

AAPL Newsletter

American Academy of Psychiatry and the Law



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Susan Hatters Friedman, MD and the Group for the Advancement of Psychiatry, Recipient of the Guttmacher Award

Renée Sorrentino, MD



The Manfred S. Guttmacher Award, co-sponsored by AAPL and the APA and established in 1975, recognizes an outstanding contribution to the literature of forensic psychiatry. The 2020 Guttmacher Award recipient is Susan Hatters Friedman, MD and the Group for the Advancement of Psychiatry (GAP), for the book, *Family Murder: Pathologies of Love and Hate* (published 2019). The annual Guttmacher Award Lecture was given remotely as part of the APA On Demand 2020, an online collection of expert-led presentations, in lieu of the cancelled APA annual meeting. This book provides a comprehensive analysis of the different types of murder within families. The chapters are organized similarly, with sections

on epidemiology, motivations, unique assessment needs and prevention, and each chapter is authored by a forensic psychiatrist with content expertise on the topic. The chapter authors are the members of GAP's Committee on Psychiatry and the Law.

Dr. Hatters Friedman's presentation began with acknowledgment that cases of murder within the family frequently appear in media headlines, citing Susan Smith, the Menendez brothers, and Nicole Brown Simpson. The book utilizes such high-profile cases as a framework to discuss the psychiatric understanding of each category of family murder. Identifying violence and homicide within the family as important public health issues, Dr. Hatters Friedman drew attention to the frequency with which mental health professionals are confronted with violence within the family. Furthermore, she suggested that it is critical that psychiatrists understand the various motives for these homicides, because the various motives

have critically different prevention strategies.

The presentation highlighted topics from the book, outlining various murders within the family, their motives, and prevention approaches flowing from these motives. The types of family murder discussed included intimate partner violence, neonaticide, infanticide/filicide, siblicide, parricide and familicide. Motives for family murder include mental health-related motives such as those caused by psychosis, as well as non-psychiatric reasons of jealousy, greed, pride, anger and revenge.

Like the book, the presentation began with intimate partner homicides and progressed through the life cycle of the family. Dr. Hatters Friedman introduced the categories of family murder including both the forensic and clinical aspects of the specific type of homicide. The role of psychiatric illness in each type of familial murder was reviewed.

In conclusion, Dr. Hatters Friedman discussed preventive measures such as addressing dynamic risk factors for family violence including treating serious mental illness. Preventative strategies such as Safe Havens, anonymous delivery and baby hatches, were discussed in the neonaticide section of the talk. These

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Members pictured: Phil Resnick, Peter Ash, Susan Hatters Friedman, Jacob Appel, Deborah Giorgi-Guarnieri, Rick Frierson

Members not pictured: Alec Buchanan, Jacqueline Landess, Debra Pinals



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EDITOR'S COLUMN

2020: The Unprecedented Year

Joseph R. Simpson, MD, PhD



The COVID-19 pandemic has inflicted great suffering and hardship on the globe and has created numerous changes in every-day life that are so

familiar to us all that they need no recounting here. Similarly, the social protests that began in the late spring in the US and many other nations are sure to be well-known to all who read this Newsletter. This last edition for 2020 has several timely contributions exploring aspects of these ongoing, historic phenomena which you are sure to find enlightening.

AAPL President Dr. Newman completes his discussion of wellness in forensic psychiatry – a subject which is more important now than ever before – and announces AAPL's new peer support program. Medical Director Dr. Janofsky reflects on the impact of COVID-19 on the APA and AAPL this year and what it may mean for AAPL's future. Dr. Herman's Child Column reviews a historical episode of racism almost exactly one hundred years ago. The Ask-the-Experts Column by Drs. Kaye and Glancy is an important tutorial on keeping oneself as safe as possible from threats by those we evaluate. The stresses caused by the pandemic might be anticipated to provoke more people subject to forensic examination to make threats when they believe the expert's report may not be favorable, and possibly to try to act on those threats, so now is certainly the time to review the measures you take. AAPL's representatives to the AMA (Drs. Piel and Wall) and APA (Dr. Kushner) discuss how those organizations are responding to the unfolding events of 2020. We are also fortunate in this issue to have not one but two Fellows' Corner articles. Drs. Dornfeld and Spina describe the impact of the pandemic on the training experience, while Dr. Brennan draws on his

experience as a policeman and federal agent to examine possible causes of racism and misconduct in law enforcement, as well as solutions.

Faithful readers of this Newsletter may remember that my last column had a QR code for a brief survey about the Newsletter. I am sorry to report that the response was decidedly underwhelming. The link (below) remains active, and I encourage everyone to take just a couple of minutes to scan the QR code on this page with your smartphone, or type the link into your web browser of choice and complete the survey. AAPL is also planning to send an email to all members with the link. I will report the results in a future issue. For now, I'll just comment that a more than two-to-one majority of the (admittedly very few) respondents were opposed to eliminating the hardcopy Newsletter in favor of a digital-only product. But the Newsletter's Editorial Board wants everyone's voice to be heard, so that the Newsletter can continue to meet the needs of the AAPL membership.

I urge everyone to think positive thoughts for those who have been ill, or who have lost loved ones this year. If you're in a position to help and support someone impacted by the pandemic, keep it up, or start! Many people around the world have been demonstrating the positive attitude and can-do spirit that is so often revealed when adversity strikes. I'm sure many of you have seen the home-made signs around your town, thanking first responders and healthcare professionals for their bravery and sacrifice. One implicit message these signs convey is: Working together will help us get through this. ☪



<https://www.surveymonkey.com/r/CVDZZVM>

Professional Existential Crises in Forensic Psychiatry

William J. Newman, MD



Wellness in forensic psychiatry has received limited attention to date, despite the considerable risks to forensic psychiatrists. In this three-part

series, I aimed to stimulate discussion about specific challenges to long-term wellness. The first two pieces discussed resilience as a potential protective factor and potential long-term deleterious effects of chronic stress. This final entry is focused on additional issues unique to forensic psychiatry.

Forensic psychiatry involves challenges that are not routinely experienced in other medical disciplines, including general psychiatry. Many who train in forensic psychiatry are naturally perfectionistic. The discipline provides the allure of rewarding those who strive for perfection, while balancing the understanding that none of us can be perfect. Typos and miscommunications are part of life, even for the most skilled and cautious forensic psychiatrist. However, in forensic cases, outcomes can hinge on the interpretation of a single phrase. There is additionally risk that a considerable misstep can haunt a forensic practitioner for the rest of their career, resurfacing each time they testify. Attorneys' access to prior testimony is plentiful, particularly in the digital age.

In addition to the workplace challenges, we are developing an increased understanding of the potential impact of allowing stress from work to impact home life (1, 2). Some authors have suggested mechanisms for limiting the impact of work-related stress on home life (3). Compartmentalizing work stress is especially important in forensic psychiatry. Few understand the difficulty of reviewing hours of records about horrific acts

of child sexual abuse before immediately transitioning to a family function. Similarly, there are challenges associated with transitioning from an eight-hour day of deposition or trial testimony to a relaxed social event with friends or family. There exists no consensus on how best to accomplish these transitions. Discussing these skills is not currently part of the curriculum for forensic psychiatry fellowships, though perhaps it should be.

As I have gotten to know many forensic psychiatrists, it has become increasingly apparent that many have experienced moments or periods involving a degree of existential crisis about the career. The thoughts may occur in the setting of unwanted contact from an evaluatee, an undesirable outcome in a case, or exhaustion after late-night or early-morning report writing while trying to meet actual (or self-imposed) deadlines. Regardless of the impetus, many forensic psychiatrists at some point question aspects of this peculiar career, even if they enjoy most aspects of the work.

Vicarious trauma has received increasing attention as one aspect of promoting and maintaining wellness in individuals routinely exposed to distressing work content (4-6). The potential impact of work-related trauma was deemed sufficiently problematic as to be incorporated into the DSM-5's "A-Criteria" for PTSD, as follows: "Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)". The DSM-5 clarifies that the exposures must be work-related (7).

Peer support is one mechanism that can be utilized to limit the potential impact of vicarious trauma. The American Medical Association has publicly supported the use of peer support systems for physicians (8). Peer support has been implemented

at an institutional level (9). However, it has not yet been implemented at an organizational level.

Given the challenges unique to forensic psychiatrists, AAPL will be rolling out a new peer support program in late 2020. The program will be designed to provide structured support from fellow members to members experiencing professional stressors in a prompt, confidential, and empathetic manner. We hope to be able to provide insights to other professional organizations regarding best practices for peer support. ☯

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AAPL and the COVID-19 World

Jeffrey S. Janofsky, MD



I wrote my last newsletter article in November 2019. It was titled *AAPL: Beginning the Next 50 years*. None of us could have known then that the novel

coronavirus and the disease it causes, now named COVID-19, was just beginning its advance through China and that by March 2020 it would ignite a worldwide pandemic. National and state emergencies have been declared, shutting down many industries and essentially stopping national and international travel. As physicians are therefore essential personnel, all of us began running at 10,000 miles an hour to quickly adapt our general and forensic practices, so that we could continue safely treating patients and continue to safely evaluate forensic clients. Many of us moved to video apps so that our outpatients could remain safely in their homes, and we could safely distance from them and still provide effective treatments. Those of us who had general psychiatric inpatient or correctional practices had to make multiple modifications in our practices as well to keep ourselves, our colleagues, and our patients safe. The shortage of personal protective equipment and changing safety recommendations have made safe practice even harder.

With only several weeks' notice, the American Psychiatric Association canceled its in-person April 2020 meeting, thus AAPL had to cancel its semiannual meeting as well. With the help of Jackie Coleman and the AAPL central office staff, we were able to hire a remote video provider so that the nominating committee, the AAPL Council, and the general membership could meet via Zoom. (I wonder how many of us had even heard of Zoom before March 2020?)

The AAPL Council instructed the Executive Committee to prepare for a virtual meeting to either run paral-

lel to or to replace our face-to-face October 2020 annual meeting. The Executive Committee appointed a workgroup chaired by AAPL member Anne Hanson to outline what such a virtual meeting would look like, and to find and vet service providers for that meeting.

As I finalize this article at the end of June 2020, it is not clear what the state of the pandemic will be in the United States by October. Right now, there are significant upticks in outbreaks in Arizona, Texas, Florida, and California. Health and Human Services Secretary Alex Azar warned today that the "window is closing" for the United States to get the pandemic under control (1). Air travel is slowly opening up, but it was recently reported that some air carriers will not keep middle seats open during travel and that therefore there would be no way to achieve social distancing on flights. The consultant that AAPL uses to contract our meeting hotels (and these contracts are made five to six years in advance) has not been able to get in touch with the convention staff at the Marriott in Chicago where our meeting is scheduled to be held, because there is literally no one there to answer the phone. Given all the above I think it is likely, but not yet certain, that we will have a virtual meeting only in October 2020.

As you may recall from my previous article, AAPL Past President Richard Frierson asked me to chair a Task Force to update the Bylaws, which had not been substantially updated for many years. Along with many technical changes, our group recommended adding one Early Career Councilor, one Minority/Under Represented (M/UR) Councilor, and one Women's Councilor to the AAPL Council Structure. These changes were approved by AAPL Council, published on the Web, and were sent out by mail for a membership vote. (You will probably be happy to know that one of the technical amendments was to allow electronic voting in

the future). There were 1452 ballots mailed and 316 returned, with 313 yes votes and 3 no votes, so the amendments passed.

So where will AAPL be in the first few years of its second 50 years? We are in a rapidly changing and unpredictable world. However, our organization, with your help, will continue to strive through our staff, leadership, and membership to adapt. We will continue to be the leading organization of psychiatrists dedicated to excellence in practice, teaching, and research in forensic psychiatry in the United States.

I hope all of you and your families are well and stay safe. ☺

Reference:

(1) CNN, "State of the Union," June 28, 2020.

Cover Article

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strategies are aimed at providing alternative options for mothers to leave unwanted infants in safe circumstances without the fear of prosecution.

Dr. Hatters Friedman summarized the complex relationship between stressors and mental health, explaining that the motives in family murder are multifactorial and often extreme versions of emotions everyone has experienced. In some cases, mental illness is the direct cause of the murder, in other cases it is related but not causal. Prevention efforts must consider antecedents and motives.

For those who missed this year's online version of the Guttmacher Award lecture, it is available via the APA library. The book itself is now available as an audiobook as well. Congratulations to the Group for the Advancement of Psychiatry and to Dr. Hatters Friedman for this important contribution to the field, delivered with the wit, compassion and knowledge that we all have come to know her for. ☺

Bisbee and Beyond The Clergy-Penitent Privilege

Stephen P. Herman, MD



Bisbee, Arizona lies in Cochise County, in the southeastern part of the state, 11 miles from the Mexican border. Named after Judge DeWitt

Bisbee, the town flourished because of the discovery of large deposits of copper, gold and silver. Phelps Dodge was one of the largest copper mining companies in the area. Judge Bisbee was the principal financial backer of the Copper Queen Mine. Copper supplies seemed infinite. Bisbee shimmered with the beautiful colors of copper minerals: galena, cuprite, azurite and malachite.

However, racism was rampant. Mexicans, the largest group of miners, continually fought the Czechs, French, Italians and other ethnic groups who had come seeking work. There were also frequent battles with the Apaches. Still, Phelps Dodge and other companies needed more miners. They brought in Chinese laborers.

Anglos and Mexicans – usually suspicious of each other – united in their abhorrence of the Chinese.

But as more Mexicans crossed the border into Bisbee, violence and racism were directed toward them by their former allies, the Anglos. Mexicans were called “peons” and “dark-skinned like the Indians.” Native Americans were forced into reservations with squalid conditions. The mining corporations segregated Mexican camps from those of the white miners. The owners justified their racism based upon the “science” of social Darwinism.

Mexicans continued to ford the Rio Grande, hearing about work opportunities in Bisbee. These newcomers were permitted to work only if they spoke English.

As late as 1909, three years before the Arizona Territory was admitted to

the Union, those who could not read and explain sections of the United States Constitution were prohibited from voting.

Poorly paid Anglos and near-destitute Mexicans joined in strikes against the companies. The miners were supported by the Industrial Workers of the World, also called “Wobblies,” from their slogan, One Big Union.

While Americans went “Over There” to fight in World War I, the price of copper hit the stratosphere. As patriotic fervor gripped the nation, the mine owners thought it a perfect time to neutralize the strikers. They planned how to get rid of the strikers for good.

The miners who were thought to be traitors were pulled from their homes and paraded at gunpoint down the main streets of Bisbee to a ballpark. Twenty-three boxcars of the El Paso and Southwestern Railroad pulled into the nearby station and 1,186 men were jammed into them. They were taken to southwestern New Mexico and let out in the desert, dehydrated and starving. This became known as the Bisbee Deportation. Despite countless federal and state indictments against the leaders – and thanks to the limitless funds of Phelps Dodge and other companies – not a single person was ever convicted.

This horrible chapter of American history was told in a recent film, *Bisbee 17*, which featured townspeople reenacting the deportation. Young people did not know about the deportation; adults were reluctant to talk about it. Bisbee grew into a fine and friendly Arizona town. It still had its secrets, but many of these occurred behind closed doors, drowned out by the thrumming of air conditioners.

Bisbee made news again in 2020. One of its citizens told his Mormon bishop that he was sexually abusing his five-year-old daughter. The bishop provided “counseling,” involving the mother in the sessions. He hoped

she would keep her children safe from their father. But the bishop never reported the ongoing abuse. Neither did his successor. The man continued to abuse his daughter and another daughter just six months old. He posted videos of his abuse on the Internet which were discovered by the Department of Homeland Security. The father was charged with multiple crimes. The mother was indicted on 12 criminal counts and pleaded no contest to two counts of child abuse. There was also a criminal investigation into the church’s role.

An attorney is preparing to sue the two Latter-Day Saints bishops. A member of the Arizona Legislature has vowed to eliminate the “confessional exemption” which has protected clergy from being mandated reporters. Another legislator has vowed to make sure the exemption remains in place.

The religious exemption takes its cues from an Alice-in-Wonderland approach. Yes, Arizona’s mandatory reporting law requires clergy to report suspected, ongoing child abuse. However, if they are told of the abuse during a formal confession, they are not under obligation to report. Each cleric makes his or her own decision.

Attorneys representing religious institutions argue that this privilege has existed for centuries and is protected by the First Amendment. For example, in the ninth century, priests who violated the privilege were punished. Today, Catholic priests can be excommunicated if they reveal anything, including a confession of sexual abuse, by a penitent.

In the earliest US case regarding the privilege, *People v Phillips* (1813), the Court of General Sessions of the City of New York opined, “It is essential to the free exercise of a religion, that its ordinances should be administered – that its ceremonies as well as its essentials should be protected. Secrecy is of the essence of penance. The sinner will not confess, nor will the priest receive his confession, if the veil of secrecy is removed: To decide that the minister shall promulgate what he receives in confession, is to

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Ask the Experts

Neil S. Kaye, MD, DFAPA

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: How do you handle being threatened during an evaluation?



A. Kaye:

The best advice I can offer is to be prepared for every evaluation. Reviewing the relevant documents in advance of any evaluation

is critical for many reasons, including personal security. Does the person have a history of manipulative threats or do they have a history of genuine antisocial personality and/or criminal history involving harm to others? If you know the person's history of threats and violent actions in the past you will be better at avoiding triggering the evaluatee. If the person has a history of threatening prior evaluators or of bringing a weapon to an evaluation you can prepare for this likelihood. If they do, I will ask them if they have a weapon on them and if so, I ask them to lock it in their vehicle before we start.

Next, I would review my logistics and office set-up. It's different seeing someone alone in a private office compared to a busy unit in a forensic setting. Do you have a panic button available to summon help if needed? Is the furniture arranged so that the evaluatee can get to the door directly without having to go through (or over) you? Can you also egress immediately without directly crossing the eval-

uee? Are there windows in the office allowing other people to observe what is taking place?

If I believe the person is a significant risk, I will often do the evaluation at their lawyer's office or ask for a staff member to be present. This is one case where I find recording things can be helpful, as people are less likely to act out if there is a camera on them. I might leave the door ajar to allow colleagues to monitor the noise level, should it heighten. If the person has a real history of threats, I often ask them how the last evaluation went and then assure them I am gentler in my approach and want them to feel heard. I tell them I am aware of what happened from the records I reviewed and I remind them that they can stop and take a break at any time. I use my clinical skills to monitor the situation and if I see the person getting irritable, I suggest we take a break or tell them I need to use the bathroom and stand up to demonstrate that we are taking a break.

I might remind them that I am trying to do a good job and that I don't think as clearly when I am threatened and anxious, so if they want me at my best, they need to take a deep breath and give me time to hear them. In general, I abide by the old adage that one catches more flies with honey than with vinegar. In other words, high-pressure, confrontational interviewing isn't my style, nor does the literature show it produces better results.



A. Glancy:

When considering this question, one of my first thoughts was to honor and remember our respected colleague and late friend, Dr. Steve Pitt, who was shot and killed outside his office in 2018. This should serve as a reminder to take security seriously.

In considering attacks upon forensic psychiatrists and psychiatrists in general, the following literature, although fairly sparse, is sobering. Antonius et al. (1), while describing a case study of a psychiatric resident who was attacked by a patient, notes that a third of psychiatrists have been assaulted at least once, and 36–56% of psychiatric residents have experienced physical assault. Davies (2) surveyed psychiatrists and found 70% reported one or more assaults in the last year and 32% reported one or more threats. Regarding forensic psychiatrists, Leavitt et al. (3) surveyed forensic clinicians and found 76 out of 190 (40%) reported distressing incidents but noted that there was no greater risk of aggressive behavior in the forensic context. Madden et al. (4) found that about 40% of forensic psychiatrists had been assaulted, including 1.5% who had been shot. Miller (5) reported that 42% of AAPL members had been harassed in some way outside of court, noting that more than half the assaults arose from "attorneys, relatives and others."

I divide the type of threat into three categories. First, the evaluatee may make a simple direct physical threat. Second, they may threaten to report you to your licensing body or other disciplinary body. Third, they may threaten to harm you or your family at a later date.

Whatever the type of threat, dealing with threats can be divided into three phases. First, and most important, is prevention. Second is goals management and de-escalation. Third is dealing with the consequences, which might involve anxiety, stress, and various administrative problems.

In terms of prevention, one of the most important issues is obtaining informed consent. This helps to manage expectations right from the beginning. For instance, explaining that your role is to strive for honesty and objectivity lets the evaluatee know that you are not necessarily on a particular side right from the beginning. Thus, they may not be as angry at you when they realize that you are not heading in the direction of giving

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Ask the Experts

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them whatever goal is on their mind. It is also important to advise them at the start of the limited confidentiality of the report. During an assessment that I did of a schoolteacher's fitness to work, a complaint was filed with my disciplinary body stating that I should not have shared his psychiatric diagnosis. I was able to produce a signed consent form which specifically stated that anything he told me or that I concluded may go in a report to the responsible body. It is helpful if this procedure is in writing so that it can be produced later for these purposes.

I also inform the evaluatee that I am trying to write things down verbatim and I may not react to what they are saying in a way that they expect. This is an attempt to head off possible irritation that they just told me, for example their wife left them, and I may not have reacted with concern. This is partly because of my own personal style, as I am trying to maintain the stance of what Kenneth Appelbaum, MD called the forensic equivalent of empathy (6) – what I like to call detached concern.

Dr. Kaye has rightly pointed out to pay attention to the physical layout of the examination room. Forensic psychiatrists are often “playing away from home” and we have to see people in jails, detention centers, or spaces not really designed with our safety in mind. Consequently, we often lose control of the situation right from the beginning. It is most helpful if you try and slow the process down. When you are shown into the examination room, ask the person hosting about their opinion regarding safety procedures. This demonstrates to them that you respect their opinion, and they then take responsibility for the situation. Thus, they may say that the evaluatee should sit in a certain place, that you should be nearest to the alarm button, and that they will be vigilant for any signs of hostility or agitation. At this stage, you can guide the ideas based on your knowledge of safety procedures, and even make

it sound as though these are their ideas. In short, you should be nearest to the emergency button, you and the evaluatee should be equidistant from the door, and if it can be arranged, you should not be in their way when they want to storm out. One of my colleagues who teaches de-escalation for mental health workers in the jail, made the clever observation that when sitting on the “picnic table” that we are often stuck with in jails, try not to have both legs underneath the table, since if you have to make a hasty exit this can make it very difficult.

In your own office, if you are anticipating any sort of threats, you should have a security plan worked out with the office staff. It is helpful if this involves set procedures, and that you have had a chance to rehearse it.

It may also be important to be aware of linguistic and cultural issues, whereby your behavior may be particularly insulting or aggressive as perceived by the evaluatee. Prior awareness of these issues may prevent the situation from deteriorating and spinning out of control. It is also helpful to clearly set limits of behavior prior to beginning the interview.

Another aspect of prevention is to consider another person either accompanying you or being right outside the door, especially if prior information on file suggests that the interview could result in aggression. The other person may be a colleague, but in some circumstances may be a security officer, a correctional officer, or a police officer. Sometimes this will meet with opposition from the evaluatee, as well as confidentiality issues. However, if your physical safety is really at risk, compromises will need to be made.

In terms of managing the incident, de-escalation techniques are obviously helpful. Many institutions offer training in de-escalation, and you should take the opportunity to do this if at all possible. On a side note, the same training sessions often demonstrate self-defense techniques. These techniques likely are helpful, but only if you are willing to then practice them two or three times a week for about a year, and then for

the rest of your career. My view, although somewhat idiosyncratic, is that a single training session in these techniques gives people a false sense of security and unless they are of the most basic kind, such as put both hands up to cover your face, they give people a false sense of security, which might end up with them getting into physical altercations (James Knoll, MD, personal communication). The best techniques are psychological. They involve addressing the evaluatee's obvious escalation and discomfort. You should also pay attention to physical space. If the situation arises, as it does sometimes in assessments in jails, that you are standing face-to-face with an evaluatee, I always shuffle to their right side. This de-escalates the aggressive face-to-face contact and also makes it more difficult for them to hit me with their right hand, which is usually how people try to strike.

In dealing with the third threatening situation, when the evaluatee utters the dreaded “I know where you live,” you should be in the situation where you can say “No, you probably don't.” As the literature shows, victims of stalking often feel that they are under siege. This may involve letters or messages or even gifts being dropped off at your office or even worse at your home. It is helpful if you do not use your home address for anything, except when you are legally required to do so (7). For instance, when registering at a fitness club, dance class, or theater subscription, use your office address if at all possible. Nowadays the medium of electronic communication makes stalking even easier. In order to prevent this, it is helpful if you keep your social media presence to an absolute minimum. This means either not having a presence on Facebook, Instagram, etc., or if you really need to consider paying attention to such, anonymizing them or paying the highest possible attention to security settings. Consider using such techniques as having unlisted home phone numbers, PO boxes, and home and office security systems. Cars should be parked in

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RAPPEPORT FELLOWSHIP AWARDS, 2020-2021

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

The prestigious AAPL Rappeport Fellowship was named in honor of AAPL's founding president, Jonas Rappeport, MD. It offers the opportunity for outstanding senior residents with a dedicated career interest in forensic psychiatry to receive mentorship by senior forensic psychiatrists. Rappeport Fellows will receive a scholarship to attend the AAPL forensic psychiatry review course and the annual AAPL meeting, and a one-year mentorship by two Rappeport Fellowship Committee members. We wish to thank the AAPL Executive Leadership, the Rappeport Fellowship Committee members, and all Rappeport preceptors for their ongoing support of this superb training opportunity! The Rappeport Fellowship Committee and AAPL are excited to announce the 2020-21 Rappeport Fellows: Dr. Kathryn Baselice, Dr. Ayala Danzig, Dr. Tyler Durns, Dr. Gregory Iannuzzi, Dr. Laura Sloan, and Dr. Tianyi Zhang. Congratulations! Please join us in extending a warm welcome our 2020 Rappeport Fellows!



Kathryn Baselice, MD

Dr. Kathryn Baselice is a PGY-4 in the Adult Psychiatry Residency at New York University. She completed her undergraduate education in psychology at Johns Hopkins University and was named to the Phi Beta Kappa honor society. Dr. Baselice decided on a career in forensic psychiatry during her undergraduate years, and interned at the National Institute for the Study, Prevention, and Treatment of Sexual Trauma in Baltimore, working with sexual offenders. She completed her medical school education at the University of Virginia School of Medicine. Throughout her time at UVA, she was an active participant and presenter at The Institute of Law, Psychiatry and Public Policy in Charlottesville, VA.

During her final year of medical school, she designed and implemented a project educating various groups within the lay and medical community about postpartum psychosis. She was also asked to present on postpartum psychosis at the Judge Advocate General (JAG) School at UVA. She has co-presented several Grand Rounds presentations on topics such as Not Guilty by Reason of Insanity pleas, postpartum psychosis and online dating. She recorded a lecture on online dating with several of her co-residents for the American Psychiatric Association (in lieu of a scheduled workshop that was accepted to the 2020 Annual Meeting). She has co-authored book chapters on evolutionary psychology, with various themes including "evil," violence, arrogance, and eroticism. In 2021, she will begin her forensic psychiatry fellowship at the University of Virginia. Her Rappeport mentors are Dr. Sara West and Dr. Gary Chaimowitz.



Ayala Danzig, MD

Dr. Ayala Danzig is a PGY-4 in the Department of General Psychiatry at the Yale University School of Medicine. Originally from New York City, she completed a Master of Social Work at New York University and had a career in elementary education prior to medical school. Dr. Danzig graduated from the University of Rochester School of Medicine and Dentistry as a member of both the Alpha Omega Alpha and the Gold Humanism honor societies. She was also awarded the Leonard Tow Humanism Award by her medical school class. During residency, Dr. Danzig has been actively involved in advocacy and medical education, both areas of passion and interest. She has also co-authored three publications in JAAPL including a legal digest article about helping psychiatric patients navigate the legal system. At the conclusion of her PGY-2 year Dr. Danzig received a resident teaching award and an award for clinical excellence. Dr. Danzig's interests include criminal justice reform, balancing patient rights with community safety and addressing racial inequities in medicine. Dr. Danzig is an APA Leadership Fellow as well as the Chair of the Assembly Organization of Residents and Fellows of the APA. In 2021, she will begin her forensic fellowship in the Law and Psychiatry department at Yale University. Her Rappeport mentors are Dr. Susan Hatters Friedman and Dr. Renee Sorrentino.

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Tyler Durns, MD

Dr. Tyler Durns is currently a Chief Resident at the University Neuropsychiatric Institute with the University of Utah, where he also serves on the Ethics and Safety Committees for the hospital. As a medical student at the University of Arizona, he began working in mental health advocacy, starting a free full-service psychiatric clinic that is still running today. He has carried this sentiment through in residency, now working as part of a legislative action committee to institute an insanity defense in the state of Utah. Having taught and helped create undergraduate courses prior to medical school, Dr. Durns has since been involved in educational endeavors. This includes instituting a forensic curriculum for residents and fellows at the University of Utah, and lecturing on other topics central to the residency curriculum. Dr. Durns has published and presented numerous works in peer-reviewed journals and at national/international conferences including the APA and AAPL, where he serves on the Law Enforcement Liaison, Neuropsychiatry, and Psychopharmacology Committees. His areas of research range from risk assessment to psychotherapy and the use of novel compounds for treatment-resistant mood disorders. In 2021, he will begin his forensic psychiatry fellowship at the University of California, Davis. His Rappeport mentors are Dr. Nathan Kolla and Dr. Catherine Lewis.

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RAPPEPORT FELLOWSHIP AWARDS, 2020-2021



Gregory Iannuzzi, MD

Dr. Gregory Iannuzzi currently serves as Chief Fellow for the Child and Adolescent Psychiatry Fellowship at the University of South Florida Morsani College of Medicine. He completed his undergraduate degree in biochemistry at the University of Maryland, College Park and earned his medical degree at the University of Maryland, Baltimore. During medical school, he became interested in forensic psychiatry while working with juvenile offenders through a volunteer mentorship program. He completed the General Psychiatry Residency at the University of South Florida and “fast-tracked” into child and adolescent fellowship. He received the 10th Annual AAPL Research Poster Award for his submission, ‘The Prevalence of Adverse Childhood Experiences in Florida Youth Referred to the Department of Juvenile Justice’. He has presented nationally at APA and AAPL and was twice awarded Outstanding Resident Teacher. He is the primary author for the chapter on suicide risk evaluation in the emergency setting for the second edition of *Emergency Psychiatry: Principles and Practice*. He currently serves on both AAPL’s Addiction and Child and Adolescent committees. His interests include youth violence risk assessment and restorative justice. In 2021, he will begin the Forensic Psychiatry Fellowship at the University of South Florida under the tutelage of past Rappeport Fellows Dr. Ryan C. Wagoner and Dr. Isis Marrero. His Rappeport mentors are Dr. Joseph Penn and Dr. Ryan C.W. Hall.



Laura Sloan, MD

Dr. Laura Sloan is a PGY-4 resident at the University of Minnesota. She completed her undergraduate studies at Tufts University and earned her medical degree from Tufts University School of Medicine. Prior to medical school, she served as an AmeriCorps volunteer in an HIV department. Dr. Sloan was a Health Justice Scholar in medical school for students interested in underserved medicine. She has authored publications in JAAPL including a legal digest and an editorial “Where We Are on the Twentieth Anniversary of *Olmstead v. L.C.*” Dr. Sloan has an interest in the care of individuals with developmental disabilities and has presented on this at the Minnesota Department of Human Services Grand Rounds. She is an APA Public Psychiatry Fellow and is a workgroup member for the APA Foundation’s Justice and Behavioral Health Tool. Dr. Sloan is the head of advocacy programming for her residency and has led psychiatry residents to lobby at the Minnesota State Capitol. She hopes to pursue clinical and research work in criminal justice reform. She is currently interviewing for a forensic psychiatry fellowship position. Her Rappeport mentors are Dr. Jackie Landess and Dr. Alan Newman.



Tianyi Zhang, MD

Dr. Tianyi Zhang is in her fourth year of adult psychiatry residency at the University of California, San Francisco. She earned her bachelor degrees in Latin American literature and biology from the University of California, Berkeley and conducted research on tuberculosis detection in Brazil through a training grant from the National Institute on Minority Health and Health Disparities. She then completed medical school at UCSF. Her long-standing interest is in correctional forensic psychiatry. Her research in the San Francisco county jail system has evaluated the implementation of a peer health educator program and explored the outcomes of making long-acting reversible contraception available to women who are incarcerated. She has received a resident teacher award, taught medical student didactics on legal issues in psychiatry, and led medical students in facilitating a weekly women’s health empowerment class at the San Francisco County Jail. She presented on the use of expert witness testimony in sex trafficking prosecutions at our 2019 AAPL meeting. In 2020, she will start forensic psychiatry fellowship at UCSF. Her Rappeport mentors are Dr. Britta Ostermeyer and Dr. Ryan Wagoner.

AAPL is pleased to announce the 34th Annual Rappeport Fellowship competition. Registration to the Forensic Review Course and 2021 Annual Meeting along with travel, lodging, and educational expenses are provided to the winners. Contact the AAPL Executive Office for details.

Britta K. Ostermeyer, MD, MBA

Philip J. Candilis, MD



Growing up in the countryside of Hanover, Germany, Britta Klara Ostermeyer is an unexpected Bayern Munich fan. The region is daft for Hanover 96,

the soccer club representing Lower Saxony since 1896. Dr. Ostermeyer may be forgiven for her turncoat ways, given Bayern’s extraordinary flair and success over the decades. In her defense, Britta, who is proud of her Jewish heritage, notes that Bayern is the world’s largest sports club and was founded by Kurt Landauer, a German Jew. Some may even speculate that it was the team’s brainy attacking style that inspired her interest in neurosurgery as a teen.

Indeed, Britta served as a medical school teaching assistant in neuroanatomy and underwent neurology training. Dr. Ostermeyer took on prestigious fellowships and rotations from the combined National Institute of Neurology and National Hospital for Neurology and Neurosurgery in Queen Square, London, to the University of Vienna, Austria, and eventually the Baylor College of Medicine in Houston. With a full-year stipend to visit Baylor, Britta eventually settled on psychiatry. It was her best friend from medical school who finally convinced her: “She knew more about the patients than anyone,” Britta says; “Their personal history, related treatment options. It wasn’t all steroids and immuno-suppressants.”

Dr. Ostermeyer ultimately trained at Columbia University and the New York Psychiatric Institute, finding another reason to remain in the US: her husband Dr. Saul Puszkin. A neuroscientist, Saul was a presence at medical meetings they both attended. Together, they made their home in New York City.

Dr. Ostermeyer credits Columbia’s former residency director, Dr. Ronald Rieder, with encouraging her to apply

for the AAPL Rappeport Fellowship, which she won in 2002. Dr. Charles Scott became her Rappeport mentor, who in turn introduced her to Dr. Phillip Resnick – a trifecta of mentors who cemented the transition to forensic psychiatry. Because Saul was not initially eager to leave New York, Phil invited them both to Cleveland, winning over the reluctant neuroscientist. Britta subsequently completed her forensic fellowship at Case.

“Britta, who considers AAPL her organizational home, is a firm believer that the united voice of professional organizations offers much greater political impact.”

Soon, Baylor was once again Dr. Ostermeyer’s practice setting, this time for a lengthy academic appointment. Britta committed her energy to the city’s access-to-care challenges, teaching trainees about vulnerable, underserved groups, improving connections with primary care, and developing a forensic curriculum. In 2007, she won APA’s Gold Achievement Award for founding and serving the Community Behavioral Health Program in Houston. This integrated primary care-behavioral health program may now be the largest in the nation, with behavioral health specialists and counselors staffing approximately 40 large-scale primary care centers in the city.

Fortified by an MBA from the University of Tennessee, Britta ascended to the Psychiatry chair at the University of Oklahoma, where she also received the endowed Paul and Ruth Jonas Chair in Mental Health. She simultaneously became Chief of Psychiatry for OU’s hospital system.

It was an opportunity to expand forensic programming – especially through connections with city and state agencies treating correctional populations. Today, Britta heads the mental health team at Oklahoma County Detention Center in her relatively new role as the institution’s Mental Health Authority. Not only was this an opportunity to improve the care of the neediest, but also to bring resources into her Department. She consequently expanded interdisciplinary training across her county and at OU, increased her Department’s capabilities for forensic assessment, and improved access to care. Most importantly, she made a profound personal contribution to the medical profession: her son, Anim, is currently a medical student at the OU College of Medicine.

Presently, Dr. Ostermeyer serves AAPL as a Councilor, and as co-chair of the Rappeport Committee, mentoring the next generation of forensic psychiatrists and integrating them into AAPL. She finds this to be an important aspect of her leadership obligations as a Department Chair as well, enjoying the hiring of new faculty and residents, and mentoring each group as they pass through. The APA recognized her talent in this arena, awarding Britta the 2019 George Tarjan Award for her work on behalf of international medical graduates and their incorporation into American psychiatry. Britta, who considers AAPL her organizational home, is a firm believer that the united voice of professional organizations offers much greater political impact. In this spirit, Britta holds offices in Oklahoma’s psychiatric associations and in the American Association of Chairs of Departments of Psychiatry, serving the latter as President-Elect.

Britta Ostermeyer finds her focus in the advocacy and lobbying for patients, colleagues, and the profession. She believes in taking on the stigma facing patients and their families. Seeing her work as an opportunity for community service, mentorship, and advocacy, Dr. Ostermeyer is at the heart of AAPL’s professional and community mission. ☯

Understanding Police Culture from a Former Police Officer

Douglas Brennan, MD



It is impossible to read the news these days without coming across allegations of police racism that arise following violent arrests or other police misconduct.

These reports are not confined to one department or region, but rather are occurring nationwide with ever-increasing frequency. Although each incident is unique and should be evaluated on a case-by-case basis, there are common elements which have provoked widespread outrage. This has led to demonstrations, civil disobedience and riots, and in some occasions, violence targeted towards the police. This societal reaction suggests near-universal concern regarding a culture of racism embedded in law enforcement, particularly towards African-Americans. This is a complex issue, one that is emotionally charged and fraught with frustration around the lack of progress towards the fundamental goal of egalitarianism in law enforcement. Despite this complexity, it is clear that change needs to happen and happen soon. What is less clear is exactly what needs to be changed.

What is the root cause of racism in law enforcement? Is there an organizational culture that molds young officers to act a certain way? Is it due to the type of person who is drawn to this career path? Can it be the result of enforcing laws within an inherently racist legal framework? The latter question is more a debate for legal scholars, so I will focus more on the first two topics, police personnel and culture.

To address these questions, it is helpful to learn more about the entity known as American law enforcement. There are a wide range of organizations who provide this service, with over 15,000 different law enforcement agencies across the United States,

varying in size, location and communities served (1). There are differences in which laws are enforced, even in overlapping jurisdictions as seen between county, state and local municipalities. The populations served by these organizations range from rural regions with few inhabitants to densely populated and more ethnically diverse cities. However, most police departments (over 12,000) are local and serve a defined geographic area and population; they are responsible for enforcing local and state ordinances as well as providing a first response to emergencies. It is these local police departments which bear the brunt of increased scrutiny and society's indignation.

“What is the root cause of racism in law enforcement? Is there an organizational culture that molds young officers to act a certain way?”

An article in the *Journal of Criminal Law and Criminology* (2) summarizes law enforcement organization well. “Policing was largely a local responsibility. Departments were organized hierarchically and quasi-militarily. Line officers exercised wide discretion. Patrol and detective functions were separated, and most officers were assigned to patrol. Detectives, like supervisors, started out as patrol officers and were promoted from within. The critical operation unit was the squad: a handful of line officers supervised by a sergeant, or in the case of detectives, by a lieutenant. Officers generally began police work at a young age and made it their career.” “As a legal and organizational

entity, the public police look much the same today as they did 30 years ago.” (2, 3) In other words, the faces may have changed, but the underlying organization has not.

Speaking of the faces of law enforcement, a common concern is that police departments do not reflect the racial composition of their communities. In years past, this was certainly true. According to data from the U.S. Department of Justice, Bureau of Justice Statistics (4), in 1993, black officers were 11.3% of the total full-time work force, Hispanic officers were 6.2% and white officers were 80.9%. Of this total, 8.8% were female. In 2016, the most recent data available (5), these numbers have changed to 71.5% white, 11.4% black, 12.5% Hispanic, and 12% of this total being female. These numbers more closely approximate the U.S. population ethnic breakdown of 76.5% white, 13.4% black, 18.3% Hispanic. Asian and other ethnicities were not as closely tracked in the past, so these numbers are not included. Individual departments vary in these ratios and how representative they are of their communities.

Returning to the question of the root cause of racism in law enforcement, in my opinion it is not due to the people who are drawn to work in law enforcement. There are bad actors in all career fields, and law enforcement is not immune to this, but the overwhelming majority of police departments screen their applicants for disciplinary and other behavioral issues. And, as noted above, departments increasingly reflect the demographics of their communities. It is also worth noting that in several high-profile cases, some of the officers involved were non-white.

What then of police culture? As a psychiatrist, I work in a specialty clinic that provides mental health services to first responders. In addition to this ongoing and regular contact with police officers, I have the rare perspective of having worked in law enforcement for several years, first as a local police officer and later as a federal agent. Before attending med-

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APA Assembly Updates

Danielle B. Kushner, MD

AAPL Representative to APA Assembly

The APA 2020 Annual Meeting originally scheduled for April in Philadelphia, Pennsylvania was cancelled due to the COVID-19 pandemic. The last time the APA did not hold the Annual Meeting was in 1945 because of World War II. Instead of the live meeting, the APA worked with program speakers to develop APA On Demand 2020, an online collection of expert-led presentations. This online library was first released in April, with plans for additional sessions to be added on a rolling basis. The APA also conducted a free live online 2020 Spring Highlights meeting in April for CME credit. The presentations are available on the APA website for review. The highlights included talks by APA leadership and former AMA President, Patrice Harris, MD.

The end of the Spring Highlights meeting marked the beginning of the Presidential term for Jeffrey Geller, MD. In Dr. Geller's talk, he emphasized the problems in the public mental health system that predated the COVID-19 pandemic and will remain in its aftermath. He called for a focus on the discrimination against those with serious mental illness and the psychiatric bed shortage at the heart of the mental health crisis.

The APA Assembly met on April 25, 2020 via online videoconference. It opened with a reflection and a moment of silence for those lost and affected by the COVID-19 epidemic. The meeting content was shortened due to the online format and several agenda pieces were moved to November's meeting. There were five Action Papers presented at the meeting, all of which were approved. Topics of note included a Position Statement on the treatment of transgender and gender diverse youth and an Action Paper promoting continued advocacy against the Medicare Executive Order of October 2019 that ordered equal reimbursement regardless of the expertise of the provider.

Key forensic issues from the As-

sembly meeting included approval of several Position Statements submitted by the Council of Psychiatry and the Law.

The first statement, "Competence Evaluation and Restoration Services and the Interface with Criminal Justice and Mental Health Services" provided key recommendations for assessing competency and restoration services, including the importance of timely services and availability of jail diversion, among others. The statement "Pharmaceutical Marketing to Justice Entities regarding Medication Treatment for Substance Use Disorders" emphasized that states should not enter agreements or enact legislation that favors particular substance use treatments in criminal justice settings. Another statement provided recommendations for consent for mental health treatment by guardians and other surrogate decision makers. It stated that alternatives to guardianship should be encouraged along with advance instructions about preferences when a patient has capacity, along with other recommendations. Lastly, a position statement regarding principles to govern involuntary and voluntary hospitalization for adults with mental illness was passed after being resubmitted to the Assembly following edits.

Other important recent APA actions include the establishment of the Presidential Task Force to Address Structural Racism Throughout Psychiatry following increased nationwide calls for action on racial justice. The chair of the task force is APA Area 4 Board of Trustee and AAPL member, Cheryl D. Wills, MD. The task force had its first meeting on June 27 and is initially charged with providing education and resources on APA's and psychiatry's history regarding structural racism, describing the current impact of structural racism on the mental health of patients and colleagues, and developing achievable and actionable recommendations for

change to eliminate structural racism in APA and psychiatry. APA CEO and Medical Director, Saul Levin, MD, MPA, stated that this is a time for reflection, accountability, and action for the APA.

Lastly, the APA has been active in promoting telepsychiatry and mental health services throughout the COVID-19 pandemic. On June 30, Dr. Geller testified before Congress to support pending mental health legislation to enforce the parity law, continue expanded telehealth rules beyond the COVID-19 emergency, boost crisis services, and strengthen congressional efforts to prevent suicide, among others. The APA Foundation has also developed the COVID-19 Disaster Relief Fund supporting mental health needs of front line health care workers along with other response work.

The next Assembly meeting is scheduled for November 2020 via videoconference. APA's 2021 Annual Meeting is scheduled for May 1-5 in Los Angeles, California. The meeting's theme is "Finding Equity Through Advances in Mind and Brain." ☎

SAVE THE DATE

**AMERICAN
PSYCHIATRIC
ASSOCIATION**

**ANNUAL
MEETING**

May 1-5, 2021

**Los Angeles,
California**

American Medical Association 2020 Virtual Annual Meeting Highlights

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

The American Medical Association's (AMA) 2020 Annual meeting was held virtually on Sunday, June 7, 2020. Given the COVID-19 pandemic and demands on physicians and the healthcare system during this challenging time, the traditional large-scale meeting was suspended per the association's bylaws for emergency conditions and reimagined as an online meeting. The meeting was abbreviated to conduct only essential business and elections for leadership positions within the organization. Nearly 1000 delegates attended the virtual meeting with alternate delegates and others also attending as guests.

Although it was an abbreviated meeting, the day started with several comments about the COVID-19 pandemic and its effects on healthcare delivery. A minute of silence was observed to recognize the loss of lives as a result of the pandemic – to patients, colleagues, and friends. This was followed by recognition of the protests over the death of George Floyd after he was arrested by Minneapolis police officers, societal racism, and police brutality. AMA Board of Trustees Chair, Dr. Jesse Ehrenfeld, emphasized that we must recognize that “many who serve in law enforcement are committed to justice” and that the “violence inflicted by police in news headlines today must be understood in relation to larger social and economic arrangements that put individuals and populations in harm’s way leading to premature illness and death.” Existing AMA policy recognizes that physical or verbal violence between law enforcement officers and the public, particularly those who are Black and Brown where these incidents have increased prevalence, is a determinant of health and supports research into the public health consequences of such violent interactions.

The AMA issued the following

statement about racism:

“The AMA recognizes that racism in its systemic, structural, institutional, and interpersonal forms is an urgent threat to public health, the advancement of health equity and a barrier to excellence in the delivery of medical care. The AMA opposes all forms of racism. The AMA denounces police brutality and all forms of racially motivated violence. The AMA will actively work to dismantle racist and discriminatory policies and practices across all of health care.” (1)

“...the day started with several comments about the COVID-19 pandemic and its effects on health-care delivery. A minute of silence was observed to recognize the loss of lives as a result of the pandemic – to patients, colleagues, and friends.”

In her final presidential address, outgoing AMA President Patrice Harris, MD, MA, a child and forensic psychiatrist, echoed the challenges of healthcare delivery in the setting of COVID-19 and highlighted ways in which the AMA has been advocating for patients and physicians during the pandemic. She also shared personal insights and experiences she and her family members have faced as Black Americans. Her powerful speech had a theme of gratitude and hope, despite the challenges currently faced by so many. Dr. Harris skillfully reminded the delegation that orga-

nized medicine and physicians can play instrumental roles in advancing the discussion about race – and other challenging topics – that affect the healthcare of the American public.

In her inaugural address, incoming AMA President Susan Bailey, MD, an anesthesiologist from Texas, used movie references to describe the hero's journey of a physician. She described the ways that physicians strive to overcome obstacles and join with friends and collaborators to partner through the journey. She emphasized the role of organized medicine to support doctors in “letting doctors be doctors” by removing obstacles to patient care and to supporting physicians in delivery of care through various practice models and settings. She asked that we lean on one another and share this journey together during this challenging time.

The meeting was followed by a special town hall on COVID-19. The AAPL delegation to the AMA looks forward to resuming regular business at the 2020 interim meeting in November 2020. Dr. Barry Wall continues as a Vice Chair for the AMA Section Council on Psychiatry. In addition, the AMA Board of Trustees has appointed him to be a member of the Committee on Conduct at AMA Meetings and Events. He went on to be elected Vice-Chair of that Committee.

You can find more information on the actions of the AMA House of Delegates at the 2020 Virtual Meeting at <https://www.ama-assn.org/about/house-delegates-hod>. ☎

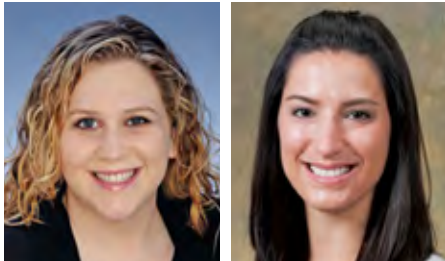
References:

(1) AMA Board of Trustees pledges action against racism and police brutality. Available at: <https://www.youtube.com/watch?v=EDQ8Mf5S-GZM> (accessed June 7, 2020)

The American Medical Association will be holding several virtual meetings and symposiums through the end of the year. Please visit www.ama-assn.org for more information.

Fellows Called to Action at Local and State Policy Levels During COVID-19

Bradleigh Dornfeld, MD and Anne Spina, MD



What a year! On December 31, 2019, officials in Wuhan, China confirmed dozens of cases of pneumonia from an unknown cause. A week later, the illness was identified as resulting from a new coronavirus (1). The COVID-19 pandemic hit the United States with the first case confirmed on January 21, 2020 and first death on February 29, 2020 (2). By March, sporting events were suspended, schools closed, and states were going into lockdown (3). Medical education fell under level three pandemic status and programs considered what training would look like amidst a global pandemic.

As the virus spread, public systems were impacted: courts shut down, jails were emptied, and hospitals ramped up to handle patient loads. State hospitals around the country were not immune from the virus, and many had outbreaks. In Michigan, the identified “forensic hospital” was among those impacted, being located in one of the community hotspots. As fellows, we were in a unique position to be involved simultaneously with multiple rapidly changing systems. Here’s how we participated and adapted.

Impacts on Forensic Work and Training

As general psychiatry rapidly transitioned to telepsychiatry, the forensic world adapted, too. Prior to COVID-19, we participated in forensic risk assessments within the state hospital system. The work was transitioned to a virtual format for the first time. We discussed how to obtain consent for this unique interview, the logistics

of who is physically present with the patient, interviewing with masks, and caveats of video interviewing. Having a supervisor model the appropriate skills helped us become comfortable with the format.

Evaluations for competency to stand trial and criminal responsibility also transitioned to virtual format for the first time at our facility. As fellows, we attended planning discussions and trainings about the implementation of this new format. We saw a system respond quickly to fill a need, with staff very conscious of doing what was necessary for vulnerable evaluatees. In “normal” times, system changes of this magnitude would take months to develop and implement, but with the diligent members of our evaluation and forensic services departments, the transition was completed in a mere three weeks!

As fellows, we were tasked with being both the learners and teachers through a virtual medium. We participated virtually in civil case discussions, landmark cases seminar, didactics, law school classes, and mock trials. We gave presentations to residents and led virtual journal clubs. We attended the Weizman Institute’s lectures on COVID-19 best practices. This transition to virtual learning made it possible to continue our forensic education in the midst of a pandemic.

Hospital-Level Policy

As fellows we are members of the treatment teams at the state forensic hospital. As cases of COVID-19 surged in Michigan, we were involved with the rest of the medical staff in planning the hospital’s response to the virus. Virtual daily medical staff meetings were called to address evolving challenges to contain the virus. When one of our units became the sole admission unit for patients under quarantine, a major restructure for the hospital, we both volunteered to step in and assist with the shifting burden of work. We continued to treat patients during the

outbreak and worked with our teams to implement safety measures including social distancing, sanitizing, proper use of personal protective equipment, screening, and establishing a quarantine period for new admissions. With these steps, our hospital was able to contain the outbreak and protect both patients and staff.

State-Level Policy

As part of our training we are supervised by Dr. Debra Pinals, Past President of AAPL and the medical director of behavioral health and forensic programs for the Michigan Department of Health and Human Services. We were quickly enlisted with the creation of public policy and support documents. The larger psychiatric community had a burgeoning need to shift practice in ways that balanced minimizing spread of the virus and maximizing supports to maintain individual psychiatric stability. We created resources that helped guide psychiatric practice, such as guidelines related to long-acting injectable medications (4). We addressed the mental health of specific groups such as patients newly diagnosed with COVID-19 (5) and the clinicians serving them (6), law enforcement officers (7) and correctional workers (8). We had the unique opportunity to learn from leaders in our field by joining a conference call of medical directors discussing ways that COVID-19 affected their regions and how it was being addressed.

Conclusion:

We expected to be challenged during fellowship, but never imagined the systematic changes we faced during COVID-19. Completing a forensic psychiatry fellowship during a global pandemic created unique learning experiences related to forensic patient care and public policy. As we reflect back on the year, the ability to be flexible and respond to the call to action were of utmost importance. We learned the importance of being patient with supervisors and administrators as they themselves navigated changes, then working together with them to find solutions. As we become

(continued on page 16)

Royal College of Psychiatrists Forensic Faculty Annual Conference Liverpool 2020

*Dr. John Baird, Dr. Mary Whittle, Dr. Navneet Sidhu, Dr. Rachael Sibbett,
Dr. Chris O'Shea and Ms. Ramandeep Purewal
International Relations Committee*

The Forensic Faculty of the Royal College of Psychiatrists held its annual meeting this year in Liverpool, England, from 4th to 6th March 2020. Liverpool is a proud and very independently minded city. Those who were born and brought up there take pride in their hometown, and there is much for visitors to see. Everyone knows about the Beatles but American visitors may be interested to find, for example, a display telling the story of Rosa Parks in the Civil Rights Museum, which is part of the restored waterfront.

This conference was the last during the Chairmanship of Professor Pamela Taylor, who has for many years been a leading light in the Faculty. The event was a fitting finale to her term of office.

Conference organizer Dr Andrew Forrester had put together a very varied and original program and the three days of the conference were attended by about 300 delegates. Topics reflected the diverse nature of modern forensic psychiatry, but, within the space available, we can do little more than mention themes, memories and impressions.

Early sessions dealt with the importance of collaboration between clinicians and team working, and discussed the serious problems which can arise when patients who suffer from autism spectrum disorder are detained in hospital. We were reminded of how untreated or incompletely treated personality disorder inevitably increases risk and the likelihood of re-offending. We heard a report of a follow-up study of 900 patients who had been in a medium secure unit, with somewhat alarming mortality, morbidity, re-offending and re-admission rates.

Robust science transcends political

boundaries and Professor Giovanni de Girolamo from Italy spoke of similar problems in that country, with increased rates of re-offending particularly among patients who had previously committed violent offences and who had a personality disorder.

A lively debate addressed the question of whether victims and relatives of victims should have a central role in decisions about release of patients from secure hospitals. A clear majority of delegates did not support the motion. While victims and relatives of victims must be able to contribute to the proceedings and be kept informed if they wish to be, the 'house view' was that it would be wrong for them to have primacy.

During the afternoon two very lively and well-received plenary sessions were delivered by experts in their field who were not forensic psychiatrists - psychopharmacology by Professor David Cunningham Owens and artificial intelligence by Professor Mischa Dohler. Both these talks would have suited the lunch time sessions which have become an established feature at AAPL annual meetings.

The second day of the conference continued with a number of parallel sessions, notable among which was a session on the death penalty. American colleagues may wonder what interest there is in the death penalty within the United Kingdom where the death penalty was abolished over fifty years ago, but within some British Commonwealth countries the death penalty is still available and executions still occur. British psychiatrists can be involved in assessments in such cases and as a result are required to confront the formidable ethical and professional issues which arise.

Next came a lively session on the

topic of fitness to plead, or competency as it is known in North America. The history of this concept was described imaginatively and with great dramatic effect against the background of a play by Shakespeare. This led to discussions, not just of that concept, but also to the issue of culpability for a criminal act. The meeting concluded that these concepts are complex and precise definitions are elusive.

We were treated to a discussion on the possible myths of risk assessment. Based upon robust research evidence, it was proposed that risk assessment on its own would not improve outcome and to improve outcome it must be associated with appropriate interventions. The limitations of clinical judgement were highlighted, as was the value of even simple actuarial tools which should never be overlooked when supported by randomized clinical trials. We were told that, when applied properly, risk assessment could identify individuals who were likely to present particular concerns and that the oft quoted limitation that risk assessment deals only with groups rather than individuals did not withstand careful scrutiny.

Other particular highlights were Professor Hilary Marland and Professor Catherine Cox examining the history of prisons and imprisonment and a Masterclass on mental health chaired by Professor Iain McKinnon with, among other speakers, Professor Tina Dorn from the Netherlands and Professor Patrick Chariot from Paris.

The conference committee were particularly pleased to welcome these colleagues from Europe, and continuing the international theme, to also welcome Professor David M. Diamond from the University of South Florida, Tampa who, via video link, delivered a powerful presentation on catastrophic memory errors.

The annual medical student essay prize is run ably for the Faculty by Dr. Aideen O'Halloran. As in previous years, four medical students were short-listed present their work, all within a forensic context. The presentations were, as ever, of a high

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An Insider's Look at the AAPL Diversity Committee

Bethany Hughes, MD, and Barry Wall, MD
Diversity Committee

When the inaugural meeting of the AAPL Diversity Committee was held in October 2016, we made sure to be present. Any group that advanced the action and dialogue on how age, gender, race/ethnicity, nationality, gender identity, sexual orientation, religion, disability or socio-economic background play out in the workplace was a group we wanted to join. As we strive for inclusion (both personal and professional) in today's society, these efforts add immense value to the drive for continued excellence in our field.

AAPL is committed to providing a professional home for all forensic fellows and psychiatrists, honoring the individual differences that make each person unique. Because its membership has become more diverse over the years, the AAPL Council formed this Diversity Committee, chaired by Dr. Charles Dike, to build on AAPL's welcoming environment and to promote equity within the organization. Our main charge is to create a nurturing and accepting environment for all minority and under-represented persons within our organization.

The Diversity Committee is currently comprised of enthusiastic members unafraid to engage in robust discussions of issues confronting minority groups in professional associations. During the meetings, we address a variety of topics, such as the meaning of institutionalized forms of discrimination/disadvantage, the definitions/dimensions of diversity, and the impact of race, ethnicity, and LGBTQ status on disability issues.

Our committee plans to contribute to AAPL in many ways, including offering workshops on diversity and inclusion, establishing a diversity/minority mentorship program, and participating in leadership and policy initiatives. Supporting forensic psychiatrists from minority and under-represented groups and increasing

skills in cultural competence can help reduce the health disparities common in forensic settings.

It is our hope that the Diversity Committee will continue to grow while striving to create a community for the personal and professional growth of all minority and under-represented groups within AAPL. If you have suggestions or you are interested in joining the Diversity Committee, please contact Dr. Charles Dike. ☎

Fellows Called to Action

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new attendings during the COVID-19 pandemic, we will likely continue to face new challenges, and we feel prepared with our acquired skills and knowledge. In the future, as supervisors of others, we will reflect back and continue to learn from this time, remembering how adaptable systems and people can be in the face of a mounting crisis. ☎

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Aging Death Row: Constitutional Law, Competence and *Madison v. Alabama*

Sherif Soliman, MD; Margaret S. Russell, Esq;
and S. Marc Testa, PhD, ABPP-CN
Geriatric Psychiatry and the Law Committee

Cognitive decline may render an older inmate incompetent to be executed, an issue addressed in the Supreme Court's recent decision in *Madison v. Alabama* (1). Vernon Madison, a 67-year-old death row inmate, suffered multiple strokes and has been diagnosed with dementia. He could not recall the 1985 killing for which he was sentenced to death. The Court held that amnesia, per se, does not render a prisoner incompetent to be executed. However, dementia may prevent an inmate from rationally understanding the reasons for his proposed execution.

Legal Standards

America's death row population is aging: 459 prisoners were 60 years old or older as of 2016. According to the Death Penalty Information Center, this figure represents a growing senior death row population, which numbered just 39 in 1996. (2) The vast majority of seniors are on death row because of the length of the capital appeals process and a reluctance to execute. Dementia and other age-related health problems increase due to the "death row lifestyle" – solitary confinement, poor nutrition, stress, lack of healthcare, and minimal to nonexistent exercise. This leads to an increase in claims of incompetency for appellate and warrant proceedings in preparation for executions.

The basis for excluding incompetent defendants from trial is based on the 5th Amendment to the United States Constitution, which states that "No person shall be ...deprived of life, liberty or property without due process of law." By contrast, the basis for excluding incompetent defendants from being executed is the 8th Amendment – "...nor cruel and unusual punishments inflicted." States are free to expand these basic protections, but the interpretation by the Supreme

Court of the United States sets the minimum constitutional standard for competency nationwide.

State standards for competency for execution vary widely. The majority of states and the federal government follow the *Ford* (3) and *Panetti* (4) standards for competence for execution. Six states (Missouri, Mississippi, Oklahoma, Nebraska, North Carolina and South Carolina) offer additional or different protections through statute and case law.

One thing that is practically certain is that the legal standards for competency for execution will continue to change and be tested as death row ages. In addition, the practitioner should be aware of the varying legal standards that govern the law of the jurisdiction of each unique case.

Evaluation

At a minimum, a mental health evaluation of competence to be executed should include a review of the defendant's history, current functioning, and understanding of the impending execution and the reasons for it. In addition, there are unique considerations that vary by jurisdiction. For example, in states where the standard is similar to competence to stand trial, a consideration of the defendant's ability to assist their attorney may become relevant.

A standardized neuropsychological assessment is the gold standard methodology used to provide evidence that an individual has experienced significant cognitive decline in one or more domains of cognitive functioning. While there is no "standard" test battery used to evaluate suspected dementia, a neuropsychological test battery should include measures designed to better understand cognitive functioning related to orientation, intelligence, attention, information processing speed, motor speed, executive

functions (e.g., reasoning, judgment, mental flexibility, decision-making, and inhibitory control), learning and memory, language expression and comprehension, and visual-spatial processing.

Emotional functioning should also be examined as part of a standard neuropsychological assessment of dementia. These symptoms include depression, anxiety, irritability, agitation, visual and auditory hallucinations, delusional thinking, and apathy.

Performance validity tests (PVTs) are employed to ensure that the derived test results are valid and reliable measurements of the examinee's actual cognitive abilities. While PVTs are well-studied and widely employed by neuropsychologists in a variety of contexts, they can be problematic in the evaluation of dementia due to unacceptably high false-positive rates (i.e., an inaccurate conclusion that test performance is not valid) (5). Interpretation of PVT failure must be made cautiously, based on measures deemed to be appropriate for use in dementia populations, and within the broader functional context. (6, 7)

In the context of one's personal and medical history, the overall cognitive profile and pattern of relative strengths and weaknesses can help determine the presence of cognitive dysfunction and which brain systems may be implicated. Because different dementia-causing syndromes involve dysfunction of specific brain regions, the neuropsychological test results can be used to help determine possible etiologies of cognitive decline.

Conclusion

The *Madison* decision has implications for evaluating competence to be executed in the cognitively impaired. First, the Supreme Court admonished lower courts to not focus exclusively on the presence or absence of psychosis. Prior Supreme Court precedents on competence to be executed, such as *Ford* and *Panetti*, had focused on delusions, but, as the Court pointed out, that focus was dictated by the facts of each case rather than a legal standard requiring psychosis. The

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Forensic Psychiatry Liaison to Policymakers: New Mental Health Laws

*Karen B. Rosenbaum, MD; Christopher Thompson, MD; Charles Scott, MD; Robert L. Trestman, PhD, MD; and Michael Champion MD
Government Affairs Committee*

At the 2019 AAPL Annual Meeting, members of the Government Affairs Committee presented on local legislation related to forensic psychiatry and federal legislation, and explained the Consortium of Forensic Science Organizations (CFSO), which AAPL recently joined. The CFSO is now composed of six forensic science organizations providing a liaison between forensic science organizations and policy makers at the national level.

Christopher Thompson introduced the speakers and moderated the panel, as well as introducing the concept of the CFSO.

Karen Rosenbaum presented on a New York state bill, A00118, which was reintroduced on January 9, 2019. The bill proposes a women's health education program in correctional facilities, which would allow female inmates in New York State prisons and jails access to pregnancy counseling services and a support person to accompany inmates during delivery. The bill would require that pregnant inmates be provided a prenatal diet designed to help with maternal and fetal health, and would require the state to study and report on women's overall health in prison during their prison stay. The impetus for the bill included a 2015 Report on Reproductive Injustice which noted, "Some findings are positive, as DOCCS [Department of Corrections and Community Supervision] is performing well in certain areas related to mental health. Overall, however, we found that reproductive health care for women in New York State prisons is woefully substandard...with women routinely facing poor-quality care and assaults on their human dignity and reproductive rights. The damage the prison setting does to women's emotional well-being is profound, and women's emotional well-being

is deeply connected to their physical health. Many women we spoke with talked about this connection." (1)

In her dissertation in 2016, Kate Walsh noted three areas of particular concern in women's correctional healthcare: 1) access to gynecological examinations; 2) access to sanitary supplies; 3) and access to contraception. (2) Between 1980 and 2016, the number of incarcerated women in the US has increased 700 percent. This is in part because of new mandatory sentencing guidelines for co-conspirators (i.e., women of limited financial means are being convicted along with their male partners, who are more often the actual perpetrators of the crime). (3)

In New York state prisons, rates of solitary confinement are higher than the national average. Women with mental disorders or symptoms and women who are pregnant or suffering from conditions such as endometriosis often have even less access to healthcare when in solitary and also are more susceptible to the negative effects of solitary confinement. (1) Bill A00118 has been held in the state legislature's Ways and Means Committee while revenue for the proposed changes is being collected.

Charles Scott presented on California's Assembly Bill 1810, which was enacted in June 2018. It allocates \$100 million to the counties to enhance pre-trial diversion programs. Key aspects of this bill include: postponement of prosecution to allow mental health treatment; provisions for enrollment in inpatient or outpatient treatment; a requirement that the relevant court approve the treatment program; and an expectation that regular reports on defendant's progress will be submitted. It set forth the following conditions for diversion:

1. The defendant suffers from a mental disorder identified in the

most recent edition of the Diagnostic and Statistical Manual, with the diagnoses of antisocial personality disorder, borderline personality disorder, and pedophilia excluded from eligibility;

2. The defendant's mental disorder played a significant role in the commission of the charged offense;
3. A qualified mental health expert opines that the defendant's symptoms motivating the behavior will respond to mental health treatment;
4. The defendant consents to diversion and waives his or her right to a speedy trial;
5. The defendant agrees to comply with treatment as a condition of diversion; and
6. The defendant will not pose an unreasonable risk of danger to public safety if treated in the community.

A defendant's period of diversion cannot last longer than two years. If the defendant successfully completes the diversion program, the court must dismiss the defendant's criminal charges and the defendant's record of arrest for that offense is expunged. Charges may be reinstated under the following conditions: the defendant is charged with a felony or a misdemeanor that reflects a propensity for violence; the defendant engages in conduct making him or her unsuitable for diversion; or a qualified expert opines that the defendant is performing unsatisfactorily or is gravely disabled. The success of this deferred prosecution will depend on the accurate identification of individuals appropriate to the program, accuracy of risk assessments, and matching of appropriate treatment services to the specific needs of each individual.

Robert Trestman discussed Virginia Bill § 37.2-308.1, Acute Psychiatric Bed Registry, which involves developing a web-based psychiatric bed registry (PBR) to collect, aggregate, and display data on the availability of acute beds in all of the state's inpa-

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Bad or Mad: Send 'em to Solitary?

KyleeAnn Stevens, MD

Criminal Behavior Committee

During the 50th annual AAPL meeting held in Baltimore, members of the Criminal Behavior Committee (Drs. Ryan Shugarman, KyleeAnn Stevens, Sohrab Zahedi, Joe Simpson, and Anthony Tamburello) held a panel discussion on the topic of segregation within corrections, the indications (if any) for its use, and the potential impact on individuals with mental illness, substance use disorders, and on other special populations. Guidelines issued by American and international professional organizations were also reviewed. The panel and audience discussion focused on the difficult decisions around management of unsafe behaviors within a correctional setting. Of note, the terms “administrative segregation,” “restrictive housing” (RH), “solitary confinement” and “extended control” are used interchangeably and typically involve single-cell confinement for 23 hours daily; inmates are allowed one hour out of the cell for exercise and showers. (1)

From a historical perspective, the use of solitary confinement in America is a relatively recent development. Prior to the early 20th century, prisoners demonstrating problem behavior(s) were generally dispersed among prisons. (2) The first and most well-known example of a maximum-security prison was Alcatraz, which opened in 1934 and held federal prisoners whose problem behavior was defined as “habitual and intractable.” Upon its closure, its former prisoners were dispersed across the country.

The American prison population stayed relatively stable until the late 1970s, after which the population quintupled over the next few decades, largely due to mass incarceration for drug offenses and a tough-on-crime approach by state legislatures. (2) Several high-security units within existing prisons or high security prisons were built during this time and as of the year 2000, sources estimate there are 60 such facilities with over 40,000

inmates throughout the United States. (3)

Criteria for admission to these restrictive housing units are not well standardized, though generally people who are deemed a threat to the safety and security of the institution are candidates for this placement. Those who demonstrate repeated or serious acts of aggression, disruptive behaviors, and serious rule infractions find themselves in extended control placement. Individuals with symptoms of mental illness, cognitive impairments, or who are suffering from the effects of substances may engage in assaultive, self-harming or seriously disruptive behaviors. As a result, those with mental illness are disproportionately represented in segregation.

While there are challenges in studying this segregated population, there are numerous studies and case reports of the impact of segregation on individuals. Though too exhaustive to review here, most studies have found that inmates in RH have higher levels of psychological distress and significantly higher risk of suicide and self-injury compared to control groups, and those with mental illness tend to fare worse than their counterparts. These effects may persist beyond release from the restricted environment. (2, 8)

The US Department of Justice (DOJ) issued a report in 2016 about the use of RH for special populations, such as those with serious mental illness (SMI), gender identity and sexual orientation differences, juveniles and young adults, and pregnant or postpartum women. (4) DOJ recommends avoiding RH for inmates with SMI, but if thought necessary, evaluation by a mental health professional should first take place. This evaluation should include assessment of suicide risk, presence of psychotic symptoms, and a determination of whether symptoms contributed to the reason for misconduct. After the required evaluation, if an inmate with SMI is

placed in RH, DOJ advises that there must be intensive, clinically appropriate treatment, enhanced opportunities for therapeutic activities, weekly review and face-to-face mental health contact, with removal after thirty days unless a warden certifies otherwise. The DOJ advises that young adults (ages 18-24) should not be placed in RH, but if behaviors pose “serious and immediate risk of harm,” young adults have a brief placement in RH as a “cooldown” period, in consultation with a mental health professional. (4) Enhanced training of correctional staff on young adult development, de-escalation, and therapeutic communities to reflect an adapted approach to young adults is also advised. The DOJ stresses the importance of not using restrictive housing solely on the basis of sexual orientation or gender identity, and advises that women who are pregnant, postpartum, or who have experienced loss of pregnancy should not be placed in RH unless there is a serious and immediate risk of physical harm.

Other national organizations have weighed in similarly, including the National Commission on Correctional Healthcare and the American Psychiatric Association, which stated in 2012 that prisoners with serious mental illness should not be in prolonged segregation and RH should be avoided in juveniles in all circumstances. In both cases, the APA recommends meaningful access to care, education, and recreation. (5, 6) On an international stage, the World Health Organization, World Medical Association, and the United Nations have issued statements or rules on the use of solitary confinement which are closely aligned with the guidelines summarized here.

The panel further discussed the role of medication assisted treatment (MAT) in corrections for treatment of Substance Use Disorders (SUDs). While corrections collectively has been slow to implement a full array of MAT, the 1st Circuit Court of Appeals recently enforced the obligation to do so under the Americans with Disabilities Act and the Eighth Amendment

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Challenges in Inpatient Psychiatric Settings Amidst the COVID-19 Pandemic in Maryland

Kamal Bhatia, MD
Technology Committee

All states have different and at times, complicated commitment processes both for civil and criminal cases. For instance, in the state of Maryland (1), individuals requiring a psychiatric evaluation may be taken to the emergency room involuntarily under an “emergency petition” filed by a concerned and designated individual. In the emergency room, individuals may be deemed “certified” when two assessors are of the clinical opinion that an individual requires inpatient psychiatric care on an involuntary status. Upon arrival to an inpatient unit, these individuals may continue to refuse or decline all scheduled psychotropic medications, until the hearing officer formally “retains” the individual, *and* a medication panel is completed successfully. After this, the individual may be administered medications over their objection. The entire process from inpatient admission to involuntary medication administration may last as much as two to six weeks, depending on how the individual chooses to pursue his treatment and how the hearing process is completed.

These legal processes work both to protect patient autonomy, as well as to preserve patient rights. However, sometimes, these processes can also arguably result in delaying necessary treatment to those with severe mental illnesses. In Maryland, the process of civil commitment becomes all the more important, as there are no outpatient civil commitment provisions (known in some states as Assisted Outpatient Treatment) available.

The COVID-19 pandemic has created unique challenges for psychiatric care in clinical and forensic settings. Several states, including Maryland, moved to an online platform to conduct commitment hearings from remote locations. Some states moved more quickly than others, while for some it took weeks before the online

platforms were reliably established. Online platforms such as Zoom and Google Meetup were explored, all of which had learning curves of their own. From a civil inpatient psychiatrist’s perspective, this additional “lag” time arguably may have led to a delay in care. For example, individuals in this “uncertain” status i.e., awaiting administration of medication over objection - may theoretically continue to refuse treatment for an indeterminate period of time, leading to a further clinical decline in mental

“...video-conferencing also may create interesting situations for the patient as well as the psychiatrist – for example, the refusal to comply with the “new” hearing process and the lack of meaningful alliance with the attorney.”

state. Other unintended complications – longer hospitalizations due to delays in treatment, treatment resistance, and unit disruptions due to behavioral problems – may occur due to the delay in care. Additionally, video-conferencing also may create interesting situations for the patient as well as the psychiatrist – for example, the refusal to comply with the “new” hearing process and the lack of meaningful alliance with the attorney. Technical issues such as privacy concerns, encryption-related uncertainties, connectivity issues, and audio-video limitations can also cause further delays or postponement of hearings. Important as these issues are, specific data on the

number of hearings affected by these delays is lacking.

This poses several interesting questions with regards to autonomy, due process, and beneficence. For example:

- Does a delay due to technical difficulties constitute a delay in due process?
- Are outcomes of treatment affected with this delay in care?
- What are the individual’s rights in this situation? Can an individual demand an in-person hearing? If so, can it be declined?
- Should we, as physicians, adjust our thresholds to seek care for someone in need of urgent psychiatric care, if a delay is foreseeable?

As physicians, we always strive for a balance between beneficence and autonomy; however, this unusual situation has created hitherto unheard-of scenarios from a medico-legal perspective. In uncertain emergent situations like these, can state governments allow the use of emergency powers that could make it easier for treatment to be accessed for individuals in need? Should a national pandemic be considered a situation where new emergency commitment procedures may be activated to avoid delays in treatment?

Further studies to look into specific issues of exacerbation of mental illness as a result of this abrupt change in the delivery of due process and delays in treatment (*if supported*) would certainly be helpful in addressing the questions outlined above. ☯

Reference:

(1) Maryland Health-General Code § 10-632 (2018)

MUSE & VIEWS

LAWYER: When he went, had you gone and had she, if she wanted to and were able, for the time being excluding all the restraints on her not to go, gone also, would he have brought you, meaning you and she, with him to the station?

OTHER LAWYER: Objection. That question should be taken out and shot.

Source: <https://www.boredpanda.com/funny-court-reports-disorder-in-court/>

Update on the Parkland Shooting Civil Cases

Ryan C.W. Hall, MD

On February 14, 2018, Nickolas Cruz is alleged to have shot and killed 17 people and wounded 17 others at the Marjory Stoneman Douglas High School in Parkland, Florida. At this time, Cruz's criminal case is still proceeding. The shooting captured the attention of the nation and brought several issues to the national forefront, such as gun control, violence, and mental health treatment. In addition to the criminal matters, there are several civil lawsuits that have also been filed. The civil case brought by the Estate of Meadow Pollack named Henderson Behavioral Health Inc. as a defendant, along with other individuals and organizations, including Cruz himself. The trial judge for the case initially dismissed Henderson Behavioral Health from the complaint. This dismissal was recently upheld on May 27, 2020 by the Fourth District Appellate Court of Florida. (1) The legal theory of the complaint was that Henderson Behavioral Health was negligent for failing to prevent Cruz from being mainstreamed into the public school system (past history of alternative schooling) and failing to warn of Cruz' "dangerous propensities." (1) The Fourth District Appellate Court of Florida affirmed the dismissal "because Henderson violated no legal duty that extended to cover the victims in the shooting." (1)

The appellate court accepted the complaint's factual background as accurate and "considered [the fact pattern] in the light most favorable to the appellants" since the criminal case was ongoing. (1) Per the Fourth District's ruling Henderson Behavioral Health Inc. had provided services to Cruz on and off from 2009 to December 2016. Cruz terminated therapy when he turned 18, with his case being closed by Henderson on December 27, 2016. Although the date of an investigation done by the Florida Department of Children and Families (DCF) was not specifically mentioned in the appellate court's ruling (but was

most likely prior to him terminating with Henderson Behavioral Health), it was noted that a two-month investigation of Cruz was carried out by DCF. The reported findings of the DCF investigation were that "Cruz took his medications regularly, that he kept his appointments, and that his 'final level of risk was low.'" (1) The tragedy at Marjory Stoneman Douglas High School occurred more than a year after Cruz last had contact with Henderson Behavioral Health. During the time between his last contact with Henderson Behavioral Health and the shooting, Cruz engaged in "low assault" in January 2017 at the school, which resulted in him being suspended and referred for a school threat assessment. (1) He was ultimately expelled from the school due to fighting in February 2017. Cruz purchased the AR-15 he allegedly used in the shooting the same month that he was expelled. Between November 2017 and January 2018, at least two calls expressing concern were made to law enforcement. A call to the FBI specifically raised concern about Cruz' "gun ownership, desire to kill people, erratic behavior, and disturbing social media posts as well as the potential of him conducting a school shooting." (1)

The appellate court based its opinion on Florida statute and case law for the time period leading up to the shooting (of note, after the event Florida changed its statutes, going from a permissive duty-to-warn state to a mandatory duty to warn law enforcement, but permissive duty to warn for victims). The court focused primarily on whether Henderson Behavioral Health had a duty to the victims when it came to the negligence analysis. Specifically, the court referenced Florida case law in *Surloff v. Regions Bank*, 179 So. 3d 472,476:

[A] legal duty requires more than just foreseeability alone. A duty requires one to be in a position to 'control the risk'. (1)

The court also stated that:

[F]lorida law establishing that a criminal attack on third parties by an outpatient mental health patient is not within the foreseeable zone of risk created by the mental health provider. Florida law does not recognize a duty of mental health providers to warn third parties that a patient may be dangerous. This is because of "the inherent unpredictability associated with mental illnesses and the 'near-impossibility of accurately or reliably predicting dangerousness.'" [citations omitted]. (1)

This is a far different view from that of the Washington State Supreme Court in *Volk v. DeMeerleer*, (2) which involved an active outpatient who had not been seen for months. In *Volk*, the Washington Supreme Court wrote:

As evidenced by this court's decision in *Petersen*, and by the *Tarasoff* court, society has a strong interest in protecting itself from mentally ill patients who pose a substantial risk of harm. Both statutorily and through common sense, society relies on mental health professionals to identify and control such risks. The mental health community therefore has a broad responsibility to protect society against the dangers associated with mental illness. (2)

As noted above, Florida has relatively strong case law limiting liability to mental health providers when it comes to criminal acts committed by their patients. To try to overcome this, the appellants cited the Florida case of *Pate v. Threlkel*, 661 So. 2d 278 (Fla. 1995), an oncology medical malpractice case, which determined "a duty exists if the statutory standard of care requires a reasonably prudent health care provider to warn a patient of the genetically transferable nature of the condition for which the physician was treating the patient." (3) However, the Fourth District noted that *Pate* dealt with a far narrower scope of duty than the one at issue in the Henderson case. In addition, in the *Pate* case, the duty related to identified third parties [i.e., genetic descendants], "whose existence is

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Television and Podcast Series: Teaching Forensic Psychiatry and using Narrative Medicine through True Crime and Fiction

Karen B. Rosenbaum, MD; Cathleen Cerny-Suelzer, MD;
Susan Hatters Friedman, MD; and Tobias Wasser, MD

Even though APA was not live in Philadelphia, we presented virtually on Zoom for the On Demand program, and since the topic included watching television, the medium was fitting. Dr. Cerny-Suelzer discussed the benefits of using these modalities to teach and discussed narrative medicine, as well as the typology of forensic psychiatrists in fiction. Dr. Rosenbaum then focused on teaching using true crime podcasts and television series. Dr. Hatters Friedman discussed using film to teach about difficult to access subjects including matricide and Munchausen's by proxy/medical child abuse. Finally, Dr. Wasser, editor of the media review section of *JAAPL* explained why media reviews of stories with forensic themed content can be useful in teaching forensic psychiatry and used the examples of Netflix's *Mindhunter* (1), HBO's *Leaving Neverland* (2), Showtime's *Escape at Dannemora* (3), and Netflix's *The Umbrella Academy*. (4)

In explaining why stories are an important way of teaching, Mark Turner, cognitive scientist and author of *The Literary Mind*, wrote "Narrative imagining — story — is the fundamental instrument of thought. Rational capacities depend on it. It is our chief means of looking into the future, of predicting, of planning, and of explaining. . . . Most of our experience, our knowledge and our thinking are organized as stories." (5)

There are many benefits to teaching students through popular stories. The material is readily available as are the technologies to consume that material. Viewers can easily replay the media, and hone in on specific segments. Most learners are millennials (born 1981-1996) and Generation Z (born 1997 and beyond). They are "Digital Natives" vs. "Digital Immigrants" (such as some of Generation X and Baby Boomer generations). In

addition, TV clips (auditory and visual presentation of material) engage both hemispheres of the brain.

Another advantage is that television characters are not protected by HIPAA. Fictional examples can help people understand the psychology of characters. Unconscious material is available and can be discussed openly. Sometimes television characters can perpetuate stigma of mental illness, but other times fictional works can present mental illness realistically.

According to one author, media clips grab attention, focus concentration, generate interest, create a sense of anticipation, energize or relax the students, draw on imagination, improve attitudes towards content and learning, build connections with other students and instructor, increase memory of content, increase understanding, foster creativity, provide opportunity for freedom of expression, stimulate the flow of ideas, foster deeper learning, serve as a vehicle for collaboration, inspire and motivate, make learning fun, set an appropriate mood or tone, decrease anxiety and tension on scary topics, and can create memorable visual images. (6)

Specific to forensic psychiatry, there are many examples (especially criminal) due to the public's fascination with psychopathology, serial killers and "profilers." There are examples of public perception of forensic experts and of the insanity defense. There are good and bad, accurate and inaccurate glimpses of what forensic experts do. Boundaries and boundary violations are depicted or discussed, and issues of malingering are portrayed. The typology of forensic psychiatrists in film included Dr. Evil, the Professor, the Hired Gun/Whore of the Court, and the Jack/Jill of All Trades. (7)

Narrative medicine is defined by Dr. Rita Charon as, "The effective

practice of medicine requires narrative competence, that is, the ability to acknowledge, absorb, interpret, and act on the stories and plights of others. Adopting methods such as close reading of literature and reflective writing allows narrative medicine to examine and illuminate four of medicine's central narrative situations: physician and patient, physician and self, physician and colleagues, and physicians and society." (8) Deconstructing a television episode or an account provided in a podcast has parallels to the "close reading" work of narrative medicine. This can foster curiosity and ability to pay attention to the story of patients and evaluatees. Media can keep providers in contact with suffering and the humanity of others and ourselves.

The true crime genre dates back to at least the Ming Dynasty, but has escalated in the last 15 years, possibly with the rise in popularity of the Investigation Discovery channel and other outlets. Truman Capote's *In Cold Blood* is credited with being the first modern book of the genre, about the horrific murder of a family in Kansas in 1959. In true crime documentaries, there is often an unreliable narrator. In an attempt to tell a story from multiple angles, it is often difficult to figure out which, if any, of the narrators to believe. The "Rashomon Effect" in storytelling, and its relevance for clinical and forensic psychiatry was recently described in the *Affair*. (9) The term was coined after the movie *Rashomon* (A. Kurosawa, dir., 1950) in which a crime took place and there were four witnesses, each with their own differing and plausible account of the story. Examples of this in true crime are many, but include the Netflix documentary about a cult in Oregon, *Wild Wild Country*, and a newer series from Netflix about eccentric exotic animal zookeepers, *Tiger King: Murder, Mayhem and Madness*.

Other unifying themes in recent true crime television and podcasting include serial killers. The popular drama, *Mindhunter* is an adaption of the book *Mindhunter* by John Douglas and Mark Olshaker about the origins

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Update in Suicide Trends

Jason Beaman DO, MS, MPH, FAPA and Elizabeth Chen, DO

Forensic psychiatrists are often asked to evaluate suicide risk. This evaluation request can come in many forms, such as medical malpractice cases, suicide risk assessments or during treatment of their own patients. Knowledge of the most recent suicide trends can be helpful in providing up-to-date evidence for forming opinions and testimony. Understanding these trends can help forensic psychiatrists determine if there is a shift in risk in a demographic group as a whole, which may influence their opinions. Further, it can assist in testimony, as the circumstances surrounding a particular suicide can be placed into a wider construct of national suicide data. Finally, such knowledge allows the forensic psychiatrist to assert their position as an authority in the matter by staying up-to-date with the most recent available information. The focus of this article is to review recent demographic trends in suicide.

One of the most used sources of information on suicide is the WONDER dataset published by the US Centers for Disease and Prevention (CDC) (1). The WONDER database collates information by cause of death using submitted data from state medical examiners. The most recent year of available data is 2018. The WONDER dataset allows the sorting by location, cause of death, age, gender, and race, among others. We have summarized the basic demographics below. All rates discussed are per 100,000 people.

The suicide rate increased from 14.5 in 2017 to 14.8 in 2018. The highest demographic (based on age, sex, and race) was 25-29 year old American Indian/Alaska Native males, with a rate of 44.4. This represents an increase of 6.4 for the demographic compared to 2017. It is also a shift from 2017 in that for that year the top demographic was 80-84-year-old white males with a rate of 42.6. For 2018, the second highest demographic was 80-84 year old white males with a rate of 43.7.

Overall, the rates of both demographics (young Native American men and elderly white males) remain very high.

When evaluating based on race alone, the highest overall rate was white at 16.8, an increase from 16.5 in 2017. Table 1 lists the rates based on race. The lowest rate by race was African American at 7.0. While this rate is lower than others, it still increased 4.3% from 2017.

When evaluating suicide trends based on gender, the rate for males remained significantly higher than for females, at 23.4 versus 6.4. This difference shows that men are 3.6 times more likely to die of suicide than women. This trend remained consistent with 2017 (22.9 versus 6.3). While the individual rates have increased, the difference was stable. It must be noted that these numbers only

reflect completed suicides and not suicide attempts. The 2018 National Survey of Drug Use and Mental Health reported that females attempted suicide one and a half times more than males.

There is a building crescendo in suicide with regard to age. For 2018 the rate increases from 2.9 for the 10-14 age group and peaks at 21.7 for the 55-59 age group. The trend then decreases to a low at 16.2 for the 70-74 group, increasing towards the end of the lifespan at 18.9 for the 75-79 group and 18.4 for the 80-84 group. The pattern is consistent with data from 2016.

WONDER also has the ability to examine rates by geographical location, including by state. Table 2 lists the 10 states with the highest suicide rates in 2018. The highest rate was in New Mexico at 25.6, while the lowest rate was in the District of Columbia at 7.7. This represents a shift from 2017, when Montana had the highest rate at 29.6 (New Mexico was 4th at 23.5);

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Table 1: Suicide Rates by Race, 2018

Race	Number of Suicides	Crude Rate
American Indian or Alaska Native	669	14.1
Asian or Pacific Islander	1546	7.2
Black or African American	3254	7
White	42875	16.8

Table 2: Top 10 States for Suicide Rate Per 100,000, 2018

Rank	State	Crude Rate
1	New Mexico	25.6
2	Wyoming	25.4
3	Alaska	25
4	Montana	24.9
5	Idaho	23.8
6	Colorado	22.5
7	West Virginia	21.9
8	Nevada	21.7
9	Utah	21
10	New Hampshire	20.6

Announcing the First Neurolaw-focused Forensic Psychiatry Fellowship

Octavio Choi, MD, PhD

In 2019, I was fortunate enough to be invited to join the psychiatry faculty at Stanford to design and direct their new forensic psychiatry fellowship program. It's not every day that an opportunity comes along to create something new and with the potential to shape a generation of trainees, so I jumped at the chance. Stanford's leadership in technology and innovation fit perfectly with my background and interests in neurolaw. I am happy to announce that we are on track for ACGME approval, and are accepting applications for July 2022 fellows, our inaugural year for the Stanford forensic psychiatry fellowship. While the fellowship will have all ACGME-required components for forensic psychiatry training, it will additionally offer specialized training in neurolaw. To my knowledge, this will be the first neurolaw-focused forensic fellowship in the world, and for the right applicant, it is a chance to get in at the ground level in an exciting new field in the very fertile incubator that is Stanford University.

Why neurolaw?

Neurolaw is an emerging interdisciplinary field which studies and grapples with the ever-increasing use of neuroscience in legal settings. The rise of neurolaw reflects the fact that for the past few decades we have been living in a golden era of neuroscience, and this has started to make its way into the legal system. Breakthroughs in neurosciences have been sparked by new tools such as diffusion tensor imaging and fMRI that have fundamentally advanced our ability to peer into the structure and activity of the brain, and coupled with advances in computing (particularly machine learning approaches in artificial intelligence), have allowed increasingly precise decoding of mental states from brain activity (aka "mind-reading" – I highly recommend looking at Jack Gallant's work for those interest-

ed in the topic). This has attracted the interest of the law, which we all know is very interested in capacities and mental states, because they form the foundation of assessments of culpability, dangerousness, and competence, among others. Looking forward, interventional tools such as focused ultrasound with nanoparticles (1) are laying the groundwork for precise and safe neuromodulation, which will bring up some really interesting neuroethical questions in the future. For example, what are acceptable limits of neuro-modification? Frontal lobotomy to reduce aggression is rightly considered barbaric, but what if targeted neuromodulation could precisely and safely diminish a sexual predator's attraction for a specific paraphilia?

My personal interest in neurolaw began with a fascination for neuroscience that began quite early. I remember reading Oliver Sacks' *The Man Who Mistook his Wife for a Hat* in high school and being just completely fascinated by his stories of how brains go wrong, and what they told us about being human. Later, as an undergraduate at Stanford I had the good fortune of participating in neuroscience graduate seminars where the latest findings of the day were discussed and picked apart. I remember being boggled by the discovery of face-selective neurons in monkeys (neurons that fire only when seeing a face). How on earth could evolution sculpt a neural circuit that would fire only to faces? At the time I was a computer science student, and knew about the struggles computer vision scientists were having with even very simple object recognition. It was only recently, with the rise of brain-style machine-learning approaches, that computers were able to exceed human capabilities in object recognition.

Ultimately, my interests culminated in obtaining a PhD in Neurosciences as part of an MD/PhD program at

UC San Diego, but figuring out how to integrate my love of neuroscience into medicine took a while. It wasn't until after psychiatry residency that I discovered the field of neurolaw, by way of an NPR story about James Fallon, a neuroscientist studying neural correlates of psychopathy, who discovered in the course of his research that he had a brain similar to the psychopaths that he studied. Later, he discovered that his family tree was rich in murderers, including the infamous Lizzie Borden. The story of James Fallon is a great example, because it illustrates that while certain fundamental capacities such as empathy are neurally-determined, whether this results in a productive neuroscientist or a cold-blooded murderer depends on a host of other factors, such as childhood environment. My interest in neurolaw drew me to the University of Pennsylvania, where I was exposed to brilliant minds such as Stephen Morse, Adrian Raine, and Martha Farah during my forensic fellowship year. Afterwards, I set about developing a neurolaw forensic psychiatry practice.

One of the reasons to create this fellowship is that I think we need more well-trained neuroscience experts in the courtroom. Historically, in addition to geniuses and innovators, neuroscience has also always drawn its share of hucksters and snake oil salesmen (think of the descendants of phrenology), and my experiences thus far testifying in court confirm that they are still very much alive. The problem is that the brain is so baffling and complex, and our knowledge so incomplete, that it becomes easy to "spin stories" out of the little we do know, and peddle those stories to unsuspecting lay people. The job of a neuroscience expert in court is to articulate how legal claims square with the state of current neuroscience knowledge. It is a job that requires on the one hand, the hubris to tackle the study of the most complex object in the universe, and on the other hand, the humility to admit what we do not know. As far as we've come in the past 100 years in understanding the

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Parkland Shooting

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known to the physician.” (1)

The plaintiffs also raised Florida’s so-called “undertaker’s doctrine,” which states that “whenever one undertakes to provide a service to others, whether one does so gratuitously or by contact, the individual who undertakes to provide the service – i.e., the ‘undertaker’ – thereby assumes a duty to act carefully and to not put others at an undue risk of harm.” (1) The Court rejected the notion that Henderson Behavioral Health played a key role in the decision to mainstream Cruz when they “undertook” being involved in the process with the school system. The ultimate decision was up to the school board, not Henderson Behavioral Health. In addition, the Court rejected the appellants’ argument that a special relationship existed between Henderson and the students at the high school, with the Court noting “Generally, there is no duty to control the conduct of a third person to prevent that person from causing physical harm to another. . . [unless] the defendant has a “special relationship” with the plaintiff.” (1) The Court noted there is no special relationship between a patient’s health provider and other students who attend school with the patient.

The Court, in closing, wrote:

In this case, a holding that Henderson owed a legal duty to protect or warn students that attended the same school as one of its patients would not only undermine effective patient-therapist relationships, but it also would discourage mental health professionals from providing mental health services to students. It is difficult to predict any human being’s future conduct. Unlike scientific disciplines firmly grounded in mathematics, psychology is not a precise science, so courts should be cautious about expanding liability beyond the therapist-patient relationship. (1)

As noted above, much of this ruling is based on Florida case law. Rationale and reasoning may be different for other jurisdictions (e.g. *Volk v DeMeerleer*). It is unknown at

this time if the Florida Supreme Court will become involved or if a higher level of appellate review will occur, but to date it appears that the Marjory Stoneman Douglas High School tragedy has not led to an expansion of duty-to-warn case law obligations at this time. ☞

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- (2) Volk v. DeMeerleer, 386 P. 3d 254 - Wash: Supreme Court 2016
- (3) Pate v. Threlkel, 661 So. 2d 278 (Fla. 1995)

Bad or Mad

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in the *Smith v. Aroostook County* decision. (7) Inmates with SUDs are at elevated risk for institutional infractions due to possession of and testing for prohibited substances. Repeated infractions or other behaviors lead to placement of users in restrictive housing. The use of MAT even in the highly controlled environment helps to diminish cravings, reduce chance of overdose, and while some modifications to process are necessary, some states, such as New Jersey, are finding the use of MAT in RH helpful.

In summary, the need to maintain a safe and controlled environment within jails and prisons is inarguably important. The use of segregation to help maintain that environment does, however, require examination, particularly in the case of individuals with mental illness or substance use disorders and other special populations. National and international professional organizations and regulatory bodies have issued guidelines regarding segregation practices, and as outlined here there are several potential risks and consequences for inmates so confined. The panel and audience discussion focused on the difficult decisions around management of unsafe behaviors within a correctional setting, and the role of psychiatrists in helping to reach a balance of maintaining safety and protecting inmates’ health. There are no easy solutions to achieving this balance, but continued emphasis on

its importance must continue, as the current RH situation in general is not satisfactory. ☞

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Bisbee and Beyond

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declare that there shall be no penance.”

Just a few years later, also in New York, *People v Smith* (1817) distinguished between a person approaching a minister as a friend or informal adviser, rather than as clergy. In this case, the religious leader is free to report a crime, either past or ongoing.

The protection of the clergy-penitent privilege has been supported by legal scholars and the courts. For example, former Chief Justice of the United States, Warren Burger, wrote, “The clergy privilege is rooted in the imperative need for confidence and trust. The . . . privilege recognizes the human need to disclose to a spiritual counselor, in total and absolute confidence, what are believed to be flawed acts or thoughts and to receive consolations and guidance in return.”

In January 2020, the Montana Supreme Court ruled in *Nunez v. Watchtower* that Jehovah’s Witness elders, aware of a member’s ongoing sexual abuse of a child, should be granted the clergy-penitent privilege. The court opined that the elders did not have to report “because their church doctrine, canon, or practice required that clergy keep reports of child abuse confidential.”

Last year legislation was introduced in California to remove or modify the exemption. It failed, as did similar legislation in Utah and Arizona.

Every state and the District of Columbia have had some version this privilege. Yet, all states require mandatory reporting if there is a suspicion of child abuse or neglect.

This contradiction has not been resolved. For example, 26 states consider clergy to be mandated reporters. Yet, even in these states there are exemptions if the clergy hears of abuse in his or her role as a religious confidante. Presently, six states have abrogated the clergy-penitent privilege and maintain that clergy must be considered mandatory reporters: New Hampshire, North Carolina, Rhode Island, Tennessee, Texas and West Virginia.

Nevertheless, these cases still arise in all states. Plaintiffs are suing churches for failure to report their childhood abuse. Defense attorneys maintain that the clergy-penitent privilege should hold, because of its history. State legislators, courts, and lawyers, try to parse out definitions: What is a religion? Who constitutes “clergy?” What does “penance” mean? What is “privilege” or “confidentiality” as used in these situations? These words are not always clear-cut in the statutes.

In the opinion of this writer, who is a pediatrician and child psychiatrist, there should be no penitent-privilege regarding child abuse and neglect. Protection of children comes before protection of religious tenets. There is an expectation of confidentiality in psychotherapy, but it is not absolute. The same should hold true for religious confessions.

The argument goes on – not only in Bisbee, Arizona, but throughout this country and in other nations. At one time, Bisbee was a muck of racism, corruption and violence. Now it’s a lovely tourist destination. But some of its citizens still have their deplorable secrets, as do those throughout the country. Protected by the “sanctity” of clergy-penitent privilege, covert, abusive behaviors continue, causing devastating, and potentially lifelong, harm to children. ☹

Police Culture

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ical school and embarking on a career as a physician, I was a police officer for a medium-sized city, starting in the early 1990’s. During my years as a police officer, I worked in patrol, interacted with neighborhood leaders as a member of the “Problem Oriented Policing” team, acted as a field training officer, and was a member of the department’s SWAT team.

My experience as a patrol officer was typical at the time and is similar to what is seen even today. (2, 3) There were multiple shifts, allowing for overlapping 24-hour coverage.

Staffing was such that each shift had enough officers to provide adequate coverage for the entire city, which was divided along neighborhood lines into areas known as “beats.” Each officer was assigned to a beat, which meant that they were expected to cover calls for service within the beat boundaries. However, during busier periods there was frequently cross-coverage where officers would temporarily leave their beat to aid an officer in a different area, returning to their beat when the call was resolved. Calls for service generally came in as 911 calls, with operators entering call information (location, parties involved, risk of violence) into a dispatch message, which would then be transmitted to the officer working in that beat. Emergencies such as shootings or other crimes of violence were broadcast city-wide to all officers, to alert them in case there was a need for a large-scale response.

The reasoning behind the beat system was that officers would have a better response time to emergencies, as well as becoming more familiar with the neighborhood and its residents, since patrol units would remain in roughly the same location for the duration of their shift. However, the reality was quite different. During my rookie year, the city where I worked, San Bernardino, was known as one of the most violent cities in America, based on the per capita violent crime rate. This made for fast-paced and busy shifts with little or no downtime. In fact, the prevailing wisdom was to pack a meal to eat while driving from one call to the next, as there was frequently no opportunity to take a lunch break for the entirety of a 10-hour shift. This made for an environment where one always felt rushed and under pressure to handle calls quickly. There were always other calls pending, and it was considered poor form for outside officers to regularly take calls in your beat. This pressure to continually move on to the next call fostered a brusque approach, with little time or incentive to foster community relationships. An important additional downside to being chronically so busy was that non-emergent

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Royal College

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standard and considered dementia (Ramandeep Purewal); infanticide (Chloe Challen); psychopathy (Ben Griffin) and autism (Grace Pike). A common theme emerged across the four presentations. During their investigations the students found clear evidence that individuals in prison within any of these four groups tended to be disadvantaged and that, often, their treatment needs were not met. A version of Ramandeep Purewal's winning essay will be published soon as an editorial in *Criminal Behaviour and Mental Health* (DOI: 10.1002/cbm.2150).

While an international conference provides opportunity to listen to the great and the good, it also allows people to exchange and share impressions. On occasion these impressions and passing exchanges can provide gems and this conference report finishes with some such moments.

Ramandeep Purewal, a final year medical student from the University of Nottingham commented that "thoughts around psychopathy have been somewhat stagnating for a while, so it's been exciting to potentially reframe it and perhaps look into considering it as more of a neurodevelopmental problem, allowing there to be consideration for early intervention and support of children presenting with early signs of low empathy."

Dr Rachael Sibbett and Dr Chris O'Shea, both forensic psychiatrists in training from Edinburgh observed:

"This year's conference in a two-word summary: weird and wonderful.

Weird – the descriptive psychopathology behind delusions, described by Femi Oyeboade. Some of these apparently have their underpinnings in 'the asymmetry of sexual strategy between male and female species'. Who knew spider and mouse sex was fraught with such complexity and apparently underpins the origins of pathological jealousy!

Wonderful – we most certainly embark on a time of great technological change. Advances in AI may,

among many things, generate our risk scenarios and end the need for lengthy file note reviews. Who would be sad to see the back of mountains of paper volumes of notes? Not us! How else can we apply this within forensic psychiatry, and what can history/Hollywood caution us on? The keynote speech from Professor Mischa Dohler envisioned a future where 'AI will automate jobs, and humanize work,' and free up our creativity. It certainly sounds enticing.

Standout moments and learning aside, what the conference never fails to deliver is an opportunity to catch up with old colleagues, meet new ones, and to remind ourselves why we do this interesting and important work."

I (JAB) spoke briefly to a senior colleague from London and we shared reflections as we both looked back on our careers. His view was... "If I had my time over again, I'd do the same things, all of them, but second time around I'd do them all so much better..." To avoid embarrassment I'll not name him, but I can confirm that I took these wise words home with me.

Shortly after the Liverpool conference the coronavirus pandemic hit and at time of writing all future planning is uncertain. There will however be another Forensic Faculty event next year and, as before, colleagues from AAPL will be made very welcome. ☺



The four winning medical students enjoy a group hug with Professor Pamela Taylor, (R) Faculty Chair and Dr Aideen O'Halloran, (L) competition organizer



Some delegates relax in the evening

Police Culture

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calls, such as burglaries and other property crimes, were held for hours until things cooled down and officers were available to take a report. Compounding this problem further was the tendency to dispatch officers to every call that came in through 911, such as civil disputes, because there was no one else to send. This led to people waiting for hours until a tired, overworked and yes, brusque officer would respond.

Another important thing to note about the beat system is how they are defined geographically. Although beat boundaries are sometimes defined due to geographic constraints (a river or major thoroughfare, for example), often they are divided into neighborhoods. In certain cities, including San Bernardino, these neighborhoods tend to be defined along socioeconomic lines. Beats with a higher number of calls for service tend to be more heavily staffed, leading to a larger police presence.

Returning to our root cause analysis, in my opinion, the pressure from working as a police officer in an area with a high call burden, such as an inner city, coupled with a lack of downtime due to the responsibility for handling non-emergent calls, including those not appropriate for police, leads to a culture where police can be increasingly disconnected from the community where they serve. This disconnect can lead to indifference, cultural insensitivity and uneven enforcement of the law and application of resources. In other words, a form of institutional racism.

Over the years, departments have done what they can to address this disconnect between police and the public they serve. One way is by increasing community outreach. The city of Camden, New Jersey exemplifies how successful improved outreach can be in conjunction with increasing officer diversity, although the approach used (firing the entire police department and building *de novo*) was drastic. And even after such draconian measures, some problems remain.

However, the crime rate in Camden has dropped significantly, by some estimates up to 50%, and resident satisfaction with law enforcement has improved.

Another approach, as seen in Eugene, Oregon, involved creating an organization comprised of medical and mental health workers who work separately from the police and who handle non-criminal calls for service. (7) The organization, called CAHOOTS (Crisis Assistance Helping Out on the Streets), is non-governmental and is completely independent of the police department other than being available through the 911 center. CAHOOTS has been around for almost 30 years, and over time the initial mistrust between police and social/medical workers has given way to mutual respect. The department has embraced it as a way of reducing the burden on officers by limiting the nature of calls that they respond to. For calls that involve civil, mental health or other non-law enforcement issues, the police would not respond unless there were associated safety issues. Even when police respond to these types of calls, they would be more of a background presence and play a supporting role. This has allowed for the police to narrow their focus to criminal matters, as well as allowing people who are better suited to address civil and mental health issues to be involved early on. In areas where there are calls to defund the police, the approach taken in Oregon may be particularly apt. However, Eugene is not a diverse city (the population is less than 2% African American), so it is less clear what impact this approach would have in areas such as institutional racism. Likely the best approach for most communities would be a hybrid of the Camden and Eugene programs, where the police departments focus their efforts on diversity and community outreach, and there is increased support and funding for social programs that are independent of the police. (8)

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Suicide Trends

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the District of Columbia remained the lowest in 2017 with a rate of 6.8.

In conclusion, suicides in the United States are increasing, based on the most recent available data from the CDC. A very concerning trend is the fact that young Native American men are now the highest demographic, replacing elderly white males. Epidemiological studies are needed to examine the nature and extent of this trend. The available data should serve as a concise source for forensic psychiatrists to reference regarding their important work in the area of suicide. (9)

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Television and Podcast

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of the FBI's Elite Serial Crime Unit and the first psychological profiling based on behavioral analysis created by FBI agents with the help of forensic psychologists. Many popular podcasts also deal with serial killers including *Dating Game Killer*, *Crime Junkie*, *My Favorite Murder*, the *Last Podcast on the Left*, and the *Serial Killer Podcast*, among others. Popular podcasts also deal with missing person cases and cold cases.

Wrongful convictions are also a common theme. One of the first popular podcasts about true crime was *Serial*, in which host Sarah Koenig dealt with the possibility that Adnan Syed was falsely accused of murdering his ex-girlfriend Hae Min Lee in Baltimore in 1999. The series was designed to consider the evidence against Syed from all sides, and the listener could make up their own mind, along with the investigative journalist.

Making a Murderer on Netflix examined the case of Steven Avery, who spent 18 years in prison before being exonerated. Three weeks after depositions were taken for his wrongful conviction lawsuit, he was indicted for murder in a new and unrelated case. The series explores his second conviction and the possibility that the Sheriff's Department of Manitowoc County, Wisconsin planted evidence against him.

Making a Murderer also deals with false confessions, as Steven Avery's nephew, sixteen-year old Brendan Dassey, who was intellectually disabled, was questioned for hours by police until he gave them the statement they wanted.

False confessions are also dealt with in HBO's *When They See Us*, about the Central Park Five. *Making a Murderer* discussed three errors that can lead to false confessions: 1. Misclassification Error: i.e. False narrative = guilty or certain posture=guilty. 2. Coercion Error: Goal is to bring interviewee confidence down. "We already know" and other deceptive tactics such as "You'll go home as

soon as you tell us." 3. Contamination error: Feeding the suspect critical facts instead of getting them from the suspect directly.

Netflix's *How to Fix a Drug Scandal*, the *Innocence Files* and others deal with the credibility of expert testimony and forensic evidence, which can also lead to wrongful convictions. Finally, true-crime podcasts have dealt with doctors violating their oath and boundaries, such as the Wondry site's podcasts, *Dr. Death* and the *Shrink Next Door*.

True crime on television and podcasting can be educational and instructive. Knowing what our patients are watching and listening to can help us understand them better.

As forensic psychiatrists, true crime is a reminder that the narrator is not always reliable even if they are not intentionally lying. True crime on television and podcasting has revealed what many forensic psychiatrists have had first-hand experience with, that the justice system is often not fair and can be biased toward the side with the most money, and often biased against people with mental illness. Recent podcasts and documentaries have even brought about changes in the justice system. ☪

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Ask the Experts

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well-lit areas, and consideration to having security escort you to your car at the end of the day should be given when the threat level is raised.

Take-Home Points:

Our work has inherent dangers of which we each much remain constantly aware. As physicians, we are well-trained and experienced in risk assessment and risk management. Employing such skills, getting additional knowledge and information where indicated, and implementing our knowledge can usually reduce the risk to a manageable level. If you don't feel the risk in a given case is manageable, don't take the assignment. ☪

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Georgia County Sheriff's Attempt to Protect Trick-or-Treaters

Bernard Sarmiento (MD expected 2023) and Ryan Hall, MD

With \$2.6 billion spent on candy and \$2.7 billion spent on decorations last Halloween alone (1), there is no doubt that the American pastime of trick-or-treating continues to thrive. The nature of kids stopping by homes and receiving sweets from strangers, however, can produce anxious thoughts for families and local law enforcement agencies alike. It is the primary reason why many officials have attempted to increase the dissemination of information relating to registered sex offenders. The efforts of Sheriff Gary Long of Butts County, Georgia recently made national headlines with his efforts to keep trick-or-treating safe. (2) In order to prevent children from entering the property of a registered sex offender, the Sheriff's Office entered the properties themselves to post large, white signs in front of their homes stating:

“WARNING!
NO TRICK-OR-TREAT
AT THIS ADDRESS!!

A Community Safety Message From
Butts County Sheriff Gary Long” (2)

The Sheriff's Office had already performed this strategy the previous year in 2018, from October 24th to November 2nd. But it was only picked up by the national media after a group of registered sex offenders filed a class-action lawsuit shortly before Halloween 2019 against the office. (2) The lawsuit emphasized the violation of privacy laws relating to trespassing on private property (in order to place the signs) and the violation of the plaintiff's constitutional rights against forced speech. The lawsuit also mentioned an incident where an offender was told he would be arrested if he removed the sign himself.

Shortly after the story broke, the small community of 24,000 received hundreds of supportive comments on their Facebook and other social media platform. (3) Sheriff Long, who has

three children himself (4), commented on how his decision was founded on ensuring the safety of the children of the community. The Sheriff's Office also referenced Georgia law, which states: “The Sheriff's Office in each county shall: Inform the public of the presence of sexual offenders in each community.” (5) The law allows for the disclosure of names, photos and addresses of sex offenders to the public, but does not mention the delivery of such information through physical signs on private property.

The Georgia law is based on New Jersey's Megan's Law which was named after 7-year-old Megan Kanka. (6) Megan was kidnapped, raped and murdered in July, 1994 by her neighbor Jesse Timmendequas. Her parents believed they would never have allowed Megan to play outside alone knowing a sexual predator was in close proximity to their home. (7) “Megan's Law” required communities and law enforcement agencies to inform the public when sex offenders moved into their neighborhoods. Although many states had created an in-house sex offender registry due to the Jacob Wetterling Act of 1994, a federal version of Megan's Law and the subsequent Georgia law were enacted that required law enforcement to disclose name and location of registered sex offenders publicly.

The Sheriff Long story raised interesting questions for national pundits: does the public safety of children outweigh the individual rights of registered sex offenders? The media concern for public safety is related to previously covered incidents of child abduction and abuse occurring on Halloween night. The 1973 abduction, rape and murder of nine-year old Lisa French in Wisconsin shocked many after it was found out that her neighbor, Gerald Turner Jr., confessed to abducting her while she was trick-or-treating alone at night. (8) The traumatic event has had a residual impact

on the community, Fond du Lac, which has established trick-or-treating hours from 3:30-5:30PM. There have been other, more recent incidents of child abductions during Halloween night, such as the 2013 abduction and rape of a 14-year old girl with a learning disability. It was found that the two men disguised themselves as police officers to lure the young girl into their truck where she was held hostage for 10 hours. (9) And in the UK, there was a case where a 38-year-old man wielding a knife sexually assaulted and raped an 11-year-old boy who was trick-or-treating in the evening hours. (10)

However, although these cases are important to consider from a policy perspective, it is also crucial to look at the statistics related to child sex crime rates on or near Halloween. Using the National Incident-Based Reporting System (NIBRS) crime report data to look at 67,045 sex offender victims from 1997 to 2005, a 2009 study found no increased risk for nonfamilial child sexual abuse on or near Halloween. (11) Rates of abuse were not different from expected, after accounting for trend, seasonal and periodic cycle. Although the data did not include information on whether the crime occurred in a trick-or-treat context or was perpetrated by a registered sex offender, it helps debunk the myth that there is an epidemic of trick-or-treating child abduction.

By looking at state legislation on Halloween sex offender policy, law enforcement and legislatures alike continue to be motivated to find additional methods to protect young children during Halloween. Sheriff Long's signs represent one of several Halloween-specific sign policies established in other counties across the United States. Lamar and Monroe counties in Georgia both have used “No Trick-or-Treat” signs but offenders could be exempt from posting them if they instead waited at the sheriff's office during trick-or-treat hours (12). The Plaquemines Parish Sheriff's Office in Louisiana also has mandated that all registered sex offenders post similar signs on their lawns. (13) In New York

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Liaison

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tient psychiatric facilities and residential crisis stabilization units. The law was intended to eliminate the practice of discharging involuntary patients from the emergency department at the end of a six-hour emergency hold period if a psychiatric bed was not available. Additionally, the law required that patients be transferred to any accepting facility in the state, even if that facility were located far from the transferring emergency department. Additional provisions of the law required that: assessments for involuntary hospitalization not be done by a psychiatrist (or any physician) but by certified (not necessarily licensed) assessors from the local community service board; if a bed were not found somewhere in the state within eight hours, the involuntary patient be admitted to a state facility (regardless of capacity status). Since the legislation went into effect in 2014, admissions to state facilities have more than tripled and lengths of stay have decreased by 80%. (4) This has crippled Virginia's system, which was not designed for rapid turnover, and has prevented transfer of patients from private, short-term facilities. There has been no meaningful increase in beds or other resources. The legislation has caused overflowing emergency departments, impaired discharge planning for patients living in rural communities, and significant stress on the state's mental health system. This legislation is a cautionary tale about how laws written with good intentions can have significant negative consequences if modeling is inadequate or input from psychiatrists limited.

Michael Champion discussed the federal First Step Act of 2018, a bipartisan criminal justice bill that focused on reforming the federal prison system and reducing recidivism. Key provisions of the Act include: sentencing reform for persons convicted of drug-related offenses, requiring mental health and de-escalation training for correctional staff, eliminating the use of solitary

confinement of juveniles, requiring assessments of inmates' criminogenic needs, and reporting on the availability of evidence-based treatment of opioid use disorders, including medication assisted treatment. Dr. Champion also described criminal justice reform efforts in Hawaii as an example of the opportunity to be involved in state-level liaison work with policymakers and legislators. Recent reforms in Hawaii include the development of a task force on Criminal Pretrial Practices and a taskforce on Effective Incarceration Policies. The work of the task forces led to subsequent legislative initiatives to create an oversight commission to monitor jails and prisons, to create a state criminal justice institute, and to advance bail reform.

Finally, Beth Lavach, a CFSO legislative analyst from D.C discussed other initiatives in more detail including the VAWA (Violence Against Women Act), which was re-authorized on February 14, 2019. ☯

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Stanford Fellowship

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brain, our knowledge is still in its infancy.

That is not to say that we know nothing. Neuroscience is increasingly relevant to courts because it is

becoming increasingly powerful in explaining and predicting behaviors. We take as a generally accepted fact that the brain, and activity arising from the brain, is the basis of all thought and behavior. For hundreds of years, in the absence of ways to image the brain and its activity, humans developed predictive models derived from observed behaviors, giving rise to the field of psychology. In the past hundred years, the rise of medicine added knowledge of biological factors influencing thoughts and behaviors, such as hormone levels and metabolic derangements. In the 1970s, the rise of genomics (culminating in the Human Genome Project's complete elucidation of the human genome in 2003) introduced the idea of genetic influences of behavior to a wide audience.

In the past 20 years, advances in neuroimaging and interventional tools have led to accelerating discoveries of neural circuits and brain-wide networks thought to underlie fundamental human capacities such as empathy, self-reflection, and moral reasoning. At least at a group level, neuroscientists are increasingly confident in the ability of neuroimaging to distinguish psychopaths from non-psychopaths, liars from truth-tellers, and individuals at high risk vs. low risk for recidivism. The problem is that group level findings are often of uncertain relevance at the individual level, because of biovariability. On average, females are shorter than males, but how confident would you be in predicting someone's sex if I just gave you their height?

Why Stanford?

Although our neurolaw forensic program is new, it is being built upon Stanford's already-existing strengths in neuroscience, law, and medicine. Fellows will be able to tap into that deep expertise by engaging with faculty and trainees across the university, and will work closely with me on neurolaw cases. The fact that all the schools are on one campus helps promote interdisciplinary collaborations,

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Trick-or-Treaters

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and California, there is a curfew prohibiting sex offenders from going out or opening their door on Halloween. (14) At least 10 states have passed “No Candy” laws preventing registered sex offenders from participating in passing out candy. (15) In states such as Virginia and Ohio, offenders are even required to attend meetings with law enforcement during Halloween evening. (16, 17) Many of these state-specific policies were based on the assumption that Halloween represented the perfect hunting ground for sex offenders to abduct and attack young children. Being able to conceal your identity and avoid detection seemed like the ideal world for those who wished to commit heinous crimes against children. However, several of the implementing law enforcement agencies have admitted that these policies were not introduced as a result of reported attacks. (16)

Despite similar actions having taken place in other jurisdictions, less than a week after the lawsuit was filed in court, an injunction was granted for the plaintiffs due to the complaints of trespassing and forced speech. Judge Marc Treadwell noted the Sheriff’s Office provided no evidence that the offenders posed a threat to children trick-or-treating and that the signs themselves violated the plaintiffs’ free speech. Long made it clear in a follow-up post on Facebook (3) that he disagrees with the ruling, but because of the timing would instead opt to increase police presence in areas of known sex offenders rather than wait for an untimely appeal. ☹

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Aging Death Row

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Court indicated that the diagnosis, per se, was not of primary interest. The broader issue is whether that mental condition causes the person to not be able to understand the impending execution and the reasons for it. Second, dementia (major neurocognitive disorder) is potentially relevant if it affects one of the domains of competence to be executed. Third, amnesia about the facts of the crime does not automatically result in a finding that a defendant is incompetent to be executed under the 8th Amendment.

A cognitive evaluation (often including neuropsychological testing) is often highly relevant in determining competency for execution. It is important to communicate not only whether the person is currently competent to be executed, but whether their condition is expected to decline (dementia) or improve (e.g. delirium, medication side effect) over time. Serial evaluations are sometimes necessary since the appellate process often takes years to unfold. While amnesia alone does not render a defendant incompetent to be executed, severe dementia with amnesia for the crime could impair a defendant’s rational understanding of the reasons for the execution and result in a finding of incompetence for execution. In addition, the *Ford* Court noted that one of the reasons for barring execution of “insane” prisoners was that the prisoner would not have a chance to prepare to meet their maker. One wonders if a prisoner who must be reminded repeatedly why he is being executed can truly engage in the reflection about his life and impending death contemplated by *Ford*. ☹

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Nathan Sidley, MD, AAPL President, 1979-1980

Tom Sidley



Dr. Nathan Theodore (Ted) Sidley passed away on Friday, June 12, 2020, at the age of 91. He is survived by his wife Barbara, his children Karen,

Thomas and his wife Jessie, and Ann and her husband Tom. Ted also has five grandchildren, Patrick, Melissa, Sam, Sylvia, and Lena.

Ted grew up in St. Paul, Minnesota, and stayed there to attend the University of Minnesota and subsequently the University of Minnesota Medical School. After medical school he entered a residency program in psychiatry at Yale University. When he was drafted, he served as a psychiatrist at Chanute Air Force base in Illinois. Upon receiving his honorable discharge from the military, he completed his psychiatric training at Harvard University.

Ted's career in psychiatry spanned six decades and took many forms. He began in private practice, but his interest in forensic psychiatry led him to a job as the Woburn (MA) District Court psychiatrist, where he worked for many years. Later he would serve as head psychiatrist for the New Hampshire Department of Corrections. Then, back in Massachusetts, he had another chapter working at the Veterans Affairs hospital.

Throughout his career, he was an active participant in a number of professional organizations, including serving as the president of the American Academy of Psychiatry and the Law. He was truly dedicated to his field, and, even after his official retirement, he never tired of ministering to those in need, and he continued to work into his eighties. He also edited and contributed to books on the subject of psychiatry.

Ted had a voracious curiosity about the world. He had a love of

knowledge, science and language. Any question that came up, he was not satisfied with a brief or partial answer—he really wanted to deeply understand any subject. A new word would invariably send him to his one foot thick dictionary in its place of honor on the nearby bookshelf. He had a profound understanding of such a broad scope of subjects that family members would often use him as a reference. More importantly, he had the integrity to use that knowledge to teach and help others, and a dedication to try to make the world a better place. Curiosity, for Ted, included a deep fascination with people. From family to friends, he loved to welcome people of all ages and walks of life into his home for food and conversation. He was truly interested in everyone, asking questions and listening intently.

Ted also had a passion for the outdoors and for nature. He loved to hike and ski near the family house in Albany, NH. His love for the mountains was evident in his tireless work in conservation, which included several multi-year projects to protect them from development. Exceptionally active in the WODC, he also spent multiple years as the president of the WPA (both organizations' mission was to conserve the natural order and beauty of their little corner of New Hampshire, as well as maintain trails enjoyed by thousands of folks who loved the outdoors like him). Committing countless hours of research, organizing and lobbying, Ted's dedication and effort proved integral to many successes. As a result of his and others' work, the Sandwich Range Wilderness area was created by an act of Congress.

Ted's curiosity and passion for understanding and improving the world were truly inspiring. A devoted and patient husband, father, and friend, he will be greatly missed by those who knew and loved him. ☪

Aging Death Row

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Stanford Fellowship

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as does the collegial academic culture. My hope is that we will attract candidates with a strong background or interest in neuroscience that will go on to leadership positions in forensic psychiatry both at Stanford and worldwide. ☪

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AAPL SPECIAL COMMITTEES

AAPL members interested in joining a Special Committee should contact and communicate exclusively with the Committee Chair. Requests to join Special Committees should be made to Special Committee Chairs between October 15 and December 1 of each calendar year. Requests for committee membership will not be considered after December 1. If members miss the "enrollment period" deadline one year, and are still interested in joining the Committee, they can ask the Committee Chair to put their names forward in the subsequent year's "enrollment period." Special Committee Chairs will forward their recommendations to the President no later than December 1.

see page 34 for a list of special committees

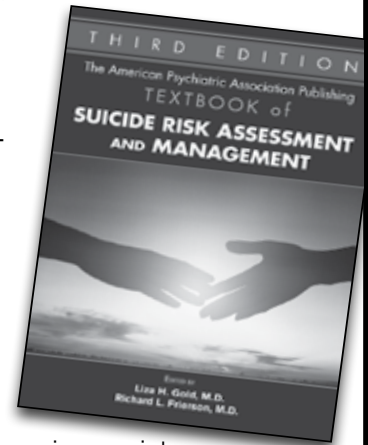
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