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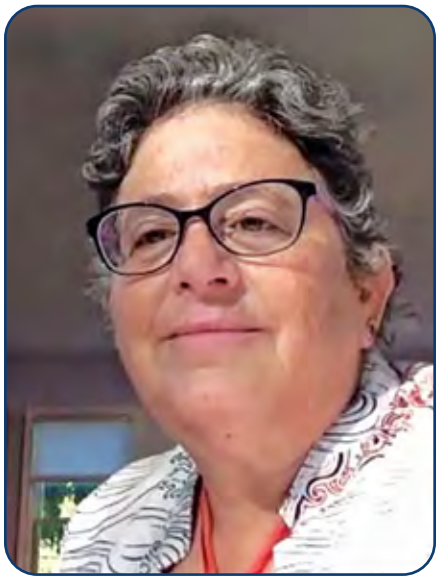
2021 AAPL Presidential Address

Dr. Liza H. Gold, MD: AAPL Post-COVID: Behind the Mask

Britta K. Ostermeyer, MD, MBA, DFAPA



Dr. Liza H. Gold, AAPL's 47th President, was introduced by her long-standing, close friend and colleague, Dr. Carmel Heinsohn, MD. Dr. Gold acknowledged and thanked many AAPL members and AAPL leadership for their contributions, including Dr. Renée Sorrentino, AAPL's Program Chair for the 2021 annual meeting.

Dr. Gold struggled with the idea of delivering the traditional Presidential AAPL Address because it has been anything but a typical presidential year. Dr. Gold's term was heavily branded by the impact of COVID. She acknowledged that many AAPL members and/or their family members had fallen ill with COVID or had lost loved ones. Therefore, she decided to present an insightful review of AAPL's accomplishments and challenges under COVID and discussed how AAPL can and should position itself in the post-COVID era.

Dr. Gold explained that while major AAPL meetings usually take years of planning, AAPL's 2020 and 2021 meetings had to be "converted" into virtual Zoom meetings in very little time. For many AAPL members, the fall Annual Meeting represents their social and educational highlight of the year. Not meeting in person had its impact on collegial membership networking. While AAPL had been losing members prior to COVID, the pandemic accelerated membership decline: in October 2016, AAPL had 2,074 members. In October 2019, just before the pandemic, membership had declined to 1,890, a loss of almost 10%. In October 2020, AAPL had 1,728 members, a loss of just over 17% from the 2016 high. Dr. Gold expressed concern that membership loss was unlikely to be reversed without in-person annual meetings. Of note, a significant amount of AAPL's operating income dissipated with no in-person meetings. Dr. Gold stated that nothing was business-as-usual, past experience did not suggest a path forward, and everyone was reeling from the impact of COVID on their own lives. However, AAPL rose to the challenge and organized a successful, online 2020 annual meeting. In addition, the American Board of Psychiatry and Neurology (ABPN) gave AAPL a $100,000 educational grant in 2020 and again in 2021, which substantially helped AAPL fiscally plan during these challenging times.

Dr. Gold stated that if AAPL was to survive the pandemic as well as prosper post-COVID, then AAPL had to make a number of changes. First of all, we had to make major CME program changes. Dr. Gold worked with Executive Director Jackie Coleman to create year-round virtual AAPL programming, including a new non-CME format, a town hall, that we hoped would stimulate member interest and participation. Dr. Gold then appointed Dr. Charles Scott to be the inaugural Program Director of Virtual AAPL (VAAPL), first as a volunteer and now confirmed as a formal position. This placed AAPL in a position to host a number of exceptional educational programs.

Dr. Gold remarked that VAAPL's attendee evaluations have been "extremely positive," and VAAPL was able to generate approximately $45,000 in revenue. However, the recording of these programs and issuing of CME certificates poses challenges yet to be solved. Dr. Gold also emphasized that AAPL lacks policies and infrastructure to manage recorded and stored educational content.

Clearly, AAPL needs to create and manage an online learning program as soon as possible. To that end, Dr. Gold appointed the Virtual AAPL Task Force II, chaired by Dr. David Burrow, Chair of the Technology Committee, and Dr. Anne Hanson, Co-chair of the Education Committee. While the first VAAPL task force selected the platform used for the 2020 and 2021 meetings, this new committee was tasked with developing an RFP for soliciting proposals from technology companies for an online learning management system. VAAPL Task Force II completed its mission, and AAPL Council voted unanimously to approve a three-year contract with a company which AAPL will be "onboarding" at the end of 2021. Dr. Gold explained that AAPL's next steps should be to create an online infrastructure system for live streaming and a library of on-demand educational recordings.

Importantly, Dr. Gold stressed that the development of an informative, communicative, and interactive

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American Academy of Psychiatry and the Law

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AAPL ANNUAL AWARDS

Top row, left to right: Jeffrey L. Metzner, MD; Patricia R. Recupero, MD, JD; Donna Vanderpool, JD
Bottom row, left to right: Annette L. Hanson, MD; Reena Kapoor, MD; Anne B. McBride, MD

SEYMOUR POLLACK AWARD 2021
Patricia R. Recupero, MD, JD

GOLDEN AAPL AWARD 2021
Jeffrey L. Metzner, MD

RED AAPL AWARD 2021
Annette L. Hanson, MD
-and-
Reena Kapoor, MD

AMICUS AWARD 2021
Donna Vanderpool, JD

BEST TEACHER IN A FELLOWSHIP PROGRAM 2021
Anne B. McBride, MD

"The Times, They Are A-Changin'"

Susan Hatters Friedman, MD

When Bob Dylan wrote his folk anthem more than half a century ago, the lyrics referred to the Civil Rights Movement. When I first heard Dylan's harmonica and warbling voice in 1988, in front of our family TV watching *The Wonder Years,* it was a throwback to a generation before, along with songs by Joan Baez, the Byrds, and Joni Mitchell. I pulled out my parents' old records, stacked them on the turntable, and played them for days.

Bob Dylan was awarded the Nobel Prize for Literature in 2016, "for having created new poetic expressions within the great American song tradition." I am not a Bob Dylan scholar, but as we reflect on where we are today in 2022 (and when there is a *Wonder Years* reboot), "The Times, They Are A-Changin'" might well again be an anthem. Building on all that has come before, we find ourselves in a unique place in time with technology and the pandemic. Yet there are still inherent biases within the justice system in which we practice.

My theme for the 2022 AAPL Annual Meeting is "The Whole Truth: Recognizing Culture and Gender in Forensic Psychiatry." Culture and gender, and their intersection, is critical in all of our work. International perspectives have much to teach us too. As forensic psychiatrists, we need to be thoughtful about how we work in this space now and in the future. Many of us AAPL members have been writing and teaching about culture, gender, and inequities for years, but I want to encourage all of us to think along these lines during this AAPL year.

We know our "old road is rapidly agin'." During the COVID-19 pandemic, AAPL has had to rapidly shift from in-person to online-only meetings, under the leadership of Drs. Will Newman and Liza Gold, with hard work by many AAPL members and leaders, as well as Dr. Jeff Janofsky, Executive Director Jackie Coleman, and AAPL staff. Through this we've been able to use technology to increase collaboration and connection with members throughout the year in addition to annually at our October meeting. Dr. Charles Scott, at the helm of Virtual AAPL, has been helping us navigate this course.

This is a time of much change in our society and in organizations. The Presidential Task Forces that I've appointed for this year are already hard at work. Again, I'm not a Bob Dylan scholar (I'm one generation off in each direction, more a scholar of either Duke Ellington or Robert Smith and The Cure, depending on the day). But our windows have been shaking, and our walls rattling.

AAPL has been my professional home for two decades, and one of my goals for the upcoming year is for us to re-invigorate AAPL membership in these complex times. Dr. Beesh Jain is chairing the Task Force for Membership Engagement, Recruitment, and Retention (MERR). This Task Force is charged with making recommendations about recruiting and retaining new and diverse members, including U.S., Canadian, and international forensic psychiatrists. This is with the recognition that our field is broad, including academia, various sub-specialties, correctional psychiatry, forensic hospitalist services, community forensics, court psychiatry, and private practice. This will be accomplished by leveraging the experience of early career, midcareer, and long-term AAPL members, with the experiences of the Membership committee, Forensic Training of Residents committee, and Early Career Psychiatry committee.

Virtual AAPL should help us to all feel more connected to our home organization in these challenging times. The MERR Task Force will also make recommendations regarding how to make AAPL more valuable to members (and potential members). To do this, we need to consider how AAPL continues to be our professional home as we respond to contemporary challenges. Finally, this Task Force is also considering how we might increase the profile of AAPL membership, and the importance of our ethical rules and practice guidelines—to non-members in the field of psychiatry, other medical sub-specialties, other forensic sciences, and the legal field.

Grammy-winning Cleveland native Tracy Chapman was born in 1964, the year "The Times, They Are A-Changin'" was released. She does an excellent cover of the song. She wrote in her iconic "Fast Car" that "we gotta' make a decision, leave tonight or live and die this way." This line has stuck with me for decades. There reaches a point where we need to do something, or we have decided that we are not.

Another Presidential Task Force will focus on the topic of Understanding Disparities in Evaluations and Addressing our Biases in Forensic Practice. Drs. Sandy Simpson and Gary Chaimowitz are the co-chairs for this Task Force. They are rigorously considering the literature about race, culture, and poverty increasing the risk of becoming involved in, and staying involved with, the criminal justice system. As forensic psychiatrists, we practice in this space daily. Bob Dylan's anthem reminds us "Don't criticize what [we] can't understand." We need to make further strides to understand, at this crossroads. Being mindful that AAPL is an educational organization rather than an advocacy organization, the Task Force is considering how these issues manifest in our day-to-day practice as forensic psychiatrists—our tools, our methods. But the hypnotic song is about hope for the future, "as the present now will later be past." We must consider the ethical implications on our work of this evidence, and figure out how to understand these impacts and our personal biases (be they related to socio-economic status, race, gender, culture, ethnicity, religion, migration, or sexual identity) impact our professional roles now and into the future.

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Best Practices for Forensic Psychiatric Participation in Death Penalty Cases

Jeffrey S. Janofsky, MD

The American Psychiatric Association's (APA) Committee on Judicial Action (CJA) reviews amicus briefs written by other organizations to decide whether APA should sign on to the brief and perhaps suggest modifications. As AAPL's Medical Director I represent AAPL's interest as a member of CJA. CJA recently reviewed two death penalty petitions for certiorari to the US Supreme Court (USSC) that were brought to our attention by the American Psychological Association (ApA). For various reasons, CJA decided not to sign on to the ApA's amicus brief. However, during the deliberation of one of the cases, it became clear that a psychologist hired by the defense did not follow best practices for psychological evaluation. This led to a discussion in CJA regarding a recurring theme: poor performance by mental health evaluators, including psychiatrists, in many of the death penalty cases we review. Furthermore, neither AAPL nor APA has ever proposed best practices for psychiatric forensic evaluation in death penalty cases. I was tasked by CJA to bring this to AAPL Council's attention.

As a reminder for those AAPL members who do not do work in capital punishment cases, in 1972 in *Furman v. Georgia* (1) the Supreme Court held that the then-existing death penalty framework in the US was unconstitutional, finding that death sentences had been imposed on only a small minority of death-eligible defendants without any guidelines or standards, and that this represented cruel and unusual punishment under the Eighth Amendment. Some states then attempted to overcome this problem by making the death penalty mandatory in a specified class of case, but this was also rejected by the Supreme Court as unconstitutional.

Other states adopted specific sentencing standards to guide discretion and adopted procedures to ensure those standards were enforced. This was held constitutional in *Gregg v. Georgia* (2). State legislatures decide which homicides should warrant the death penalty, but must provide a meaningful basis for distinguishing the few cases in which the death penalty is imposed from the many cases in which it is not. Sentencers must then be allowed to consider any available evidence which might convince them that the defendant should not be put to death, no matter how severe the offense or reprehensible the defendant's past. (3, 4) States have discretion in their capital sentencing schemes, but individualization of sentencing selection is mandatory.

At least two capital sentencing schemes had been found constitutional by the USSC. In one scheme (for example Maryland's former process) aggravating circumstances are based entirely on the severity of the crime charged (for example the defendant committed more than one offense of murder in the first degree arising out of the same incident). Only if the jury finds beyond a reasonable doubt that an aggravator is present does the jury proceed to mitigating circumstances. These statutory mitigators include many factors where forensic psychiatric evaluation and testimony might be useful including:

- The murder was committed while the capacity of the defendant to appreciate the criminality of his conduct or to conform his conduct to the requirements of law was substantially impaired as a result of mental incapacity, mental disorder or emotional disturbance; or
- It is unlikely that the defendant will engage in further criminal activity that would constitute a continuing threat to society; or
- Any other facts which the jury or the court specifically sets forth in writing that it finds as mitigating circumstances in the case.

In contrast, the Texas death penalty scheme requires the jury to determine:

- Whether there is a probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society;
- Whether, taking into consideration all of the evidence, including the circumstances of the offense, the defendant's character and background, and the personal moral culpability of the defendant, there is a sufficient mitigating circumstance or circumstances to warrant that a sentence of life imprisonment rather than a death sentence be imposed (Added by Texas legislature after *Penry v. Lynaugh)*. (5)

Capital defendants under both schemes could benefit from psychiatric evaluation to look at potential mitigating circumstances. The Texas scheme always requires an assessment of future dangerousness as an aggravating circumstance.

Under a separate series of cases the USSC has held that it is unconstitutional under the Eighth Amendment to execute persons with Developmental Disability. (6-8) Although this issue is primarily the realm of psychologists, forensic psychiatrists may also have a role in those assessments.

The use of the insanity defense in capital cases is also unusually problematic. A failed insanity defense in a trial's guilt/innocence phase might be perceived as an aggravating circumstance by a capital jury in the sentencing phase. (9)

AAPL had signed on to four capital case amicus briefs to date:

- Petition for certiorari to the USSC in *Moore I* (7) (with the Constitution Project and The Southern Center for Human Rights)
- USSC case-in-chief in *Moore I* (7) (with APA, ApA and others)
- *Ex parte Bobby James Moore*

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How Do Forensic Psychiatrists Add Value?

Joseph R. Simpson, MD, PhD

Years ago, I had the privilege of being interviewed for a National Public Radio broadcast. The topic was firearms and mental illness, and I was invited on because I had published some articles on mental health firearms laws. Although I spoke with the interviewer for about 20 minutes, in the piece that aired, they only used one statement from me, which was about the fact that people who have serious mental illness are not, statistically speaking, substantially more violent than those who do not have such a diagnosis. This was something that did not require expertise in firearms laws, or even in forensic psychiatry – most psychiatrists could have and probably would have said the same.

In addition to being a good lesson about the vagaries of the media, the experience got me thinking about what it is that forensic psychiatrists have to offer by virtue of their training in fellowship or their experiences in the field. In other words, if we stipulate a certain level of common knowledge and skills among psychiatrists as a group, what is the *added value*, to use a business term, of hiring a forensic psychiatrist, instead of an otherwise well-trained psychiatrist who doesn't have the forensic background? While the answer may seem self-evident, it might be helpful to pause and reflect on the question from time to time. Naturally, each of us wants to do a high-quality job for the party, court, or agency that engages our services. How do we do that? And how do we help others learn to do it?

Of course this is a huge subject. I will just offer what I hope will be a little food for thought. Forensic psychiatrists should add value through their understanding of the fundamental mechanics of medicolegal work. This includes such elements as maintaining open communication, such as timely notification when more time is needed to complete a report, so the retaining party isn't surprised by a last-minute request for an extension. Attorneys and judges do not like surprises in the course of their work day! Another example is thoroughly reviewing reports for typographical and other errors (such as forgetting to change a name or case number when using text from a previous report). This may seem mundane, even picayune, but a report with multiple errors undermines the confidence of the recipient that the author spent adequate time and reached sound conclusions, as opposed to rushing through, trying to make a quick buck. When learning a musical instrument, a sport, or a second language, most people wish they could skip all the boring, repetitive stuff and go straight to the exciting parts. But neglect of fundamentals because they are considered boring or trivial generally ends badly. This is as true in forensic psychiatry as in other pursuits.

Forensic training and experience also hone our ability to keep an open mind and search for data to confirm or disprove our working hypotheses about a case. A diligent forensic psychiatrist does not draw conclusions prematurely, and changes her formulation when new data are obtained. I once evaluated a criminal defendant who had written letters to the FBI and the US President regarding a local, personal grievance. This sounds like behavior driven by delusions, but there was no psychosis present. My report explained why the defendant was competent to stand trial, avoiding a trip to the state hospital for restoration, and also the psychological motives for his actions, assisting his public defender in securing a probationary sentence for charges that could have carried prison time.

Of course, there is great value in understanding legal standards, case law, principles of risk assessment, and all the other specifically forensic topics covered in fellowship. The ability, acquired through practice, to think clearly about the medicolegal question being asked, and avoid being led off-track by extraneous factors, can definitely separate a forensically-trained psychiatrist from one who is not, particularly in cases with more gray areas, ambiguities, and complexities.

Readers who have been out of training for a while can undoubtedly think of many other examples of how a forensic psychiatrist adds value. Cases where you changed your opinion in the process of writing up your report, or where it seemed like things were going in a bad direction until you got to the heart of the issue and helped the trier-of-fact understand the true picture. I hope that reading this brief column stimulates you to think about what you bring to the table, and maybe helps you a bit in your approach to teaching if you work with trainees as they build up their own "storehouse of value" to use in their chosen profession.

Finally, how does one maintain one's knowledge and skills? The journey of learning certainly does not end after fellowship. AAPL should be an essential resource for every forensic psychiatrist. Attend AAPL meetings and courses (in person and now online) when feasible, and read the *Journal* and *Newsletter*. That is a solid strategy for making yourself an asset to those who will use your services.

SAVE THE DATE

AAPL 2022
53rd Annual Meeting

October 27-30, 2022

Sheraton,
New Orleans, LA

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 need some advice on how to respond to lengthy detailed discovery requests and do I really need to provide drafts of my reports?

A. Kaye:

A great compound question! Discovery is a pre-trial procedure in which each party can obtain evidence from the other party or parties by means of "discovery" devices such as interrogatories, requests for documents, requests for admissions, and deposition. In Law, "discovery" is the exchange of legal information and known facts of a case. Think of discovery as obtaining and disclosing the evidence and position of each side of a case so that all parties involved can decide what their best options are before deciding to move forward toward trial or negotiate an early settlement.

Over the last 35 years, the detailed requests for records and work product have become longer and more complex. In a recent case, I was asked to provide: the original or any copy of a writing or other form of record-preserving system including without limitation, anything, either typed, printed, handwritten, visually reproduced, electronically generated including computer files, records, lists, papers, notes, memoranda, correspondence, e-mails, schedules, photographs, charts, reports, inter and intra-office communications, recordings, contracts, agreements, invoices, bills and any other forms or preserved information in my possession, custody or control and/or in the possession, custody, or control of my agents, servants, employees, attorneys, or any person acting on my behalf, or of which I have knowledge, whether or not in my possession, custody or control.

The documents I was "required to produce" included but were not limited to: all documents I reviewed; all documents to which I might, did, will, or would refer to in writing a report or formulating an opinion, or might rely on at any deposition or testimony; all medical records associated with the examinee or any other person involved in any way with the case; all correspondence and all electronic correspondence including that between me and any lawyer, expert, treater, family member, or party involved in the case; any notes, memoranda, or other materials related in any way to the case; any documents produced by anyone else about any person/party involved or potentially directly/indirectly or peripherally in the case; any and all work product generated by me with any potential relevance to the case; all invoices related to work in the case; all notes taken while evaluating the litigant or anyone else evaluated for any reason; a copy of any tests administered including test booklets and answer sheets with raw scores; all engagement agreements; a listing of all forensic cases in which I have had any involvement at any level in the last five years, including but not limited to the names of the parties, the lawyers with a designation of who hired me, the judge, court, and case citation, a summary of my opinion and the results of the case; and a copy of any/all articles, journals, texts, treatises, writing, that forms any portion of the basis of any opinion to which I might testify at any level of the case. I was also asked to provide copies of any testimony in any and every case in which I have ever had any role and a copy of every article or publication I have ever authored, co-authored, or reviewed. Of course, a full accounting of any research into the topic of the case was expected and copies of all articles and materials I read regardless of their influence on my opinions.

Finally, I was asked to produce copies of anything that I might use at trial including but not limited to: diagrams, models, photographs, videos, drawings, images, films, scans, X-rays, electronic media, and enlargements of any page or portion of any record or reference material that may form any part of the basis of any of my opinions or be used in any way to proffer testimony or to explain any opinion to the trier of fact.

Clearly, this was overreaching! After catching my breath, I called the retaining lawyer and expressed my dismay at being asked to provide a copy/proof of everything I have ever read in my nearly 40 years of medical education and life-long learning. The patient lawyer, donning her hat as councilor-at-law, calmed me down, and explained that the rules in the state in which the case was calendared did not allow for such an "overly broad" request and clarified what actually needed to be produced: my notes (if I had any), my report, and, if I had them, any references on which I relied for this specific case. She further clarified that only if the case was to go forward to trial would we be discussing courtroom exhibits.

So, what must an expert typically provide as part of discovery and how is this best done? Certainly, expect that a copy of any written correspondence, electronic correspondence (if available) and report(s) issued will be discovered as are any test results for tests you ordered or conducted. If you keep billing records for a case these will generally be discoverable but not everyone keeps these records once a bill is paid.

If you relied on or cite specific ar-

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Ask the Experts

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ticles, books, and references you can be asked to provide copies, although I usually don't and tell the lawyer that the other side can obtain these public materials at their time and expense and that I won't, so long as I provide the correct citations. Testing answers are fair game, but many test questions or booklets are proprietary and many courts have upheld the right of the expert and testing company to not provide the actual questions or scoring algorithms. I do not generally provide a copy of everything I have reviewed as it all came from retaining counsel so they have it and they can share it with the other side. I also think it's important NOT to give discovery materials directly to the other side (such as *duces tecum* materials at depositions). I almost always give my materials to the lawyer who retained me, for transmittal to the other side as appropriate, allowing them to remove items they believe aren't discoverable.

As for "draft" reports, there are substantial differences from state to state regarding these being discoverable. Therefore, you need to know what are the rules or precedents. Today, many of us don't have drafts as we create an initial document in word-processing software and simply continuously edit until it is finalized.

A. Glancy:

Hamlet contemplates the pain and unfairness of life: "To be or not to be? Whether tis nobler in the mind to suffer the slings and arrows of outrageous fortune, Or to take arms against a sea of troubles, And by opposing end them." (1)

One of the facets of a career in forensic psychiatry is that there are times when we must endure the slings and arrows of the various parties of the legal system. To a certain extent we are in the hands of lawyers in the system and we have to accept that this is the case. Sometimes, as Dr. Kaye has pointed out, lawyers try to intimidate and bully us, and one of the ways of doing this is to make unreasonable requests. As Dr. Kaye points out, generally speaking, the retaining lawyer can deal with these issues and save us from unnecessary burdens.

Nevertheless, it is incumbent upon us to retain all of our records in a psycholegal case. This may include any handwritten or typed records of interviews with an evaluee or other interested parties. It may also include copies of billing documents or invoices. The issue of draft reports is an interesting one. Whether or not draft reports have to be produced is dependent upon the rules or precedent in each particular jurisdiction. As Dr. Kaye points out, many of us in this day and age add incrementally to a report in a computer file as various sources of information come into our possession. For instance, when a collateral source contacted me, I may add a section on that interview. The issue really is whether the retaining lawyer has influenced you to change your report. Hopefully you can be convincing about this issue. It might be possible to get ahead of this and assure the parties that of course you would never change your opinion due to pressure from the retaining lawyer, but you did add to the report as information came in as we have discussed above. If you have changed the report, it is not unreasonable again to explain that yes, you did make some changes because the lawyer pointed out some of the dates or facts were mistaken or not in evidence and so you removed or changed certain points. If this is the case you would of course have some record to jog your memory of what changes were made, and you would have to expect some questions about this in deposition. It may also be helpful to ensure that you retain any billing documents or invoices, which are often raised either in depositions or at trial, generally with the inference that you would say anything considering the amount that you have been paid. You will of course try to make the point that you are paid for your time, just like everybody else in court, but not for your opinion.

In a recent case, I made what some may consider a rookie mistake. I was entering the second day of virtual cross-examination on a difficult case, which split the cross-examination into one day in December, followed by one day in January, followed by one day in February. In order to keep track of where I thought counsel was going, I made some handwritten notes at the end of the first day and had them in front of me ready for the next day. The perspicacious counsel noticed me shuffling pieces of paper and asked me what was in front of me. Under oath, I had to tell him the situation and of course he demanded to see the notes. Since I was testifying virtually from home, I had to scan the notes and send them to the parties and wait for him to cross-examine me. The notes were to remind me of the crucial points that I wanted to hammer home-including the unreliability of the history given by the evaluee, the tendency of the evaluee to control information, and the fact that these issues supported my contention that he suffered from psychopathy and antisocial personality traits. I was, rather cynically, duly cross-examined about this, but I believe that it only strengthened my position in the end, because I was able to repeat these points yet again. There is, nevertheless, a lesson to be learned from this: if you're going to be a forensic psychiatrist, you have to learn to suffer the slings and arrows of outrageous lawyers and to ensure that you do not let it get to you and throw you off your stride.

Take Home Points:

The rules of discovery are determined by each state and codified. Like many things in forensic psychiatry, it is critical to know the rules specific to the jurisdiction. It is appropriate to ask the retaining lawyer about discovery rules applicable to the case and we advise so doing.

Reference:

(1) Shakespeare W. Hamlet. Act 3, scene 1

Addressing Sexual Violence and Gender Discrimination: Moving from Institutional Betrayal to Institutional Courage: Jennifer J. Freyd, PhD

Karen B. Rosenbaum, MD

The Friday October 22, 2021 virtual lunch-time speaker for the 52nd AAPL conference was Dr. Jennifer Freyd, a Professor Emerita of Psychology, University of Oregon; an Adjunct Professor of Psychiatry and Behavioral Sciences in the School of Medicine at Stanford University; and the Founder and President of the Center for Institutional Courage. (1) Dr. Freyd is an expert in memory and trauma and is also the editor of the *Journal of Trauma and Dissociation*. She is the author of *Betrayal Trauma: The Logic of Forgetting Childhood Abuse*. She developed and published her theories of institutional betrayal and DARVO, which stands for Deny, Attack, Reverse Victim and Offender. This is a common psychological strategy employed by those accused of abuse. The abuser claims that he or she or the institution is the actual victim in the situation, attempting to reverse the reality for the victim and the offender.

Dr. Freyd began her talk discussing Betrayal Trauma and Betrayal Blindness, using the example of Frank Fitzpatrick, who after nearly thirty years uncovered memories of having been molested by Reverend R. Porter. A *New York Times* article from July 21, 1992 used this and other cases to illustrate the controversy surrounding uncovered childhood memories. (2) Dr. Freyd proposed that the reasons individuals forget or are unaware of past abuse is due to betrayal trauma. She asked that we consider our sensitivity to betrayal. The ability to evaluate trustworthiness is highly important to our survival. We depend on social contracts and we are harmed by cheating and betrayal. She said that when empowered, people have exquisite sensitivity to cheating and betrayal.

Regarding Betrayal Trauma theory, humans are profoundly dependent on others. The attachment system protects the dependent person. The baby has a "job" which is to engage love and to be loveable. The child rewards the engaged parents with eye contact, cooing and hugs. The attachment system is biological. With varying degrees, dependence and attachment continue throughout life including in school, in the workplace, and toward one's country.

The question becomes: What happens when the caregiver is also the betrayer, and what does the dependent person do when betrayed? The dependent person cannot afford to feel betrayed by the person or institution the person is dependent on and so there is a conflict. This conflict can lead to "betrayal blindness." Unawareness and forgetting are sometimes an adaptive response to betrayal. The dependent person cannot see something right in front of their eyes that is apparent to others. In the short run, this ability helps with survival but there is a long-term cost.

Dr. Freyd explained that Betrayal Trauma theory suggests that there are two primary dimensions of traumatic events. She showed a graph where social betrayal (low to high) was on the Y axis and terror/fear-inducing (low to high) was on the X axis. Examples given that were high in social betrayal and high in terror/fear-inducing were: sadistic abuse by a caregiver and the Holocaust. Dr. Freyd asked if rates and symptoms of forgetting depended on these dimensions. She explained that twenty-plus years of research has shown that high betrayal is associated with increases in symptoms of forgetting, unawareness, not telling; depression; anxiety; shame; PTSD, dissociation; physical illness; hallucinations; self-harm; problematic substance use; and revictimization. Dr. Freyd also found that women/girls are at higher risk than men/boys of betrayal exposure.

Dr. Freyd then asked the question, can institutions betray? And if so, is it harmful and is there institutional betrayal blindness? She defined institutional betrayal as institutions harming those dependent on the institution which includes the failure to prevent or respond supportively and creating an environment in which the experience was more likely to occur. Dr. Freyd and her colleague Dr. Smith developed the Institutional Betrayal Questionnaire. (3) They found that institutional betrayal exacerbates trauma symptoms including anxiety, dissociation, sexual problems, and sexual-abuse related symptoms.

Dr. Freyd and colleagues also found that institutional betrayal exposure and then staying in the institution is also associated with dissociative symptoms (unawareness, forgetting) even when controlling for the betrayal trauma exposure. She explained that institutional betrayal is also associated with racism and homophobia and that it is costly for the institutions perpetrating the betrayal. People disengage from the system, it leads to illness, absenteeism and high rates of turn-over. There is a loss of potential talent. There is internal rot, corruption, and eventual collapse. There is also a reputational cost. Not trusting institutions has risks for democracy and society as a whole.

The harm of institutional betrayal is both pragmatic and psychological. An example of pragmatic is: There is lead in the water when the government says there is no lead in the water. But institutional betrayal also hurts feelings. Dr. Freyd's solution is to make institutions more trustworthy as people cannot help being vulnerable and loving institutions. It goes back to the attachment system discussed earlier. An example given was that after a rape allegation in March of

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Freyd Lunch

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2014 at the University of Oregon, the university had prioritized its athletic reputation over students' safety and let the basketball team (including the accused members) compete in March Madness. The students pushed the university to make changes and apologize and a survey showed that the changes helped.

Dr. Freyd also showed that there is an association between COVID risk and risk for sexual harassment at universities. COVID risk practices were associated with misogyny and gender/based violence and harassment more than with personality disorders or rule-breaking behaviors.

Dr. Freyd discussed the problem with reporting, and how without reporting it is difficult to stop assault and harassment. Victims often do not report: reporting is risky, due to potential harmful responses such as blaming, invalidating, and punishing. Her research on DARVO helps illustrate this. Deny: "it never happened;" Attack: "you're a liar;" Reverse Victim and Offender: "I'm the real victim." (4) Regarding mandatory reporting, the research suggests that taking away control of disclosure of information is harmful to survivors of sexual violence. Dr. Freyd suggested that a better policy is survivor-directed.

Dr. Freyd discussed institutional courage and ten steps to promote institutional courage:

1. Comply with laws and go beyond mere compliance, beware risk management mindset
2. Educate institutional community (especially leadership)
3. Respond well to victim disclosures (and create a trauma-informed reporting policy)
4. Bear witness, be accountable, apologize
5. Cherish the truth-tellers
6. Conduct scientifically sound anonymous surveys
7. Regularly engage in self-study
8. Be transparent about data and policy
9. Use the organization to address the societal problem
10. Comment on on-going resources to 1-9

In the Question and Answer session, Dr. Freyd explained that the more prestigious the institution, the more potential it has to commit institutional betrayal, including responding poorly to a whistle-blower or accusation. There was a question about medical errors and Dr. Freyd explained that research has demonstrated that when institutions show courage vs. betrayal it is better for patient outcome. She explained that apologies are very powerful. People are afraid of lawsuits, so they do not apologize, but they are more likely to have to deal with a lawsuit if an apology has not occurred. When asked how to get an institution that has harmed through betrayal to apologize, Dr. Freyd suggested that the survivor draft the apology on behalf of the institution. The very act of drafting the apology can bring a kind of psychological relief; also, often the institution does not know where to begin, and a draft can give them something to work with. An apology that is carefully worded and meets the need of the victim for acknowledgment without putting the institution at terrifying legal risks can be very powerful.

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What is the NCCHC?

Joseph Penn, MD, CCHP, FAPA
AAPL Representative to the National Commission on Correctional Health Care (NCCHC)

The NCCHC provides voluntary accreditation and technical assistance to jails, prisons, juvenile, and opioid treatment programs within correctional facilities in the United States. I serve as the AAPL representative to the NCCHC Board of Directors, a multidisciplinary group composed of over 30 different professional member organizations [this includes the AMA, both APAs (psychiatrists and psychologists), ABA (bar association), ADA (dentists) to name a few].

The NCCHC jail, prison, juvenile, mental health, and opioid treatment standards are reviewed and updated every 3-5 years. The juvenile and mental health standards are now up for revision/review. I have been invited to serve on both work group revisions. I recently chaired the juvenile standards work group and look forward to the mental health standards revisions, anticipated to begin in the Spring 2022. I chaired the NCCHC Board until the Fall 2021 meeting, and am now serving as the immediate past chair.

NCCHC holds three conferences per year, the spring and fall conferences and a summer conference with a mental health focus. NCCHC also oversees the peer-reviewed *Journal of Correctional Health Care*, the nation's only professional journal dedicated to scholarly inquiry in this field.

NCCHC has a certified correctional health program (CCHP) program for individuals who have demonstrated mastery of national standards via a written examination. The CCHP-MH (Certified Correctional Health Professional-Mental Health) is an opportunity for correctional and forensic psychiatrists, psychologists, and other qualified mental health professional staff to pursue this additional certification.

For more information, go to www.ncchc.org.

Taking the BITE out of Disinformation and Cult Effects in the Time of COVID

Karen B. Rosenbaum MD; Susan Hatters Friedman, MD; Ryan Hall, MD; and Cathleen Cerny-Suelzer, MD
Media and Public Relations Committee

This panel discussion was presented at the 2021 Annual Meeting. Dr. Rosenbaum presented an overview of the problem of disinformation and how it can lead to indoctrination into cults which can come in many forms including multi-level marketing (MLM) scams or pyramid schemes, exemplified by the recent example of the clothing MLM LuLaRoe, documented in the Amazon Prime four-part series *LulaRich*. (1) She explained how disinformation is different from misinformation (false information) because it is purposely meant to fool or deceive the receiver of the false information. She went through several examples of ways in which disinformation has led to cult involvement. The belief that a group has the answers to someone's underlying issues can be compelling to a vulnerable person, which was the initial premise of NXIVM led by Keith Raniere, who was called "Vanguard" by his followers and was recently sentenced to 120 years in prison for sex trafficking and racketeering, among other federal crimes. (2)

Next, Dr. Hatters Friedman discussed disentangling false beliefs from psychotic delusions. In reviewing the history of the concept of delusions, it was noted that historically, as reality was constructed by the insider group, indigenous people were believed to have false beliefs. By 1980 in the DSM-III, delusions were considered mainly as an individual belief due to incorrect inferences about reality. In contrast, Wernicke first described an 'overvalued idea' in 1892 and viewed them as ego-syntonic and of lessened intensity. Overvalued ideas are not usually accepted by other members of the culture or sub-culture. Rahman and colleagues (3) described "extreme overvalued beliefs" as beliefs which may be amplified and more dominant over time, for which there is intense commitment, and which is shared by others in the person's subcultural group. Pierre (4) discussed "delusion-like beliefs" which only superficially resemble delusions, such as conspiracy theories. The "Incel" subculture was discussed as an example, and recommendations were made, including that evaluators become familiar with both the beliefs and the lingo of the subculture as well as considering whether the evaluee has any non-delusional symptoms of a psychotic disorder. (5) Finally, Pierre (6) suggested that in identifying delusions, the evaluator consider the evidence or explanation given for the belief, whether the belief is self-referential, and whether there is overlap.

Dr. Hall discussed the current state of journalism. In his view, of significant concern is the fact that confidence in news journalism has been decreasing over the last 20 years. Although there may be a greater divergence in trust based on political parties, the overall trends for members of both major parties have been a decrease. Per the Pew Research Center 2020 data, only 39% of the United States' population have a fair amount to a great deal of confidence that journalists will act in the best interest of the public. (7) Although this is down some from 2018, it may represent aspects of the COVID-19 pandemic (In 2018 41% felt a fair amount of confidence, 15% a great deal). The overall trend has been downward for many years. Part of this decrease may also be related to views of journalistic ethics, with a majority of US adults identifying that journalists have either low or very low ethical standards.

According to the Gallup Poll reported on October 7, 2021, the highest percentage of trust and confidence in "mass media such as newspapers, television, and radio" occurred in 1976 at the height of the Watergate scandal, with 72% of the country reporting that they trusted news sources. (8) At that time, again, the majority of the population felt that media were reporting the news fully, accurately, and fairly. In contrast, the most recent numbers in the Gallup Poll for 2021 show that only 36% of Americans view the media in such a manner. This is the second lowest, with the lowest being 32% in 2016. However, the news media has consistently been below a 50% rating in the Gallup Polls since roughly 2005. This is concerning because this suggests that over the past sixteen years, more Americans distrust the news media than trust them, which suggests that there may be an entire generation of individuals who are raised with this view and perspective. This new reality will make it harder to provide or identify trusted news sources and makes it more difficult to dispel myths or conspiracy theories. Similar trends have been found in other democracies as well. (9)

Dr. Cerny-Suelzer explained why it is necessary to provide our trainees with guidelines for evaluating what they read in print and online so they can separate fact from fiction and help their patients do the same. Forensic psychiatrists do not have the luxury of burying our heads in the sand and hoping that this "infodemic" resolves without our active participation in combating disinformation. The World Health Organization has a list of tips for spotting fake news that provide a useful framework for learners at any level. (10) Going beyond provocative headlines and self-assessing for bias are key. Resisting oversimplification and doing additional background research are also helpful recommendations. (11) These guidelines can be used in psychiatric training journal clubs and applied to information from popular media sources.

Forensic psychiatrists also need to give trainees guidance for patient interactions. The use of open-ended questions should be encouraged. Trainees need to ask about early life experiences, trauma and important relationships. It is important to provide

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Taking the BITE

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residents and fellows with instruction on how they can help their patients with decision-making skills including sharing how to evaluate information they are presented with.

As forensic evaluators, identifying fake news and gathering full histories are crucial skills, but it is also crucial to understand the forces responsible for the false narratives. Malignant narcissists exercising undue influence over unwitting victims do exist, and some of us may end up evaluating them or their victims. Dr. Steven Hassan's BITE model provides a helpful framework for this effort.

Dr. Hassan, discussant, began by acknowledging that we do NOT live in a "post-truth world." He discussed the model he developed to explain authoritarian control, the 'BITE model,' for behavioral, informational, thought, and emotional control. (12) He explained that someone exerting this control is exercising undue influence and mind control. He explained that being influenced can happen to anyone who is in a vulnerable place, and he used his own story about when he was young and three smiling women approached him after he had been "dumped" by his girlfriend, and he subsequently joined the "Moonies," believing Sun Myung Moon was the messiah.

Dr. Hassan explained that in the 21st century, of the four means of control, informational control is the most important to consider. In recent years there have been widespread lying, withholding or manipulation of information, propaganda, and using information against one another. Dr. Hassan discussed how he created a three-step intervention called the Strategic Interactive Approach (SIA) where he helped create a network of trained individuals (family, friends, ex-cult members, media, clergy, and therapists) to orchestrate a step-by-step, ethical influence program to empower an individual or set of individuals to think for themselves.

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Public Safety and Unrestorability: What is the end game?

Stephanie Maya Lopez, MD
Forensic Hospital Services Committee

In Oregon, the detention period for competency restoration is three years or the maximum potential sentence for each alleged crime, whichever is shorter. If a defendant is found to be incompetent to stand trial and not restorable (IST/NR) at or before the end of this period, all charges must be dismissed with or without prejudice and the defendant released. While civil commitment proceedings can be pursued, the bar is high and requires a finding of dangerousness "in the near future," a standard that has been interpreted by appellate courts to be dangerousness that is both high and imminent. (1)

As the census at Oregon State Hospital (OSH) swelled with defendants committed for trial competency restoration, some of whom were charged with dangerous crimes that outraged the public, there was concern that dangerous defendants would be released into the community without treatment and supervision. In response to this concern, Oregon Senate Bill 426 was introduced in the state legislature in 2013. A public letter from the City Manager's Office in Eugene, Oregon explains the rationale:

> As recent events have underscored, Oregon's justice system needs work in this area, particularly with respect to dangerous or homicidal offenders who are released from custody after being found "unable to aid and assist" in their own defense... SB 421 and SB 426 are an attempt to improve Oregon's statutory interface between the criminal justice system and dangerous offenders who are mentally ill. (2)

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Public Safety

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The letter also provided an explanation of the rationale for extending due process review to two years because extension avoids "meaningless reviews that are difficult for the offender, and or victims and their families." (2)

The bill became law, creating the Extremely Dangerous Person Commitment (EDPC), on August 1, 2013. It allows for the commitment of a defendant who is found at a clear and convincing level to be "extremely dangerous" with a treatment-resistant mental disorder and who, "because of the disorder that is resistant to treatment, the person committed one of the following acts…." defined as six categories of serious person-on-person offenses. The court is required to make a finding as to whether the person is too dangerous to be supervised and treated in the community. All commitments, regardless of treatment setting, are overseen by the state's Psychiatric Security Review Board (PSRB). The individual under petition and later, commitment, is given due process rights, such as the right to a hearing at the time of petition, a subsequent hearing with the PSRB within 180 days after commitment, and every two years thereafter. (3)

The United States Supreme Court case *Jackson v. Indiana* states, "[A] person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than a reasonable period of time necessary to determine whether there is substantial probability that he will attain capacity in the foreseeable future. If it is determined that this is not the case, then the State must either institute the customary civil commitment proceedings that would be required to commit indefinitely any other citizen, or release the defendant." (4) Drs. Bloom and Kirkorsky observed that "If the process outlined in *Jackson* were followed in every case…all individuals found IST/NR would have all charges dropped and would be released, with or without prejudice, or civilly committed under the same civil commitment rules that apply to all citizens of the state. If the charges were dismissed without prejudice, they could be reinstated at the discretion of prosecutors at any time within the statute of limitations for the crime charged…." (5) Bloom and Kirkorsky further observed that numerous states developed compensatory methods for prolonging the time allowed for competency restoration in response to the *Jackson* decision, but the determination of IST/NR cannot be avoided indefinitely.

The first EDPC commitment occurred in November 2013. (6) Since that time, 29 individuals have been committed. Data was obtained for 28 of these commitments. (6) The number of commitments has steadily increased, starting with one commitment each in 2013 and 2014. In 2019 and 2020, there were five and four commitments, respectively. As of this writing in early November 2021, there were five commitments for the year so far. Of the data for 28 commitments between 2013 and July 2021, all but one were deemed too dangerous for treatment in the community and committed to OSH. Of the 13 orders containing a diagnosis, 12 of them listed a primary psychotic disorder. Fifteen of the 28 orders were for having caused the death of another person, 10 were for having injured another person with a weapon, one was for a sexual offense against a child under the age of 14, one was for a sexual offense against a person aged 14 or older, and one was for causing a fire or explosion that resulted in property damage or placed another person in danger of physical injury. Five of the committed persons are now living in a community setting under PSRB supervision, and 19 of them are at the Oregon State Hospital. Three have been released from supervision altogether, and there was one death. (6) In 2021 there was a 29th commitment, which did not go through the IST/NR process; this person is on the waitlist for admission to OSH (7).

That nearly all defendants were initially sent to OSH is not unexpected. What is surprising is that only five of them are living in the community under supervision. By contrast, approximately two-thirds of defendants in Oregon found not criminally responsible are living successfully in a community setting under PSRB supervision (including those charged with murder). Although defendants who are so symptomatic as to be unrestorable may be less likely to be candidates for community supervision, this also may suggest that there may be a higher bar for release into community supervision for those committed via an EDPC.

The fact that only three of them have been released from supervision raises constitutional concerns, as it suggests that the EDPC may effectively become a lifetime commitment for many. An important practical concern for the patient is that charges can be dismissed without prejudice, and therefore the patient may face a trial if competency is ultimately restored. This can potentially create an incentive to remain symptomatic.

Commitment for a dangerous act because of a treatment-resistant disorder is akin to a *Durham* product test or "but for" standard for insanity, and thus may have created a lower bar for an EDPC than for the American Law Institute's Model Penal Code standard, which is used in Oregon (8, 9). Will this create an ethical quandary for defense attorneys who must act as vigorous advocates for their clients as they pursue the least harmful defense? (In other words, should the attorney try to ensure that their client is not restored to competency, so they don't have to meet the higher burden of an insanity defense?)

The data thus far represent a small number of individuals, and long-term trends are unknown. While the EDPC may serve to protect public safety, it raises significant questions regarding its constitutionality, as well as ethics concerns for those defending people who may be subject to it.

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People v. Sanchez: Hearsay Evidence and Expert Witness Testimony

Viviana Alvarez-Toro, MD; Michael MacIntyre, MD; and Charles Scott, MD
Judicial Action Committee

On October 16, 2011, two officers patrolling an area of Santa Ana, California known to be associated with drug sales noticed Marcos Arturo Sanchez sitting on an apartment building staircase. Upon making eye contact with him, they stopped their cruiser and got out. After appearing to grab something quickly, Mr. Sanchez ran up the stairs into an apartment. A building resident assured the police that Mr. Sanchez did not live there. The police consequently apprehended him. Outside, they found a loaded gun and a plastic bag, both of which appeared to have been thrown out of a window of the apartment. The bag contained heroin and methamphetamine. Mr. Sanchez was charged with firearm and drug-related offenses, active participation in the Delhi street gang, and commission of a felony for the gang's benefit.

In order to tie Mr. Sanchez' criminal activity to the gang, the prosecution retained Santa Ana Police Detective David Stow as an expert. He had been a gang suppression officer for 17 years, had received formal training in gang recognition and subcultures, and had been involved in hundreds of gang-related investigations. During his testimony, Detective Stow indicated that Mr. Sanchez was a member of the Delhi gang based on the defendant's statements, prior contacts with the police, past association with known gang members, and his current offense. Detective Stow based his testimony solely on police records; he had no personal experiences with the defendant.

Mr. Sanchez was convicted on all counts. On appeal, the California Court of Appeal reversed his conviction for active gang participation and affirmed the other convictions. Mr. Sanchez then petitioned the Supreme Court of California for review. In its decision, it addressed the question: to what degree can an expert rely on case-specific hearsay to form an expert opinion?

Mr. Sanchez argued that the police records Detective Stow relied upon constituted testimonial hearsay because they had been considered truthful. He added that admission of Detective Stow's testimony violated his Sixth Amendment rights because the declarants who prepared the police reports were not unavailable, and he was not given the opportunity to cross-examine them. The California Attorney General responded that the statements Detective Stow relied upon were not admitted for their truth, were not testimonial, and were therefore admissible.

The California Supreme Court held that the case-specific information relied upon by Detective Stow was inadmissible hearsay, given that he had presented them as true without proper, independent verification (1). In addition, the court held that the admission of this testimony was not harmless, and reversed the gang-related enhancements to his convictions.

The Court relied on both state law and case law to reach its decision. As defined by the Court, hearsay is "an out-of-court statement offered for the truth of its content." Conversely, when considering admissibility of expert opinions, experts traditionally have been granted some leeway when relying on hearsay, particularly when it has contributed to general knowledge in their field of expertise. However, experts are not typically allowed to rely on unverified case-specific facts and assume their truthfulness when forming their expert opinion. In this case, the Court found that the police information Detective Stow relied upon was case-specific hearsay, and that he had assumed their truthfulness when forming his opinion. The Court also cited *Crawford v. Washington*, where testimonial hearsay was deemed inadmissible as a violation of the Sixth Amendment right to confront and cross-examine witnesses. (2)

Currently the *Sanchez* ruling applies to expert testimony in California, so whether other states will adopt it remains to be seen. However, for California experts, this ruling makes clear that an expert cannot present case-specific facts as true when they are simply asserted in hearsay statements. They must be independently proven by competent evidence or covered by a hearsay exception.

The expert can avoid relying on hearsay by obtaining firsthand knowledge of case-specific information; she may simply ask the evaluee for a personal account of events known through collateral reports. For example, if non-admissible records document an evaluee's medication non-adherence, the interviewer can explicitly ask the evaluee why they refused treatment. That direct knowledge would then be allowed as a basis for an opinion.

Building a strong database of information requires that the expert be familiar with collateral data prior to the evaluation. Knowing what hearsay evidence may affect one's opinion allows an opportunity to verify relevant facts specific to the case.

Nonetheless, there may be situations where the expert is unable to verify case-specific facts. For example, the evaluee may claim they do not remember, or deny information in the record. In these circumstances, the expert should work with the retaining attorney to ensure relevant collateral evidence is admitted through a business record exception that allows the introduction of medical records developed as a standard part of business practice. The expert should provide the attorney with specific information about the medical record that is relied on to render an opinion, including the date and author of the note.

Given the relevance of the *Sanchez* ruling to forensic testimony, forensic psychiatrists outside California should be on the alert for court rulings that apply a *Sanchez*-like approach to the admissibility of hearsay testimony.

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Forensic Training of General Psychiatrists with International Backgrounds

Eri Shoji, MD and Astik Joshi, MD
Forensic Training of Psychiatry Residents Committee

As of 2021, 13.7% or about forty-five million people in the US were born in another country. (1) Physicians trained abroad (or "international physicians") who migrate to the US form a substantial component of the physician workforce, thus, broadly impacting the healthcare system in the country. According to a database of the Association of American Medical Colleges, one in four physicians currently practicing medicine in the US graduated from a foreign medical school and 30.4% (11,800 of 38,792) of active psychiatrists are International Medical Graduates (IMGs), (2) with 16% (309 of 1904) of the 2021 PGY-1 categorical psychiatry matches identifying as IMGs. (3)

Physicians worldwide often do not adequately understand the US legal system and its applicability in patient care. International physicians gain significant legal knowledge pertinent to their sociocultural environments during their undergraduate medical education, which may be substantially different from traditional legal education in the US. (4) For example, international physicians may differ in their understanding of the right to liberty and the perception or interpretation of freedom. Some medical systems utilize a more paternalistic approach and discrepancies exist in the shared decision-making model, doctor-patient relationship, and emphasis on patient autonomy. (5) This gap in essential knowledge may lead to unnecessary interruptions in patient care when uninformed international physicians attempt to apply non-US legal concepts in clinical practice.

The World Federation for Medical Education (WFME) recognized the significance of social expertise and published recommendations in its initial Global Standards in 2003. WFME requires medical school curricula to incorporate behavioral and social sciences, medical ethics, and jurisprudence for effective communication, clinical decision-making, and ethical practice. Schools may specifically tailor the content to meet local needs, interests, and traditions. (6-8)

US medical schools have increasingly begun incorporating legal competency into the expected criteria for medical student education. Although the Liaison Committee on Medical Education does not mandate a course in health law, approximately 50 to 80% of US medical schools require some type of education in medical litigation. (9, 10) Curricula often emphasize physician-patient relationships, malpractice, death, informed consent, and capacity as they impact clinical practice. (11) Furthermore, 54% of responding medical schools in a 2019 survey reported integrating criminal justice topics into medical education. (12)

Legal understanding is critical in psychiatry because individuals with mental illness are at greater risk for criminal justice involvement, and there is significant legal regulation of psychiatric practice. The responsibility to provide legal training to the psychiatric trainees ultimately falls on the residency training program. For example, formal legal education regarding the Eighth and Fourteenth Amendments to the Constitution may guide trainees' clinical determinations in emergency psychiatry settings regarding the least restrictive setting for a given patient. Sufficient knowledge about individuals' right to treatment, right to refuse treatment, and capacity for informed consent is also critical to residents' clinical decision-making. Adequate training is particularly salient given the psychiatrist's power in many jurisdictions to restrict an individual's liberty: US physicians participate in and authorize over one million emergency psychiatric detentions per year. (13) A 2006 survey found that 62% of treating psychiatrists directly participated in involuntary commitment proceedings within the previous 24 months. (14)

There are no studies that measure the level of US legal knowledge comparing foreign physicians and US graduates. However, there is evidence that decision-making in medical practice differs between jurisdictions and cultures. (15) Although internationally-educated physicians may be aware of the cultural gap in ethical and legal conventions between countries and jurisdictions, it is through clinical practice that this setting-specific knowledge gap becomes apparent. (5, 16) Regardless of the physician's country of origin or graduation, however, one study demonstrated that 38.3% of psychiatric detentions lacked sufficient clinical and legal justification in physician documentation, highlighting generally inadequate legal education in psychiatry. (17) Unfortunately, there is competition for educational time, and psychiatry residency programs may overlook forensic training.

We propose that psychiatry residency programs take specific measures to address the gap in the legal knowledge of general psychiatry residents who have immigrated to the US. These measures include the formalization of didactic series, which provide:

- Essential information on mental health law and ethics; and
- Training in legal writing relevant to general mental health practice.

Furthermore, programs should adequately inform residents about landmark cases in forensic psychiatry for a deeper understanding of fundamental values underlying current medical practice. We also recommend that program directors take an active interest in training the internationally-educated psychiatric trainees on essential legal matters and their legal writing, which may inspire some to pursue a forensic psychiatry fellowship. In addition, having an elective in forensic psychiatry may enable such residents to further explore forensic topics. These educational interventions will enhance residents' ability

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Annual Conference, 2021, Forensic Faculty, Royal College of Psychiatrists

John Baird, MD
International Relations Committee

The Forensic Faculty of the Royal College of Psychiatrists held their 2021 Conference from March 3rd to 5th. Five hundred and eighty-seven delegates registered for the event, by far the largest number ever, and the conference organiser, Professor Andrew Forrester, put together another lively and diverse program. Last year's conference was in Liverpool and in normal times, this year's would have been in continental Europe. Despite the additional complexities of travel which are a consequence of Brexit, there is every reason to assume that the conference would have been well-attended and a great success both professionally and socially. It is the professional and social exchanges, catching up with familiar colleagues and meeting with new, against the background of a stimulating and sometimes challenging program, which marks out a successful conference. But these, as we all know, are not normal times and the conference was virtual. The large number of registrations however, as Professor Forrester reflected after the event, probably reflects the desire of people to connect, if only on a screen, during this lingering lockdown.

For a few years now, it has been my pleasure, as a member of the International Relations Committee of AAPL, to prepare a short report on the conference and until this year, some colleagues from the Faculty have also generously given of their time to contribute to the report. This year, sadly, there could be no such collaboration and what follows therefore lacks the leavening input of others.

The conference was opened by Dr. Josanne Holloway who, as Chair of the Faculty, was presiding over her first annual conference. Dr. Holloway gave a report on the work of the Faculty Executive Committee over the last year and she was accompanied on the virtual podium by Mr. Alain Aldridge, the Patient Representative, and Ms. Sheena Foster, the Family and Career Representative, who are both members of the Faculty Executive and who each gave short presentations helpfully setting out their perspectives. Completing an engaging opening session were the Dean of the College, Dr. Kate Lovett, and the President of the College, Dr. Adrian James, who gave concise and informative reports on their priorities.

There then followed the academic program itself with speakers mostly seated in their offices or living rooms in the UK, Australia or North America. The sessions on the first day dealt with the assessment and management of serious sexual offenders, alcohol-related violence, and autism. A feature every year has been a formal but lighthearted debate on a controversial issue, and this year, very topically, the motion was 'This House believes that Tele-Health.... leads us to trade psychological depth for convenience'. The practice is to take a vote at the start of the session for or against the motion, listen to the speakers and the debate and then take another vote and record the change, if any. This year, before the vote, the audience supported the motion by a comfortable margin but after the debate, the vote was to oppose it by a narrow margin. Almost 200 votes were cast each time. I leave it to you to decide where you would stand on this important question.

In a prerecorded session, three medical students presented on the topic of their entry in the student essay competition. This event has become a regular feature of the conference for long enough now that some of the former student presenters are now consultants in the specialty. Something to consider for the AAPL Annual Meeting?

Among highlights on the second day was a thought-provoking session on the assessment of those who have recently been arrested and who are in police custody. Major mental illness, acute physical conditions and questions of competence and vulnerability can arise and the assessments are often undertaken by doctors with a background only in primary care. I do not know details of the systems in place in the US for these assessments. In another session, judicial attitudes to sentencing were examined during an engaging discussion between Professor Pamela Taylor, the outgoing Chair of the Faculty, and Her Honour Judge Rosa Dean. The relatively informal format worked very well, l thought.

Topics away from forensic practice are always welcome and we were treated to a session on the medical implications of COVID, all the more appreciated because what was presented could be described as the pandemic without the politics or the panic. We learned that there are clear links with a number of medical conditions, but three which are emerging strongly from follow-up studies as being particularly linked to COVID infection were stroke, encephalopathy, and PTSD. Undoubted highlights on the third day were presentations on the challenges of adolescence, the inevitability of bias in expert witness testimony and the trauma which is so often in the background of referrals to a prison in-reach service.

There was a lot more too, and a short summary could never do justice to all the presentations. Overall, the academic content of the conference was up to the usual high standards and the arrangements for virtual attendees were excellent. But nothing can substitute for the experience and impact of a proper conference and barring anything unforeseen in the interim, normal arrangements will resume for 2022. As ever, AAPL members will be made most welcome.

Diversity Committee Hosts Town Hall Meetings on Increasing Equity in AAPL

Charles C. Dike, MD and Ren Belcher, MD
Diversity Committee

2020 was a turbulent and challenging year, marked by the tragedies and disruptions of COVID-19 and racial upheavals around the world. At its close, the AAPL Diversity Committee took on the task of bringing to life AAPL President Dr. Liza Gold's vision of focusing on inequities within AAPL, especially as they related to ethnic and racial minorities. As the Committee planned a town hall to begin public discussion of these inequities in our organization, it became clear we would need more than one event, and a second town hall meeting was planned to discuss LGBTQ+ inclusion.

On April 28, 2021, AAPL members and guests participated in a forum moderated by Charles Dike, Chair of the Diversity Committee, and Reena Kapoor, member of the committee. Dr. Dike opened the town hall by thanking current AAPL president, Liza Gold, whose vision, enthusiasm, support, and dogged determination made the project possible. He remarked that Dr. Gold had joined a select group of recent past AAPL presidents in putting a spotlight on diversity issues at AAPL. These include Dr. Emily Keram, who in her presidency year in 2017 established the Diversity Committee as separate and distinct from the Cross-Cultural and International Relations Committees, both of which were already in existence. Later, in 2019, Dr. Will Newman constituted a presidential advisory committee on racial inequities and discrimination, out of which several recommendations were made to AAPL's Executive Council. In addition to the efforts of these AAPL presidents, Dr. Dike highlighted the excellent works of multiple AAPL scholars such as Drs. Ezra Griffith, Rick Martinez, Phil Candilis, Mike Norko, Alec Buchanan and many others who have tackled social justice issues in their writings and thereby elevated the status of AAPL in these regards. He observed that despite these rays of progress, however, AAPL still had a long way to go to become as diverse and inclusive as we would like and to demonstrate equity in all its activities.

Dr. Dike then defined the goals of the town hall meetings: to increase diversity and inclusion in AAPL by addressing factors that have negatively impacted AAPL members of color, as well as to recognize, support, and nurture existing underrepresented members of AAPL.

Speakers at the inaugural town hall were Dr. Ezra Griffith, Professor Emeritus of Psychiatry and African American Studies at Yale University, to speak on the African-American experience at AAPL, and Dr. Carolina Klein, Chief of Forensic Services at Napa State Hospital, to speak on the Latinx experience. Other panelists included Dr. Cheryl Wills, Associate Professor of Psychiatry, Case Western Reserve University and chair of APA's Structural Racism Task Force (SRTF), and Dr. Jagannathan Srinivasaraghavan (Ashok Van), Professor Emeritus of Psychiatry at Southern Illinois University School of Medicine.

Dr. Griffith began his remarks by acknowledging the challenges facing Black and ethnic minorities in AAPL, but in typical fashion, he immediately segued into offering an approach to addressing the complex underlying issues. He highlighted the importance of curiosity in understanding diversity and inclusion. This includes listening with openness and speaking with thoughtfulness and wisdom. He offered that curiosity should be bidirectional and intended to facilitate bilateral understanding one of the other. This difficult task of bidirectional reflection with a desire to learn, and without any preconceived notions or judgement, is a necessary ingredient in addressing the challenging issues of diversity and inclusion.

Dr. Klein began her presentation by lamenting the dearth of Hispanic psychiatrists, along with the current decline in medical school enrollment among Latinx students. She opined that efforts to increase equity and diversity in AAPL must necessarily include a multipronged approach – engagement through outreach, innovation, integration, and creating a welcoming and comfortable environment with individually tailored opportunities.

These brief presentations were followed by robust discussions stimulated by questions from audience members. Some of the questions addressed by the panel included: What should AAPL senior leadership do to address what some have termed an "old boys' club" that does not value racial diversity or care about issues related to race? How can AAPL senior leadership address this in a way that does not overly burden members of color/make members of color responsible for doing the "heavy lifting" of diversifying AAPL and changing how AAPL is perceived? How would AAPL explain why the low numbers of AAPL members of Asian descent do not reflect the high numbers of Asian/Asian-American forensic fellows? Do we think social justice, discrimination and bias issues should be taught in fellowship? If so, how would we recommend program directors approach them? What lessons from Dr. Wills' experience as chair of APA's SRTF can be applied to AAPL?

On June 24th, 32 AAPL members and guests gathered for the second committee-sponsored town hall, addressing LGBTQ+ diversity within the organization. Dr. Charles Dike and Dr. Elie Aoun delivered introductory remarks. The first speaker, Dr. Jack Drescher, outlined the history of LGBTQ+ psychiatrists, highlighting several landmark moments: the removal of homosexuality from the DSM-II in 1973; the influence of John Fryer, MD, an early openly gay psychiatrist; and the "Committee of Homosexually-Identified Psychiatrists," which preceded an LGBT Caucus within the American Psychiatric Association. He emphasized the historic importance of committees, caucuses, and program tracks pertinent to LGBTQ+ advancement within organized psychiatry, and

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Envy & Extreme Violence

George David Annas, MD, MPH and Adrienne Saxton, MD
Criminal Behavior Committee

Envy generally refers to having ill-will for another because of superior attributes or possessions. This may occur in a multitude of ways. For example, a supervisor with low self-esteem might go out of his way to sabotage one of his employees because he is envious of the person's talent, and feels inferior. However, envy can be the cause of significantly more damaging acts. The 2021 AAPL panel presentation "Envy & Extreme Violence" took a deep dive into this complex and powerful emotion and its relevance to the field.

After a brief introduction by Dr. James Knoll, Dr. Jungjin Kim provided a detailed history of the various ways in which extreme envy has manifested itself throughout history. His talk included a discussion of the "evil eye," a cultural practice as old as recorded time. While used as a general curse for any reason, it is most often attributed to malicious desire due to feelings of inferiority or coveting another's possessions. Hence, it is often referred to as the "evil eye of envy." Dr. Kim also distinguished envy and jealousy.

While the two terms are often used synonymously, there are some important distinctions. The term jealousy can imply being overprotective of what one has, to the point of feeling – and potentially behaving – vindictively towards the person who threatens it. A classic example involves a romantic couple and a third party flirting with one of the partners. This causes jealousy because one party feels threatened by a potential loss. Thus, while envy can take the form of resentment towards a single person for her physical possessions, achievements, or anything that can make someone feel inferior, jealousy often involves a three-person dynamic. As Dr. Knoll described, envy can also be felt towards a group of people, as in the case of mass murderers who turn their rage against subgroups of society or even the world at large.

Following Dr. Kim was Dr. Vanesa Disla de Jesus, who provided an overview of the concept of *schadenfreude*, the delight or pleasure in another's misfortune. She reviewed the evolution, development, and neuroscience of envy, noting that many psychological researchers believe that envy has a benign form. Followers of this topic may wish to explore the psychological research in this area, which helps clarify the subtle differences between benign envy and admiration: the former being associated with self-motivation for positive change and the latter not. (1)

Dr. Jarrod Marks approached envy through the lens of psychoanalysis, an approach that gets less attention in our field than it is often due. He reviewed the theories behind the paranoid-schizoid position and the persecutory mindset that is often seen in Antisocial Personality Disorder (ASPD). In the spirit of robust analysis, Dr. Marks concluded his talk by inviting the audience to imagine with him the possibility of using a psychodynamic approach to treat such individuals – helping them transition from the persecutory mindset to what Melanie Klein referred to as the "depressive position," where one starts taking responsibility for destructive impulses.

Dr. Knoll picked up these themes, noting that envy as a psychological construct can be helpful in understanding some individuals within the corrections system who are chronically angry, externalize blame, and view the world as entirely persecutory. Various developmental factors including adverse childhood experiences may cause one to settle into this "paranoid position." These individuals often become help-rejecting, exhibit poor self-regulation, and ruminate on revenge fantasies. These fantasies may serve the psychological purpose of offering a sense of "pseudo-power" and a brief escape from painful emotions. This can subsequently spiral into a profound sense of nihilism, where life has no meaning, and lead to suicidality.

A similar but significantly exaggerated manifestation of envy is seen in some individuals who commit mass violence. Two psychological constructs that may be found along the path to mass violence include the "obliterative mindset" and a "pseudo-spiritual" transformation. In the obliterative mindset, emotions include rigid fatalism and anger, with the goal of entirely negating a detested situation. To that end, the individual believes that destroying others and the self is required.

The pseudo-spiritual transformation involves attaching spiritual meaning to revenge, further motivating and justifying the perpetrator's actions. The vengeful violence is now a sacred act, the morally correct thing to do. The perpetrator views himself as heroic and as a martyr. Though overvalued ideas may be present, these views are not necessarily psychotic in nature.

Among the cases Dr. Knoll reviewed were those of Seung-Hui Cho, the 2007 Virginia Tech mass shooter, and Elliott Rodger, the perpetrator of the 2014 Isla Vista killings. Using pictures, quotes, and video clips, he described commonalities between them, including envy as the primary motivating factor, their persecutory views of society, the development of the obliterative mindset, and their pseudo-spiritual transformations. Dr. Knoll pointed out the extreme and hyperbolic persecution that both perpetrators felt. Cho's writings included, "You have vandalized my heart, raped my soul, and torched my conscience…" Another quote demonstrated the level of envy Cho experienced: "You had everything you wanted. Your Mercedes wasn't enough, you brats. Your golden necklaces weren't enough, you snobs. Your trust fund wasn't enough…to fulfill your hedonistic needs. You had everything." (2)

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New Disclosure Forms

The ACCME has revised and redefined its conflict of interest standards. Below is an explanation of the new rules. On the next page is a sample form.

Dear Planner/Faculty Member/Presenter/Abstract Submitter:

We are looking forward to having the opportunity to include you as a <proposed role for person—e.g. planner, faculty, reviewer, etc.> in the accredited continuing education, <Insert activity title or working title and date/location information, if appropriate>.

Why am I receiving this communication?

The American Academy of Psychiatry and the Law (AAPL) is accredited by the Accreditation Council for Continuing Medical Education (ACCME). We appreciate your help in partnering with us to follow accreditation guidelines and help us create high-quality education that is independent of industry influence. In order to participate as a person who will be able to control the educational content of this accredited continuing medical education activity, we ask that you disclose all financial relationships with any ineligible companies that you have had over the past 24 months.

We define ineligible companies as those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. There is no minimum financial threshold; you must disclose all financial relationships, regardless of the amount, with ineligible companies. We ask you to disclose regardless of whether you view the financial relationships as relevant to the education.

For more information on the Standards for Integrity and Independence in Accredited Continuing Education, please visit accme.org/standards.

What are the next steps in this process?

After we receive your disclosure information, we will review it to determine whether your financial relationships are relevant to the education. Please note: the identification of relevant financial relationships does not necessarily mean that you are unable to participate in the planning and implementation of this educational activity. Rather, the accreditation standards require that relevant financial relationships are mitigated before you assume your role in this activity.

To help us meet these expectations, please use the form we have provided to share all financial relationships you have had with ineligible companies during the past 24 months. This information is necessary in order for us to be able to move to the next steps in planning this continuing education activity.

If you have questions about these expectations please contact **Marie Westlake (mwestlake@ssmgt.com) or Jackie Coleman (jcoleman@ssmgt.com).**

Liza H. Gold, M.D.

Annette Hanson, M.D.

Co-Chairs, Education Committee

American Academy of Psychiatry and the Law
Standards for Integrity and Independence
Disclosure Form

Name:
Title of Activity:
Date(s) of Activity:

Prospective role(s) in activity (check all that apply):

- ☐ Planner
- ☐ Presenter/Faculty
- ☐ Author/Question-Writer
- ☐ Reviewer
- ☐ Other_____

Please complete this form and return it to the AAPL Executive Office (office@AAPL.org or fax 860-286-0787) upon receipt.

The Accreditation Council for Continuing Medical Education (ACCME) Standards for Integrity and Independence require that we disqualify individuals who refuse to provide the information from involvement in the planning and implementation of accredited continuing education. Thank you for your diligence and assistance. If you have questions please contact us at office@AAPL.org or 800-331-1389.

Please disclose **all financial relationships** that you have had in the past 24 months with ineligible companies (see definition below). For each financial relationship, enter the name of the ineligible company and the nature of the financial relationship(s). There is no minimum threshold; we ask that you disclose all financial relationships, regardless of the amount, with ineligible companies. You should disclose all financial relationships regardless of the potential relevance of each relationship to the education.

Name of Ineligible Company An ineligible company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. For specific examples of ineligible companies, visit accme.org/standards.	**Nature of Financial Relationship** Examples of financial relationships include employee, researcher, consultant, advisor, speaker, independent contractor, royalties, executive role, and ownership interest. Individual stocks and stock options should be disclosed. Research funding from ineligible companies should be disclosed by the principal or named investigator even if that individual's institution receives the research grant and manages the funds.	**Has the Relationship Ended?** If the financial relationship existed during the last 24 months, but has now ended, please check the box in this column. This will help the education staff determine if any mitigation steps need to be taken.
Example: ABC Company	Consultant	☒

☐ In the past 24 months, I have not had **any** financial relationships with **any** ineligible companies.

I attest that the above information is correct as of the date of this submission:

Name: Date:

Medical Testimony: Telling the Truth, the Whole Truth, and Nothing but the Truth

Brandon Simons, Medical Student; Bao Nguyen, Medical Student; Ryan C. W. Hall, MD

For this edition of "In the Media" we examine potential disciplinary outcomes related to medical expert testimony. In April 2021, "Maryland to investigate Derek Chauvin defense witness' tenure as state's chief medical examiner" was published online by Fox News, and "Maryland To Probe Cases Handled By Ex-Medical Examiner Who Testified In Chauvin Trial" by NPR. (1, 2) The articles discussed Dr. David Fowler, a pathologist and the former chief medical examiner for Maryland from 2002 to 2009, who testified that the cause of George Floyd's death was a "sudden heart rhythm disturbance during police restraint due to underlying heart disease." (1, 2) Dr. Fowler, serving as a defense expert, testified that the contributing causes of George Floyd's arrythmia and subsequent death were fentanyl, methamphetamine, as well as possible carbon monoxide poisoning, in contrast to other experts who identified lack of oxygen as the cause of death. (1) Dr. Fowler's opinion has been seen as controversial and lacking in objectivity and potential scientific support by some in the medical community. For example, Washington, DC's former chief medical examiner sent a letter signed by 431 doctors to Maryland's Attorney General, the Maryland Department of Health and other local and national governmental figures such as US Attorney General Merrick Garland, stating:

> The cause of death opinion, particularly the portion that suggested open-air carbon monoxide exposure as contributory, was baseless, revealed obvious bias, and raised malpractice concerns…Dr. Fowler's stated opinion that George Floyd's death during active police restraint should be certified with an "undetermined" manner is outside the standard practice and conventions for investigating and certification of in-custody deaths…Our disagreement with Dr. Fowler is not a matter of opinion. Our disagreement with Dr. Fowler is a matter of ethics. (3)

The Maryland Attorney General's office has begun conducting an investigation into all deaths in police custody reviewed by Dr. Fowler during his tenure as a Maryland forensic pathologist. (1, 2) The letter from the former Washington chief medical examiner also called for examination of Dr. Fowler's medical licensure. (1, 2) It should be noted that although investigations are underway, whether Dr. Fowler has done anything wrong has not been officially determined. Dr. Fowler has also made a public statement that "[My] opinion was formulated after the collaboration of thirteen other highly experienced colleagues in multiple disciplines… [which] set an ethical standard for the work needed in sensitive litigation." (2)

The controversy surrounding Dr. Fowler's testimony highlights potential risks and legal liabilities in practicing forensic work. The practice of forensic psychiatry is considered the practice of medicine even though there is a limited doctor-patient relationship. Multiple professional organizations, such as the American Medical Association (AMA), have taken such a position, hence the concern for negligent medical care or medical malpractice potentially occurring from the work. (4)

An area that forensic psychiatrists need to be aware of beyond potential tort concerns are Board of Medicine complaints and disciplinary actions by other organizations. Those who believe they have been wronged by a forensic expert may file a complaint with the state medical licensure board or a professional group such as the AMA or American Psychiatric Association (APA). Unlike a civil suit, these types of complaints do not require damages, and often do not have statutes of limitations. (4) All board complaints are considered to some degree (i.e., reviewed at some level, even if not forwarded for a full investigation) regardless of apparent merit, and filing costs are often negligible, if any. (4) Additionally, malpractice insurance may or may not cover board investigations, depending on the specifics of the insurance policy.

Many medical societies have established their own procedures for handling complaints. For example, AAPL does not adjudicate complaints of unethical conduct, but rather refers complainants to the APA or other organizations deemed appropriate. (4) If the APA expels or suspends a member, AAPL will take similar actions.

Perhaps the most important, yet challenging, aspect of expert medical testimony is the ability to eliminate implicit and explicit biases. AAPL's Code of Ethics includes a strong stance on honesty and striving for objectivity in its Ethics Guidelines for the Practice of Forensic Psychiatry:

When psychiatrists function as experts within the legal process, they should adhere to the principle of honesty and should strive for objectivity. Although they may be retained by one party to a civil or criminal matter, psychiatrists should adhere to these principles when conducting evaluations, applying clinical data to legal criteria, and expressing opinions. (5)

The word "striving" was used because being 100% objective is a difficult or impossible goal to obtain, and similarly challenging to validate or even measure. The ultimate issue that a forensic expert testifies to is an opinion, and it is often the case that reasonable experts may have a difference of opinions. However, with this stated, several professional organizations have a review mechanism in place to censor members who provide forensic opinions which they believe are extremely one-sided or made without support of medical literature or standard practice. (4)

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AAPL Council Approves Strategic Planning Task Force Recommendations

Stuart Anfang MD, AAPL Treasurer

In November 2020, President Liza Gold appointed a Strategic Planning Task Force, with the following charge: Consider the following and, to the extent possible given current circumstances relating to pandemic, propose a reasonable plan for the next 5+ years to: (a) help assure AAPL's financial security and long-term sustainability, and (b) help support members' goals and expectations for AAPL, including:

- Review current AAPL Mission Statement and decide if there is a need to revisit or reaffirm
- Review AAPL Finances, including past results, current trends, and future expectations, and how this impacts what we can/cannot do balancing expenses vs. revenues, including other potential revenue sources.
- Leadership planning projection over next 5-7 years, including the Executive Director and the Medical Director.
- Challenges/opportunities in a COVID/virtual world, including AAPL's online presence, educational programs, and annual review course.
- Challenges/opportunities to increase gender and racial equity in membership and leadership.

Members of the Task Force included Stuart Anfang (chair), Jackie Coleman, Charles Dike, Richard Frierson, Graham Glancy, Susan Hatters-Friedman, Jeff Janofsky, Reena Kapoor, Michael Norko, and Barry Wall. Our goal was to submit a final report to AAPL Council by October 2021. The Task Force met by Zoom conference call on 6 occasions with members completing drafts and assignments between calls. We submitted our interim report in May to President and Council. We held two feedback sessions for Council via Zoom in August, and welcomed any additional comments via email. Our final deliberations and recommendations were presented to AAPL Council in September 2021, and unanimously approved. These actions are detailed as follows:

A. Review the current AAPL Mission Statement: We looked at current material from our website, including definitions and goals. AAPL does not currently have a contemporary mission statement. After extensive further discussion, Council approved the following mission statement:

"**The American Academy of Psychiatry and the Law is an organization of psychiatrists whose mission is to promote excellence in forensic practice and policy, to provide and support educational activities, and to foster research that enhances knowledge about forensic psychiatry while supporting diversity and inclusion in the profession."**

In addition, Council agreed to develop AAPL Values and Goals Statements. Reena Kapoor and Charles Dike offered to work on a brief set of example values/goals to guide Council's consideration.

B. Review AAPL Finances: past results, current trends, and future expectations, and how this impacts what we can/cannot do balancing expenses vs. revenues, including potential other revenue sources. Background data was reviewed by the TF. Treasurer Stuart Anfang provided a high-level summary, noting we generally have been profitable (largely from annual meeting/review course) for many years, accumulating a reserve of $2,000,000 (inclusive of Rappeport Fellowship fund) and we generally use reserve dollars to support special expenditures or pilot programs. However, in recent years, we have run deficits due to increasing expenses and less revenue generation (e.g., review course has run at a loss for the last several years). After extensive further discussion, the Council approved the following recommendations:

- Forensic review course will aim to break even at a minimum, recognizing that hotel contractual obligations are in place for the next several years. Consider virtual course, targeting broader audience, and increased fee/decreased expenses for live course.
- There is reluctance to increase annual dues when membership numbers are flat or decreasing, and there are concerns about the "value of membership."
- Increase CME revenue – both virtual CME (what is optimal charge/CME hour?) and in-person CME (annual meeting fee, i.e., a $75 fee increase across all categories would generate an additional $60,000; a $100 fee increase would generate an additional $80,000).
- Enhancing our virtual CME will require additional investment in infrastructure resources, e.g., a learning management system, other virtual enhancements/support.
- Explore other potential revenue sources.

As part of our financial review, we had a thoughtful discussion of the pros/cons of de-linking AAPL membership from APA/AACAP membership. No other psychiatric subspecialty organization appears to require such a linkage. Historically, AAPL wanted to use the APA ethics process, etc. AAPL has long been very involved and well-represented in forensic-related activities in Assembly, Components (e.g., CPL, CJA, CALF), and Board. Ultimately, the TF concluded that we did not have sufficient data to make an informed decision on this question. Council tasked the Membership Committee, Executive Director and Medical Director to analyze the pros/cons of delinking. Would de-linking lead to

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significant increase in AAPL membership/dues revenue? Would there be a "cost" in terms of AAPL-APA collaboration?

C. Leadership planning projection over next 5-7 years, including Executive Director and Medical Director.

Executive Director/Management: Jackie Coleman's goal is to work with AAPL for approximately another 5 years (until 2026), and S&S Management is committed to us (we are one of their larger clients) and going strong. There is opportunity to work with S&S Management about specific goals we seek, e.g., identification and cultivation of Jackie's successor and further specific expectations of S&S Management, such as technology enhancement. We reviewed our relationship with S&S Management, including the advantages of having professional association management for a sub-specialty organization of our size vs. directly employing our own staff with associated overhead. Council approved the recommendations that: (a) AAPL should continue to employ a professional association management company; (b) AAPL expects that S&S Management will identify Jackie's successor within 18-24 months of her planned retirement; (c) Budget Committee and Medical Director will review our relationship with S&S Management and assess their future capacity and viability; and (d) our goals for enhanced IT needs (including improved and quickly updated website, Learning Management System, easy interface with Impexium) will require investments and personnel outside of S&S Management. Council approved adoption of a new Learning Management System (funded initially from our reserves), and will designate an AAPL member to be the "Virtual Editor" (analogous to JAAPL or Newsletter Editor) whose task will be to oversee updated website, liaison with AAPL staff and outside IT vendors, and coordinate with Education Committee and Council regarding Virtual AAPL needs.

Medical Director: Jeff Janofsky anticipates completing his AAPL Medical Director (MD) service at the end of his current term on October 31, 2023. This is an opportunity for AAPL to think about the role of MD, and any potential changes. We have gone through the MD transition only twice before in 50+ years. We reviewed the current job description and MD contract. Council approved the recommendations that: (a) AAPL continues to need a part-time medical director, and (b) a search committee will be appointed by Susan Hatters Friedman to begin a process of MD search, including reviewing current job description and contract. Several items were raised as potential considerations for Council as it embarks on a search for the new Medical Director.

Lay Leadership: We had extensive discussion about recent bylaws changes about officers, VP terms, Council membership, and requirement that presidential appointees to Nominating Committee be past presidents. It is too soon to assess the impact on leadership development. We discussed our anecdotal individual experiences on Nominating Committee, reaching agreement that there are no clear current guidelines/rules how the Nominating Committee should function, and it would be helpful to fill that void. Mike Norko and Susan Hatters Friedman led a thoughtful process to create proposed guidelines for the AAPL Nomination Committee process. These were shared with Liza Gold, who agreed to pilot them for the spring 2021 Nominating Committee process and provided useful feedback for review by the Task Force and Council. After incorporating suggested changes/feedback received, Council adopted the new process guidelines for the Nominating Committee.

D. Challenges/opportunities to increase gender and racial equity in membership and leadership. The Task Force spoke with leaders from the Women's Committee and Diversity Committee to learn of their activities/agenda, and how the TF could support and highlight their work. Ultimately, Council approved continued support to the Diversity Committee as it continues its important work to: (a) survey fellowship directors regarding needs assessment for a proposed model fellowship curriculum on racial and social justice; (b) continue Town Halls regarding Diversity, Equity, and Inclusion (DEI) issues; (c) work towards increased educational resources regarding DEI, including a relevant course at the AAPL Annual Meeting; and (d) remind all Council and committee members that we all share responsibility for sensitivity and specific attention to thinking of AAPL's actions from an Underrepresented Minority (URM) perspective (e.g., regarding AAPL awards, recruitment of leaders, etc.).

As suggested by the Women's Committee, Council voted to instruct AAPL Central Office to collect demographic data regarding gender and race via a process designed by Executive Director with guidance from Diversity Committee and Medical Director. In addition, the current URM Councilor offered to serve as a direct email contact for members interested in further DEI/URM initiatives. Separate from the Task Force process, the Women's Committee also developed a proposed AAPL Code of Conduct, which is currently being finalized.

Overall, the Strategic Planning Task Force was delighted to reach unanimous Council approval for all 18 specific and concrete actions. We hope that these efforts will help sustain AAPL's successful financial, leadership, and organizational future.

The Current State of Mental Health Courts

Celeste Peay, MD, JD

Mental Health Courts (MHCs) have been in existence since the early 1990s, initially modeled after their sister "problem-solving" courts, drug courts. In general, MHCs serve as a diversionary mechanism for individuals with mental illness, moving away from the carceral system and into community-based treatment programs. Currently, there are over 350 MHCs nationwide with varying models. The efficacy, however, of MHCs remains unknown. To date there has been little research on MHCs' efficacy in: (1) treating psychiatric issues and (2) reducing recidivism and involvement in the criminal justice system. (1, 2) Despite the proliferation of mental health courts across the nation, there is considerable variability across courts in the referral process, administration, and graduation requirements for programs. (3) As court consultants, forensic psychiatrists are well positioned to advocate for evidence based best practices in mental health courts, and for continued research into MHCs efficacy and operationalization. The following are some evidence-based practices for establishing and administrating mental health courts, as well as several areas where additional research and investigation is needed.

Current Best Practices

1. *Engagement of Diverse, Broad-Based Stakeholders* – Given the intersectional nature of MHCs, court personnel administrating the program should include representatives from the involved sectors including mental health, substance abuse treatment, social services, and criminal justice. This diverse panel of stakeholders should be tasked with the design and implementation of the desired MHC model, with additional structures/monitoring in place to ensure model and mission adherence.
2. *Explicit Terms of Participation* – Generally speaking, the length of mental health court participation should not extend beyond the maximum sentence a defendant could have received if adjudicated guilty in a traditional court process. Program duration is expected to vary depending on a defendant's program progress, and progress is explicitly tied to adherence to the court-ordered conditions and ties to community treatment. Importantly, once a defendant satisfies the terms of his or her participation, there should be a positive legal outcome. According to the Bureau of Justice Assistance's Manual on "The Essential Elements of a Mental Health Court," each defendant should receive an individualized, written document outlining the terms of participation in the session prior to making his or her decision to enter the program. (4)
3. *Implementation of Performance Measures Tracking and Case Review* – One of the ongoing tensions MHCs face is maintaining consistent standards, while also providing the flexibility and individual tailoring that is the hallmark of a mental health court. Given the individualized process inherent in MHCs, the court must be on guard for systemic bias. One of the best ways to eliminate systemic bias is by reviewing comprehensive outcomes data. Any evidence of bias should emerge through the objective analysis of collected data. The National Center for State Courts has developed a Mental Health Court Performance Measures Toolkit wherein they identify 14 measures mental health courts should be tracking. (5) Instituting rigorous outcomes measure tracking has numerous benefits for the session. First and foremost, it helps to identify areas of weakness and bias in the system, and allows for targeting specific problem areas. It also provides data points for demonstrating program success to state governments when making the case for yearly funding. Finally, it also helps create more standardized mental health court sessions to ensure the sessions aren't run by one powerful or charismatic individual.

Areas Requiring More Research

1. *Outcomes Measures for a Pre-adjudication vs. Post-adjudication MHC model* – MHCs generally employ either a pre-adjudication model, wherein prosecution is deferred while the defendant completes the recommended program/treatment, or a post-adjudication model, where the defendant submits a guilty plea as a required prerequisite to participate in the program. Among the roughly 350 courts in existence, the percentage using each model is unknown. Additionally, there are no data measuring outcomes between the models.
2. *Outcomes Measures for MHCs restricted to non-violent misdemeanor cases vs. MHCs accepting felonies and violent misdemeanors* – Each MHC has defined eligibility criteria for participation, which vary widely across jurisdictions. Many MHCs limit eligibility to non-violent misdemeanor offenses, while others allow more serious, violent cases, including felonies. There are no data comparing the outcomes of these two different approaches to eligibility criteria.
3. *Optimal MHC Operationalization* – Across the country there is considerable variation in MHC focus, size, and logistical operations including participation screening, offered services, method of court supervision, compliance monitoring, and sanctions. While some data exists to suggest efficacy of MHCs in reducing recidivism,

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World Congress Psychiatry 2021: Ethical and Legal Issues

Kavita Khajuria, MD

The World Congress of Psychiatry held its annual conference virtually from October 18-21, 2021. A variety of panels and special sessions represented global issues, including a Presidential Forum on the Application of Ethical Rules in Psychiatry.

Dr. Soumitra Pathare from India spoke about the death penalty. As of December 2020, 144 countries have abolished the death penalty, but 86% of the world's population are located in the 55 countries that retain it. Iraq was cited as responsible for the majority of the global death sentences, followed by Pakistan and Nigeria. In 2019, China reportedly led the global execution rates, although the true extent is unknown. He noted that execution of those with severe mental illness is unlawful per international law, yet many continue to receive the death penalty, as the legal focus is on criminal liability.

The Supreme Courts of India and Pakistan have held severe mental illness to be a mitigating factor in death sentence commutation for prisoners on death row, but the burden of proof lies on the prisoner – such determinations are to be made by qualified professionals, and with exclusionary requirements and processes, i.e., they are applied only to those with mental illnesses "severe enough," which have been a challenge for psychiatrists. Other complications include prison conditions as risk factors for mental illness, unfair trial procedures, limited access to mental health care and treatment in prison, lack of access to mental health professionals for the identification of mental illness, and inadequate legal representation. Dr. Pathare stressed that it is incumbent on mental health professionals to challenge the unfairness of the death penalty, specifically for prisoners with mental illnesses or intellectual disabilities. Referencing the World Psychiatric Association's firm stance on a physician's participation in capital punishment as unethical, the World Psychiatric Association was encouraged to analyze practice in retentionist countries and issue a position statement to encourage countries and courts to eliminate or commute the death penalty, specifically on the grounds of mental illness and intellectual disability.

Dr. Silvana Galderisi from Italy spoke about mental health and domestic violence – a "neglected tragedy" with severe adverse consequences on the mental health of women and children, and with increased risk for the development of eating disorders, psychosis and substance use. Both sexual and domestic violence were noted to continue to be underreported and overlooked in mental health research, services, and policies. She stressed the need to be alert to signs and symptoms of interpersonal violence, as well as opportunities for initiatives in advocacy and awareness.

Dr. Oye Cureje from Nigeria spoke about the ethics of quality care for persons with mental illness, including public loss of trust in health systems. He noted many reports, including those provided by Human Rights Watch, which reveal the occasional culpability of psychiatric facilities in the abuse of human rights in West Africa. Quality of care was outlined in four areas in West Africa, each referenced with World Health Organization Quality Rights Tools, including the assessment team, methods, and themes – most had partial fulfillment. Common shortcomings included inadequate medical and mental health staff, poor quality of care, inadequate training of staff on human rights, and poor attention to policies. Most hospital admissions were involuntary, unregulated, and based solely on the demands of relatives of the patient. Other problems included verbal abuse, inappropriate use of seclusion and restraints, stigma, and absence of services for housing, education and employment. Psychiatrists were encouraged to play a major role in change through clinical practice, leadership and advocacy for change.

Dr. Guadalupe Morales from Spain spoke about violence in psychiatric units as an ongoing global phenomena, and referenced inhumane conditions in a number of psychiatric facilities. Select photos from different countries were included to illustrate the point – one of a mentally ill man chained by his leg in his elderly parents' home, another tied to his bed in a psychiatric facility. Coercion was noted to be a complex problem. She encouraged the notion of converging "objects of care" with "holders of rights," rather than viewing them as a dichotomy. The Hippocratic Oath was frequently referenced, and a human rights perspective heavily encouraged.

Dr. Paul Appelbaum from the US discussed psychiatrists' relationships with the pharmaceutical industry. The WPA guidelines and recommendations were outlined to discourage psychiatrists and organizations from meeting pharmaceutical representatives or accepting meals or gifts. He noted the nuances and conditions of accepting medication samples and factors to consider when accepting financial support in low-income countries for conference travel costs. Conducting research was discouraged if one is already in a financial relationship with a company, and attendees were discouraged from participation in presentations wherein the presenter lacks control over the content.

This was an interesting global update on select issues from different continents. The next World Congress Psychiatry will be held in Bangkok, Thailand from August 3-6, 2022.

Are Mental Health Clinicians Receiving Relevant Legal Updates?

Carol Barnes, MD and Jennifer Piel, JD, MD

Psychiatrists and other mental health clinicians have professional responsibilities to stay informed of recent legal developments that affect their care delivery and the regulation of mental health practice. A significant legal change to the Washington State Involuntary Treatment Act (ITA) (1), implemented in January 2021, revealed that many mental health clinicians in the state were unaware of the change in law or how it would affect care of persons with behavioral health conditions. With implementation of the state's revised ITA, emergency detention of psychiatric patients was expanded from 72 hours to 120 hours. Although several organizations provided educational resources on the changes to the ITA, lack of widespread awareness by mental health professionals prompted a study of how mental health clinicians in Washington learn of legal updates, what sources of legal information they find reliable and useful for their practice, and how they would best like to be informed of relevant legal updates in the future.

In August 2021, a convenience-sample survey was distributed to mental health clinicians across Washington State. Respondents were required to be enrolled in a training program or licensed to practice psychiatry (including independent practice psychiatric nursing), psychology, or clinical social work in the state. An anonymous survey was distributed through the following sources: Washington State Psychiatric Association Online Newsletter; University of Washington Psychiatry Residency Training Program Listserv; University of Washington Psychiatry and Behavioral Sciences Faculty Listserv; University of Washington Psychiatry and Behavioral Sciences Weekly Online Newsletter; University of Washington Center for Mental Health, Policy, and the Law Listserv; and University of Washington School of Clinical Social Work. The survey instructions included an invitation to forward the survey to other colleagues. Data were collected for ten days. One hundred and fifteen survey responses were collected. Because surveys were disseminated through various protected listservs and word of mouth, a response rate could not be calculated.

Although professional standards require mental health professionals to stay up-to-date regarding important legal developments, the results of this survey revealed that only 37% of surveyed clinicians actively seek out legal updates from any source. Although the study was conducted nine months after implementation of the state's change in the emergency detention law under the ITA, 57% of respondents disclosed lack of current knowledge about the change in law. Several respondents indicated that they had previously received useful trainings on changes in mental health laws from specific faculty members or professional organizations, and the majority of respondents welcomed opportunities to learn about legal updates that affect them or their patients. Of respondents who received or participated in a program for legal updates in the past year, most received the updates via electronic communications from their employer or professional organization. The results reveal that some clinicians are getting this information without actively seeking updates, suggesting some success on the part of local experts and institutions who have disseminated relevant legal updates for mental health clinicians through newsletters and other sources.

With more than 60% of respondents indicating that they do not actively seek out legal developments, the study results suggest that clinicians have difficulty staying informed and understanding the significance of legal changes. There are likely a lot of reasons for the relatively low percentage of clinicians who seek legal updates, including need for continuing education in other topics; not knowing where to turn for legal updates; difficulty understanding how the law affects clinical practice or clinicians' responsibilities; and other time and logistical constraints. We theorize that the lack of a centralized resource for timely, reliable, and trusted information about legal updates is a barrier for some clinicians staying abreast of legal changes. In this study, survey respondents indicated preferences for obtaining legal updates via newsletter, website, or on-demand webinar, suggesting that time constraints and ease of access to the resource are important factors for clinicians seeking out these resources. Although these resources are useful for timely dissemination of information on new legal changes, clinicians would likely benefit from live discussions and opportunities to ask questions regarding the application or implications of new laws and how they relate to their clinical practice.

This study was limited by the duration of data collection and breadth of practitioner respondents. There was limited distribution to mid-level providers and forensic evaluators in this study, and these are important members of the behavioral health workforce in Washington State. Given that the survey was distributed through several sources from the University of Washington, there may also be geographical differences not captured in the results.

Overall, these findings indicate the importance of increasing awareness about the responsibility to stay abreast of legal developments that shape clinical practice and making use of formats and reliable sources that will be used by clinicians.

Reference:

(1) Involuntary Treatment Act, RCW 71.05.153 (2020)

To the Editor:

I congratulate authors Verret, Scott, Sanderson and Spruiell on their Newsletter piece (1) for the thoroughness and precision of their article, "What's in a name?", examining differential diagnosis of gender dysphoria (GD) and the social effect on an adolescent unit. Though remarkably comprehensive, I felt that it omitted an important factor that was only alluded to in the case of Jacob (who may have simulated GD as revenge for having had his phone taken away): that claiming GD can join the long list – smoking, sex, heavy metal music – of things that drive parents crazy and are chosen for that effect. Often there is an element of testing parental discipline. The description of the forces the treater has to balance in the assessment was the best part of an excellent article.

Reference:

(1) Verret L, Scott H, Sanderson J, Spruiell G. What's in a Name? Disputes about Sexual Identity on a Child and Adolescent Psychiatric Unit. *AAPL Newsletter.* 2021; 46(3): 12, 17.

Thomas G. Gutheil, MD
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American Psychiatric Association (APA) Assembly Updates

Danielle B. Kushner, MD

The APA Assembly met virtually on November 6-7, 2021, with all committees and area meetings convening virtually prior to the meeting. This was the third virtual Assembly meeting as a result of the COVID-19 pandemic. The meeting opened with a discussion of Inclusivity and Inclusive Language by Kenneth Ashley, MD. He provided an overview of basic principles about identity and how to be thoughtful and intentional in addressing others.

In the Report of the Medical Director, Saul Levin, MD, MPA, discussed the organization's important legislative issues for the upcoming year with a focus on scope-of-practice issues. He discussed APA's ongoing work to fight psychology prescribing legislation and nurse practitioner and physician assistant scope expansion, including proposed state legislation involving involuntary commitment, competency, and capacity evaluations. Additionally, he discussed ongoing lobbying for investment in the Collaborative Care model in primary care offices. He promoted increased member involvement in the APA Political Action Committee to advocate for psychiatrists and mental health issues at the state and local levels.

Other updates reviewed included the upcoming release of *DSM 5 TR* in March 2022. The new update will include cultural changes, addition of Prolonged Grief Disorder, and updated ICD codes, among others. Dr. Levin also discussed ongoing participation and expansion of the PsychPro Registry, which helps simplify administrative reporting requirements and maintain professional recertification.

President Vivian Pender, MD, discussed the theme of her presidency and new presidential task force, Social Determinants of Mental Health**.** The Task Force is charged with developing sustainable policies and programs to bring about change in the healthcare of affected populations by addressing social and structural determinants of mental health. It is a shift from an individual to a population approach to help improve outcomes. The four areas of focus include clinical, policy, public health, and research/education workgroups. Current goals include upcoming round tables, lobbying Congress, developing a training curriculum, publishing and presenting on the topic, and forming a caucus to continue the work. Dr. Pender also discussed the development of a Structural Racism Accountability Committee to ensure the recommendations of the Structural Racism Task Force continue to be implemented, to monitor and evaluate success, and to develop future actions.

President-Elect and forensic psychiatrist, Rebecca Brendel, MD, JD, discussed upcoming projects on APA Assembly and Joint Reference Committee (JRC) operations and procedures, including improving communication and monitoring work projects. She also discussed a plan to include more underrepresented voices and diversity topics in APA Councils.

Seventeen Action Papers were submitted for the Fall Assembly meeting. *Studying the Decriminalization of Illicit Substance Possession and Use* was approved, with the plan to propose a Position Statement on the issue by the 2023 Assembly meeting. The Assembly also approved *Changes to Improve MOC*, which requests the APA advocate that any psychiatrist employed by an accredited organization be considered in compliance with the Improvement in Medical Practice (PIP) section; adequate self-assessment credits be gained from article-based Part III study to satisfy all self-assessment requirements; and the number of articles required of psychiatrists with multiple board certifications be reduced to the same as general psychiatrists. Additional forensic issues from the Assembly

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Presidential Address

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AAPL website needs to be a priority. Therefore, AAPL Council approved the recruitment of a paid webmaster who can transform our website to function effectively as a gateway to membership, information, and online education.

Next, Dr. Gold discussed AAPL's future and reported that under the leadership of our treasurer, Dr. Stuart Anfang, a strategic planning task force met this year to examine AAPL's current and future challenges, including issues of diversity and inclusion. Their comprehensive review resulted in many recommendations which were unanimously approved by Council. These recommendations included: (1) the adoption of an updated mission statement; (2) the tasking of Council to develop a Values and Goals Statement; (3) implementing the collection of membership demographic data as part of annual membership renewal to facilitate evaluation of AAPL's efforts to improve diversity and inclusion; (4) formal consideration of the pros and cons of "de-linking" AAPL membership from American Psychiatric Association membership; and (5) adoption of a standard procedure for Nominating Committee deliberations. In addition, a work group of the Women's Committee, led by Dr. Corina Freitas with the assistance of Dr. Barry Wall, developed and proposed a Code of Conduct for AAPL.

Dr. Gold pointed out that since VAAPL will be providing year-round CME programs, AAPL should rethink goals for its annual meeting and expand opportunities for non-CME member events promoting networking; mentorship; diversity and inclusion; and smaller group interests. Creating online courses could also be advertised to affiliated forensic and clinical organizations, providing educational opportunities to non-forensic psychiatrists, and to individuals who are unlikely to attend an in-person forensic psychiatry meeting, such as general psychiatry residents. Dr. Gold pointed out that in response to decreasing membership, AAPL needed to think about educating and attracting non-forensic psychiatrists as well, since making up membership numbers through the limited pool of 60-70 forensic fellows per year is not fruitful, as pointed out by Dr. Octavio Choi in his recent *JAAPL* article.

Dr. Gold concluded by stressing that post-COVID AAPL is going to look different. AAPL can be more prosperous in this post-pandemic world if we think how members can use AAPL's strengths and resources to take advantage of these many new opportunities.

"The Times"

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As President, I've had recent engaging meetings with 47 chairs and co-chairs of AAPL committees. There is so much amazing work afoot, despite these difficult times. At the upcoming annual meeting, we will continue the track of correctional psychiatry introduced by Dr. Mike Norko. No one who knows me well will be surprised to learn that we're also encouraging folks to submit presentations about creativity. Creativity in thinking of solutions in our field, and also creativity in maintaining our own wellness.

The Rock and Roll Hall of Fame is an iconic building on Cleveland's north shore, a couple of blocks away from our Court Psychiatric Clinic offices in Cleveland's Justice Center. Bob Dylan was inducted into the Rock and Roll Hall of Fame in 1988. More than thirty years later, in 2019, The Cure were inducted. (So, I might suggest that the AAPL President in three decades writes a newsletter article with a song by The Cure flowing through it.) Tracy Chapman, with her platinum albums, has been eligible for nomination to the Rock Hall for the past seven years. (Stay tuned.)

Thank you for placing your trust in me as your President. The future of AAPL is bright if we all "lend [a] hand." I look forward to seeing everyone this October in New Orleans. And definitely catching some jazz in the French Quarter.

Best Practices

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in the Texas Court of Criminal Appeals (10) (on remand from USSC) (with APA, ApA and others)

- Petition for certiorari to the USSC in *Moore II (*8) (with APA, ApA and others)

I have received permission from AAPL's Council to put together a work group to discuss creating an AAPL resource document on best practices in forensic psychiatric evaluations and testimony in capital cases. I hope to have a proposal for the AAPL Council to consider soon.

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(4) Lockett v. Ohio 438 U.S. 586 (1978)
(5) Penry v. Lynaugh 492 U.S. 302 (1989)
(6) Atkins v. Virginia 536 U.S. 304 (2002)
(7) Moore v. Texas No. 15-797, 581 US ___ (2017); 137 S.Ct. 1039 (2017)
(8) Moore v. Texas 586 US ___ (2019)
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Public Safety

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Public Safety

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Forensic Training

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to achieve further competency in the practice of psychiatry in the US, and, potentially, to fill openings in forensic settings, where basic knowledge of the law is critical.

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Diversity Committee

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suggested that AAPL implement the same.

The second speaker at the LGBT forum, Dr. Evan Eyler, discussed organizational initiatives that have been successful in other professional societies at increasing the inclusion of transgender persons. He highlighted that most of the legal protections passed in the past several decades for LGBTQ+ people have advanced the rights of gay and lesbian Americans more than those of transgender Americans. He suggested that board exams and MOC exams include questions addressing topics salient to transgender mental health as well as including transgender people in question stems for questions that are not particularly salient to transgender issues. He also suggested that routine solicitation of pronouns at AAPL events would signal transgender inclusion and invite more transgender people into the organization. Dr. Eyler emphasized invisibility as a theme in the experience of transphobia, and recommended that fellowships specifically solicit applications from transgender candidates, referring to them as such. He suggested AAPL consider whether it would be within the organization's mission to file Amicus Curiae briefs when transgender-relevant jurisprudence is heard before major courts. Finally, Dr. Eyler discussed the importance of collecting gender identity information for all AAPL members alongside race, religion, and other pertinent information.

Panelist Dr. Jessica Zonana highlighted that AAPL is in a unique position to advance LGBTQ+ inclusion within organized psychiatry, as the organization intrinsically interacts with judicial and legislative agencies. She also emphasized the importance of public-facing materials specifically naming sexual minorities as a target audience and offered that diversity within the entry points to the organization (such as travel awards and fellowships) are of particular importance.

Panelist Dr. Barry Wall discussed landmark and other influential court cases that addressed LGBTQ+ issues. Dr. Ariana Nesbit suggested that *Bostock v. Clayton County* (1) be considered for inclusion in the AAPL Landmark Cases collection.

Several participants described barriers to coming out as a sexual minority in the AAPL community. Dr. Liza Gold suggested that disclosure of sexual orientation risks conflation with issues in the public sphere,

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Diversity Committee

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potentially undermining testimony or expert opinions in legal settings. Dr. Jack Dresher discussed structural heterosexism and highlighted the rapid expansion of a gay psychiatry caucus in New York City, noting that when a few members start to come out, many are inspired to follow.

Dr. Barry Wall concluded the discussion by sharing that the AAPL Diversity Committee is exploring a minority mentorship program where early career AAPL members have a chance to meet senior members with a shared lived experience.

Reference:

(1) *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020).

Envy

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Rodger's pathological envy stemmed from his inability to establish intimate relationships and led to his self-described feeling of being "livid with envious hatred." Those who have read Rodger's autobiography will note multiple instances demonstrating both the obliterative mindset and the pseudo-spiritual transformation, complaining how he has been "deprived" of the pleasures of women, how he thought of himself as a god, and how he fantasized about eradicating women from the earth. (3)

While it comes as no surprise that envy is a common motive for malignant and destructive behavior, this presentation provided an in-depth look at the psychological and social factors that may help practitioners better understand otherwise unthinkable acts, as well as the perpetrators behind them. Forensic practitioners are often tasked with determining when a criminal act flows from a delusional system and when it does not. An improved discernment of envy may ultimately help find ways to explain to a lay jury how a severe and catastrophic criminal act can be birthed from a non-psychotic mind. Further research in this area may even have the potential to tap into the taboo topic of treating patients with severe ASPD. Perhaps someday the profession may even get closer to deterring some of these acts from their most violent endpoints.

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(3) Rodger E. My Twisted World: The Story of Elliot Rodger. http://files.crimescenedb.com/pdf/Elliot-Rodger-Manifesto-My-Twisted-World.pdf Accessed: 11/15/2021.

Medical Testimony

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Courts have ruled that professional organizations are allowed to censor members based on testimony that they believe is biased or unrepresentative of the current knowledge base of the field. (3) In *Austin v. American Association of Neurological Surgeons* (AANS), the US Court of Appeals for the Seventh Circuit held that a professional society could discipline a member for improper testimony. (6) Dr. Donald Austin, a neurosurgeon, filed suit against the AANS, which had suspended his membership for providing biased testimony against another neurosurgeon member in a malpractice case. (6) The court dismissed Austin's suit, supporting the AANS' right to discipline. (6) The court ruled Austin provided insufficient evidence for his opinion and failed to determine whether or not the majority of the profession agreed with his opinion, which violated the ethical provisions of the AANS. (6) The key points of this case are clearly stated in the AMA's Code of Medical Ethics: "Testimony [ought to] reflect current scientific thought and standards of care that have gained acceptance among peers in the relevant field." (7)

This article addresses some of the concerns of malpractice that arose from the George Floyd case as presented in the media. However, it needs to be noted that there are varying jurisdictions, unique aspects of cases, and times where there can be reasonable disagreement between psychiatric opinions. Also, ethics and legality are not always the same, but if one follows forensic and general psychiatric ethics, the risk of malpractice lawsuits or other types of professional action can be minimized. The investigation of Dr. Fowler demonstrates the importance of adhering to guidelines recommended by AAPL and other professional societies when testifying as an expert witness. Practitioners should remember the notions of honesty, striving for objectivity, and performing structured assessments as taught in general psychiatric and forensic training programs.

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The Current State

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there is no discussion or study of how variations across courts may play a role in recidivism rates or overall efficacy on psychiatric symptom treatment. (6, 7)

While mental health court sessions aren't a panacea for the many challenges faced by justice-involved individuals with serious mental illness, they represent an important tool in the arsenal. During my own time interning in a MHC in Boston, I repeatedly spoke with individuals for whom the MHC provided a life-saving opportunity to be connected with needed treatment, and met former participants who had gone on to live successful lives in the community with meaningful employment and relationships. Forensic psychiatrists would do well to advocate for continued research and strategic implementation of these specialty courts in their home jurisdictions.

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Assembly Updates

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meeting included approval of several new and updated Position Statements including *Police Interactions with Children and Adolescents in Mental Health Crisis*, *Civil Commitment of Minors*, *Sexual Harassment*, *Location of Civil Commitment*, and *Trial Sentencing of Juveniles in Criminal Justice System*.

After the formal Assembly meeting, there was a virtual memorial for Dr. Paul O'Leary, forensic psychiatrist and former APA Assembly Speaker who died in May 2021. The APA Foundation is developing a future Award Scholarship in honor of Dr. O'Leary. The next Annual Meeting will be in person, May 21-25, 2022 in New Orleans, Louisiana. The theme of the meeting is Sociopolitical Determinants of Mental Health. A small virtual component is planned for two weeks after the meeting.

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