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American Academy of Psychiatry and the Law



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2020 AAPL Presidential Address

Dr. William J. Newman, MD: Promoting Wellness in Forensic Psychiatry

Britta K. Ostermeyer, MD, MBA, DFAPA



Dr. Newman, AAPL's 46th President, was introduced by Charles Scott, MD. Dr. Newman is Professor and Interim Chair in the Department of Psychiatry and Behavioral Neurosciences at the St. Louis University School of Medicine in St. Louis, Missouri.

In his introduction, Dr. Newman stated that we tend to speak very little about well-being despite being psychiatrists, and that this topic has been an infrequent part of presentations at AAPL. He has had personal experiences that led him to focus more on wellness and staying healthy.

He explained that while acute stress in response to danger is important and adaptive, a prolonged stress response is maladaptive and leads to negative long-term emotional and physical sequelae. Chronic stress causes inflammatory processes which can cause a host of medical conditions, including cancer, cardiovascular disease, and neurological conditions. Brain inflammation due to peripheral pro-inflammatory cytokines crossing the blood-brain barrier can lead to

cognitive impairment, fatigue, depression, anxiety, and visual changes. In particular, Neuropeptide-Y (NPY), synthesized in the hypothalamus, is becoming increasingly understood as having an important role in stress, anxiety, and resiliency. Chronically stressed individuals have higher serum NPY levels than patients diagnosed with PTSD or MDD.

Dr. Newman shared that he was stalked by a former patient who had serious plans to kill him. Severe, chronic stress due to stalking often is followed by inflammatory conditions, including cancer. He was diagnosed with metastatic cancer some time after experiencing severe and chronic stress due to the stalking.

Burnout, defined as emotional, physical, and mental exhaustion caused by prolonged stress, has been classified by the World Health Organization as an occupational phenomenon. Of note, while medical students start with higher levels of resilience than other graduate students, after medical school, physicians experience burnout at a higher rate than other matched professionals. It is a real concern for organizations to place the onus for wellness onto physicians, as they are already prone to self-reproach. In his opinion, physician burnout must be addressed through a variety of systemic changes within medicine. "It's not enough to focus on individual physicians fixing themselves or addressing this problem. There really need to be some big-picture goals." Factors promoting burnout include sleep deprivation, perfectionism, demands, financial struggles, unreasonable expectations, negative relationships, lack of support, high workload, call, overstretching one-

self, and work-life imbalance. Studies show that medical errors are higher for individuals with burnout. On the other hand, higher levels of empathy are a protective factor against burnout.

National data shows that 45% and 54% of physicians in 2011 and 2014, respectively, reported burnout. Although a 2013 Stanford University survey of physicians yielded only a 26% reported rate of burnout, three years later burnout had increased to 39% despite Stanford's burnout prevention efforts. The Stanford study also looked at professional fulfillment and found that 24% of physicians reported fulfillment in 2013, which subsequently decreased to 14% in 2016. Dr. Newman highlighted that reported burnout rates increased even though Stanford as an institution is very committed to burnout prevention.

On the topic of helping to promote wellness and preventing burnout, Dr. Newman explained the Stanford model, called "Well MD Center." Its priorities are: (1) "The Culture of Wellness," meaning that leadership is engaged; (2) "Efficiency of Practice," ensuring that physicians have the resources they need to practice at the top of their license; and (3) "Personal Resilience," which facilitates building one's own self-appreciation and how to recognize one's limitations as well as strengths.

Physicians are an unusual group, psychiatrists an unusual subset of physicians, and forensic psychiatrists make up an even more unusual subclass. A 2014 Canadian survey found that 62% of physicians self-identify as having "Type A personality," 53% agreed that they are a "workaholic," and 35% agreed that they are a "control freak." He commented that in particular "within forensic psychiatry probably a lot of people would identify with these descriptors."

Identified maladaptive physician traits include neuroticism, anger, and

(continued on page 2)



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COVER STORY

Presidential Address

continued from page 1

pride. We as forensic psychiatrists may have identified ways to channel neuroticism, such as being detail-oriented and somewhat obsessive. Anger in physicians may not necessarily surface as temper outbursts but is more likely to manifest as impatience and intolerance. Physicians must learn to recognize anger and think through ways to address it, much like in a CBT-type model. Lastly, pride in itself is not unhealthy but may become problematic when it comes across as arrogance and begins to impact others negatively. Dr. Newman noted, "One thing I often tell my trainees is that in forensic psychiatry I think it's a good thing to be confident but you have to stop short of being arrogant, "and that's a challenge...Take your work seriously but try not to take yourself too seriously." He further suggested it is important to obtain feedback from others, including constructive criticism. "Being open to that, I think, is a major part of developing throughout your career."

Dr. Newman noted that forensic psychiatrists are unusual in part due to unique challenges. Looking at the job description, there is (1) a heavy emphasis on public speaking, which creates significant anxiety in about one-third of the U.S. population; (2) exposure to chronic stress, both internally and externally, via real and self-imposed deadlines; (3) great potential for punishment for any career imperfections, such as failing an exam; and (4) repeated exposure to potentially traumatizing content with a high risk of vicarious trauma, defined as experiencing repeated or extreme exposure to aversive details of the traumatic event(s), which may lead to PTSD. Dr. Newman pointed out that our 2020 AAPL program included a presentation by Dr. John Bradford on this topic.

Dr. Newman moved on to discuss workaholism, which was first described in the 1970s by psychologist Dr. Wayne Oates as "the compulsion or the uncontrollable need to work incessantly." While Dr. Newman reflected that he probably is a member

of this group, he has learned to identify more with the term "work engagement," which is defined as "a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption." According to Dr. Malissa Clark (a 2020 AAPL presenter), workaholism includes feeling compelled to work because of internal pressures; having persistent thoughts about work when not working; and working beyond what is reasonably expected, despite the potential for negative consequences and impact on personal relationships. Interestingly, Dr. Clark found that workaholism is only moderately correlated with actual hours worked, and that it has more to do with the way one interprets and relates to one's work. Workaholism is highly correlated with Type A personality and perfectionism; early studies show it likely correlates with narcissism, which does not have to do with the amount that somebody works, but the way it is impacting them personally.

Next, Dr. Newman shared insights about the psychology of hate, which is generally viewed as a distraction from internal feelings such as helplessness, inadequacy, and shame. It provides a temporary release of such internal discomfort. Knowledge and education are the most effective tools for addressing hate. There are increasing reports about the long-term physical and emotional impacts of hate, related to chronic stress and its impact. "The Dalai Lama gives a very nice quote to this point: 'Don't let the behavior of others destroy your inner peace.'"

Dr. Newman listed useful habits that can counteract chronic stress and reduce inflammation, including a healthy diet, regular exercise, enough sleep, relaxation, engagement with family, travel, mindfulness, job satisfaction, yoga, Netflix, and knitting. He pointed out that "every individual has to determine what makes a healthy Wellness Wheel for them. While it is different for different people, it is some combination of elements for each person." It is very important to foster good relationships, while relieving oneself of those that do not bring positive

(continued on page 7)

AAPL Post-COVID: Pivoting to a New Normal

Liza H. Gold, MD



I hope this issue of the newsletter finds everyone safe and well. By the time you read this, I also hope we will be turning the corner on a year

of loss, hardship, and uncertainty. My heart goes out to all who have struggled to meet the challenges this year presented, especially our AAPL members who have been providing frontline care despite the personal risks to themselves and their families. I have never been prouder of my medical colleagues and the health care professionals with whom we work, as they have risen to meet an unimaginable challenge.

Although we are not “post-COVID” yet, eventually and together we will get there. But what will the “new normal” look like? The need to adapt to the pandemic has resulted in many changes, including some profound changes in perspective. Some of these were not optimal. For example, many of us look forward to the AAPL Annual Meetings as a highlight of our professional year. There is no doubt that not being able to hold our Annual Meetings in person in October 2020, and now again in October 2021, are losses.

But necessity being the mother of invention, 2020 Program Chairs Ryan Wagoner and Trent Holmberg, Executive Director Jackie Coleman and her staff, and the “Virtual AAPL Task Force” headed up by Annette Hanson organized an excellent live-streamed Annual Meeting. Renée Sorrentino, our 2021 Program Chair, is well on her way to building on that experience. Our in-person Annual Meetings will resume as soon as possible, hopefully in New Orleans in 2022. In the meantime, AAPL can and must have a robust online presence for the organization to thrive, not only through the

pandemic, but also into the future.

To that end, with the support and assistance of Executive Council members, and again, Jackie Coleman, her staff, and the second iteration of the Virtual AAPL Task Force, we are developing “AAPL OnLine.” Some of these new endeavors are likely to be very successful; others maybe not so much. But there can be no doubt that trial and evaluation of innovative online offerings will result in AAPL being able to advance its educational mission in new ways as part of the “new normal.”

Projects currently underway include:

- Organization of “open house” committee meetings, coordinated with Forensic Fellowship Training Directors, for fellows (and others) to have an opportunity to explore and meet with committees in which they might have an interest;
- Development of live-stream online courses and other types of presentations for CME credit;
- Organization of members-only Town Hall meetings to address issues and current events affecting AAPL and forensic psychiatry;
- An “Expert Lecture” series, live-streaming a member presenting a 60-90 minute lecture for CME credit;
- Development of the capability to access on-demand materials, such as recordings of courses and meetings, podcasts, and other digital modalities;
- Redesign of the AAPL website, the “Digital Face” of AAPL, to be more dynamic and interactive, for members and nonmembers.

The most obvious advantage of online learning (aside from being able to attend in your pajamas) is time flexibility. Before the pandemic, almost all of AAPL’s annual activities took place in one hectic week at the Annual Meeting. Going forward, we will be

able to combine the advantages of online education with the social and educational advantages of being in the same place at the same time with colleagues. For example, the Annual Meeting call for submissions usually yields far more proposals for presentations than can be accommodated. If online CME courses are successful, courses might become a primarily online learning modality, thus allowing more panels, workshops, and other presentations at the Annual Meeting.

In addition, AAPL will be advertising our online offerings to members, nonmembers, and all psychiatric residencies. Topics in forensic psychiatry are often of great interest to nonforensic clinicians, and many psychiatric residencies do not have a forensic fellowship program. Online offerings could result in significantly increased attendance and elevate AAPL’s profile, which might lead to increased membership and increased recruitment of forensic fellows.

Certainly, for the next two years or so, AAPL’s ability to translate the unique teaching talents and expertise of our members to online offerings will be critical to the strength of the organization. So I encourage members to propose additional innovations. Please get in touch with any ideas or proposals you might have (lhgoldmd@gmail.com); no idea or suggestion will be rejected without consideration!

In 2020, we did not have control of many aspects of our lives. We fell into our current circumstances unprepared for the changes and challenges we have been forced to confront. However, we can have control in defining AAPL’s “new normal,” especially in regard to our primary mission of education. Your suggestions for innovation and your evaluations of our online endeavors will be invaluable in determining which of these will help AAPL thrive through and after these difficult times. I know AAPL is up to the challenge. I leave you with Hurin’s words of hope (J.R.R. Tolkien, *The Silmarillion*): “*Aure entuluva!* Day shall come again!” ☯

Jonas R. Rappeport, in Memoriam

Jeffrey S. Janofsky, MD



I am devoting my AAPL Medical Director's column to the memory of Jonas R. Rappeport, who died on September 8, 2020 after a long

illness. (1) He was a founding father of AAPL and was AAPL's first President and first Medical Director. (2) Jonas was an important figure to many of us. He was my teacher, mentor, and friend. After AAPL announced Jonas' death I received anecdotes from all over the world describing how Jonas was important in helping others in their professional and personal lives. I thought the best tribute to Jonas would be to print excerpts from those comments, which I have edited for content and space:

I will never forget the time I was doing grand rounds at the University of Maryland and Jonas and Joan showed up at the talk in matching orange shirts and black pants, and took me right from there to the Orioles game at Camden Yards. He was a great guy.

— Paul S. Appelbaum

Jonas was so helpful to me in my early years in AAPL and so supportive later when we were developing the website for AAPL. I relished his wit - he had so many wonderful ways of putting things. My favorite was his advice about risk management: "When in doubt, shout!" (Get a second opinion, formal or informal, and document it). The first time I cited his saying in a chapter draft, the editor wrote, "Love It!" next to it. I still say it whenever I am teaching residents about risk management situations. Another favorite was when he talked about the "nature and quality of the act" clause in the M'Naghten Rule. "The nature of the act? What? The defendant thought he was shooting at a tree, not a man. That's not a question

for a psychiatrist - that's a question for an ophthalmologist!"

— Peter Ash

Sad news to waken to here in the UK. His personal qualities epitomized the unique characteristics of the very special organization which he created.

— John Baird

Jonas was a "mensch" in every sense of the word. He was a role model, a wonderful teacher, a good friend, and a devoted spouse. I knew him in many of these roles and admired him in all. I turned to him many times for support and advice and he was always patient and generous. I will miss him greatly.

— Elissa Benedek

Like many others, I owe my forensic career to Jonas. I had 2 areas of special relationship with Jonas, photography and the Michael Reese Hospital. In about 1990, Jonas approached John Behrs and me at an AAPL meeting. He noticed that we each carried cameras. He asked us to help him take photos at the AAPL meetings. John dropped off after a couple years, but I continued as Assistant Photographer. When I would describe my appointment as the Assistant Jonas, people knew what I meant. In my forensic work, I learned to answer only the question asked. As the Assistant Jonas, I learned to do only the assigned task, not more. He did let me know that he appreciated my doing my assigned tasks. Jonas did his internship at Michael Reese Hospital in Chicago in about 1950. He met Joan there. She was a psychiatric nurse. I did my internship at Michael Reese in 1972, and then psychiatry residency there, too. I enjoyed reminiscing about Michael Reese with Jonas and Joan on several occasions. Nothing lasts forever. Now Michael Reese Hospital and Jonas are both gone.

— Steve Berger

Jonas was a true giant of forensic psychiatry. He mentored all of us. May he rest in peace.

— Renee Binder

I have been thinking about Jonas overnight and concluded that the best way I could characterize Jonas was as a master builder. The goal for Jonas as leader and for those around him was to build a new medical specialty. If you want to do this follow his plan. Start by creating a new organization, AAPL, with a singular goal, continuing education for the practitioners of the dark arts of forensic psychiatry with a yearly conference and its own professional journal. Soon follow this up by creating a committee dedicated to advancing sub-specialty training in this new specialty, and as soon as these fellowships were sufficiently up and running develop your own certifying exam and a darn good one it was. And most important insist from the very beginning that only psychiatrists could be full members of AAPL and further that they had to be members of APA, potentially AAPL's best friend, and at the same time its biggest obstacle to recognition. And, finally when the time came you had to give up your own darn good exam in favor of more important recognition. That was a hard one. But you cannot be a master builder just by having ideas in your head. You had to have the positive personality attributes, political adroitness, and the absolute dedication to accomplish the goal. Jonas had all this plus personal warmth, an ability to listen and to formulate ideas clearly and positively. All were part of his makeup. Jonas was a help to most all who sought out his help and support, and the most he ever asked of anyone in return was arranging a good fishing trip.

— Joe Bloom

I interviewed Jonas for an article in the Journal of Forensic Psychiatry in 1997, when I worked in the UK. He suggested we talk in

(continued on page 5)

In Memoriam

continued from page 4

his hotel bedroom in Denver at an AAPL meeting. He spent part of the time sat propped up on his bed and part of it getting dressed. He was generous and helpful throughout to someone he had never heard of who was asking him a series of slightly impertinent questions. What made the strongest impression on me was the complete lack of pretension in a figure who was regularly described as the doyen of US forensic psychiatry.

— Alec Buchanan

I remember Jonas not only for his foundational contributions to forensic psychiatry and his remarkable capacity to change his mind, but also as a welcoming mensch for all seasons. May his memory be a blessing to us all as we continue to learn to change our own minds.

— Harold Bursztajn

I will always remember Jonas as a warm, kind, supportive, inspiring leader who blazed the trails that we now traverse. His spirit and influence lives on in each one of us. That is a wonderful gift from a generous man. May he rest well in peace.

— Michael Champion

So sorry to hear that Jonas has died. He was a large and important figure in our field.

— Brian Crowley

Jonas was the father of AAPL and the father figure to generations of AAPL members, many of whom he nurtured and mentored. I first met Jonas the evening before the 1971 APPL meeting in Pittsburgh, and he invited me to look him up if I were ever in Baltimore. Herb Thomas gave me his number, and when I moved to Baltimore as a medical student in 1972, Jonas invited me to his home to meet his family. For the next 10 years, we were in weekly contact, at his Court Clinic, at lectures he gave at Hopkins and the University of Maryland, at Maryland Psychiatric

Society events, at AAPL, at APA, at GAP, at committee meetings, in his woodshop, and once fishing for bluefish. He made it possible for me to survey Maryland psychiatrists for my PhD dissertation research. It seemed he spent every evening on the phone doing work for all the committees and organizations for which he volunteered. No one was more generous than Jonas in donating time and energy to the betterment of the profession, and his most prolific channels of influence were organized psychiatry and mentorship. Jonas did not keep his opinions to himself. He had a way of telling you that you were wrong without giving offense or insisting you come around to his point of view. By 1982, when we were teammates with Jim Cavanaugh and John Monahan in the evaluation of John Hinckley, Jonas treated me as a colleague. I like to think that Jonas took me under his wing, as he has so many others, and then set me free to find my way in the world.

We will all miss him, his kindly smile, and the way he emanated love.

— Park Dietz

I am so sad and sorry too. I had the privilege of sharing Jonas' birthdate October 16, so we've exchanged birthday greetings over the years. He meant so much to many of us and was such a spiritual and instrumental force in the development of AAPL, indeed of our forensic psychiatry discipline.

— Alan Felthous

I first met Jonas in 1979 at the Del Coronado meeting. I was so impressed that I followed Joe Bloom's advice to me to join APPL and pursue certification in forensic psychiatry. It was the best thing I ever did in my professional career. We will all miss Jonas. What a visionary and kind mentor. What a sad loss.

— Robert P. Granacher, Jr.

One of the giants, fallen; he was the seed crystal for AAPL so many decades ago.

— Thomas G. Gutheil

Jonas was very kind and nurturing to all of us up-and-coming younger forensic psychiatrists. AAPL will be emptier without him.

— Bruce Harry

A rare kind of genius and founding greatness. "Reasonable medical certainty is not what I thought it was. It is neither reasonable nor certain." His words and deeds remain with us.

— James L. Knoll, IV

May we all have the positive impact that Jonas had...

— Jeffrey L. Metzner

APPL's loss is Heaven's gain. We will miss him. We are sad.

— Richard Rada

Lost a very good man. Worth remembering for a long time.

— William H. Reid

(continued on page 6)



Dr. Rappeport, AAPL's first president, cutting the cake at our 40th Annual Meeting celebration in Baltimore.

AAPL Post-2020: More Reasons to Get Involved

Joseph R. Simpson, MD, PhD



The world is increasingly complex. Scientific advances accumulate at a dizzying pace. Keeping up with the latest technology in computers and cell phones seems like practically a full-time job in itself. (Being helped with tech by your children—or even grandchildren—may be somewhat embarrassing, but for many it is now just a fact of life.) Individuals, regions and nations are more and more interconnected for good and ill. The US political scene has reached a level of turmoil not seen for half a century.

The COVID-19 pandemic and several other national and international developments in 2020 have made these recent trends in human affairs crystal-clear. To take just the scientific arena, whereas previously it typically took at least 10 years to produce a successful vaccine, several companies made COVID-19 vaccines, using different approaches, in less than one year. Meanwhile, the governments of China, France and the US have acknowledged their interest in using genetic engineering or other biological methods to improve the performance of military personnel – or as some more sensationalistic media outlets like to say, creating “super-soldiers.”

The events of 2020 have been difficult and stressful for many of us, in our personal or professional lives, or both. Of course, an impact in one domain of life almost always influences others. By what could only have been coincidence, AAPL's immediate past president, William Newman, chose “Wellness in Forensic Psychiatry” as the theme for his presidential year. And a fortuitous coincidence it turned out to be. In this first post-2020 issue of the *AAPL Newsletter*, you will find several articles addressing issues related to physician wellness and burnout. There is Dr. Newman's Pres-

idential Address from AAPL's first virtual Annual Meeting, as well as summaries of the Meeting's featured speeches: Dr. Giamberdino's talk on the substance abuse recovery journey, and Dr. Clark's talk on workaholism and how to have a better relationship with work. You'll also want to read Dr. Burrows' contribution from the Early Career Committee on physician burnout, and the proposal for a new Wellness Committee by Drs. Perkins and Newman.

Through that committee and other initiatives, AAPL is developing resources for maintaining and increasing your wellness. Participation in AAPL is a great way to remain connected; it provides opportunities for networking and for a collegial experience. These benefits are in addition to the opportunities to increase your professional knowledge and expertise by attending AAPL educational events and reading its publications. The emphasis on wellness, and on improving diversity and equity within the organization, promises to add even more value to your membership in AAPL.

You need not limit yourself to engagement with one professional body; you might want to consider volunteering with others (always keeping AAPL as your first priority, of course). There are numerous large and small professional organizations to get involved in, such as the APA, the AMA, the AAFS (see the report by Drs. Freitas and De Crisce in this issue), and the NCCHC, as well as state and local medical and psychiatric groups. In addition to educational benefits, many of these organizations monitor the legal and regulatory landscape for our profession, endeavoring to improve bills that seek to change regulations on psychiatry, and to prevent bad bills from becoming laws.

Forensic psychiatry can be a very isolating specialty, particularly if one practices it exclusively. For those of you who already understand the benefits of engagement with AAPL

and other groups, this is preaching to the choir. But for those who are new to AAPL, or who for whatever reason have remained on the sidelines, we encourage you to start participating – join a committee, submit a proposal for one of the 2021 AAPL virtual events, or write an article for this newsletter. After the juggernaut of 2020, the benefits of being part of an active, responsive and supportive professional organization are hard to overstate.

On a different note I would like to thank those AAPL members who filled out our brief survey. The results suggest that the state of the Newsletter is strong. While we welcome future feedback and suggestions, for now we plan to continue on pretty much as before. Despite 2020 and the years preceding it, technological changes haven't completely swept away all the old media paradigms yet, and we will not be eliminating the print version any time soon. ☪

In Memoriam

continued from page 5

Jonas could just easily say he or we were wrong about something as insist on a truth or opinion.

He fathered a profession.

— David Rosmarin

He was enormously supportive to us all and brought me into AAPL. He played a major role in the establishment of our modern field. We will miss him.

— Howard Zonana ☪

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“Working Hard or Workaholic? Fostering a Healthy and Productive Relationship with Work” by Malissa A. Clark, PhD

Renée M. Sorrentino, MD

In keeping with this year’s AAPL Annual Meeting theme, Malissa A. Clark, PhD, presented on the topic of “Working Hard or Workaholic? Fostering a Healthy and Productive Relationship with Work.” Dr. Clark is Associate Professor of Industrial/Organizational Psychology at the University of Georgia. According to Dr. Clark and her research group, about one-fifth of us spend 60 hours or more per week working, one-half of us feel overworked, and 77% of us fail to use all of our earned paid time off. This “hustle” culture, highlighted by Elon Musk’s proclamation of working an 80-hour work week, is embedded in our society. But working long hours is only one component of “workaholicism,” a term coined in the 1970s by Wayne E. Oates, who authored the book *Confessions of a Workaholic*. Workaholicism, or a marked compulsion towards work, consists of four key dimensions: excessive hours or time beyond expectations, persistent, uncontrollable thoughts about work, an inner pressure or compulsion towards work, and experiencing negative emotions when not working.

Dr. Clark’s research included the development of a brief self-assessment tool to evaluate one’s relationship with work. They found that behavioral and motivational dimensions correlated with individuals who were “perfection striving” compared to individuals who were motivated by perfectionist concerns or fears that their work would be criticized. Research examining the outcomes of workaholicism include a variety of negative outcomes. Dr. Clark summarized the following outcomes: lower life satisfaction, greater burnout, poor emotional and mental health, lower job satisfaction, relationship stress and greater work-family conflict. Interestingly there was no significant relationship between workaholicism and work performance. Sleep was

correlated with workaholicism, and was a risk factor for cardiovascular conditions.

“Work engaged” is distinct from workaholicism. Work engaged refers to an individual who is pulled as opposed to pushed to work and is generally related to positive work outcomes.

Dr. Clark pointed out, however, that one can be “too engaged” which can lead to exhaustion and poor outcomes over time. Dr. Clark addressed the impact of COVID-19 on work hours. Remote work in general tends to increase work hours. However, studies examining work hours in the setting of COVID-19 have found that most people have maintained their pre-pandemic work hours.

In conclusion, Dr. Clark identified an approach to fostering a healthy and productive relationship with work. Psychological detachment, a strategy to decrease our cognitive ruminations and rest for the next week is one approach. Others included physical detachment such as frequent, scheduled break and physical activity. Competitive sports were the most effective sports activity in terms of reducing work-related stress. The number of steps traversed per day was correlated with greater end-of-the-day satisfaction and work-life balance. Individuals who were forced to take breaks and days off were found to have higher job satisfaction and improved work performance and delivery. In summary, workaholicism is associated with more negative outcomes compared to being work engaged. Both can be detrimental and have the potential to cause negative outcomes. ☯

Presidential Address

continued from page 2

aspects to one’s life unless they are out of necessity. Compartmentalization—not bringing stressful work aspects home—is a very worthwhile endeavor, especially for forensic psychiatrists.

Studies show fewer inflammatory proteins and lower stress hormones in individuals with strong social support networks. He emphasized that peer support is beneficial for addressing burnout and workaholicism as it can mitigate the risks of chronic stress. Having personally experienced severe, chronic stress and supported others who have been stalked, he stated that it is important for him as AAPL President to develop an AAPL peer support system for members to share work experiences and provide support to each other.

Dr. Newman explained that a discussion on burnout and stress should include a conversation about resiliency, which is the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant stress. He also introduced the concept as referred to as “grit,” which stands for “perseverance and passion for long-term goals,” and that this may be a more useful tool for individuals to build with. He recommended a book by Dr. Angela Duckworth, who has been identifying and studying successful and resilient individuals with “grit.”

Finally, he talked about endocrinologist Hans Selye, who was one of the earliest researchers on chronic stress. Dr. Selye said, “It’s not stress that kills us. It is our reaction to it” and, “Adopting the right attitude can convert a negative stress into a positive one.” These statements go hand-in-hand with “grit;” reframing the ways in which one experiences work can be the difference between work satisfaction and workaholicism and burnout.

Dr. Newman ended his 2020 Presidential Address by relating that AAPL has been his professional home throughout his career, and sincerely thanked AAPL members for allowing him to serve as AAPL President. ☯

Anthony Giamberdino, MD: Trudging the Road to Happy Destiny

Karen B. Rosenbaum, MD

On the final day of AAPL's 51st annual meeting held over Zoom in lieu of Chicago due to the pandemic, anesthesiologist Dr. Anthony Giamberdino spoke candidly about his "experience, strength and hope" in the tradition of a twelve-step meeting, and explained that he is a "recovering drug addict and alcoholic." He works with the Illinois Professional Health Program and has practiced anesthesiology for thirty years in the Chicago area. By telling his own inspiring story, he focused on physician wellness, the theme of the meeting.

He explained that by telling his story, he hoped to increase understanding in case attendees ever find themselves, or their friends, family, or colleagues in a similar situation, and so that attendees could potentially help a colleague in a similar situation reintegrate their career.

Dr. Giamberdino explained that he had a good childhood and that he initially used "weed" and alcohol as a teenager and in college mainly as a reward, and for a long time even when using daily, he was able to juggle his use while being an excellent student. He was also a musician in a rock band growing up. In college, he did well on the MCAT and decided on medical school in the Chicago area where he became AOA and compartmentalized his using and drinking. He said that he married his wife before his last year in medical school and stayed in Chicago for residency where she was attending graduate school. He said that initially because he was working 80 hours per week, the alcohol use toned down.

However, there were two significant life events that occurred while Dr. Giamberdino was in residency that accelerated his addiction. His mother tragically died after battling a long illness and while cleaning, he found 100 Percocet pills in her medicine cabinet. Also, in residency, his wife was diagnosed with choriocarcinoma after a miscarriage and started treatment. He said that once he started using Percocet

it was an "instant love affair" with opiates and it was easy to continue his habit through the fentanyl that was left over from cases at work. He soon became a daily user and managed to live and work this way for a year. He explained that at this point, he had lost all illusion of control over his addiction. Despite having a new adopted baby, a private practice position with an academic appointment, and a life that looked great on the outside, he felt miserable inside.

He said he tried every strategy to "fix" himself. He did not reach out for help because he lived in fear of the consequences and he worried he would lose his career and his marriage. He also did not know anyone in recovery to speak to.

When he was finally asked by work to attend a meeting in which he was confronted about his using, he drove to a forest preserve and tried to kill himself with a lethal injection, but instead woke up in an ICU two days later with multiple complications. A doctor on the team recognized that his problem was due to substances and discharged him to a program in Atlanta for physicians.

In Atlanta, he learned the twelve steps of Alcoholics Anonymous, starting with admitting he was powerless over drugs and alcohol and that his life had become unmanageable. He became willing to do whatever they told him to do. He explained that the next eleven steps outlined a plan of action, which was a relief.

After spending three and a half months in the treatment center in Atlanta, he had to face the Illinois licensing board. He was told that with professional aftercare and supervision, he would be able to work again as an anesthesiologist. He said he worked the Twelve Steps and went to meetings, completed an aftercare program, and was able to secure advocacy from the Illinois Professional Health Program (IPHP). He complied with random drug screenings as well and

took oral naltrexone.

When he eventually made it to Step Nine, he made direct amends to people including to his colleagues at the private practice job he had to leave, and to his residency program. The chairman of the anesthesia program there offered him a three-month position as a resident, and he gratefully accepted it. He said he needed his ego to be broken so that he could be humble and teachable again.

A colleague eventually vouched for him and he was able to get the job where he currently remains, west of Chicago in St. Charles, IL. He said that he was honest at his interview and said that with the grace of God he is becoming someone who will not use again. He was able to get his board certification when he had five years of proven abstinence. He also had to rebuild the trust in his marriage and was able to do that and raise three children with his wife. The title of his talk is from the Big Book of AA, and he feels that every day he is "trudging the road of happy destiny." (1)

Today Dr. Giamberdino is 31 years sober and still goes to two meetings per week; he has a sponsor and sponsors others in the program. He explained that when someone shows up, does the right thing and is honest in this program, they naturally become a leader. He is currently the medical director at the surgery center and has been for fourteen years. He is a leader in church, serving on councils and various committees. He also maintained his affiliation with IPHP and is currently on the advisory board. While raising his children, he coached on soccer and baseball teams and was involved with outdoor education and other trips.

Dr. Giamberdino explained that unfortunately over the past five or ten years, healthcare has become more corporatized, with negative effects. For example, he said that several funding sources have been withdrawn from the IPHP. He has noticed that it is now harder for a recovering physician to get a second start. He lamented that it is a "terrible, tragic irony" that we have a healthcare system where

(continued on page 9)

Anthony Giamberdino

continued from page 8

our job is to help and heal people, but the system will not allow us to do that for ourselves. He said that when the opportunity arises, it is rewarding to help people in this situation, but they have to want to get better and be willing to do anything.

Dr. Giamberdino clarified that people with good recovery are grateful and take full responsibility for their prior behavior. Physicians in recovery admit the consequences of their past behaviors and are willing to comply with any reasonable request to ensure the safety of their practice and patients. He explained that people with addiction cannot fix themselves but that there is help available and it is important to ask for it. He said that he is living proof that there is a life beyond addiction, and that it is more fulfilling than his wildest dreams. He said that despite the difficult road, his story needed to be what it was so that he could be speaking to us on October 25, 2020.

There were numerous questions for Dr. Giamberdino after his talk. He explained that sometimes recovering physicians could potentially run into patients at AA meetings, but worrying about that should not keep a physician from AA. The culture in AA is that everything is anonymous and confidential. There are always other meetings to go to, especially now that everything is on Zoom. Currently, a person can go to a meeting anywhere in the world.

Dr. Giamberdino further explained that AA saved his life, and IPHP saved his career. He said that sometimes he has a thought of using again like most people in recovery, but he explained that a sponsor told him that the key is thinking it through and playing the tape forward. He knows that using will eventually lead him to the back of a pickup truck with an IV in his foot, so he does not take the first drink. He explained the common triggers using the acronym HALT (Hungry, Angry, Lonely, Tired) and that ties into the importance of physician wellness and self-care. He explained that AA is a

spiritual program, not a religious one, and that someone only needs to find a “higher power.” In addition, the only requirement for AA membership is a desire to stop drinking and/or using. He explained that just as a diabetic will risk going into DKA if they stop insulin, someone with addiction could risk relapse if they stop going to meetings. He acknowledged that although there are other recovery programs out there, AA is the only program that he knows of that has a decades-long track record of success.

In conclusion, Dr. Giamberdino’s heartfelt presentation emphasizes the importance of physicians, especially psychiatrists and forensic psychiatrists, understanding the program of Alcoholics Anonymous so that we can educate our patients, colleagues, friends, family members, and the courts when necessary on the benefits of the program, and dispel any myths that could keep people from getting the help that they need. ☯

Reference:

(1) Alcoholics Anonymous Big Book-4th Edition (2001)

SEEKING CLINICIANS AND FELLOWS FOR RESEARCH PARTICIPATION (COMPENSATED)

We seek participants for a study of clinical decision-making in forensic evaluations. Participants must be clinicians in the U.S. with a terminal doctoral degree (e.g., M.D., Ph.D., Psy.D.) and some form of field experience in forensic evaluation (supervised or unsupervised). Those currently in supervised practice (post-docs, fellows, residents) are eligible.

Participants review online case materials and conduct a mock criminal responsibility evaluation (prior criminal responsibility evaluation experience not required). Approximately 60-90 minutes to complete.

Participants receive \$150.00 in compensation.

To participate, follow the link below (or paste into your Internet Browser):

https://iup.co1.qualtrics.com/jfe/form/SV_4Gi8ZAwf5oAzPgx

Questions may be referred to the co-PIs:

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This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the protection of human subjects (irb-research@iup.edu; 724-357-7730)

Forensic Psychiatrist Joseph Penn Is New Chair of NCCHC Board

Chicago – Joseph Penn, MD, CCHP-MH, has been elected chair of the National Commission on Correctional Health Care Governance Board.

He is director of Mental Health Services for the University of Texas Medical Branch (UTMB) Correctional Managed Care program, which provides health care services in approximately 90 adult and juvenile correctional facilities throughout the state of Texas. He is also a clinical professor in the UTMB Department of Psychiatry.

Dr. Penn has served on the NCCHC board since 2003 and was previously board chair in 2008-2009. He is currently the American Academy of Psychiatry and the Law board liaison; previously, he was liaison of the American Academy of Child and Adolescent Psychiatry. He has chaired the accreditation and juvenile health committees, served on multiple task forces to revise NCCHC standards, and served on the editorial board of The Journal of Correctional Health Care. He also is a physician surveyor for NCCHC.

Dr. Penn is triple board-certified in general psychiatry, child and adolescent psychiatry, and forensic psychiatry by the American Board of Psychiatry and Neurology.

Ask the Experts

Neil S. Kaye, MD, DLFAPA

Graham Glancy, MB, ChB, FRC Psych, FRCP

Neil 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 define “expert?”



A. Kaye:

Expertise is not just about knowledge, but also about the capacity to spot errors.

Without affirmative action, efforts to be thoughtful,

and practice, most of us are more likely to fall in the former group than the latter. Humans hunger for information, but often lack the know-how to evaluate it or the sources that we reference. This is the epistemological crisis of the moment: there’s a lot of “expertise” around, but fewer tools than ever to distinguish it from everything else. “Pure credentialism” doesn’t always work. A well-credentialed person may not really be an expert and their ability to teach to a trier of fact may be woefully lacking. Or, their viewpoint may be tainted by significant bias or an undisclosed agenda.

Real experts have experience in making decisions and knowledge of how things usually play out in a similar set of circumstances. This idea is reflected in Gladwell’s book *Outliers*. (1) Education, fellowship training, and clinical practice are part of becoming an expert, but they alone cannot substitute for experience.

A lack of expertise becomes especially problematic when it is combined with extreme overconfidence,

and with society’s tendency to reward projected confidence over humility. When scientists offer caveats instead of absolutes, the uncertainty we are trained to acknowledge makes it sound as if we don’t know what’s really happening. This creates opportunities for people who present as skeptics to undermine our profession and our testimony.

The idea that there are no experts (Douthat) is overly glib (2). The issue is more that modern expertise tends to be deep, but narrow in their expertise. Even within a hard science such as epidemiology, someone who studies infectious diseases knows more about epidemics than, say, someone who studies nutrition. Our work as forensic psychiatrists demands both depth and breadth of expertise.

A major area of concern should be that knowledge is tinged by confirmation bias. When doing our work as scientists we should be happier when we find people, opinions, viewpoints and/or facts with which we disagree. This provides the opportunity to reconsider our methodology and processes, and can enlighten our formulations, conclusions, and ultimate opinions.

Knowledge is often thought of as a quantity of information. A person who “knows” a lot is often referred to as knowledgeable. The Internet has become the font of knowledge in today’s world. Many people turn to the Internet for answers and in the medical world, we are constantly faced with the idea that “Dr. Google” has the answer to all of our medical problems. In reality, Google is a great example of endless knowledge with no expertise. It is no surprise that Internet-based medical diagnosing is accurate only about 50% of the time. (3) While the hope for artificial intelligence remains high, there is still no substitute for an experienced physician!

In court, the strongest attractor of trust shouldn’t be confidence, but the

recognition of one’s limits, including the willingness to acknowledge expertise beyond one’s own. It is very difficult to walk this line, as overconfidence is associated with persuasiveness, especially when espoused by a court admitted expert and hiring lawyers look for persuasive experts.

A recent New Jersey Appellate case (4) provides some guidance specific to psychiatric expert testimony. The court gave a thoughtful analysis of a scientific report in terms of objectivity and providing a basis for an opinion. Although psychiatry has little in the way of objective diagnostic tests, the court noted that expert reports cannot be admitted if they simply repeat the subject’s reporting of subjective symptoms. There must be more. The objective piece, then, should be what the expert brings to the table. Although excellence is not necessarily the standard, expert witnesses must do more than fact witnesses—if they want to give opinions. The court makes its reasoning clear and insists on a standardized diagnostic approach, gives credence to objective testing, and also stresses methodology in reaching an opinion, which I favor and believe is what *Daubert* (5) is about.



A. Glancy:

I remember very early on in my career being called as an expert in Superior Court and being cross-examined on my CV.

In particular I was asked how many times had I been qualified as an expert in court and I answered that I had been qualified on one occasion previously. The distinguished judge peered at me and, accepting me as an expert in forensic psychiatry, stated, “Well, he is the only expert that we have here so I suppose he’ll have to do.”

This is a simple question that is very difficult to answer. I can approach this in two ways: First, what is the legal definition, and second, how is an expert defined outside of the legal forum.

(continued on page 11)

Ask the Experts

continued from page 10

At the most basic level an expert witness could be said to be somebody who possesses the necessary expertise in a given field. Most particularly, the expert must strive for objectivity and honesty (6, 7) and give their opinion in a non-partisan manner, which is free of conflict. Gutheil and Simon (8) discuss the inherent tensions in the relationship between forensic experts and lawyers, stemming from the different roles that they adopt. Most importantly, the expert witness must adhere to the duty to provide fair, objective, and non-partisan assistance to the courts. In a recent Canadian case, the judge was charged with the gatekeeper function of ensuring this, prior to admitting expert evidence (9), as opposed to this issue going to weight as it did previously. A frequent role conflict is between the concept of providing treatment and that of providing expert opinion. Strasburger and others (10) describe this conflict in an important paper, which has been enshrined in the ethical principles of forensic psychiatry.

Interestingly, Canadian courts have come to an awkward compromise on this issue, differentiating between ‘litigation experts’ who may be forensic experts retained for the case; and ‘participant experts’, for instance, treating physiotherapists or rehabilitation specialists (11). The role of forensic expert therefore is to undertake a search for the facts of the case, supported by evidence-based tests and come to an objective opinion. It is common in forensic practice to review collateral information, such as that provided by informants who may have relevant information. A number of cases in Canada have reviewed this practice (12) and have ruled that experts are allowed to use what amounts to hearsay evidence but, if these facts are not proven in court, this goes to the weight of the expert opinion. If relying on this evidence, therefore, it is important to communicate with the retaining attorney and suggest that this evidence be proven prior to your final opinion.

The admissibility of expert evidence has been subject to various legal decisions. In Canada, the prevailing decision is *R v Mohan* (13), which set out four factors that should be considered. These included the relevance of the evidence; the necessity of the evidence; the absence of an exclusionary rule; and the assurance that the expert was properly qualified. In the United States, two major cases prevail, namely the general acceptance rule (14) and more comprehensively, the *Daubert* decision (5). This case cited three additional factors beyond the general acceptance rule, which included whether the theory or technique is testable and has been tested; whether the theory or technique has been subjected to peer review; and whether the error or potential rate of error has been identified.

Perhaps most importantly for forensic psychiatrists is a consideration of whether we can give an objective and honest opinion that is not advocacy, considering the limits of our expertise, and educating the courts.

Regehr (15) defines, at the basic level, an expert as one who possesses authoritative knowledge or basic skills. She emphasizes that the expert’s expert possesses intuitive decision-making and problem solving, beyond simple knowledge. She outlines the contrasting theories of whether expertise is inherited or the result of what Ericsson calls deliberate practice. I argued for the role of “deliberate practice” (16), the kind that makes you sweat, but with good coaching, delivering actionable feedback. This was supported by a qualitative study that I performed (17) interviewing some of the “Greats” of forensic psychiatry, who all spontaneously said that working 60-80 hours in at least the first ten years of their career, corresponding to Gladwell’s 10,000 hours, helped them become an expert’s expert. Most of us strive merely for “competence;” Dreyfus (18) describes a five-stage model, where the progression goes from novice to advanced beginner to competence to proficiency to expert.

Take Home Points:

The difference between knowledge and experience is a critical distinction to keep in mind. You will notice Dr. Glancy’s inclusion of his wife’s publications in his citations. There is no doubt he is a true expert! ☯

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Massachusetts General Hospital v. CR: Due Process Regarding Emergency Department “Boarding” Prior to Involuntary Psychiatric Hospitalization

Ren Belcher, MD

Patients in psychiatric crisis are often “boarded” in an emergency room or medical floor of a general hospital while waiting for an appropriate psychiatric placement (1-4). The frequency and duration of boarding appear to have increased in recent years given the rise in psychiatric visits to emergency rooms without concordant expansions in available resources (1, 5). In Massachusetts, where the present case was decided, the Department of Mental Health (DMH) reported 481 patients boarding over 96 hours in the first year of a program designed to expedite psychiatric placement (6).

For patients involuntarily brought to care, boarding can be especially problematic: delays in a medical hospital can add to the amount of time patients are detained, may aggravate psychiatric symptoms (7), and may offer fewer due process protections than patients would receive in a psychiatric hospital. Relevant case history on this topic includes *In Re: the Detention of D.W., et al.*, decided in 2014 by the Washington Supreme Court (8), highlighted in forensic psychiatry articles (9, 10), and cited in the *Massachusetts General Hospital v. CR* decision. The court ruled that the common practice of emergency rooms seeking a “single bed certification” to hold psychiatric patients under the state’s initial 72-hour and subsequent 14-day emergency commitments (in lieu of an available psychiatric hospital) violated the state’s Involuntary Treatment Act (11). The court found that involuntary detention for psychiatric purposes was lawful only when it occurred “in certified evaluation and treatment facilities,” clarifying that “this definition does not include hospital emergency rooms.” (Ref. 8, pp. 8-9)

In Massachusetts, the emergency commitment statute (12) divides

involuntary psychiatric evaluation into two distinct phases. The first, Massachusetts General Law Chapter 123 § 12(a) (“Section 12(a)”), allows several types of mental health clinicians and police officers to transport and hold for preliminary evaluation any person whom they have “reason to believe” may be at risk of harm to themselves or others. The second phase, “Section 12(b),” requires a more thorough assessment in a psychiatric hospital if the admitting physician at a DMH-certified facility finds that there is a “likelihood to cause harm” if the patient is released – a higher threshold than that required for the initial evaluation.

Importantly, Section 12(b) is limited to three business days, while Section 12(a) does not have a statutory time limit. The question of due process during a prolonged Section 12(a) hold was initially raised by the appellant CR in *CR v. Massachusetts General Hospital* (13), heard by the Appellate Division of the Boston Municipal Court in September 2019. CR had been detained by police after exhibiting disruptive behavior. A Section 12(a) hold was initiated by police and the patient was brought to the emergency room of Massachusetts General Hospital (MGH) for involuntary psychiatric evaluation. While in the emergency room, CR was significantly agitated. The consulting psychiatrists determined that she would require psychiatric admission, and further that she would need a private room. It took five days to secure admission to a suitable psychiatric bed on MGH’s inpatient psychiatric unit, during which time CR boarded in the emergency department. When CR was ultimately admitted, the inpatient psychiatrist filed a petition for civil commitment and involuntary treatment. This petition was filed one

day after she arrived at the psychiatric unit, but six days (four business days) after she presented to the emergency room.

The question before the municipal court was whether the three-business-day time limit under Section 12(b) – after which the hospital must either discharge the patient or file a civil commitment petition – should start from the time a patient is admitted to an emergency room rather than the time they are admitted to a psychiatric hospital. The court found in favor of CR, arguing that if the clock only began when the patient arrived at a psychiatric facility, “a hospital could indefinitely detain psychiatric patients in an emergency department while waiting for an open bed. Indefinite restraint without any due process is, on its face, the most egregious infringement upon a person’s fundamental right to liberty and cannot possibly be harmonized with § 12(a).” (Ref. 13, p. 10) The court ordered that “§ 12’s three day detention period begins when a patient arrives at an emergency department *or* psychiatric facility.” (Ref. 13, p. 11) It directed emergency rooms to release detained patients after three business days of boarding, regardless of outstanding safety concerns.

MGH appealed this decision, and in *Massachusetts General Hospital v. CR* (6), the Supreme Judicial Court reversed the lower court’s ruling:

Although the § 12(a) time period for application to and acceptance by an authorized facility has extended beyond the Legislature’s original expectations, the Legislature has not yet chosen to include a specific deadline despite its recognition of the issue. Absent demonstrated constitutional violations, we will not impose a specific requirement ourselves. As applied to CR, we conclude that the statute did not violate due process, as the § 12(a) period of confinement was no longer than necessary given the difficulty of finding her an appropriate placement. (Ref. 6, pp. 34-35)

(continued on page 29)

All Rise, the Judge has Entered the Zoom Call

Ryan C.W. Hall, MD

For this edition of In the Media, we are going to be looking at news articles related to COVID-19. On May 20, 2020, the MSN website posted the article “Singapore slammed for ‘cruel’ Zoom death sentence” by AFP and “Man in Singapore Sentenced to Death by Hanging Via Zoom Call” by Newsweek. (1, 2) The articles discussed the case of Punithan Genasan, who is a Malaysian citizen who was sentenced to death for drug trafficking. (1, 2) Due to the sentence being handed down during the COVID-19 pandemic, Mr. Genasan received the judge’s sentence via Zoom. Singapore, like many countries at the time, had engaged in social distancing and had closure of most businesses. At the time, the city-state of Singapore, which has a population of roughly 5,800,000, had 29,000 COVID-19 cases and 22 deaths from the virus. (1) Apparently, this was the second death sentence to be issued by Zoom, with the first occurring in Nigeria earlier in the month. (2)

Watchdog groups, such as Human Rights Watch and Amnesty International, criticized the sentencing in Singapore as cruel and inhuman. (1, 2) The Deputy Director of Human Rights Watch, Asia Division, Phil Robertson, was quoted as saying:

It is pretty astounding. The prosecutors and the court are so callous that they failed to see that a man facing capital punishment should have the right to be present in court to see his accusers. (1)

Although the death penalty was an obvious focus of the original articles, this column is going to primarily focus on the aspects of the incorporation of technology into the court room and whether “telecourt” is an acceptable venue for judicial hearings in America in general. Prior to COVID-19, there had been various policies and allowances for use of telecourt,

depending on jurisdiction. Many jurisdictions allowed for an expert or other witness to testify via technology, either by telephone, video stream, or taped deposition. Many jurisdictions also allow for lower-level processing hearings to occur via telecourt. However, some court business has to be conducted with the judge and the defendant in the same room unless the defendant had waived their right to be present. For example, the Florida Supreme Court had prohibited judges from presiding over mandated telecourt civil commitment hearings. The rationale provided was similar to the concerns raised in Singapore – that people needed to have access to the judge; realize that the hearing had weight/significance, for lack of a better word; and have a sense that the judicial branch respected the dignity of the individual. As noted in the opinion issued by the Florida Supreme Court in their ruling in *John Doe v. State of Florida* (3):

[J]udicial officer’s physical presence over such hearings is a constituent component of his or her ministerial duty to preside over a trial or evidentiary hearing. (Ref. 3, p. 1032)

Of note, prior to the ruling related to civil commitment hearings, the state of Florida also had a similar prohibition on juvenile court appearances being conducted by teleconferencing, which was also referenced:

In our view, solutions to many of the troubling issues in our criminal justice system may be found in proper, early, individualized intervention in a young life and not in the mechanical and robotic processing of numbers. Respect for individual begets respect while we fear coldness and sterility may breed contempt. (Ref. 3, p. 1030)

One of the earliest case rulings relating to the appropriateness of telecourt, at least for civil commitment, was *US v. Baker*, 45 F.3d 837, 840 (4th Cir. 1995) (4). That ruling came about due to the Eastern District of North Carolina partaking in a pilot program related to commitment hearings using videoconferencing. Baker raised concern that telecourt violated his due process rights under Federal statute (18 USC § 4247d) and cited landmark case law such as *Vitek v. Jones*. (5) One of the issues that Baker raised was that a key factor, especially for commitment hearings, was the impression that a respondent makes on the presiding judge. The court rejected this claim, indicating that judges were more likely to be swayed by documentary and testimonial evidence of the respondent’s mental state. In terms of the defendant’s impression of a court hearing done by teleconference, the court stated in its opinion:

With regard to the notion that a respondent may lose confidence in a hearing conducted by video conference, the government properly notes that such a concern is, in general, largely irrelevant to the constitutionality of the proceeding. Quite often, as the government appropriately observes, criminal defendants lack confidence in a criminal proceeding conducted with the full panoply of constitutional protections. In other words, there is no constitutional right to a hearing in which the participants have confidence. (Ref. 4, p. 846)

Since the ruling in *Baker*, the APA issued a Resource Document on Telepsychiatry via Videoconferencing in 1998, which supported allowing use of video conferencing for conducting a commitment hearing. (6) In addition, there have been psychiatric papers discussing various states’ uses of telecourt for psychiatric treatment. For example, an experimental trial of telecourt hearings in a Michigan jurisdiction, published in 2007, (6) estimated that over five years telecourt usage

(continued on page 30)

AAPL ANNUAL AWARDS



Stephen Billick, MD the 2020 Gold AAPL award winner for his many significant contributions to the field of forensic psychiatry.



James Knoll, MD awarded the 2020 Seymour Pollack Award for his distinguished contributions to the teaching and educational functions of forensic psychiatry.



Aaron Panner, JD is the 2020 Amicus Award winner for his many contributions to AAPL.



The Best Teacher in a Fellowship (Howard Zonana Award) 2020 recipient was Ryan Wagoner, MD. This is awarded each year to outstanding faculty members.



Alan Newman, MD received the 2020 Red AAPL award for his longtime outstanding service to AAPL dedication to the organization through committees, task forces and much more.

**Submit your nominees
for the 2021 AAPL Awards to
Dr. Scott at clscott@ucdavis.edu
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Effects of Media on Psychiatrist and Patient Wellness

Karen B. Rosenbaum, MD; Praveen Kambam, MD; Vasilis K. Pozios, MD; Ryan Wagoner, MD; and Susan Hatters Friedman, MD
Media and Public Relations Committee

The Media and Public Relations Committee presented the panel *Effects of Media on Psychiatrist and Patient Wellness* during the AAPL 2020 Remote Meeting. It illustrated the ways in which various types of media can contribute to stigma related to mental illness and psychiatry and the ways in which psychiatrists, especially forensic psychiatrists, could help counteract these messages and promote patient and psychiatrist wellness.

Dr. Rosenbaum discussed some of the recent literature from around the world examining the relationship between media and mental illness stigma. Media can be in the form of Internet, television, radio, podcasts, newspapers, movies, magazines, newsletters and other forms of print media. Media acts as a mirror of society and in turn influences society (1); this is especially true with social media. There are multiple ways in which media can use devices to negatively portray persons with mental illness including the way in which information is framed. (2) If violent language is used in depicting someone with mental illness, this can negatively impact the ways in which the public views people with mental illness.

Dr. Rosenbaum and Dr. Kambam both discussed a recent example, examining the series *Ratched*, on Netflix, that can perpetuate stigma related to mental illness and psychiatry. The limited series is based on the character of Nurse Ratched from the book and movie, *One Flew Over the Cuckoo's Nest*. The series favored style over substance. The State Hospital was luxurious, with bright colors, and the nurse's perfectly tailored and ironed uniforms matched the turquoise furniture. However, the barbaric nature of treatment for mental illness was highlighted, even in the context of it being set in 1947. Many confounding diagnoses and treatments were

portrayed, including hydrotherapy and lobotomy for people attracted to the same sex.

Dr. Rosenbaum explained that besides character and language, other techniques are used in cinema and television to depict mental illness as dangerous such as music, lighting, sound effects, and horror conventions. (3) News coverage in the U.S as well as internationally has also perpetuated mental illness stigma. In 2019, President Trump was quoted as saying of mass shooters after the tragic events in Dayton, OH and El Paso, TX, "These people are mentally ill. And nobody talks about that." (4) A study in Germany demonstrated that when people read an article associating mental illness and violence, they were more likely to later describe a person with mental illness as violent. (5) In Japan, Aoki et al explained that when the Japanese word for schizophrenia was changed from meaning "Split-Mind Disease" to "Integration Disorder," newspaper articles associating people with schizophrenia and violence decreased in number. (6) Overall, research in this area has shown some improvement in decreasing the stigma of mental illness in countries that have made a concerted effort in this area, however there is still a long way to go, especially in the United States.

Dr. Kambam introduced other television shows about mental illness such as *Never Have I Ever*, *Atypical*, *BoJack Horseman*, *Euphoria*, *Homeland*, and *The Punisher*. He explained that media has effects on both the individual, through direct and indirect pathways, and society. Media depictions can affect an individual's knowledge, attitudes and behaviors regarding mental health matters. Knowledge-based errors about mental health information may include misconceptions about disorders

and their prevalence, etiologies of the disorders, treatments and side effects, and dangerousness associated with certain illnesses. Dr. Kambam defined mental illness stigma as "the pervasive degradation, social judgment, and devaluation of people because they have psychiatric symptoms or have been labelled as having mental illness." Both self-stigma and public stigma exists, and there can be affiliate stigma as well. An example of effects on behaviors of individuals is a contagion effect, in which depictions may exacerbate harmful behaviors in susceptible individuals. For example, after Netflix's first season of *Thirteen Reasons Why*, a series about teenage suicide, aired, there was an increase in psychiatric hospitalizations for suicidality. The movie *Joker* (7, 8) which both conflated mental illness and violence and offers a cultural script for violence, especially relevant for threat assessment, was discussed.

Dr. Pozios continued the presentation, highlighting indirect pathway effects on individuals with mental illness through media influences on societal knowledge, attitudes and behaviors. He explained the Social Cognitive Model of Stigma, in which cues lead to stereotypes that lead to prejudice which results in discrimination against groups or individuals. He described various impacts of mental illness stigma including loss of job and income, loss of housing, loss of social interactions, and increased interactions with the criminal justice system. Dr. Pozios additionally focused on effects of media depictions on societal beliefs and attitudes toward individuals in the forensic psychiatric system, emphasizing common NGRI myths. He concluded that progress of media depictions on forensic-related topics lags behind other mental health topics and that there is an opportunity for forensic psychiatrists to improve the wellness of individuals with mental illness by interfacing with the media.

Dr. Wagoner discussed dealing with bad press and the impact this can have on the psychiatrist. He discussed four tips for dealing with this, including

(continued on page 31)

Teleforensics: Standard of Care and Malpractice in Telepsychiatry-Workshop

Presented at AAPL Annual Meeting, October 27th, 2019.

Neil Kaye, MD; Manish Fozdar, MD; Michael Syffert, MD; Rami Abukamil, MD; and Donna Vanderpool, MBA, JD.

Forensic Neuropsychiatry Committee and Private Practice Committee

Electronic means of communication and incorporation of data into the clinical practice of medicine has been underway for over a decade; it has come to be known as telemedicine. This same technology has been used similarly in forensic psychiatry for nearly as long. In clinical work, the standard of care for telemedicine (SOC-T) is precisely the same as that in an in-person or face-to-face setting (SOC), a premise of all State laws governing its practice. Despite this legislative decree, there is little data on care outcomes, whether they differ, and whether doctors believe that compliance with the law is even possible.

This workshop was highly interactive and used the audience response system (ARS) to gather data from the participating AAPL members. Seventy-five percent of the responders were board-certified, 43% have been in practice for over ten years, 27% 6-10 years, and 30% were in their first five years of practice.

The fictitious case used for the workshop is an amalgam of four actual medical malpractice (med-mal) cases provided by the presenters and was chosen for the neuropsychiatric perspective but also because one of the leading cases in telemed-malpractice is quite similar. This article is intended to focus on the SOC-T issue.

Case: A 42-year old woman, weighing 275 pounds, but with a 150-pound weight loss over the prior year presented to the hospital ER. She had intermittent vomiting and nausea, shortness of breath, fatigue, and weakness. Medications were non-contributory. A psychiatric evaluation did not reveal anxiety or depression, and she was sent home.

Five days later, she presented again at the ER, alert but not oriented, with an altered level of consciousness, confused, uncooperative, with inappropri-

ate mood and affect. The ER doctor felt this was likely depression, and a telepsych consult was initiated.

- Telepsychiatrist's note: Video call with patient. Consulted for depression. Patient reliability fair. Patient presented lying in a hospital bed, lucid, uncooperative, refusing to directly answer questions when asked, and required her nurse to repeat everything. She denied anxiety, depression, sadness, crying spells, loss of appetite, sleep disturbance, or suicidal ideation, plans, or intentions. She could not explain why she was in the hospital but denied any physical issues or medical problems. She denied any A/V hallucinations or delusions. She denied she was experiencing any pain or discomfort but did appear to grimace a few times during the evaluation. She denied any past psychiatric history.
- No change in sleep, eating, no suicide risk, no homicide risk, low elopement risk, no self-mutilative risk, denies aggression. Psychomotor retardation. Affect constricted. Calm. Uncooperative attitude. Thoughts logical, clear with unremarkable content. Speech halting.
- Impression: Patient does not appear to suffer from a mental illness, denies any depressive symptoms, denies any thoughts of self-harm, and is not an imminent threat of harm or incapacitated due to a serious mental illness.
- Her behavior appears volitional in nature and may be a subconscious means of appearing dependent, so she can be taken care of by her family and/or medical professionals. Discharge home with support.

ER Doctor-Summary: Telepsych consulted for possible depression and told she has attention-seeking behavior. No psychiatric medications were ordered. Discharge home.

Two hours later, the family calls 911.

- EMS notes: Found patient supine in bed, responsive only to painful stimuli. The family says she was released from the hospital today and delivered by ambulance in this condition.
- The family stated that the patient was faking her condition and that there was nothing medically wrong.
- Has been malnourished for past couple of months.
- She was unwilling to open her eyes, and when opened manually, she would clench them closed.

She was transported to the hospital where ER notes reveal:

- At the hospital, she opened her eyes willingly and began looking around spontaneously. She started to speak and answer questions correctly.
- Differential diagnosis: confusion, dementia, CVA, TIA, hypoglycemia, UTI, pneumonia, drug abuse, delirium, dehydration, electrolyte imbalance, depression, anxiety, intracranial hemorrhage.
- Head CT normal.
- Neurologist. Multifactorial encephalopathy.
- Rare alcohol consumption
- Admit

The following day:

- Brain MRI. Abnormal Flair and T2 hyperintensities within the base of the brain most suggestive of Wernicke's encephalopathy (WE.)
- Started thiamine iv

However, plaintiff:

- Never recovered
- Now fully dependent

Plaintiff's forensic neuropsychiatric expert opines:

(continued on page 31)

Recovery: Now, More Than Ever

Eugene Lee, MD

Recovery Committee

Prior to fellowship, I understood little of “recovery” outside of addictions. Many of my patients spoke of “being” in recovery and on personal journeys punctuated with hard-earned wisdom. Others “recovered,” having progressed beyond some salient endpoint.

Recovery means different things to different people. It can be framed in terms of a person’s goals with social and occupational functioning; others might narrowly focus on symptom and behavioral control, medication adherence, hospitalization rates and lengths-of-stay. I learned in my Public Psychiatry fellowship’s academic module on Recovery (1) that the only thing which cannot be recovered is time; broadly speaking, all else is recoverable in some form or fashion. The article “What Is Recovery?” by Jacobson (2) is, arguably, still as good a summary on the topic as can be found. It frames Recovery as encompassing both *internal* conditions experienced by persons who describe themselves as being in recovery – hope, healing, empowerment and connection – and *external* conditions that facilitate recovery – implementation of the principle of human rights, a positive culture of healing and recovery-oriented services.

In 2018, the American Psychiatric Association strongly affirmed the application of the principles of recovery to the comprehensive care and treatment of individuals with mental illness, highlighting the importance of striving for care that does not leave those individuals feeling powerless or disenfranchised. (3) Surely, these principles have their place in forensic mental health settings. Consider your patient’s repeated applications for conditional release from her state hospital, or my patient feeling sad, back in prison as unable to secure competitive employment and stable housing as a felon and with trouble paying his parole and administrative fees as well. As freedoms are increasingly stripped

from forensically-involved persons, the psychiatrist’s impact becomes even more crucial to empower them for successful behaviors.

“Recovery” may sound pleasing to the ear, but do we all agree on its principles? Certainly, the Recovery hat can complement (4) and augment (5) our traditional risk assessment and management roles. “True risk mitigation” assists (6) patients in changing and moving forward to living meaningful lives by understanding their life experiences, strivings and goals, and changing the very circumstance(s) driving them to have entered the forensic psychiatric system to begin with.

Incorporating the principles of Recovery into my own clinical practice has transformed how I approach my work as a psychiatrist. For example, even asking my patients for their perspectives on what recovery means (or would mean) to them has proven richly informative. I learn about their core values, longer-term goals and, sometimes, philosophies on the role (or non-role) of treatment. In my full-time work now as a prison psychiatrist, I often hear about the punishment of “serving time;” focusing on the recoverable here becomes all the more relevant, realistic and, frankly, easier on me in providing correctional healthcare. This is consistent with the suggestion that the recovery orientation can (7) assuage the burdens of parentalism on our side of the doctor-patient relationship.

Power differentials among physician, judge and service recipient warrant special consideration. What is the right term for this latter person burdened with numerous monikers, from perpetrator to patient? Even the term “justice-involved person” is questionable, given conflicted perceptions of “justice.” In the Recovery Movement, the term “Consumer” is used. The idea of the forensic consumer (8) is not new and, though it might not be universally applied, prompts the

cognitive exercise of conceptualizing services as centered around the person. Consider that “[t]he social contract that has created forensic mental health systems demands not only the detention and risk management of our patients, but also the rehabilitation of those self-same patients.” (Ref. 6, p. 2) Thus, working in the forensic system requires us to balance our public safety role with our work as clinicians in helping people to maximize their functioning and, we hope, independence. As a hypothetical example, would an insanity acquittee’s experience be more patient-centered if she were paying cash for a fee-for-service forensic hospitalization? Can the forensic mental health system be more person-centered without paying extra?

Innovations we are now seeing in recovery-oriented services include peer support workers becoming more mainstream in service provision. (9) The availability of peer support for forensic populations appears ripe to grow with time. (10) Another example is the Baer Reintegration Scholarship, which provides financial support to individuals living with schizophrenia, schizoaffective disorder or bipolar disorder, who are attending degree and certificate programs. (11) ☯

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(continued on page 21)

Mental Health and COVID-19: Suicidality as an Emerging Concern

Patricia Westmoreland, MD

Suicidology Committee

The coronavirus pandemic is taking a huge toll on our mental as well as physical health. An editorial in the *Journal of the American Medical Association* indicated that for the entirety of 2020 there will be at least 400,000 excess deaths in the US due to both COVID-19 and excess mortality from the impact of the pandemic on other ills. (1) That number far exceeds deaths from the Vietnam War, the Korean War and from other pandemics and approaches the number of US deaths from the Second World War. (1) Compared to times in history when people were able to come together and support one another through periods of societal crisis, the loss of human life on such a massive scale has been worsened by social distancing and quarantining measures, financial stressors, disruptions in schooling as well as recreation and religious activities (2).

It is estimated that for every person who dies of COVID-19 there are at least nine loved ones who may develop prolonged grief or PTSD, and based on the number of deaths thus far, over 3.5 million people could develop major mental health needs (2, 3). Psychological responses to prior pandemics have proved instructive as to what could be expected as a result of the COVID-19 pandemic. During the Ebola Virus Pandemic (2014-2016), fear-related behaviors such as stigmatizing infected survivors and ignoring medical procedures impeded public health efforts as well as the recovery of survivors (4). Anxiety, PTSD, and depression were found in at least half of those who survived Ebola or were in contact with someone who did (5).

Serafini et al traced the development of stress, anxiety, and depression in Wuhan, China after the emergence of COVID-19. Initial psychological reactions varied from panic and collective hysteria to pervasive feelings

of hopelessness and desperation that led to maladaptive behaviors (6). Early on in the pandemic it was also noted that healthcare workers were severely affected by what they had witnessed. Frontline healthcare workers in Wuhan directly engaged in diagnosing or treating COVID-19 patients (especially those who are nurses or female healthcare workers) experienced depression, anxiety and insomnia (7). 50% of healthcare workers in Italy developed post-traumatic stress disorder, 24% experienced depression, and 20% experienced increased anxiety (8).

Within six months of the arrival of COVID-19 in the US, mental health concerns increased. Over 40% of US adults surveyed reported at least one mental health condition: anxiety or depression (30.9%), symptoms of a trauma related to the pandemic (26.3%), and increased substance use (13.3%) (9). Loneliness and social isolation have also contributed to escalating mental and physical health concerns and themselves predict cardiovascular disease and premature mortality (10).

In addition to the psychological effects of living through a pandemic, COVID-19 itself may induce neuropsychiatric ills. Of 40,469 patients diagnosed with COVID-19, 9086 (22.5%) patients had neuropsychiatric manifestations, the most common being headache (3.7%), sleep disorders (3.4%) and encephalopathy (2.3%). The most common psychiatric manifestations were anxiety and other related disorders (4.6%), mood disorders (3.8%); 0.2% of patients had suicidal ideation (11). Those diagnosed with COVID-19 who had no prior mental health history have an increased incidence of a first psychiatric diagnosis in the 14 to 90 days that followed their COVID-19 diagnosis, compared to the psychological sequelae suffered by patients suffering from

other health events. Symptoms of anxiety, insomnia and (in elderly patients) a decline in cognition were the most common findings (12).

Data regarding the mental health effects of the pandemic has given way to concern that deaths by suicide will increase because of the effect of the pandemic in inciting risk factors for suicide (13). There was an increase in deaths by suicide during the 1918-1919 influenza pandemic, and among the elderly in Hong Kong during the 2003 SARS epidemic (14, 15). Increased distress among individuals with pre-existing mental illness may increase risk of suicide. For individuals without pre-existing mental health concerns, an increased risk for death by suicide may result from increased rates of depression, anxiety, and PTSD due to the stressors of social distancing, job loss and economic hardship, interrupted educational trajectories of teens and young adults, the stigma of being diagnosed with COVID-19 and the effect of the virus itself on the brain (12, 16).

While reports of an increased risk for suicide during this pandemic are concerning, data regarding an increase in deaths by suicide thus far are sparse. Leune et al found a slight but significant increase in deaths by suicide during the emergence of COVID-19 pandemic. The increase in deaths by suicide was mainly reported during the peak epidemic and in older adults. Psychosocial factors such as the fear of being infected by the virus or social isolation related to quarantine measures were the most prominent factors associated with deaths by suicide (17). However, data were collected fairly early in the pandemic. Although suicide rates may increase as the pandemic continues, there may be room for optimism. Suicide rates have actually been found to decline in some natural disaster or crises (18). This may speak to resilience, with people finding new strengths (19). However, suicide trends by race and ethnicity during the pandemic may differ; a recent study found that black individuals residing in Maryland had increased deaths by suicide whereas

(continued on page 34)

Rights and Responsibilities: Physical, Psychological and Legal Peril in the “Age of COVID”

Stuart B. Kleinman, MD

Trauma and Stress Committee

Employers are legally and ethically obligated to provide a safe workplace. Employees are legally and ethically obligated to not harm their coworkers. And, many employers are additionally legally required to provide reasonable accommodation to those with an Americans with Disabilities Act (ADA)-defined disability. As the COVID-19 pandemic persists, the specific nature of these obligations, and how to fulfill them, is rapidly, and in many circumstances controversially, evolving.

SARS-CoV-2 is an invisible, easily acquired, and rapidly spreading, physically and psychologically virulent bio-threat that may produce and significantly exacerbate mental disorders.

Early studies of the general population and healthcare workers suggest that a high prevalence of SARS-CoV-2, especially when there has been a significant COVID-19 mortality rate, creates a meaningful risk of some developing stress response syndromes. Although methodologically limited in multiple ways, these studies have important implications for those who remain in or may return to non-virtual workplaces, particularly, for example, for healthcare workers, first responders, and those deemed to be serving as “essential workers,” such as navy or other military personnel who are closely confined for extended periods, and those on the frontline in meat and poultry processing facilities.

Studies done in China after COVID-19 began seriously sickening population centers illustrate the significant psychological harm it may cause in certain groups and settings.

One study (1), in which two self-administered questionnaires, one of which consisted of the PTSD Checklist for DSM-5 (PCL-5), were completed by 2091 individuals

between January 30 and February 3, 2020, found that high levels of post-traumatic stress symptoms (PTSS), which were defined as a PCL-5 score of 35 or greater, were present among 18.4% of those in the study’s “high-risk public group” and 4.4% of the study’s healthcare workers. The high-risk group consisted of those with “confirmed or suspected COVID-19, and those with close contact to” COVID-19 patients.

Another early study performed in China (2), this one specifically of distress experienced by healthcare workers between January 29 and February 2, 2020, found only mild median scores of distress among most of its 1257 respondents, specifically, 39% of physicians and 61% of nurses, 72% of whom had junior titles. Potentially helpful for identifying those most at risk and for whom psychological protective mechanisms should be particularly targeted, as well as when considering malingering: (1) those working in Wuhan, as opposed to other regions of Hubei and beyond, and (2) nurses, as opposed to physicians, experienced greater manifestations of distress. Similar geographical results were found following September 11th, 2001, in which the development of psychological distress generally correlated with individuals’ distance from the World Trade Center towers.

The recent epidemic-like spread of “COVID-19 Fatigue” signals that the potential to develop vocationally impairing Burnout should also be considered. Demonstrating that those who perform certain types of work are likely at particular risk of suffering such, a study (3), done of healthcare workers in Canada 13 to 25 months following the ending in Ontario of the SARS epidemic found that those who worked at Toronto hospitals which treated individuals with suspected and

probable SARS suffered significantly higher levels of burnout and posttraumatic stress symptoms than those who worked at similar hospitals in Hamilton, where individuals with SARS were not treated.

Not all distress reflects the presence of a mental disorder, not all mental disorders impair or significantly impair functioning, and not every mental disorder that adversely affects functioning qualifies for ADA-based protection. Nevertheless, an array of SARS-CoV-2 induced mental disorders or conditions qualify or may qualify as ADA-protected entities that may require novel types of accommodations, including ones for which forensic psychiatric input is sought. Such accommodations, for example, may include:

1. Change of workplace hours due to becoming phobic of using public transportation during “rush hour,” or altogether.
2. Reassignment to a different workplace team due to a Stressor-Related Disorder that produces concentration-impairing fear of acquiring severe COVID-19 or disruptive irritability that is aggravated, for example, by exposure to teammates who, in fact, or in rumor, do not regularly wear a mask when frequenting high-risk venues such as bars and large social gatherings outside of the workplace.

Illustrating how seemingly the same or similar accommodation requests may result in different outcomes, both: (1) rational vigilance arising from a medical condition that creates significant susceptibility to acquiring SARS-CoV-2 and developing severe COVID-19 which does not reflect the presence of a mental disorder, and (2) irrational hypervigilance that is a function of PTSD or a related disorder which has resulted from exposure to COVID-19 or any other (traumatic) stressor might provoke the same transfer requests, but be analyzed and treated differently.

At the time this article was written, almost 1000 workplace-related

(continued on page 33)

Regional Forensic Didactic Programs for General Psychiatry Programs: A Possible Silver Lining of Socially-Distanced Learning?

Keri Ann Stevenson, MD and Tobias Wasser, MD
Forensic Training of Psychiatry Residents Committee

The COVID-19 pandemic has changed so much about our daily lives, and teaching psychiatry residents is no exception. Most residency programs and medical schools have moved exclusively to online didactic sessions in order to facilitate social distancing. Faculty members had to adapt quickly to the new online format with platforms such as Zoom. Like most things in life, online teaching comes with its own set of advantages and disadvantages. In the case of forensic training of psychiatry residents, this shift to online learning can mean the loss of personal contact while “spreading the wealth” of faculty members to other residency programs in need of forensic expertise.

The AAPL Practice Resource for Forensic Training in General Psychiatry Residency Programs recommends that, while core topics such as civil commitment, confidentiality, and suicide and violence risk assessment can be taught by general psychiatry faculty members (with the aid of suggested references, if necessary), the advanced topics of psychopathy, competency to stand trial, the insanity defense, and forensic issues pertaining to children should be reserved for faculty members with formal forensic training or “significant first-hand experience with these topics.” (1) This recommendation, in addition to the relative discomfort many general psychiatrists experience with forensic topics, likely presents a challenge for smaller or newer psychiatry residency programs which do not have ready access to forensically-trained psychiatrists, nor to experts in the community who are willing to teach. (2) As such, many AAPL members occasionally receive requests from directors and residents of nearby psychiatry programs to lecture on forensic topics or to offer

visiting electives for clinical forensic experience. Given that our members are often busy with existing clinical and teaching obligations and unable to travel without significant disruption to day-to-day operations, these requests may be difficult to honor and do not represent a sustainable solution for addressing this educational gap. However, in the “new normal” of online teaching, a shared online faculty may be more feasible and allow programs to expand their forensic educational offerings to include more of the topics detailed in the AAPL Practice Resource.

In his 2019 presidential address, Dr. Richard Frierson indicated that 81% of psychiatry residency programs do not have an affiliated forensic psychiatry fellowship program. (3) That is not to say that residency programs without associated forensic fellowships are necessarily lacking in forensically-trained or experienced faculty members. However, in geographic areas where forensic experts are scarce – see the geographic distribution of ABPN board-certified forensic psychiatrists according to U.S. census data below (2) – more advanced forensic topics that are encountered less frequently (such as competency to stand trial and the insanity defense) are likely to receive less attention. Given all of the obstacles to incorporating forensic training into general psychiatry residency (4), finding a way to deliver high quality forensic teaching to more residents would be a step in the right direction.

One vision for how to harness current COVID-related changes in teaching in order to expand AAPL’s educational reach could be the formation of regional didactic programs. For example, in order to consolidate resources, eliminate redundancy, and

facilitate high quality teaching, forensic psychiatry fellowships in New York City have shared a didactic program for many years. This approach could be applied to residency programs by opening existing online didactic sessions within an institution to residents from nearby institutions. Although many current teachers have a collection of preferred teaching tools, AAPL’s Forensic Training of Residents committee is capable of creating or compiling standardized content that can be used to facilitate live, online teaching so as to relieve the preparatory burden on online facilitators. The committee is currently developing online educational modules for residents focusing on topics identified in the 2019 Practice Resource (e.g., civil commitment, suicide risk assessment and decision-making capacity). The shared didactic system could supplement these ongoing efforts.

One of the biggest challenges to implementing regional forensic didactic programs is likely to be the logistics of scheduling sessions with multiple residency programs simultaneously. However, this would not be impossible to coordinate, especially if residency programs can be flexible in their scheduling. Financial considerations for those providing the education would also be an important component of any such plan. The logistics would have to be more carefully worked out, perhaps with each participating institution contributing equally to a faculty member’s compensation. In addition to the obvious benefits to psychiatry residents and programs seeking to improve their forensic education, a regional didactic program may also benefit early career academic psychiatrists establishing evidence of local and regional educational impact for promotion and tenure. ☪

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(continued on page 21)

Proposal: AAPL Wellness Committee

Finn Perkins, MD and William Newman, MD

Physician wellness has been a growing focus within medicine. This has been defined “by quality of life, which includes the absence of ill-being and the presence of positive physical, mental, social, and integrated well-being experience in connection with activities and environments that allow physicians to develop their full potentials across personal and work-life domains.” (1) The recent literature clearly supports that physician wellness has worsened, marked by burnout, decreased job satisfaction, and increased rates of physician suicide. (2)

The APA estimates that two out of five psychiatrists have professional burnout. (3) The practice of forensic psychiatry is not immune to these trends. The risks associated with vicarious trauma, workplace trauma, and PTSD have been specifically implicated in physician wellness within forensic psychiatry. (4)

With the focus on wellness during the 2020 AAPL Annual Meeting came an opportunity to have the organization focus more on our own wellness. Panels illustrated the need for thought from both a personal and systematic view. New initiatives have begun to

support AAPL members’ wellness.

We see a persisting need within AAPL for discussion and focus on wellness. Several members reached out to Dr. Newman during the 2020 AAPL Annual meeting to express interest in forming a Wellness Committee to support future endeavors within the organization. Because there is no existing committee of AAPL that attends to members’ wellness, we propose that a new committee be established with the following missions:

To promote a culture of wellness within the practice of forensic psychiatry;

To organize the AAPL peer support initiative;

To promote the study of wellness within forensic psychiatry.

Wellness is promoted by the APA and the AMA. There is an opportunity within AAPL to tailor physician wellness efforts and initiatives specifically to the field of forensic psychiatry and provide support to our fellow members. Our goal is to identify the minimum 12 AAPL members necessary to support creating a Wellness Committee. We encourage all interested members to email Dr. Perkins at finnperkins@gmail.com. ☎

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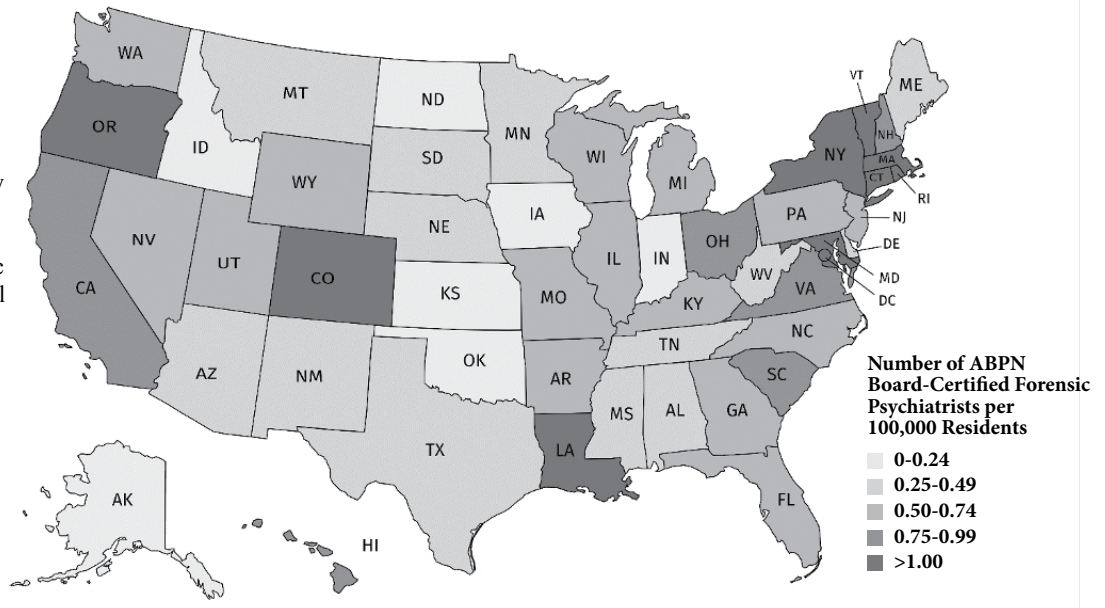
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continued from page 20

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Sex Offender Management in the Pandemic

Brad D. Booth, MD and Renée M. Sorrentino, MD

Sex Offenders Committee

The pandemic has created a new norm in psychiatry. This has included conducting virtual care via the telephone or the Internet. While telephone care provides some connection to patients, it has several drawbacks. We are no longer privy to our patients' subtle affect changes and body language. We are no longer able to emote an empathetic and reassuring expression. We have learned to ask the patient to move the phone closer or further from their mouth, depending on the degree of muffling present. Being put on hold for another call is also a now routine experience.

For those patients we see through video-conferencing, both patients and clinicians have struggled to learn how to use the technology. If we are actually able to get a stable Internet connection, there are still many hurdles. Many of us now have a reflex statement, "I think you might be on mute." We have also learned to gently encourage the patient to readjust the camera angle to capture more than above their nose, and to avoid the sunny window background. We have a new norm in establishing boundaries, including encouraging some patients to be appropriately dressed for the meeting. A new skill in sign language has also developed for when the audio goes out and we have to tell the patient to disconnect and reconnect.

Both the phone and videoconferencing bring a challenge for finding an appropriate venue for care. We have now all likely had therapy sessions with patients going for a walk or in their cars, taking the bus, hanging out at the mall, or sitting in a room with family members or roommates. Our skill is now to encourage them to find a more private venue for therapy. Some of us may have noticed our new referrals suddenly calling us by our first names, asking us more about our lives and mental health... and crunching on chips during the appointment.

Working from home, we have also had to find a private work space where the family cannot hear our patients and had to regularly excuse our dogs for interrupting.

While many in-person visits were initially barred, there were some exceptions which have been allowed. However, this in-person contact often required an explanation to administration as to why this is necessary. The patient would be met with intensive screening at the entrance of the hospital – overwhelming for some patients with significant mental health issues. A hospital staff member would then escort the patient with security to and from our offices. Prior to entrance to a large meeting space, there was mandatory scrubbing down of chairs and workspaces. Once the visit started, social distancing took precedence over a therapeutic distance. Mask-wearing and sometimes eye protection were also mandated. Again, this suddenly robbed us as psychiatrists of the usual tools to observe patients and similarly be therapeutic. Of course, the main topics of conversation have been, "What's new with COVID? What aren't they able to do? And how is this worsening their mental state?" These questions have more of the tone of peer support, rather than the usual doctor-patient dyad.

While we would agree that these diluted patient care experiences have been "better than nothing," they are likely not as effective as the in-person provision of care we all trained and became experts at.

When considering care of individuals with sexual offenses or other sexual issues, these issues are magnified. Some patients do not have the financial means for a telephone. While some homeless shelters facilitate use of the office phone, the calls are usually in the noisy common space, with distractions. Many individuals with sexual offenses also have a mandatory

ban on cell phones and Internet access, limiting possible "virtual" groups or appointments. Further, many have bans around any place a child might be, significantly limiting their ability to engage in stabilizing social, leisure and employment opportunities. Thus, while these prohibitions had been put in with the (non-evidence-based) hope of minimizing risk, today they have become significant barriers to stability and care.

Risk assessment and management of sexual offenders can be framed on the Risk, Needs, Responsivity (RNR) model or the Good Lives model (GLM). (1) While controversy exists about the best approach, both are difficult to undertake within the restrictions of the pandemic. Both place weight on improving interpersonal supports (intimate and non-intimate) and gainful employment. Neither can be adequately addressed during a pandemic. Further, increasing mental health symptoms can be a risk factor for recidivism in some patients. (2) Quarantine has been shown to increase mental illness (3) as has the current pandemic. (4)

The courts have been prone to impose strict limitations on community sexual offenders, particularly those with child pornography offenses or hands-on offenses. However, in the recent decision of *R. v. Brar*, (5) the Ontario Court of Appeals highlighted the need to balance risk management with the reasonable freedoms of a sex offender. Mr. Brar had been convicted of sexual assault, prostitution of a person less than 18 years of age, two breaches and three counts of child luring. An initial court order prohibited Mr. Brar from using the Internet except when at work, and from owning and/or using any mobile device with Internet capabilities. On appeal, the court noted that some degree of Internet access is unavoidable, highlighting it is needed for shopping, banking, and many daily activities, including what forensic psychiatry would think of as "risk reduction interventions" – e.g., finding a job or attending classes. Rather than a blanket ban, the court instead prohibited Mr. Brar from

(continued on page 30)

Performance Crimes and Social Media

George D. Annas, MD, MPH
Criminal Behavior Committee

Whether in the form of mass shooting, bombing, or other violent assaults, some criminals feel the need to publicize their actions and many of those in the public feel the need to watch. In an age where we possess instant worldwide dissemination and the “look at me” generation grips tightly onto power, it’s no surprise that crime, itself, is ever more on display.

The presenters of “Performance Crimes & Social Media” at the 2020 AAPL Meeting, provided the history, various types, and the analysis of many of these acts, as well as their interplay with broadcast and social media. Dr. James Knoll summarized the topic and noted a case from the ancient world demonstrating that such a practice is anything but new. In 356 B.C., a man known to us as “Herostratus” burned down one of the Seven Wonders of the World, later confessing he did it to become famous (1). His sentence (besides torture and execution), was to have his name stricken from existence such that even mentioning it out loud would be a crime. Likely due to his unique punishment the historian Theopompus could not resist recording the tale, thus immortalizing him and giving him what he wanted. His example shows us that trying too hard to deflect attention from criminals who act in the name of notoriety may end up having the opposite effect. Of course, providing more attention doesn’t help, as the case of Bonnie and Clyde showed how media attention could fuel public fascination with the “anti-hero.” Modern performance crimes have included the brief craze known as “Happy Slapping,” recording videos of planned random attacks on people and publishing them online. Initially starting as mild assaults, the craze “evolved” into more escalating episodes of violence. Somehow left out of his discussion was the tyrannical practice of “Rick Rolling” which has caused severe emotional distress in so many. But perhaps there was not enough time.

It remains uncertain if technology has exacerbated or simply exposed society’s voyeuristic fascination with crime, or the extent to which criminal performance and this fascination play off one another. However, Dr. Kayla Fisher showed us how terrorist groups have capitalized on both, such as the coverage of one attack causing a spike in the number of attacks within the following week. (2) Even when broadcast media limit their coverage, social media do not; a clear problem, considering that over half of the U.S. population gets their news from the latter. (3) Dr. Fisher reviewed the correlation with anti-Semitic social media postings and violent public attacks, also showing how various groups bypass rules against hate speech by using code-phrases to avoid algorithmic detection. Also described was the strange vicarious need of some citizens to document their own presence near the aftermath of mass murder, such as a man taking a selfie on the scene of the Westminster attack of March 2017.

“In an age where we possess instant worldwide dissemination and the ‘look at me’ generation grips tightly onto power, it’s no surprise that crime, itself, is ever more on display.”

Dr. Fisher, who also holds a law degree, provided a review of case law which restricts some of the ways in which such types of hate speech may be regulated in the United States, compared to many western European nations which can intervene more forcefully. There is no clear winner on who has struck the correct balance

between protecting free speech and preventing violence.

The issues and interplay with traditional media and their coverage of performance killing was presented by Dr. Park Dietz, who provided an analysis of many high-profile performance crimes, some of which he had worked on directly. He pointed out the differences between the primary motive of fame vs. impact. Some may pursue only one, while others seek varying degrees of both. An impact-seeking crime may involve one who wishes to further “a cause,” such as the Charleston shooter who sought to start a race war, without a significant wish to be famous. John Hinckley, in contrast, shot Ronald Reagan for fame, having little interest in the victim, nor any specific “political” cause.

Dr. Dietz addressed the concept of the media as a “vector” of crime and addressed some of the important challenges that the news media face, needing to cover important stories while minimizing inadvertent glorification of the perpetrator. Included in this discussion was the sensible observation that the local news may need to provide its own community with detailed information soon after such events, while the national and worldwide media do not. If fame or impact seeking ends up being the desired outcome, then such a strategy could help blunt some of the negative effects of such crimes. Some aspects of broadcast news coverage have improved, such as shifting attention away from the killer and avoiding excessive use of the person’s name. Whereas social media melds the role of producer and consumer, (4) Dr. Dietz aptly commented that choosing this outlet for information represents a “voluntary undertaking of being misled.”

Studying performance crime may cast light on a dark part of society. Interventions in regard to broadcast media coverage may be helpful in decreasing the “generalized imitation” of sensational crimes, (5) but deeper issues remain in our collective psyche. Although a popular scapegoat, the media at large are not responsible. Saying so suggests that we are all

(continued on page 27)

COVID and Reproductive Forensic Psychiatry

Cara Angelotta, MD; Anna Glezer, MD; Jill Spice, MD; Nina Ross, MD; Susan Hatters Friedman, MD
Gender Issues Committee

Reproductive psychiatry refers to the field of mental health focused on women's health from adolescence through menopause, including the perinatal and postpartum windows. Forensic reproductive psychiatry includes the clinical management of these issues in forensic settings, as well as expert opinions in legal cases.

COVID-19 has required all of us to shift the way we provide reproductive clinical care and expert opinions; it has changed the way that women engage with mental health; and it has impacted women's mental well-being, particularly during pregnancy and postpartum. COVID has placed restrictions on medical appointments, travel, and visitations. It makes it harder for women to have loved ones at their side (for appointments, labor, or postpartum). Not surprisingly, this impacts mental health. It also impacts how women plan for pregnancies, including postponing fertility treatment. The combination of physical and social isolation can increase the risks of depression during pregnancy and postpartum.

The pandemic has also unmasked and magnified inequities in social determinants of health. According to CDC data from October 2020, the COVID hospitalization rate for Latinx and Black individuals is over four times the rate for non-Hispanic whites. (1) The death rate from COVID is also higher among Latinx and Black communities. Racial disparities in pregnancy-related mortality predate the pandemic. Black women have a more than three times higher risk of death during pregnancy and the postpartum than white women. For example, Black women with at least a college degree are at five times greater risk of pregnancy-associated death than white women with a college degree. (2)

COVID-19 may worsen racial disparities in pregnancy-related health

outcomes. As of October 2020, there have been close to 35,000 reported COVID-19 infections among pregnant women in the United States and 50 maternal deaths. (3) According to CDC data, about a third of pregnant women with COVID-19 are hospitalized. Pregnancy increases the risk of ICU admission and mechanical ventilation, but not death, among individuals with COVID-19. Latinx and Black women appear to be disproportionately at risk of contracting COVID-19 during pregnancy.

Pregnancy and the postpartum represent a uniquely high-risk time for psychiatric illness in a woman's lifetime. Evidence indicates that the mental health burden of COVID is likely to fall disproportionately upon pregnant minority women. A Philadelphia study found that Black pregnant women were more likely than other women to report negative employment consequences of COVID and more worries about prenatal care, labor and delivery, and the postpartum period. (4)

Family Violence

Intimate partner violence (IPV) refers to physical, sexual, and psychological aggression by current or former romantic partners. (5, 6) IPV is a serious public health issue that often has serious mental and physical health sequela. (6) The COVID-19 pandemic has the potential to significantly increase the risk of IPV for multiple reasons. The pandemic may worsen individual risk factors for IPV, including unemployment and other economic stressors, social isolation, and relationship conflict. (5, 6) Stay-at-home mandates further increase the amount of time IPV victims are in contact with perpetrators and decrease opportunities for social support outside of the home or the creation of other protective environments. (6)

Similarly, the stressors of the pandemic increase risk factors for child abuse. Additionally, with many families at home including for home schooling, there is less opportunity for an angry parent to cool down. Teachers are usually primary reporters of child abuse, but when seeing students online they are less likely to recognize it. (7) Reporting of child abuse has decreased, despite evidence of increasing incidence of abuse during the pandemic. (7)

Incarcerated women

Over 225,000 women are incarcerated in the US. (8) The CDC recommends improved cleaning and hygiene practices, social distancing, visitor restrictions, and appropriate medical isolation and quarantine to reduce the risk of COVID-19 outbreaks within correctional environments. (9) New custodial stressors emerge with these necessary changes such as social isolation and the restriction of services, including mental health resources. (10)

Incarcerated women are more likely to have mental health problems than their male peers or women in the community. (11) Little is known about the potential mental health consequences of the pandemic and the recommended interventions to mitigate the spread of COVID-19 in correctional facilities. Higher rates of suicidal and self-injurious behavior may occur. (12) Incarcerated women may mirror women in the community and experience higher rates of post-traumatic stress symptoms, depression, and psychiatric decompensation. (13, 14)

Up to 5-10% of incarcerated women are pregnant when they are arrested, and often require off-site prenatal appointments and delivery. (15) Some correctional facilities quarantine offenders following any off-site visits. Additionally, many mothers were single parents before their incarceration. (15) Visitation suspensions may thus disproportionately affect female offenders and their children. Social distancing may be necessary, but it should not require emotional distancing from loved ones. (16) ☯

(continued on page 29)

Ignoring our Own Humanity: Burnout Among Physicians

David Burrow, MD

Early Career Committee

Michael Gungor, an American musician and author, wrote, “Burnout is what happens when you try to avoid being human for too long.” (1) Research on physician burnout is complicated. It is “plagued by large variability in reported prevalence rates and a lack of agreed terminology” (Ref. 2, p. 160); a review of 182 studies found 142 unique definitions of burnout. (2) Despite difficulty in defining burnout, most physicians have had contact with another burnt-out physician by the time they have completed training. Indeed, as Justice Potter Stewart wrote regarding “hardcore pornography” in his concurring opinion in *Jacobellis v. Ohio*, we may struggle to define burnout, “But [we] know it when [we] see it.” (Ref. 3, p. 197) Burned-out physicians have been described as, “angry, irritable, impatient, [having] increased absenteeism, decreased productivity and [providing] decreased quality of care.” (Ref. 2, p. 160)

Rates of physician burnout vary among studies, specialties, and stage of training (2, 4-8), with psychiatrists experiencing rates in the 30-50% range. (4, 7, 8) Studies have looked at a broad variety of potential risk factors for physician burnout; however, many of these factors (such as age, gender, marital and parent status, and stage of training) have yielded inconsistent associations. (2, 5, 7, 8)

Well-supported risk factors for burnout include circumstances that increase the volume, density, acuity and emotional demand of work; factors (such as electronic medical records [EMRs]) which distance physicians from patients; and factors which limit the reward (financial or otherwise) derived from work. Conflict with or lack of respect from peers, increasing bureaucracy, long working hours, increasing computerization of practice, and lack of clinical autonomy all have strong associations with burnout risk. (2) One consistent theme in the liter-

ature is having too much work, too little time to complete it, and finding too little reward in doing it.

These factors make sense within the models used to define and understand burnout. Research has long focused on three dimensions of burnout: Emotional exhaustion, depersonalization (withdrawing from, rather than engaging with work), and (perceived or actual) decreased personal accomplishment. (5, 6, 8, 9)

Although EMRs were hoped to improve efficiency and coordination of care, facilitate communication, and reduce the complexity of the practice of medicine, these benefits have largely gone unrealized. Because EMRs are designed to satisfy multiple competing (and often conflicting) needs, they are often not user-friendly. Most employ complicated, unwieldy, and poorly designed interfaces. Although they facilitate mobile access to the medical record, this often comes with expectations that physicians will work on documentation outside of clinical hours. Primary care physicians spend, on average, two hours interacting with the EMR for every hour spent with patients, including as much as 4.5 hours during the clinic day and 1.5 hours after clinic dedicated to the EMR. This is after spending 37% of their time during patient encounters also interacting with the EMR. As one physician noted, “I became a doctor to take care of patients. I have become the typist.” (Ref. 2, p. 161)

Early career forensic psychiatrists are at particular risk as they transition from training into unsupervised practice. Throughout medical school and post-graduate medical education, physicians largely cannot determine when or how much work to take on. We do the work our training programs provide, when we are told to. Even among very supportive training programs, there is so much material that must be learned in such a short period

of time that medical students and residents are seldom able to set limits or even recognize when their plate is full.

One of the most difficult things I have had to learn as I began my post-training career is that it is okay for me to decline a case I do not have time to do well, and to decline new responsibilities or opportunities in my clinical practice. This ability to say, “No, thank you,” has enabled me to find energy, interest, and vigor for the work that I do have.

Whether we begin our careers in academics, non-academic employment, private practice, or blended practices, we have to learn to balance the trade-offs in autonomy, systemic support, responsibilities, and compensation, and that the balance that was right for colleagues and mentors may not be right for us. The increased responsibility for the business aspects of practice (on which training programs often have not focused) and “imposter syndrome” with its feelings of incompetence or inadequacy leaves early career physicians at risk of being overwhelmed.

Although studies have suggested that risk for burnout decreases with the length of a physician’s career, the risk remains concerningly high, with transitions and unfamiliar clinical circumstances particularly increasing our risk. (5) Burnout is associated with increased risk of depression, anxiety, substance use disorders, and suicide. (2, 5, 6, 8) In fact, the overlap between depression and burnout is so great that screening instruments for depression can reasonably be used to screen for burnout. (2) Burnout also increases the risk for medical errors, increased physician turnover, increased absenteeism from work, and poorer patient experiences in care. (2, 5, 6)

This dark horizon, however, is not without its dawn. Many studies have found that both person-directed and organization-directed interventions can reduce work-associated stress and risk for burnout. The research has been heavily weighted toward individualized solutions (2, 6), a point often raised in criticisms of the research

(continued on page 32)

AAPL Members Active Within The American Academy of Forensic Sciences (AAFS)

Corina Freitas MD, MSc, MBA and Dean De Crisce, MD

AAPL Forensic Sciences Liaison Committee

The 72nd annual scientific meeting of the American Academy of Forensic Sciences (AAFS) took place in Anaheim, California from February 17-22, 2020. AAFS was founded in 1948 as a multi-disciplinary professional organization that provides leadership to advance science and its application to the legal system. Today with over 6,500 members, AAFS represents all forensic branches, including Psychiatry and Behavioral Science, as well as Jurisprudence, Criminalistics, Toxicology, Pathology-Biology, Digital Media, and other fields. AAFS fosters opportunities to collaborate with colleagues from other forensic fields in research, education, and practice. Since AAFS has a role in providing input to the National Academy of Science, it also coordinates standards and offers advocacy. In addition, AAFS cultivates the involvement of young members who are welcomed, mentored, and encouraged to participate. With “*Crossing Borders*” as the 2020 AAFS annual meeting theme, there were numerous exciting opportunities for interdisciplinary networking.

AAPL members have demonstrated long-standing, notable contributions to AAFS, and this year’s accomplishments continued that tradition. The following AAPL members participate or participated in the following AAFS activities:

- Dr. Richard Rosner, Past AAPL and Past AAFS President, remains a member of the AAFS Past President’s Council. Other Past AAPL Presidents who have been active in AAFS include Drs. Park Dietz, Alan Felthous, Stephen Billick, Robert Weinstock, and Christopher Thompson. Dr. Thompson serves on the AAFS Executive Committee, the Forensic Sciences Foundation Board of Trustees, the

Long-Term Planning Committee, as well as on the Membership Committee.

- Drs. David Annas, Corina Freitas, and Jarrod Marks, representing the SUNY Upstate Forensic Psychiatry Fellowship, had the privilege to present the opening evening session at AAFS’ 2020 annual meeting. Their panel, entitled “*Dracula, Twilight, and Blood Cults: Why Is It That Vampires Never Die?*,” led the captivated audience through a journey exploring the fascination with vampires based on cultural and psychoanalytic theories as well as through past historical tales of sadism and mass murder.
- Dr. Cristina Secarea, a forensic psychiatry fellow, was the recipient of the 2020 AAFS Richard Rosner Award for Best Paper by a fellow in forensic psychiatry or psychology. Her paper entitled “*Factors Influencing Adjudicative Competence and Length of Time to Restoration*” was presented at the 2020 AAFS annual meeting and will be reviewed for publication by the *Journal of Forensic Sciences*.
- Dr. Dean De Crisce is the Chair of the AAPL Forensic Science Liaison Committee, which typically corresponds with the Chair of the AAFS Psychiatry and Behavioral Science Section. He serves on the Editorial Board of the AAFS *Journal of Forensic Sciences*, the Membership Committee, and also served as this year’s 2020 AAFS Luncheon Session Chair. Also, he serves as the Workshop Co-Chair for the upcoming 2021 AAFS annual meeting. In addition, Dr. De Crisce presented together with Dr. Mohan Nair on “*Frontotemporal Dementia and Sex Offending:*

Neurological, Neuropsychiatric and Legal Issues” at AAFS’ 2020 annual meeting.

- Dr. Eleanor Vo, AAFS’ Psychiatry and Behavioral Science Section Secretary, serves on the AAFS Membership Committee. Through her participation in the AAFS Student Academy of Forensic Sciences, she acquaints high school and college students with the role of psychiatry in forensic sciences.
- Dr. Karen Rosenbaum, Past Chair of AAPL’s Liaison with Forensic Science Committee and AAFS’ Psychiatry and Behavioral Science Section, now serves on the AAFS Board of Directors as well as on the History of the Academy and the Nominating Committees.
- Italian psychiatrist and AAPL member Dr. Jimmy Troccoli is the 2021 AAFS Psychiatry and Behavioral Science Program Chair and serves on the Continuing Education Committee as well as on the International Affairs Committee, which welcomes international forensic scientists into AAFS.
- Dr. Jessica Morel, AAFS’ Psychiatry and Behavioral Science Section Assistant Program Chair, serves on the Continuing Education Committee.
- Dr. Alan Felthous collaborated with Italian forensic psychiatrist Dr. Felice Carabellese and several other international colleagues to present on topics, such as “*Differences Between Readmitted and Non-Readmitted Patients Discharged From Italian Psychiatric Security Facilities;*” “*Identification of Risk and Protective Factors for Violent Behavior in a Population of Forensic Psychiatric Patient Offenders in the Apulian and Lucan Areas of Italy;*” and “*Women and Men Who Committed Murders: Male/Female Psychopathic Homicides.*”
- Dr. Sandra Antoniak educated AAFS Jurisprudence colleagues on the topic of “*Neurodevelopment of the Transitional Age Brain*” and facilitated a much-needed interdisciplinary educational dialogue.

(continued on page 28)

American Medical Association 2020 Virtual Interim Meeting Highlights

Barry Wall MD, Delegate; Jennifer Piel MD, JD, Alternate Delegate; Sarah Baker, MD, Young Physician Delegate; and Kathryn Skimming, MD, Young Physician Delegate

The American Medical Association's (AMA) 2020 Interim meeting was held virtually from November 13th through 17th, 2020. The traditional large-scale in-person was replaced by a large-scale virtual meeting focused on priority and urgent business for the House of Delegates (HOD). Delegates, alternate delegates, and others provided testimony over the virtual platform on a full-range of issues.

Although the meeting focused on time-sensitive issues, the meeting started with the traditional presidential speech. In her speech, President Susan Bailey, MD, an allergist-immunologist from Texas, spoke about the challenges faced by the healthcare community since COVID-19. She recognized the tremendous loss of lives since the beginning of the pandemic, which has brought immense challenges and pain for so many – including physicians. She spoke about the role of physicians as leaders and trusted sources of information during this time, as well as the resolve of our physician community.

Following this, the HOD considered a number of reports and proposed resolutions relevant to COVID-19 and other timely topics. Among COVID-19 related policies, the HOD adopted a report from the AMA Council on Ethical and Judicial Affairs stating that physicians have an ethical duty to become immunized once a safe and effective vaccine is available for COVID-19, if they do not have a medical contraindication. The HOD also adopted policies supporting compassionate release for seriously ill inmates and increased infection control measures, including priority access to vaccines, in correctional facilities.

Following on prior calls from the AMA to confront systemic racism and police force, the HOD explicitly recognized racism as a public health threat. AMA Board Member Willarda Edwards, MD, MBA, said: “The AMA

recognizes that racism negatively impacts and exacerbates health inequities among historically marginalized communities. Without systemic and structural-level change, health inequities will continue to exist, and the overall health of the nation will suffer.” The new policy adopted by the HOD acknowledges that, although there are many factors that drive racial health inequities and structural racism, racism and unconscious bias within medical service delivery and research have caused harm and cause harm; that racism in many forms presents a serious threat to public health; that the AMA supports organizations to increase funding for research to prevent or repair damages related to racism; and that the AMA aims to promote educational programs to increase understanding and prevent racism. In addition, the HOD voted to adopt new policy to recognize race as a social construct that is distinct from ethnicity, genetic ancestry, or biology. With this the AMA encourage educational programs to recognize the harmful effects of presenting race as biology in medical education.

Of particular interest to AAPL members, the HOD considered the effects of bullying among physicians. The HOD adopted policy to define “workplace bullying” as “repeated emotionally or physically abusive, disrespectful, disruptive, inappropriate, insulting, intimidating or threatening behavior targeted at a specific individual or a group of individuals that manifests from a real or perceived power imbalance and is often, but not always, intended to control, embarrass, undermine, threaten, or otherwise harm the target.” The discussion focused on workplace bullying as a type of unprofessional conduct.

The HOD also adopted an AMA Board of Trustees report on establishing protocols for involuntary commitment for persons with substance

use disorders. The report included information about states that permit civil commitment for substance use disorders and concern about the procedures for commitment and available resources for treatment in some states. The adopted recommendations make clear that a physician or mental health professional must be involved in the decision for commitment; that judicial oversight is required; and the patient must be treated in a medically-appropriate facility staffed by persons with appropriate training in mental health and substance use conditions.

The AAPL delegation to the AMA welcomed the addition of two Young Physician Delegates: Sarah Baker, MD, and Kathryn Skimming, MD. Tobias Wasser, MD, has completed his term as AAPL's Young Physician Delegate; we thank him for his service and contributions to the AAPL Delegation.

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>. ☎

Performance Crimes

continued from page 23

simply mindless drones, controlled by the information we are exposed to, without the capability of individual thought or choice. The truth is far from it. And when so many of us choose – if not demand – to be in the audience, how can we be surprised by what we see on the stage?

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Report of the APA Assembly

Danielle B. Kushner, MD

AAPL Representative to APA Assembly

The APA Assembly met virtually on November 7-8, 2020. Compared to the Spring virtual Assembly schedule, the Fall meeting was a full calendar with all committees and councils scheduled virtually prior to the meeting.

In the Report of the Medical Director, Saul Levin, MD, MPA, discussed the organization's recent administrative, political, and legislative updates. He started by welcoming Regina James, MD, as the new Chief of Diversity and Deputy Medical Director. She previously worked as the Director of Clinical and Health Services Research at the National Institute on Minority Health and Health Disparities at the National Institutes of Health. Her experience is an asset as the organization works towards addressing equity and inclusion within our profession as well as health disparities facing minority and underserved patients.

Key legislative updates included the defeat of the Dept. of Veterans Affairs prescribing pilot for VA psychologists and the ongoing opposition against the redefinition of clinical psychologists as "physicians" through HR 884, the "Medicare Mental Health Access Act." The APA has also continued to advocate against the new proposed rule on J1 visa residents that would greatly impact J1 physicians.

Current APA President, Jeffrey Geller, MD, emphasized the importance of combating structural systemic racism within the APA. Dr. Geller recently authored in *Psychiatric News* an ongoing series on the history of Structural Racism in American Psychiatry and the APA. He also established the Presidential Task Force to Address Structural Racism Throughout Psychiatry, chaired by APA Area 4 Board of Trustee and AAPL member, Cheryl D. Wills, MD. Additionally, President-Elect, Vivian Pender, MD, provided a brief overview of the primary issue for her presidency tenure, Social Determinants of Mental Health.

Overall, the Assembly voted on approximately twenty Action Papers. One of the more important pieces of agenda passed included the development of a task force to explore the financial and organizational implications and membership's interests in changing the name of the APA to reflect the specific medical training of psychiatrists. The task force will report back to the Assembly with its findings and a related action plan as part of the agenda at the Spring 2021 Assembly meeting. Other important approved action papers included Enhancing APA Transparency and Accountability Regarding Human and Financial Resources Allocation; Expanding Telehealth Services; and Supporting the AMA Policy on the Independent Practice of Medicine, among others. Additionally, the diagnosis of Prolonged Grief Disorder was approved for addition to the DSM.

"Given the continued spread of COVID-19, the APA has announced educational and governance meetings will continue to be virtual through November 2021, including the Annual Meeting and the Fall Mental Health Services meeting..."

Important forensic issues of note included the passing of a Position Statement developed by the Council of Psychiatry and Law titled Concerns About Use of the Term "Excited Delirium" and Appropriate Medical Management in Out-of-Hospital Contexts. It states that the term "excited delirium" should not be used until a clear set of diagnostic criteria are

validated, recommends an investigation of such cases and their outcome, and emphasizes the need for protocols for the administration of ketamine and other sedating medications in emergency medical contexts outside of the hospital. It recommends that these protocols should prohibit the use of ketamine and other sedating medications to achieve incapacitation solely for law enforcement purposes. Other approved Position Statements included Sexual Abuse of Migrants in Immigration and Customs Enforcement (ICE) Custody; Growing Fear Over Coronavirus Spread and Mental Health Impact in ICE Detention Centers; and Abortion and Women's Reproductive Health Care Rights, among others. They have now been sent to the Board of Trustees for final approval.

Given the continued spread of COVID-19, the APA has announced educational and governance meetings will continue to be virtual through November 2021, including the Annual Meeting and the Fall Mental Health Services meeting (formerly known as Institute for Psychiatric Services). The 2021 Annual Meeting will be a three-day live online meeting scheduled for May 2021. The theme is *Finding Equity Through Advances in Mind and Brain in Unsettled Times*. ☯

AAFS

continued from page 26

- Senior AAPL members Drs. William Bernet, Gregory Leong, and Wade Myers serve on the Editorial Board of the *Journal of Forensic Sciences* and promote academic standards for forensic psychiatry research and publications.

Through the Forensic Sciences Liaison Committee and beyond, AAPL members have been more and more active within AAFS. We invite you to explore opportunities to interact with the greater forensic science community. Please join us in the Liaison with Forensic Sciences community and at the online 2021 AAFS annual scientific meeting in February 2021! ☯

MGH v. CR

continued from page 12

In rendering this decision, the court relied heavily on judicial and legislative reviews of the civil commitment process, including a committee report that determined “the three business day period is necessary to make a valid clinical determination of a patient’s need for continued psychiatric hospitalization.” (Ref. 6, p. 15) The court found that this assessment is neither realistically nor legally achievable by any facility other than a DMH-regulated psychiatric hospital, and that “the record presented to this court reveals no realistic alternative to ED boarding itself.” (Ref. 6, p. 20) Ultimately the court concluded that releasing a patient in need of Section 12(b) services before a Section 12(b) evaluation can be completed “poses a risk of serious harm to the patient or the public.” (Ref. 6, p. 20)

Despite reversing the lower court’s order to limit the time allotted for the Section 12(a) process, the high court concluded its opinion with a plea that lawmakers amend the statute “to include a time deadline for the § 12(a) evaluation process as expeditiously as possible to clarify the statute and ensure the protections of the important liberty interests at stake.” (Ref. 6, p. 35)

In Washington, over 100 new psychiatric beds were opened following the Supreme Court’s ruling *In Re: the Detention of D.W., et al*, motivated by concern that with boarding outlawed, emergency rooms would have no choice but to discharge dangerous patients. But without a major reworking of the psychiatric infrastructure nationwide, boarding will continue to be a burden for patients in crisis and for the health system at large. Additional legal challenges to psychiatric boarding may be expected in other states, given the precedent of the cases discussed here (12). ☉

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continued from page 24

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(continued on page 32)

All Rise

continued from page 13

saved over a quarter-million dollars and resulted in greater safety due to less transportation, less elopement risk, and less physical encounters with patients. In 2018, JAAPL (7) published an article related to telecourt, which noted that California, Texas, and New Jersey were using telecommunications to assist in hearings and that the process was more efficient, reduced inmates' time spent in jail, allowed out-of-state family members to participate, and increased safety due to decreased risks with transportation.

A survey of California courts in 2014 (8), with only a 19% response rate, found that 25% of respondents have used some form of video remote technology in the courtrooms. The California survey found that virtual technology was used frequently for arraignment hearings in criminal cases, with it making up 62% for felonies and 90% for misdemeanors. However, when it came to sentencing hearings, it was only used 13% of the time for felonies and 19% for misdemeanors. When telecourt was used for felony cases, both parties stipulated to its use approximately 40% of the time. When objections in felony cases were raised, roughly 10% were based on concerns that telecourt would violate constitutional or statutory rights, roughly 10% were based on insufficient or inadequate telecourt equipment, and roughly 4% were based on concerns that the telecourt equipment may not be secure. The overall findings in the California survey were that approximately 80% of the respondents (judges) expressed satisfaction with the telecourt experience. Only 2.8% expressed dissatisfaction. Forty percent reported they believed it was equivalent to having the entire proceeding in a physical courtroom, however 52% did believe that something was lost, but that the ultimate outcome was not affected.

In part due to COVID-19, as well as people gaining more familiarity and improvements in technology, issues related to telecourt proceedings are likely going to increase. To date, dif-

ferent states have taken different perspectives. As noted, many states will use this for lower-level proceedings. Some states have prohibited judges from appearing by teleconferencing unless the accused waived his right to be present. A question that may arise is at what severity of charge or potential punishment, if any, that telecourt proceedings will not be allowed. As seen from the Singapore and Nigerian cases, there is the potential that even the ultimate penalty may be issued without the defendant ever stepping foot into a physical courtroom. ☞

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Sex Offenders

continued from page 22

accessing illegal content and from participating in any manner in any social network, online forums, or chat rooms.

Although a Canadian case, *R. v. Brar* provides a thorough analysis of the balance between the offender's

needs and reasonable restrictions on liberty. It may serve as guidance for other jurisdictions. On the practical side, such a balance would also allow for appropriate follow-up and risk management during the current pandemic. Without such an approach, many sexual offenders will go without treatment during a time when other supports or coping strategies are not available. We have learned that the rates of intimate partner violence have increased during the pandemic. (6) If dynamic risk factors for sexual offending are ignored, we can anticipate an increase in recidivism. One logical answer would be to allow sexual offenders access to the Internet and phones in order to engage in what we know decreases risk: cognitive behavioral therapy targeting dynamic risk factors. Ignoring the needs of this patient population further stigmatizes this group and highlights an age-old problem in the history of sexual offenders: legal decision-making without the use of science, a dangerous endeavor. Until the courts allow patients access to telephones and the Internet, a treatable, high-risk group, sexual offenders, will remain untreated in the community. ☞

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Effects of Media

continued from page 15

identify why forensic psychiatry portrayals are inaccurate, educate family, friends, the public and patients, remember why we became forensic psychiatrist in the first place, and seek support from colleagues and mentors. He explained that being truthful and accurate does not sell papers or television programs well. Unfortunately, the extremes are what are interesting to people and what sells.

Dr. Friedman closed the panel by discussing the portrayal of psychiatrists (both general and forensic) in fiction and film. Irving Schneider described general psychiatrists as Dr. Dippy (named after the first psychiatrist in cinema, in 1906 in *Dr. Dippy's Sanitarium* (9)) who is harmless but lacking in common sense; Dr. Wonderful (who portrays psychiatry as perhaps magical but may also have sex with patients); and Dr. Evil. Forensic psychiatrists in fiction were described as either being portrayed as: Dr. Evil, The Professor, The Hired Gun, The Activist, or Jack (or Jill) of All Trades. (10) Examples of iconic forensic psychiatrists in film, television and novels over the years include Dr. Hannibal Lecter (*Silence of the Lambs*), Dr. Peter Teleborian (*Girl with the Dragon Tattoo*), Dr. George Huang (*Law and Order: Special Victims Unit*), Dr. Fred Richman (*Psycho*), and Dr. Molly Arrington (*Primal Fear*).

Dr. Friedman also examined forensic psychiatrists in film and crime fiction in the past year, including in *The Sinner* (11) and *The Silent Patient*. (12) Boundary violations abound, and mental illness seems to be conflated with violence. Dr. Friedman then explored the importance of us as forensic psychiatrists being aware of these portrayals—both for the potential for further stigmatization of mental illness, and also because defendants and jurors are much more likely to have seen our fictional counterparts than they are to know a real-life forensic psychiatrist. Dr. Friedman recommended that if forensic psychiatrists are contacted by writers, it is import-

ant to answer their questions about our field and mental health, or refer them to a colleague who is interested in doing so. She further discussed her own efforts, such as answering questions on crime writer list-serves and giving presentations for writers. (13)

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Teleforensics

continued from page 16

- Telepsych doctor deviated from the standard of care, contributing to the permanent injury of the plaintiff as a result of untimely diagnosed and treated vitamin deficiencies.

AAPL members were presented with topics to discuss and voted as follow:

Should an ER doctor be expected to diagnose Wernicke's Encephalopathy (WE)?

Yes: 63% No: 37%

Should an onsite psychiatrist be expected to diagnose WE?

Yes: 72% No: 28%

Should a telepsych doctor be expected to diagnose WE?

Yes: 38% No: 62%

It is clear that AAPL attendees held the on-site psychiatrist to a SOC slightly higher than that of the ER doctor but also and more importantly felt that the telepsych doctor was to be held to a lower standard, despite all State telemedicine laws requiring the same SOC for telemedicine and in person care.

Many AAPL members, especially those with interest in neuropsychiatry, will immediately recognize that the evaluation of a patient for WE is usually done in concert with a physical and neurological examination, looking for the tetrad of encephalopathy, nystagmus, ophthalmoplegia, and ataxia. A history of poor intake, poor absorption of thiamine, hyperemesis, alcoholism, starvation, gastric bypass surgery, and renal dialysis are also commonly implicated. A high index of suspicion is required, and a brain MRI can be diagnostic.

Could the diagnosis of WE have been made by a psychiatrist on site?

Yes: 55% No: 45%

Is a neuro exam the SOC for a psychiatrist?

Yes: 55% No: 45%

(continued on page 32)

Teleforensics

continued from page 31

Would telemed consult differ if it was done NOT in ER but on floor as a consult or as an outpatient consult?

Yes: 49% No: 51%

The above three responses show a nearly equal split in experts' opinions on these critical SOC/SOC-T issues.

Presenters led the audience on a discussion on what it means for a patient to be "medically cleared" prior to doing a psychiatric consult:

Should a Psychiatrist Proceed with an Evaluation if Consulted Prior to Medical Clearance?

Yes: 55% No: 45%

Does the fact that ED Doctor Missed the Diagnosis Exculpate the Psychiatrist?

Yes: 25% No: 75%

Here we see a nearly equal-split on whether or not medical clearance is necessary prior to a psychiatric evaluation (despite most residency programs teaching that one doesn't evaluate a person [ex.: intoxicated] until medically cleared) and the more interesting finding that although consulted as specialists, the audience felt they were less expected to get the diagnosis than the doctor who called for the consult based on our expertise.

Next was a discussion on the legal standards of SOC-T and review current case law. AAPL members voted:

Does Credentialing Imply Knowledge of SOC?

Yes: 50% No: 50%

Is There a Difference Between SOC, Evidence-based Care, and "Best Practices?"

Yes: 90% No: 10%

Does SOC differ for telepsych?

Yes: 25% No: 75%

Is there a Different Threshold for Liability under Telepsych? The discussion suggested that most members felt the answer was

(continued on page 33)

Burnout

continued from page 25

on combatting and preventing physician burnout. Although focusing on improving physician resilience has been found to have short-term benefits, it risks sending a message to overwhelmed physicians that they are to blame for problems that research tells us are actually largely systemic, even as it provides skills that can help physicians navigate challenging environments. A meta-analysis found that combining person-directed and organization-directed interventions can improve both the magnitude and duration of the anti-burn-out effects of successful interventions, though its findings were limited by the fact that of 25 studies, only 34% included organization-directed interventions. (6) Measures which improve physicians' ability to cope with stressors include: remaining actively engaged in work, taking control of work environment and conditions, receiving support and encouragement from peers, increasing autonomy and improving reward (financial and emotional) for work done. These measures can be anticipated to be associated with downstream benefits to patients and health systems. (2, 4-6)

The COVID-19 pandemic has introduced further uncertainty into clinical practice, while also driving rapid expansion of tools such as telepsychiatry, which can potentially either add to physicians' flexibility and ability to seize and maintain greater control of their practices, or thrust them into uncharted waters where they feel adrift, ineffective, and pulled where they do not wish to go by currents beyond their control. We may find ourselves increasingly separated from the patients and clients who were the reasons we entered our field, or able to connect with them in increasing ways. Two keys to physician well-being are maintaining boundaries by saying "No, thank you," to opportunities that would overtax us, and reaching out for help and support when we find ourselves struggling for things beyond our reach.

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Rights

continued from page 19

COVID-19 claims had been filed. These, for example, have included:

1. Alleged wrongful reduction of a previously granted accommodation, specifically, reduction of virtual workplace days from five to two weekly, that resulted in loss of employment. The plaintiff asserted that the same medical condition, for which she had been accommodated, rendered her physical workplace too dangerous to her health to attend. Such a case requires: a. analysis of the degree to which a medical condition, in fact, causes an individual to be inordinately vulnerable to becoming severely ill with COVID-19; b. determination of the degree of risk that merits an accommodation to work (fully) virtually; and c. consistently applying the latter threshold. Further, as a consequence of the presence of a co-existing mental disorder, e.g., anxiety disorder, an individual's perception of the degree of threat to her well-being that her physical workplace represents may significantly exceed that which her medical vulnerability objectively creates, potentially influencing the nature of any accommodation that may be required or granted.
2. Alleged wrongful termination, without cause, of a non-“at will” employee after she purportedly voiced COVID-19 related workplace safety concerns. These were reported to include: a. lack of mandated PPE use; b. lack of requirement to maintain social distancing; and c. a supervisor's treating workplace precautions lightly, despite his purported exposure to high-risk SARS-CoV-2 settings. The plaintiffs in this matter also brought a whistleblower claim under state law.
3. Alleged wrongful termination, in part, for an employee's departing the workplace after he acutely experienced symptoms that he

believed reflected development of COVID-19. Subsequently, these symptoms were determined to (seemingly solely) constitute manifestations of a panic attack.

4. Claimed intentional infliction of emotional distress for allegedly inadequately protecting an employee from contracting COVID-19, after the employer was on notice that the individual was particularly susceptible to acquiring this condition. To succeed, claims of negligent and intentional infliction of emotional distress associated with alleged contraction of COVID-19 from the workplace will require a showing of causation that will be variably difficult to establish. Even if not, in fact, acquired from workplace exposure, belief that the workplace was the responsible agent will likely generate many such claims. Reliable genetic, i.e., phenotypic, testing of SARS-CoV-2 may be invaluable in some of these cases. However, obtaining samples for comparison, especially from others at the workplace, will inevitably involve very significant privacy and practical considerations and hurdles.
5. Allegedly wrongfully subjecting an employee to adverse employment action due to an employer's purportedly believing that the employee's testing positive for SARS-CoV-2 indicated that the employee had exposed coworkers to COVID-19.

Employment-related harms, and legal liability for such, comprise rapidly evolving, potentially serious side effects from the COVID-19 pandemic that may endure for years. Forensic scientific knowledge promises to be able to assist in the equitable resolution of these controversies. ☞

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Teleforensics

continued from page 32

“possibly,” but when forced to vote answered:

Yes: 28% No: 72%

Is the SOC the Same in a State Hospital as in a Medical Hospital, Psychiatric Specialty Hospital, Prison, and General Medical Hospital?

Yes: 69% No: 31%

This case reveals the complexity of telemed in the ER setting and highlighted several limitations of knowledge and cognitive biases among AAPL members. The answers of the AAPL members on SOC are perhaps the most revealing and troubling. As “experts” in med-mal cases, we are expected to know the SOC, what it means, how it is determined, and how it is to be applied. Remember that the respondents are from the more experienced group of forensic psychiatrists, and yet many failed to get the basic concepts correct; the disagreements are significant, and for many of the questions, contradicted the law.

Discussion: Data derived from our workshop, albeit from a small, but experienced sample of forensic psychiatrists, suggest that there are significant disagreements among them regarding crucial questions involving the standard of care for the practice of telepsychiatry. These observations should serve as a wake-up call for our profession and a reminder of the ongoing need for education on this critical topic. They also have significant relevance to the practice of forensic psychiatry. Forensic experts are required to know the law and the SOC on the relevant topic. ☞

Suicidality

continued from page 18

the opposite was true for their white counterparts, highlighting racial disparities during this pandemic (20).

Encouraging physical distance while finding ways to socially connect and maintain meaningful relationships should be explored. Access to mental health treatment, substance use treatment and domestic violence shelters is of utmost importance, as is working on a local, state and national level to advocate for continued access to mental health via telepsychiatry and telephone. Research into how COVID-19 affects the brains of those afflicted with the virus will be key in tailoring treatment that focuses not only on the physical effects but the mental effects of the illness. Finally, de-stigmatizing the mental health consequences of COVID-19 not only for those who have been affected by the virus but for the millions of survivors should be our priority as we continue to move through uncharted territory. ☎

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(continued on page 35)

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Suicidality

continued from page 34

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