human spaceflight.

Dr. Beven encouraged any physician that may have an interest in NASA or working with NASA to reach out to him at gary.beven-1@nasa.gov and to consider becoming a member of the Aerospace Medical Association (www.asma.org) or the Space Medicine Association (www.spacemedicineassociation.org).

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Considerable work remains to provide for staffing needs. Forensic hospital leaders must continue to advocate for competitive salaries and incentives, including hazard pay. They must also support reduced regulatory burdens and increased autonomy at individual hospitals rather than a centralized system at the state capital. They should advocate for staff safety, recognizing that new facilities or major remodeling may be needed. States should consider jail- and community-based restoration, diversion, and ways to expedite competency assessments (10, 12). The staffing crisis and the resultant bed shortage are making community-based mental health services more critical than ever to help alleviate the competency restoration crisis and reduce reliance on inpatient treatment (3).

Although large, system-wide changes are necessary, individual hospitals

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Forensic Hospital

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can take steps to offset the ongoing loss of staff. To enhance workplace safety, they can increase security presence, which has been shown at least in one hospital to reduce violence during the pandemic (7). Bellman et al. (7) also found lower aggression rates when staff practiced positive teamwork and good communication and felt supported by the administration. They also found lower aggression associated with increased attention to patients' coping strategies, lower noise levels, more single-occupancy rooms, and more outdoor time for patients. One hospital has utilized stress-relieving quiet rooms for staff who need a break from a challenging or frightening shift.

The pandemic caused a nationwide staffing shortage, which increased patient violence and reduced psychiatric beds. State hospitals and their communities continue to struggle with this crisis. These challenges are not new; they represent chronic issues due to systemic weaknesses exposed or exacerbated by the pandemic. Although state hospitals can take steps at the local level to improve morale and reduce patient violence, it is unlikely that the crisis will be resolved until key changes occur to support our state hospital staff and their community mental health system.

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Challenges

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> physicians to deal with issues outside their scope of practice. The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP. (3)

While more restrictive than the guidance applicable to nurse practitioners, CMS guidelines for supervision of physician assistants state:

> Medicare Part B covers a PA's services only if the PA performs the services in accordance with state law and state scope of practice rules for PA's in the state in which the PA's professional services are furnished. Any state laws and scope of practice rules that describe the required practice relationship between physicians and PA's, including explicit supervisory or collaborative practice requirements. For states with no explicit state law and scope of practice rules regarding physician supervision of PA's services, physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services... (3)

Finally, psychiatrists and NP's/PA's must become familiar with risk management strategies that can help reduce the risk of board complaints and lawsuits. All providers should utilize available resources—such as continuing medical education provided by professional associations and malpractice carriers—to enhance career development, develop strategies for risk mitigation, and improve patient quality of care. Practitioners should not be reluctant in filing a Notice of First Report to notify malpractice carriers of potential board complaints or possible legal action. This precautionary measure ensures the provider will not inadvertently prejudice its defense

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(and possibly jeopardize its insurance coverage) and allows the provider to partially shift the burden of such matters to professionals with greater risk mitigation expertise.

In summary, there are structural issues that often impede successful collaborative supervision relationships between psychiatrists and NP's/PA's. However, for a collaborative care model to work, is imperative to address these issues to create solutions that effectively meet the mental health needs of millions of psychiatric patients in the United States.

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Forensic Assessment

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Conclusion

The Accreditation Council for Graduate Medical Education's Common Program Requirements partially addresses the training required to conduct evaluations of asylum seekers. For these assessments and, indeed, for any understanding of marginalized communities in the US, didactic and applied activities must address cultural competence in psychiatric diagnosis, cultural identity, and dangerousness assessment. Forensic supervisory experience that takes these elements into account is strongly recommended for those who plan to conduct forensic assessment of asylum seekers.

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Violence

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additional volunteers to remain with them while receiving services. The collective community response was that of gratefulness for the resources available at the Resiliency Center. (5)

Conclusion

The Uvalde Community Resiliency Center demonstrated the goodwill, teamwork, and leadership skills of local and national aid organizations. Communication among individual or organizational units may have been handicapped due to emergent responses required by the situation. It is necessary that all interactions with survivors and victims of mass tragedies are guided by trauma-focused responses. Organized processing opportunities may also be beneficial for crisis responders.

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Pharmacy Records

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the evaluator, but will contain a more thorough prescription history than can be pieced together from various medical records, especially if an evaluee has used different pharmacies or moved frequently.

Another potentially important pharmacy record is the database that most states maintain for controlled substances. However, most states restrict access to this information to treating physicians. A forensic evaluator could face potential disciplinary action for accessing it for a non-clinical purpose. Therefore, it may be necessary to obtain this information or report from treating physicians.

Lastly, as with any record request, it is always best to have the retaining party obtain the signed release of information and the records themselves so that they are aware of the information that the expert will receive. If the evaluator chooses to request the records, the retaining party should be advised in advance. However, we do not recommend that an evaluator request medical records directly, due to the perception of bias.

As with any record in a forensic case, pharmacy records have the potential to reveal information that is both favorable and not favorable to the retaining party. However, the ease of obtaining these records and the benefit of improving the completeness and accuracy of the available data should make requesting and obtaining pharmacy records a standard practice for the retaining party in order to better assist the expert.

Douglas Mossman

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Dr. Ann Burgess

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of the interviews that agents conducted with convicted murderers, illustrating the kinds of questions and responses elicited. Dr. Burgess provided commentary during the videos. She noted that the producers maintained a fair amount of the authenticity of the true events.

Fostering Recovery

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Professor Stevenson helped went on to graduate from a school in engineering, and calls him monthly to tell him how well he is doing.

Professor Stevenson reminded us that each of us is more than just the worst thing we have ever done. No one is just a thief, a killer, etc. The law assigns labels to people and takes away their humanity. By being proximate, we can change the narrative. He concluded by saying that he is honored to be part of the investigation.

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