

# AAPL Newsletter

American Academy of Psychiatry and the Law

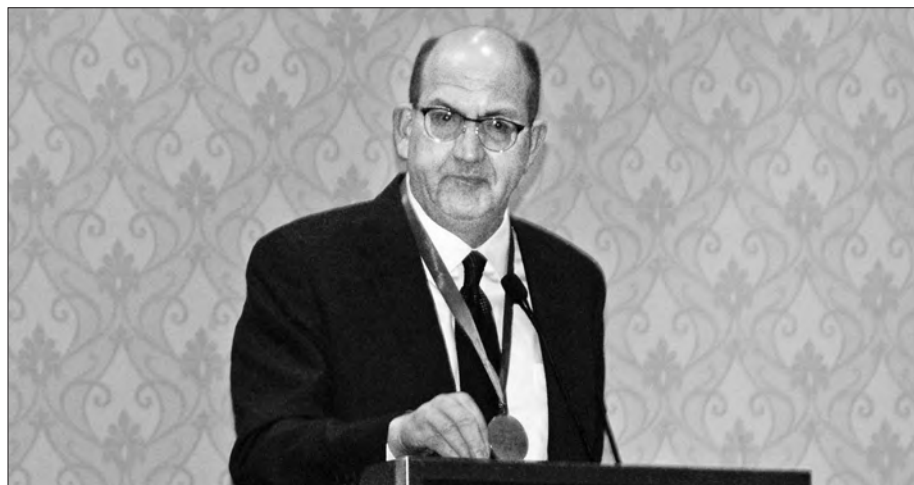


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## 2019 Presidential Address

### **Richard L. Frierson, MD: AAPL's Past and AAPL's Future: Forensic Training and Professional Advocacy**

*Britta K. Ostermeyer, MD, MBA*



Dr. Richard L. Frierson, AAPL's 45th President, was introduced by Dr. Kaustubh Joshi, MD. Frierson is the Alexander G. Donald Professor of Psychiatry, Vice Chair for Education, and Director of the Forensic Psychiatry Fellowship in the Department of Neuropsychiatry and Behavioral Sciences at the University of South Carolina School of Medicine in Columbia, South Carolina.

Dr. Frierson reminded the audience that AAPL was founded with a strong interest in promoting forensic psychiatry education, and urged that AAPL remain a strong advocate for it. He then reviewed the history of forensic psychiatry education, and discussed five future challenges, followed by recommendations to address them.

In 1967, AAPL's founding President, Dr. Jonas Rappoport, wrote to all of the forensic fellowship directors suggesting the formation of a group to promote interest and training in forensic psychiatry. In 1969 these

directors met and founded AAPL. In 1975, the APA Committee on Psychiatry and the Law (now the Council on Psychiatry and Law), called for the creation of a forensic psychiatry certification process, as there was a significant lack of rigor in expert psychiatric testimony. This was at the time of the landmark case *Washington v. U.S.* (1975), telling psychiatrists what they can and cannot say when testifying. There was an interest in improving and tightening the skills of forensic experts in court, and the U.S. Department of Justice awarded the Forensic Sciences Foundation a grant to develop board certification in several forensic specialties, including psychiatry, pathology, odontology, and anthropology. In 1976, AAPL met with the American Academy of Forensic Sciences (AAFS) and developed a two-part board examination, with 150 written questions including essay questions, and an oral exam. It was first administered in 1979, and over

the next 16 years 253 individuals were certified.

Around the same time, AAPL sponsored the Accreditation Council on Fellowships in Forensic Psychiatry, which accredited fellowships through curriculum standardization and site visits. In 1987 the Association of Directors of Forensic Psychiatry Fellowships (ADFPF) was formed, and in 1992 the American Board of Medical Specialties (ABMS) recognized forensic psychiatry as an official subspecialty. Finally, forensic psychiatry was given full recognition! In the 1990s, ABMS allowed the American Board of Psychiatry and Neurology (ABPN) to take over board certification for forensic psychiatry. Since then ABPN has certified over 2,300 forensic psychiatrists. Once ABPN took over forensic board certification, the ACGME also assumed accreditation duties for forensic psychiatry fellowships.

Next, Dr. Frierson pointed out that there will be a tremendous physician shortage in the future, with the Association of American Medical Colleges predicting a shortage of over 100,000 physicians by 2032. While there has been a significant increase of approximately 52% in combined allopathic and osteopathic medical students to meet this proposed shortage, increases in postgraduate residency positions have not kept pace, leading to a highly concerning bottleneck of medical school graduates who cannot find residencies. This issue led to the Resident Physician Shortage Reduction Act of 2019, which calls for an increase of 3,000 graduate medical education positions per year for the next five years. It includes provisions for 1,400 positions in shortage specialty areas, including psychiatry, and is currently under review in the U.S. Congress.

Dr. Frierson reported that there are 249 psychiatric residencies, and psychiatry is the fastest-growing medical

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## COVER STORY

### 2019 Presidential Address

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specialty by percentage of new programs, with 60 new residencies since 2013. Between 2014 and 2018, there was a 65% increase in applications to psychiatric residency slots, with a 2019 fill rate of 98.9%. Dr. Frierson stated, “Psychiatry is the new derm,” signifying that psychiatry residencies have become very competitive. Among applicants who ranked only one specialty type, psychiatry had the third largest percentage of unmatched applications, surpassed only by dermatology and general surgery.

Eighty-one percent of residencies have no associated forensic psychiatry fellowship, as there are only 48 fellowships. Dr. Frierson remarked that the current Accreditation Council for Graduate Medical Education (ACGME) requirements for forensic training in general residency have been substantially weakened. In comparison to other subspecialties, there is no time requirement for forensic training in general psychiatry. Psychiatry residencies are required to provide two months of child and adolescent psychiatry training, two months of consultation-liaison psychiatry, one month of addiction psychiatry, and one month of geriatric psychiatry. While in 2007 the ACGME required that a general psychiatry resident be exposed to experiences such as the evaluation of competency to stand trial, insanity, civil commitment, and violence risk assessment, current requirements only state that training must include experience in evaluating patients’ potential to harm themselves or others, their appropriateness for commitment, decisional capacity, disability, and competency. Decisional capacity and competency were not defined.

Dr. Frierson went on to state that forensic training and education in a general psychiatry residency is of significant value. Residents must understand the legal issues commonly encountered in practice, such as informed consent, duty to warn,

disability, and working with patients with a history of justice involvement. AAPL’s *Practice Resource for Forensic Training in General Psychiatry Residency Programs*, available online, outlines potential forensic experiences that can be undertaken in general psychiatry residency programs.

Forensic psychiatry is experiencing the largest growth among all psychiatry fellowship types, with an increase of 20.5% over the last five years. However, there is a lack of geographic diversity; 24 states have no forensic fellowship. Regarding forensic training requirements, ACGME makes a general statement that forensic psychiatry fellows “must demonstrate procedural proficiency in the psychiatric evaluation of individuals with criminal behavior, including evaluations of competency to stand trial, criminal responsibility, dangerousness, and sexual offenders.” While the requirements are silent in regard to procedural proficiency in civil forensic evaluations, they do call for “competence in medical knowledge related to a variety of civil evaluations.” The requirements stipulate six months of correctional system experience as well as testimony in mock or real trial situations. Program directors must “verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice,” and that they can practice independently. Most forensic programs utilize multiple training sites to implement these requirements, and programs vastly differ in the amount of exposure to criminal and civil evaluations, corrections, and consultations to general psychiatrists.

Looking into the future, Dr. Frierson discussed five future training challenges. Challenge #1 is the lack of forensic experience in general psychiatric training discussed earlier. Given that more and more people with severe mental illness are in jails and prisons, Dr. Frierson stressed the need to develop forensic skills for general psychiatry residents. Psychiatrists entering correctional locations will not be prepared unless they had correctional experiences during their

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# AAPL At Mid-Century: In Full Swing

Joseph R. Simpson, MD, PhD



As most everyone is aware AAPL has now entered its second half-century. From its relatively humble beginnings back in 1969, it

has grown into an organization with tremendous influence not only on training and education but also public policy. Dr. Frierson's Presidential address at the 50<sup>th</sup> Anniversary Annual Meeting last October, summarized in this issue of the Newsletter, provides a fascinating review of the evolution of training in forensic psychiatry since the 1970s, which was thanks in no small part to the efforts of AAPL. Also in this issue, AAPL's Medical Director Dr. Janofsky describes the transformation of AAPL from essentially a shoestring operation into the well-oiled machine we know today. His column then details how AAPL's efforts on behalf of the field have expanded beyond education and the development of quality forensic fellowships to now include subsidizing research through the AIER, advocating for the subspecialty at the APA and AMA as well as other bodies such as the National Commission on Correctional Health Care, and signing on to *amicus* briefs filed in a range of appellate courts including the US Supreme Court.

Looking at developments like these it can truly be said that AAPL has hit its stride. Another sign of AAPL's growing national profile occurred in 2018, when, under then-President Dr. Christopher Thompson, AAPL became a member of the Consortium of Forensic Science Organizations, joining the American Academy of Forensic Sciences, the American Society of Crime Lab Directors, the International Association for Identification, the National Association of Medical Examiners, and the Society of Forensic Toxicologists and American Board of Forensic Toxicology. AAPL is also now ready to look within, at the

fraught subject of stress, burnout and the mental health of forensic practitioners, and to find ways to support ourselves and maintain our bearings: the theme of Dr. Will Newman's presidential year is Wellness in Forensic Psychiatry.

I joined AAPL and attended my first meeting as a fourth-year resident in 2004. In the years since, I have been very impressed by the participation of many of my contemporaries who became AAPL members in the decade of the 2000s. They have taken on important roles in AAPL, including leadership positions ranging from Councilor to President, chairs of Committees, representatives at APA and AMA, and a variety of editorial duties with the Newsletter and the Journal. Clearly, if you are motivated to get more involved in AAPL, you don't have to wait until you are a full professor who is already starting to think about retirement. The key is simply to start volunteering. Joining one or more of the roughly 40 special or standing committees (<https://www.aapl.org/committees>) is the most common and easily-accessible entrée to AAPL participation. Then, be active in the committee(s) you have joined, by presenting at an Annual Meeting, writing an article for the Newsletter, developing AAPL Maintenance of Certification exam questions, or all of the above.

I would like to further stress the value of attending Annual Meetings. These gatherings, where hundreds of participants ranging from medical students to senior faculty interact during scientific sessions as well as informally over meals, provide both great opportunities to network and excellent educational value. You are bound to learn something new, regardless of your prior experience or the stage of your career. Several years ago I attended a session led by Phil Resnick, MD on infanticide. Just a few weeks after I returned home, an attorney contacted me about a client of his who was charged with neonaticide.

As a layman he assumed that his client must have been severely psychotic. I definitely felt more confident about accepting the case, having so recently learned directly from the leading experts on the subject. The tragic circumstances of the case actually fit the descriptions in the scholarship on the subject precisely, including a concealed pregnancy. Ultimately, I testified in a bench trial; during testimony I even mentioned having attended the AAPL workshop. I believe that I was able to give the attorneys and judge significant perspective that might otherwise have been lacking. The case was resolved with a determinate prison sentence, rather than the life sentence for 2<sup>nd</sup>-degree murder that the prosecution originally sought. I am sure many other AAPL members who have attended Annual Meetings can think of similar examples of how the knowledge they gained benefitted their practice.

AAPL is dynamic and like its members it is always seeking ways to improve. It is the opposite of hidebound and set in its ways. I refer you again to Dr. Janofsky's column in this issue for its summary of the recommendations of Dr. Liza Gold's task force on Committees. This is yet another example of how the organization is working to provide what its members need in terms of professional development. If you have been passive, not attending Annual Meetings or joining committees, I submit that you are missing out on a lot. In this new year and new decade – and second half-century of AAPL – why not see what more you can give to, and get from, AAPL? ☪

**SAVE THE DATES!**

**Forensic Psychiatry Review Course**

October 19-21, 2020

**AAPL 51st Annual Meeting**

October 22-25, 2020

Marriott Downtown,

Chicago, IL

**Wellness in Psychiatry**

Now accepting abstract submissions online at [www.aapl.org](http://www.aapl.org) until midnight Monday February 3, 2020

## Resilience in Medical Education

William Newman, MD



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

series, I aim to stimulate discussion about specific challenges to long-term wellness. I first present a brief overview of resilience in medical education.

Physicians and medical trainees are displaying alarming rates of depression and suicidal ideation, partially related to chronic stress and frequent exposure to traumatic situations (1). One study reported that 11.2% of medical students endorsed experiencing suicidal ideation during the previous year (2). Resilience, the mental processes and behaviors that enable individuals to overcome stressors, is one important consideration (3). Individuals begin medical school with higher levels of resilience than other graduate students. However, physicians experience burnout much more often than matched comparisons from other professions (4). There are broad systemic issues in medicine - such as production demands, electronic medical records, and prior authorizations - that promote burnout and job dissatisfaction.

Addressing physician burnout goes beyond merely holding informational sessions recommending striving for better work-life balance or practicing more yoga. Ironically, those informational sessions are often held outside of business hours, when physicians could otherwise be pursuing outside interests. The approach of putting the onus on physicians, a group already prone to self-reproach, may itself aggravate the problem.

The risks of burnout reach beyond individual wellness. One study demonstrated that medical error rates by surgeons correlated with each individual physician's degree of burnout


(5). The Federation of State Medical Boards (FSMB) is one of several organizations considering broader issues within the medical system (6). In the meantime, though, promoting individual self-awareness may be beneficial.

One group studied the impact of "grit," a separate characteristic from resilience, on retention rates of new cadets entering the U.S. Military Academy at West Point (7). The authors defined grit as "perseverance and passion for long-term goals." They administered the 12-item Grit Scale to cadets and assessed their performance by "first summer retention," among other measures. They reported that grit was a better predictor of performance than other measures, including cadet quality metrics used during admissions. The authors also demonstrated grit as a function of age, suggesting that levels can increase over time with experience and training.

Efforts are under way to identify traits that could help predict success in medical school and beyond. One study reported that higher levels of empathy correlated with lower rates of burnout in medical students (8). An Australian group also attempted to predict medical school performance based on resilience scales (9). The authors concluded that conceptualizing resilience required more nuance than they addressed in the initial study. Attempts to predict the performance of medical students through psychometrics will undoubtedly continue.

There are many possibilities to consider. Would providing prospective medical students feedback about their resilience levels contribute to improved outcomes? Would that information dissuade individuals with low resilience levels from pursuing careers in medicine? Could it instead help those individuals develop self-awareness that would allow them to work on improving their resilience? The optimal timing for this feedback

would be before applying for medical school. In the meantime, it may be beneficial to consider providing the feedback to applicants applying for general psychiatry residency or forensic psychiatry fellowship programs.

Although ethical concerns likely preclude sharing the results with admissions committees, measuring characteristics such as resilience and grit may be beneficial for individuals who are considering careers in medicine. Medical schools should also consider incorporating coursework designed to help promote resilience. General psychiatry and forensic psychiatry each present their own unique challenges, with likely benefits expected for individuals with high levels of resilience and grit. Psychometrics may have roles at various stages of the applications process. Further consideration of this possibility seems essential. 

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# AAPL: Beginning the Next 50 Years

Jeffrey S. Janofsky, MD



As most of you know, AAPL had its first Annual Meeting 50 years ago at the Friendship International Hotel just outside of Baltimore. The

meeting lasted for one day with an additional ½ day tour of Maryland's Patuxent Institution for "Defective Delinquents." There were 74 charter members. Jonas Rappeport was elected AAPL's first President and soon became AAPL's first Medical Director.

AAPL was originally run as a "mom-and-pop organization," with members' wives taking on meeting administrative duties (the original members were all men). AAPL continued to grow and came under professional management in January 1992, when Jackie Coleman became AAPL's first (and still current) Executive Director; in the same year Howard Zonana became AAPL's second Medical Director.

AAPL has traditionally held its Annual Meeting in Baltimore (my hometown) every ten years, and just held its 50<sup>th</sup> Annual Meeting there in October 2019. This time there were over 800 attendees, with the scientific meeting lasting for 3.5 days. There were 121 sessions and posters presented. Although Jonas was not able to join us this year, I had the recent opportunity to help him celebrate his 95th birthday. He sends his best to you all.

AAPL has significantly grown as an organization since its founding. AAPL has expanded its primary purpose as an educational organization by financially supporting research through grants in forensic psychiatry with the formation of the AAPL Institute for Education and Research, initially under President Larry Faulkner and now headed by AAPL Past President Debra Pinals.

AAPL founded the Rappeport Fellowship in 1985 to attract highly

talented residents into Forensic Psychiatry and AAPL. There have been 168 Rappeport fellows selected, including six fellows who attended this year's Annual Meeting. Many past Rappeport Fellows have established leadership roles in academic psychiatry, the APA and AAPL.

To increase general knowledge in forensic psychiatry, AAPL began producing Practice Guidelines (now called Practice Resources) in 2002 with the publication of the Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense. AAPL has subsequently produced Practice Guidelines/Resources on Competence to Stand Trial; Forensic Assessment; Psychiatric Disability; Prescribing in Corrections; and Forensic Training in General Psychiatry Residency Programs. Those of you who are interested in producing a new AAPL Practice Resource should let me know so that I can guide you through the process.

AAPL's first step into advocacy began when the AAPL Council authorized AAPL's first participation in *amicus* briefs in 1985. Since that time AAPL, after careful Council review, has signed on to 24 briefs, 20 at the United States Supreme Court level. While AAPL has never written an *amicus* brief on its own, AAPL has had significant content input into the briefs we have participated in. This was perhaps especially true in our latest brief in *Kahler v. Kansas* ([http://www.supremecourt.gov/DocketPDF/18/18-6135/102319/20190607122435025\\_18-6135tsacAPA%20et%20al.pdf](http://www.supremecourt.gov/DocketPDF/18/18-6135/102319/20190607122435025_18-6135tsacAPA%20et%20al.pdf)), a case recently argued in the USSC over whether the Insanity Defense is Constitutionally required under the Due Process Clause.

AAPL has since expanded its advocacy role by having members represent AAPL in the APA Assembly and Council on Psychiatry and Law, the AMA Psychiatry Section Council and the National Commission on Correctional Health Care (NCCHC). Linkage to these organizations has proven

invaluable to AAPL's role as the leading North American professional organization for forensic psychiatry.

As many of you also know, the day before the Annual Meeting Scientific Program starts, AAPL members who are active in Committees and who serve on AAPL's Council meet to discuss AAPL policy and scientific issues. AAPL's organizational structure is governed by its Bylaws. Earlier this year AAPL President Richard Frierson asked me to chair a Task Force to update the Bylaws, which had not been substantially updated for many years. Along with updating the functions of AAPL's standing committees to reflect how those committees were currently actually functioning as well as other technical changes, our group recommended adding one Early Career Councilor, one Minority/Under Represented (M/UR) Councilor, and one Women's Councilor to the AAPL Council Structure. These changes were approved by AAPL Council and will be sent out for review and membership vote at a future annual or semi-annual meeting.

Richard Frierson also asked Liza Gold to chair a work group to update AAPL's committee structure. AAPL's Bylaws allows Special (Subject Matter) Committees to be authorized by the AAPL Council. Committee work is key to AAPL's success as an organization. In 2019 there were thirty Special Committees, some functioning more successfully than others. Dr. Gold's group made multiple recommendations to AAPL Council and after thorough debate many were adopted. Key provisions include:

- AAPL Council, in consultation with Committee Chairs, will consider consolidating Committees with overlapping subject interest and consolidating or eliminating Committees that are duplicative of APA Committees.
- Committee Membership terms are three years.
- At the end of a three-year term, a Member who wishes to be reappointed to the Committee should ask the Committee Chair to be recommended to the AAPL Presi-

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### AMANDA KNOX AT AAPL

Stephen P. Herman, MD



At the AAPL lunch on October 24, 2019, Amanda Knox spoke about her imprisonment in Italy. In 2007, when she was 20 and studying in Perugia, Ms. Knox was arrested and charged with murdering her roommate, a fellow exchange student. She was convicted in 2009. In 2015, after countless travails through Italy's complicated court system, she was finally acquitted. Forensic experts had decried her conviction. Her experiences predictably made her a media sensation. Now she devotes her time to writing and speaking out against those deemed wrongfully convicted and incarcerated.

Ms. Knox's focus was on her incarceration. Frequently fighting tears, and with an occasional halting delivery, she described her prison life and that of other women serving time. She was open about her dissimilarities from them. She was the only American woman in the prison. She almost always had friends and family visiting her. She was unique in having gone to college and being able to read. She had all of her teeth. She had not experienced poverty or mental illness. She received letters and photographs every day. She was threatened sexually by guards but not directly abused. She witnessed brutality done to others. She knew her story had become an

ongoing tale throughout the media.

Nevertheless, she felt isolated and anxious. She taught herself ways to stay "sane." She would touch the faces of those on the photographs and imagine talking to them. She exercised. She taught herself what she labelled "prison and legal Italian" so she could follow her case. She imagined her younger self as a cell mate. Ms. Knox told young Amanda, "This will happen to you, but you'll get through it."

She was fortunate to be allowed regular visits from her family. She had permission for 10-minute telephone calls with them once a week. She never knew when that would be. One time, a guard did not come to escort her to the phones: "I screamed and shook the bars like an animal."

Ms. Knox said of her arrest, "I was certain the truth would win out." However, she averred, prosecutors lied. The Italian inquisitorial court system failed her. She told the audience, "That was 'me' in the courtroom but the real 'me' went back to prison."

Whenever her father visited, she would beg him to save her. One time, he cried. This shook her up because she had never seen him reveal such emotion.

A close friend moved to Perugia to be near her. Amanda learned of a psychologist who had researched the

phenomenon of coerced confessions. He had written a book about how police and prosecutors are able to extract false confessions. She wrote to him.

She then realized she was not alone in her nightmarish situation. "It was the worst thing to be interrogated," she said. The police questioned her for five days. They accused her of lying. They did not consider that she was traumatized by the murder and their relentless interrogation. They slapped her, insisting she remember what she had done. Two years later, the judges ruled against her: "I didn't even hear the verdict." She thought she was "insane," with no one ever knowing what she was going through.

When she finally returned to the States, Ms. Knox realized she could never get back to "normal." She had been raised in a privileged world, she admitted. However, she recognized that she would remain traumatized to some degree for the rest of her life. She learned of the Innocence Project and soon met hundreds of people - mostly men - who were wrongly imprisoned.

Now, she writes and speaks about her experiences and those of others who have suffered similar horrors. Her book, *Waiting To Be Heard*, was published in 2013, two years before she was finally acquitted.

Ms. Knox gave an impassioned talk about her life while incarcerated and her present choice to speak out on behalf of those wrongly accused.

Yet, despite her ultimate acquittal and apparent dedication to her cause, she knows there will always be those who question her motives - and even her innocence. She acknowledged she will have to live with that skepticism for years to come.

Ms. Knox spoke little about her personal life following the acquittal. For AAPL members interested in more, check out these sites:

<https://www.cnn.com/2019/06/14/europe/amanda-knox-italy-justice-festival-intl/index.html> (about her return to Italy in June of 2019)

and

[www.amandaknox.com](http://www.amandaknox.com) (her website). 

## Adam Benforado, JD: Hidden Bias: Why Our Criminal Justice System Comes Up Short

Renée M. Sorrentino, MD



On the second day of the 2019 AAPL 50<sup>th</sup> Anniversary Annual Meeting, Adam Benforado captivated the audience with his thought-provoking presentation on the inherent biases in our criminal justice system. Benforado, professor of law at the Drexel University Kline School of Law, is author of the best-selling book, *Unfair: The New Science of Criminal Injustice*. His research focusing on applying insights from psychology and neuroscience to legal issues was the subject of the luncheon talk.

Benforado began the presentation outlining the evidence that exists around us that our criminal justice system is broken. Reviewing the myths of the criminal justice system, he suggested that the edifice of law itself is built upon myth. This premise, postulated by Benforado, is that the bias or unfairness that exists in our criminal justice system is based on the inherent human qualities in all of us. Benforado pointed out a combination of factors, which contribute to bias and unfairness by well-meaning individuals. Put simply, he stated “Good people with the best of intentions ... can get things terribly, terribly wrong.”

To support his hypothesis, Benforado reviewed some of the evidence that illuminates the unintended bias in our system. He reviewed the power of labels, highlighting research that people with certain facial features receive longer sentences and that judges are more likely to grant early release if the case is heard first thing in the morning. Confirmation bias in forensic analysis was illustrated by outlining camera perspective bias. When people watched the footage shot from the perspective of the interrogator they tended to say the confession was voluntary. However when they watched the videotape from another perspective, through the eyes of the suspect, they noticed coercive factors and were more likely to view the confession as involuntary. The evidence of partiality exists in many aspects of the judicial system including forensic psychiatry.

Illustrating the profound role of bias, Benforado cited research on jurors which suggests that what determines whether someone is convicted or not, or the length of their sentence, is the particular identities of the jurors. Cultural cognition, the background and experience of jurors,

is what mattered most to criminal outcomes, not the law or the facts of the case.

After outlining the extensive bias in the criminal justice system, Benforado turned to the question of why? Debunking the common societal perception that injustices are the product of a few bad apples, Benforado suggests the problem is the entire system. The fact that our legal system says nothing about human behavior is one of the real challenges to reform in this area. As an example, Benforado explained how a jury may be instructed by the judge to be “objective” by putting aside feelings. Benforado explains this is not how bias works, suggesting that our legal system is neglecting what we know about human behavior.

In conclusion, Benforado proposed an evidence-based justice system, which embraces empiricism. More specifically, he suggested that we make the following steps towards an evidence-based justice: collecting and analyzing data, adopting empirically-grounded best practices, then repeating the first two steps. These interventions would be aimed at disrupting the effect of biases. But how quickly should we implement these principles? Should we make incremental steps or boldly move towards a less biased system?

Benforado suggested that our current approach to addressing bias is deceptive. He proposed a practical reform that could prevent injustice and achieve fairness and equality. As part of the reform, he suggested “blinding” justice by creating virtual courtrooms. Certainly other areas of science have used virtual technology to assist in high-stakes settings, such as the use of robotic-assisted surgeries. To address the inherent problems created by human behavior, he proposed the concept of trial by computers. Acknowledging the challenges in such a proposal, Benforado concluded with practical first steps. The starting point is to raise awareness about these biases. And with this luncheon talk, it’s fair to say, this first step was made. ☺

### Stephen A Young, MD: The Unique Practice Environment of the Foreign Service

Karen B. Rosenbaum, MD



AAPL's Fiftieth Anniversary Meeting's Saturday lunchtime speaker was the distinguished Dr. Stephen Young. Originally from Boston and a graduate of Tufts University School of Medicine, he completed his residency in general psychiatry and fellowship in forensic psychiatry at Walter Reed Army Medical Center. He has had faculty appointments at the Uniformed Services University of the Health Sciences, the University of Florida, and the University of South Carolina. Among his varied interests and accomplishments, he has published in areas of mood disorders in women and clinical outcomes of insanity acquittees. For the past twelve years, he has practiced as a psychiatrist for the US Department of State (DOS); he has lived and worked in Senegal, Colombia, Japan, Washington D.C, and the United Kingdom, and currently lives in Greece. He is married and has one daughter and two grandchildren.

As a Regional Medical Officer of Psychiatry (RMOP) in the Foreign Service overseas, Dr. Young described facing challenges that most of us have never encountered. He prefaced his talk by acknowledging that this is a particularly stressful and historic time

in the State Department.

He explained that to be a psychiatrist in the DOS, the physician must have completed a residency program, had five years of experience after training, be Board-certified, and be younger than 59 years old. Currently there are twenty regional psychiatrists, including the director in Washington. RMOP's serve on six continents and typically cover large geographic regions. Language barriers are a challenge on many levels. Although the majority of patients are Americans serving in embassies, many local staff have limited English abilities. Simple day-to-day tasks like going to the grocery store are much more difficult when one is lacking language skills to read labels or ask the cashier basic questions.

In the lifestyle arena, people working in embassies overseas sometimes face unique challenges, such as finding clean water or avoiding goat droppings on the way to work.

Although the RMOP is not technically a forensic psychiatric position, forensic issues arise frequently. Dr. Young offered a number of examples including: Assistance in determining medical and security clearance decisions, assessment of special

educational needs for dependent children, and family advocacy (a process similar to that seen in state and community-based Child and Family Protective Services). There is also the Foreign Service Grievance Board, a formal judicial body that publishes opinions in the Federal Registry and whose opinions may be appealed at the Federal District Court level.

Dr. Young clarified the role of RMOP's in assisting with the determination of medical clearance decisions for employees serving overseas. This is a complex area which has undergone a number of legal challenges from employees unhappy with the outcome. The State Department carefully separates clinical and administrative functions, so RMOP's are not responsible for making these decisions. Rather, a specialized team in Washington reviews all available medical information to inform the eventual determination. The assessment can also involve telephonic or in-person interviews. All new employees are expected to be "worldwide available." Should an employee develop a new condition after they are hired, their ability to serve in certain locations may be impacted. As a result, medical clearance is reviewed regularly and any time new medical information becomes available. Like many federal agencies, the DOS is increasingly supportive of employees seeking out mental health treatment and encourages them to do so.

Dr. Young described the overall mental health structure within DOS, which includes resources in Washington as well as in embassies around the world. The Mental Health Director is based in Washington, as are other programs including an Employee Assistance-type office and specialized services like substance abuse treatment and family advocacy. These providers support the RMOPs, particularly when there are not adequate resources in a host country (a scenario that occasionally results in a medical evacuation to the US).

As the RMOP, Dr. Young has three core functions. He sees individual patients, performs community

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## Ask the Experts

Neil S. Kaye, MD, DFAPA

Graham Glancy, MB, ChB, FRC Psych, FRCP (C)

Drs. Kaye and Glancy will answer questions from members related to practical issues in the real world of forensic psychiatry. Please send questions to [nskaye@aol.com](mailto:nskaye@aol.com).

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

**Q:** I am getting more referrals for cases involving disputes by heirs of deceased parents. Often, there seems to be scant material to address the issue of capacity. Any advice would be welcome.



**A. Kaye:**

As the American population continues to increase in age, issues of wills, estates, trusts, and “testamentary capacity” will

become an even bigger part of forensic psychiatric practice. These cases are interesting because this is an emerging area in the law and thus provides for ongoing educational opportunities. At the same times, these cases are difficult due to the highly emotional nature of these usually intrafamilial battles and the often bitter, adversarial approaches taken by both sides.

The threshold for testamentary capacity is quite low: knowledge of one’s bounty (extent and value of one’s property); natural heirs/beneficiaries; an awareness of the disposition being made; and a simple ability to express how one wants to dispose of the estate. Finding objective evidence to determine this can be difficult, as medical records often are silent on the facts that would support capacity. Treating doctors don’t usually document a knowledge of heirs, and I have never seen a set of records document-

ing any knowledge of the value of a patient’s estate, financial planning activities, advisors, etc.

References to “dementia” or Alzheimer’s are common, but absent some objective data are of limited significance, since the range of severity can be extreme and the course, while often predictable, may still fluctuate. Mini Mental Status Exam scores will often appear in the records, but unless they are in the teens may not be very helpful, as the MMSE questions don’t target the actual issues of testamentary capacity. There are data on the usual progression of MMSE scores in Alzheimer’s, and forensic psychiatrists should be aware of that information.

Also, in most jurisdictions, if the challenging party meets the burden of proof and shows the testator lacked capacity, the burden then shifts to the party propounding the will to show by clear and convincing evidence that the testator did possess the requisite capacity.

It is infrequent that I see a case where the deceased lacked testamentary capacity. However, the issue of undue influence is more common, and these concepts are linked in most states’ laws. Undue influence requires a person to be “susceptible,” for there to be the opportunity for exertion, for the influencer to have the disposition to exert the influence, actual exertion of the undue influence, and a result demonstrating that it occurred. In essence, the outside exertion must overcome the free will of the testator. A person with capacity may still fall prey to undue influence and thus the will may be invalidated.

As estate planning is advancing from simple wills to all sorts of trusts and complex financial arrangements (often designed to reduce tax liabilities), I have made it a practice to ask the lawyer if I am to use the usual testamentary capacity standard or the higher standard of ability to contract. If the financial instruments are seen as contracts, the threshold is raised sub-

stantially, and more often the issue of capacity to contract will be clearer and easier to evaluate. This is an emerging area in elder law; I frequently encounter lawyers who have not entertained this approach and are thankful for my raising this legal question.



**A. Glancy:**

All capacity evaluations, regardless of the specific issue at hand, share the same basic elements. These

elements are the capacity to be aware of the situation; an understanding of the issues; and an ability to manipulate the information rationally. The difference when dealing with testamentary capacity as opposed to other types of evaluation is that the evaluatee is not available for an interview. Therefore, the evaluator must rely solely on collateral information. Sources of collateral information include medical and psychiatric records, interviews with relatives and friends, and any other information that can be accessed. There is often very little information in the records. Collateral sources may be in clear conflict-of-interest situations and this should be taken into account. This exercise is often extremely difficult in practice and the evaluator should be extremely careful in coming to any conclusion. The evaluator is clearly in an ethical dilemma in that they should clearly state that they have not examined the evaluatee for obvious reasons. Any conclusion should always be tempered by noting the limitations of the exercise. It is important to state that it may not be possible to come to any conclusion given the circumstances.

**Take Home Points:**

It is important to remember that if there is not sufficient data on which to rely, one should tell the referring party that the question can’t be answered. In the future, it would be ideal if as part of estate planning, we were asked to evaluate people while they are still alive and thus focus our questions on the relevant areas in a preemptive manner. We are both seeing this emerging trend. ☺

## Physician Advocates: Advancing Policies From the Start

Selena Magalotti, MD,

Case Western Reserve University/University Hospitals Cleveland Medical Center



My journey toward developing an interest in health policy advocacy started during my PGY-1 year when I attended the local chapter

meeting of the American Psychiatric Association (APA). At that meeting, we met with a local state representative to discuss healthcare issues being considered in the Ohio legislature. Since that initial formative experience five years ago, I am grateful to have become a part of my local health policy advocacy community and learned about the difference I could make, even as a trainee. I am passionate about the importance of exposing residents and fellows to advocacy efforts in training, as I believe that early exposure is important to foster interest after training.

The American Medical Association (AMA) and APA have supported being a physician advocate. (1) Forensic psychiatrists are uniquely situated to liaison with the governmental branches for advocacy efforts, (2) as they are specially trained in dealing with issues and implications of policy and practices that bridge psychiatry and the law. It has also been argued that forensic psychiatrists have a responsibility to keep abreast of laws affecting psychiatry and possible changes to those laws in their states. (3)

It is important for psychiatrists to remember their role when they serve as advocates, because health policy advocacy is distinct from clinical and forensic work. For example, when conducting forensic evaluations, the goal is objectivity and weighing evidence to form an opinion, regardless of the retaining party. (1) Further, in clinical practice, psychiatrists advocate for their patients to receive the care and resources they need. (1) We have no allegiances in health policy advocacy but rather are voicing our

opinion to advance a position. Overall, health policy advocacy allows us to use our skills and knowledge to give a voice to people who might not have one otherwise.

The Accreditation Council for Graduate Medical Education (ACGME) references advocacy as part of the general psychiatry and forensic fellowship milestones. (4,5) Further, the AAPL practice resource for forensic training in general psychiatry residency programs suggests electives in legislative advocacy as a good learning experience for trainees. (6) Benefits to training forensic psychiatrists in health policy include: understanding the legal system, interpreting statutes, learning how lawyers think, serving as a teacher to legislators, and providing opportunities to testify to the legislature and regulatory agencies. (1)

Even with all of the benefits of learning about health policy advocacy, few programs provide specific training in health advocacy, and many physicians lack specific training on the topic.

(1) Further, although formal training in advocacy would be ideal, not all programs have the time or resources to allot to this goal. (1) My experience has been that trainees are interested in getting involved in advocacy, but don't know where to start. I have also observed that small changes in training programs, together with providing opportunities for trainees to get involved, can make a big difference. The following are easy steps to facilitate trainee involvement and interest in health policy advocacy:

- 1) **Identify and foster faculty interest in advocacy:** Trainees are often inspired and motivated by what faculty do. If an institution and its leadership value something, more trainees are likely to follow suit. Interested faculty can then provide lectures and mentor trainees about what they

do in health policy advocacy and why it is important. They can also serve as liaisons and help make connections for trainees who want to get involved.

- 2) **Once interested faculty have been identified, encourage mentorship:** "The passion for social justice shared by mentors that is absorbed by residents and launched through training and academic discipline" spurs interest in advocacy. (7) When I reflect back on my developing interest in advocacy, the catalyst was forming a mentorship relationship with faculty who had an interest in health policy advocacy efforts.
- 3) **Provide formal didactics:** Both trainees and seasoned faculty alike are often unaware of pending changes to law and governmental budgets that affect our practice, healthcare resource allocation, and the treatment of individuals with mental illness. In my experience, even brief lectures to trainees about advocacy and current mental health policy have generated interest in meeting and fostering relationships with their legislators to discuss these important issues.
- 4) **Encourage attendance at state and national advocacy days:** District branch chapters of the APA often have annual advocacy days during which psychiatrists can meet with legislators to discuss relevant issues. Giving trainees an administrative day off can be a small change that provides an opportunity to experience the world of advocacy. Meeting with legislators, watching psychiatrist mentors testify on legislation, and seeing the energy in the state house can be a moving experience. If time and geographic location are not limitations, attending national advocacy days is another great way to get involved. Further, advocacy days are not just about

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## 13 Reasons Why and Media's Interest in Suicide

Cherry Liu (MD expected 2021); Laniel Romeus (MD expected 2021); and Ryan C.W. Hall MD

National Public Radio (NPR) (1), CNN (2) and the Washington Post (3) over the last year have all run pieces on the link between the Netflix series *Thirteen Reasons Why* (first aired 2017) and an increase in adolescent suicides. In an opinion piece for *USA Today*, Dr. Harold Koplewicz, medical director of the Child Mind Institute, equates *Thirteen Reasons Why* to an infection, saying “[it is] spreading suicide like a disease.” (4) As highlighted in a recent CDC report, suicide rates among ages 10-24 between the years 2007 to 2017, increased by 56%, going from 6.8 to 10.6 deaths per 100,000. (5) Suicide is now the second-most common cause of death among teenagers and young adults, after accidents. Researchers are struggling to definitively pinpoint root causes behind this increased suicide rate, which may include shifting social structures, changes in medical treatment, lack of social support, the rise of social media, and finally the media's portrayal/coverage of suicide.

The portrayal of suicide in entertainment media eliciting a suicide epidemic dates back to the 18<sup>th</sup> century, with the widespread publication of the melodramatic novel *The Sorrows of Young Werther* by Johann Wolfgang von Goethe. This novel was credited as the cause for a string of suicides by young men in Europe, resulting in it being banned in multiple countries. Sociologist David Phillips in the 1970's coined the term “the Werther Effect,” to describe the phenomenon of suicide rates increasing after a well-publicized suicide, either from fictional media or real-life events, especially in younger populations. (6) Currently, The Netflix series *Thirteen Reasons Why* has been both championed for raising suicide and bullying awareness, as well as criticized for possibly glorifying and increasing suicide rates among its viewers. (7) The show graphically depicts the events leading up to and following a young high school student's

### Summary of recommendations from the 2017 WHO resource Preventing Suicide: a resource for media professionals: (17)

- Provide accurate information about where to seek help
- Educate the public about the facts of suicide and suicide prevention, without spreading myths
- Report stories of how to cope with life stressors or suicidal thoughts, and how to get help
- Apply particular caution when reporting celebrity suicides
- Apply caution when interviewing bereaved family or friends
- Recognize that media professionals themselves may be affected by stories about suicide
- Do not place stories about suicide prominently and do not unduly repeat such stories
- Do not use language which sensationalizes or normalizes suicide, or presents it as a constructive solution to problems
- Do not explicitly describe the method used
- Do not provide details about the site/location
- Do not use sensational headlines
- Do not use photographs, video footage or social media links

suicide, how it has affected those around her, and “thirteen reasons” she had for ending her life.

In an article published in the *Journal of the American Academy of Child and Adolescent Psychiatry*, researchers found elevated suicide rates among US adolescents aged 10-17 years in the months after the release of *Thirteen Reasons Why*. (8) While experts have previously argued that the release of the show had resulted in an increased number of search engine searches related to suicide and suicide methods, (9) this study actually focused on the rates of suicides before and after the

release of the show. The data showed elevated suicide rates for the three months studied post-release, specifically in boys in the 10-17 year age group. (4) Similarly, in an article in the *Journal of Adolescent Health*, researchers found an increased number of suicide admissions and attempts at a single children's hospital following the release of the show. (10) Finally, a 2018 letter to the *Journal of the American Academy of Child and Adolescent Psychiatry* addresses the Werther Effect in the 21<sup>st</sup> Century, in terms of the show's effect on adolescent viewers, based on a social media survey. (11) This survey found that, for adolescents who did not have a past of bullying or suicidal ideation, the show had an overall positive effect on raising awareness and promoting empathy. However, in the vulnerable populations of adolescents with a history of depressive symptoms and suicidal ideation, the show caused more negative effects, increasing suicidal ideation. (11)

It is important for forensic psychiatrists to have a basic understanding of these potential effects, as well as the content of media guidelines related to suicide depictions, since forensic experts comment on or consult about the topic of suicide. Although varying guidelines (usually targeted to news reporting) and articles exist on this topic, there is variation in recommendations. Most ask reporters to avoid utilizing phrases such as “commit suicide” or “successful suicide,” and instead use language such as “died by suicide.” Other recommendations are to avoid sensationalization of the event, leave out specific details on suicide methodology, provide helpline information, and not suggest a single specific trigger for the event. Ultimately, these guidelines emphasize that suicide should never be glamorized, and stress the importance of educating the public along with providing help to those who are vulnerable (text box). (12)

It is also important to realize that while these guidelines are suggested, adherence to these policies in media is extremely variable. A 2015 study (13) found most media (traditional and

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# American Medical Association 2019 Interim Meeting Highlights

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

The American Medical Association's (AMA) 2019 Interim meeting was held in November in San Diego, California. The interim meeting focused on advocacy.


In her opening address, AMA President Patrice Harris, MD, MA, a child and forensic psychiatrist, discussed the importance of trust in the patient-doctor relationship. She asserted that, despite frustrations toward the government and other entities, members of the American public have maintained trust with their physicians because of the values of our profession: competency, honesty and compassion. She voiced that physicians – and specifically members of the AMA – fight for science. By way of example, she explained how the AMA is fighting to make sure that vaccines are widely and safely available and that exemptions in vaccine regulations are solely for medical reasons. She described how the AMA is taking measures to make sure social media and technology companies promote accurate and scientifically sound health information. Also, Dr. Harris proudly reminded the delegation that it is the first time in the AMA's history that women have held the positions of immediate past president, president, and president-elect.

AMA CEO James Madera, MD also addressed the House of Delegates. He told the audience that the human touch is what drives (and will always drive) the future of medicine, but discussed how powerful technology tools will assist physicians and patients in the new era of personalized patient care. He focused not only on tools to address conditions for monitoring and managing chronic disease, like hypertension, but stressed how technological tools can aid in monitoring and advancing health outcomes equally across gender, income, ethnicity, and race.

After debate at multiple past

meetings, delegates adopted a report by the AMA's Council on Ethical and Judicial Affairs (CEJA) on physician competence. The report states that the ethical responsibility to provide competent care is fluid and context-dependent. It is the ethical responsibility of physicians to take measures to recognize and respond when they are not able to provide appropriate care for patients. Another important resolution passed by the delegates calls for the AMA to develop model state legislation and advocate for legislation to ban "reparative" or "conversion" therapy for sexual orientation or gender identity. Testimony on the topic stressed the urgency of this resolution, citing research estimating 350,000 adolescents have undergone conversion therapy and up to 40,000 U.S. teens will be involved in the therapy this year.

AMA also will now advocate for federal and state regulation to ban the sale and distribution of all e-cigarette and vaping products, with the exception of FDA-approved, prescription-only products used for tobacco cessation.

The AAPL delegation remained active at the interim meeting. Dr. Wall testified in reference committee in support of efforts to ban conversion therapy and provided information about its negative impacts for mental health and suicide rates. He also testified before the House of Delegates on a resolution to clarify representation among physician groups to the House of Delegates. Dr. Wall continued to serve as the Vice Chair of the Psychiatry Section Council. Dr. Piel continued to serve on the Young Physician Section Reference Committee and also served on the House of Delegates Reference Committee on Constitution and Bylaws. You can find more information on the actions of the AMA House of Delegates at <https://www.ama-assn.org/about/house-delegates-hod>. 

## 2019 Presidential Address

*continued from page 2*

general training. We should advocate for a forensic subspecialty training requirement in psychiatry residency that is at least equal to those provided in geriatric and addiction psychiatry (one month full-time equivalent rotation).

Challenge #2 pertains to forensic fellowship recruitment. Dr. Frierson stated, "Recruiting forensic fellows is a free-for-all." There is no standard application process, with each program having its own application requirements, interviewing timeline, and selection process. In addition, the forensic fellowship application process begins in the PGY-III year, which poses a problem for those who don't decide to apply until PGY-IV. Applicants may be pressured to accept a position before they have attended other scheduled interviews. As forensic psychiatry fellowship program numbers increase, the fill rate is likely to decrease, unless the recruitment process is standardized. Dr. Frierson pointed out that subspecialties participating in "The Match" have higher fill rates, and recommended standardization of the forensic application process as well as a Match. Match participation has been heavily debated among fellowship directors, and there remains tremendous disagreement over whether to participate.

Challenge #3 relates to proposals which undermine forensic training. There have been two recent attempts to move subspecialty training to the PGY-IV year and to allow graduating general psychiatry residents to be board-eligible in both general psychiatry and their chosen subspecialty. A potential problem then arises because forensic fellows may not be qualified to provide expert testimony in jurisdictions which require completion of training in order to qualify as an expert witness. Another recent proposal is to abolish fellowships altogether and increase subspecialty training during general psychiatry training. Clearly this would further erode the time residents have to ex-

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# APA Assembly 2019 Report

Danielle B. Kushner, MD

AAPL Representative to the APA Assembly

The American Psychiatric Association (APA) Assembly met twice in the past year, first in May at the APA Annual Meeting and second in November in Washington, DC. The theme of the 2019 conference in San Francisco was *Revitalize Psychiatry: Disrupt, Include, Engage, & Innovate*, which was dedicated to the work of addressing the most challenging issues facing psychiatry today. The meeting marked the end of the presidential term of Altha Stewart, MD. Her legacy as APA President has been to highlight diversity in membership and leadership and to mentor young psychiatrists to become more active in the organization. In her address to the Assembly, she additionally emphasized the ongoing issue of Maintenance of Certification (MOC) for many members and the ongoing work of the APA to resolve issues with the American Board of Psychiatry and Neurology (ABPN).

Key forensic issues from the May Assembly meeting included two Position Statements sponsored by the Council of Psychiatry and the Law. The first, Civil Commitment for Adults with Substance Use Disorders, was approved by the Assembly in light of the ongoing opioid crisis. It states that the APA does not endorse or oppose substance use disorder commitment statutes, but outlines specific standards for such treatment if it exists. The second, Voluntary and Involuntary Hospitalization of Adults with Mental Illness, lists the clinical and legal requirements for psychiatric hospitalization. This statement was sent back to the Council for revisions.

Most recently, the APA Assembly met November 15-17, 2019 in Washington. In the Report of the APA President, Bruce Schwartz, MD, emphasized the psychiatrist workforce deficit as older psychiatrists move towards retirement. He introduced his new Presidential Task Force on Collaborative Care, which brings together stakeholders from various mental health disciplines to review ways

to improve access to care. Medical Director and CEO Saul Levin, MD, MPA, discussed legislative updates including the APA's model Collaborative Care legislation being enacted in Illinois, Congressional support for the APA's Mental Health Care Parity Compliance Act, and APA's opposition to rolling back protections in the *Flores* Settlement Agreement. In addition, he discussed APA's advocacy to prevent the closure of the Uniformed Services University's affiliated medical school and residency programs and APA participation in a Hill Suicide Prevention Roundtable with Speaker of the House Nancy Pelosi, among other legislative and program updates.

In November the Assembly passed two new Position Statements which involve forensic issues. The first, Addressing Health Disparities in Substance Use Disorder and the Justice System, emphasizes the importance of access to evidence-based substance disorder treatment for all incarcerated populations, as well as a path to diversion into treatment for all non-violent drug offenders. The second statement, Mental Health Screening and Access to Mental Healthcare for Civil Immigrant Detainees of US Homeland Security, emphasizes mental health and medical treatment standards for civil detainees in immigration facilities. Other Assembly actions included developing a resource document to review state procedures regarding emergency psychiatric holds, improving the recruitment and hiring of psychiatrists, responsible disposal of prescription medications, and fighting workplace bullying at the VA.

Four new changes regarding the DSM-5 passed the Assembly and will now be sent to the APA Board of Trustees for final approval. These edits included changes in the criteria for Avoidant/Restrictive Food Intake Disorder, reinstatement of the Unspecified Mood Disorder diagnosis, changes in Narcolepsy subtypes,

and clarification that Substance/Medication Induced Disorders can also occur from withdrawal. The new Practice Guideline for Schizophrenia was also approved. Other highlights from Assembly Committees include ongoing exploration of alternatives to MOC and a new workgroup to better understand and address the future workforce challenges.

The APA Foundation, which is the charitable arm of the organization, introduced the Edwin Valdiserri Correctional Public Psychiatry Fellowship, which creates a special opportunity for current residents to receive additional experience, training, and mentorship in a correctional setting along with support to attend either the AAPL Annual Meeting or National Commission on Correctional Health Care (NCCCHC) Annual Conference. The Fellowship is open to PGY-1 or PGY-2 residents in an accredited psychiatry residency program and has an application deadline of January 31, 2020. Other Foundation activities highlighted include the Typical or Troubled?® program to educate schools in recognizing signs of mental illness, the Helping Hands Grants Program to support medical schools in mental health and substance use disorder projects, and awards to advance minority mental health, among others.

Lastly, the Assembly recognized AAPL member Pamela McPherson, MD, with the Profiles in Courage Award for her work as a whistleblower regarding the serious health risks to children in immigration detention facilities. Congratulations to Dr. McPherson!

The next APA Annual Meeting will take place in Philadelphia from April 25-29, 2020. (Of note, the meeting is earlier than in previous years.) The theme of conference is Advancing Quality: Challenges and Opportunities. 📅

**SAVE THE DATE!**  
**APA Annual Meeting**  
April 25-29, 2020  
Philadelphia, PA

# PHOTO GALLERY



2019 Program Chair Dr. Susan Hatters Friedman



2020 Meeting Program Chairs Drs. Wagoner and Holberg



A Thursday poster



AACL Executive Director Jackie Coleman addresses the Business Meeting



All smiles at the Thursday reception



Bill Reid MD, Joel Dvoskin PhD, Paul Appelbaum MD, Brian Crowley MD and Trent Holmberg MD prepare to take a walk down memory lane



Dr. Knoll and his current fellows at the review course



Dr. Joshi introduces President Frierson

# PHOTO GALLERY



New AAPL Officers



Early Career Psychiatrists enjoy a chat with Dr. Zonana at the ECP Breakfast



Enjoying the Thursday night reception



Fiftieth anniversary souvenir glasses!



Friday night 50th Anniversary Reception!



Longtime AAPL Staffer Sara Elsdon receiving the Amicus Award from Dr. Metzner



Public Psychiatry Committee



Two legendary AAPL photographers, Drs. Steven Berger and Eugene Lee

# AAPL Votes Tarasoff the Most Influential Landmark Case of the Past 50 Years!

Peter Ash, MD

The Landmark Cases in forensic psychiatry are well known to forensic psychiatrists: they study them in fellowship, learn about them at the AAPL Review Course, and are tested on them by the ABPN. For the 50<sup>th</sup> AAPL anniversary meeting, AAPL President Richard Frierson, MD, and meeting Program Chair Susan Hatters Friedman, MD, had the inspired suggestion to have a debate on the most influential Landmark Case since the founding of AAPL. I was honored to be asked to moderate.

The debaters did not have the option of choosing which case they would argue. Each had recently authored a chapter in a book on influential cases (1), and that was the case they agreed to present.

As those who were present will recall, *Tarasoff v. Regents of University of California* was voted the winner, selected by 36% of the audience using an audience response system.

Phillip Resnick, MD, presented

the case for *Tarasoff*, ably arguing that its effects on the assessment of dangerousness and duties of psychiatrists to protect others made it the most influential. A plurality of the audience agreed with him, and he won the prize for The Most Influential Landmark Case.

Prior to the compelling arguments of the debate, the audience was asked some demographic questions and also asked to identify their impression of the most influential case. These data, not available during the presentation, allow for careful and detailed statistical *post hoc* analyses of the election results, presented here for the first time. Most of the analyses were conducted using that subsample who voted both before and after the debate (N=80).

The presenters had a strong effect on the audience: Forty-two percent of the audience changed their minds from the pre-debate vote to the post-debate vote. Analyzing the predictors showed no differences by

sex, but significantly more practicing AAPL members (50%) changed their votes, compared to 34% of trainees. Practicing AAPL members demonstrated flexibility, openness to new ideas, and a commitment to lifelong learning. (An alternative hypothesis, also consistent with the data, is that practicing AAPL members, unlike trainees, have simply forgotten what many Landmark Cases are about.)

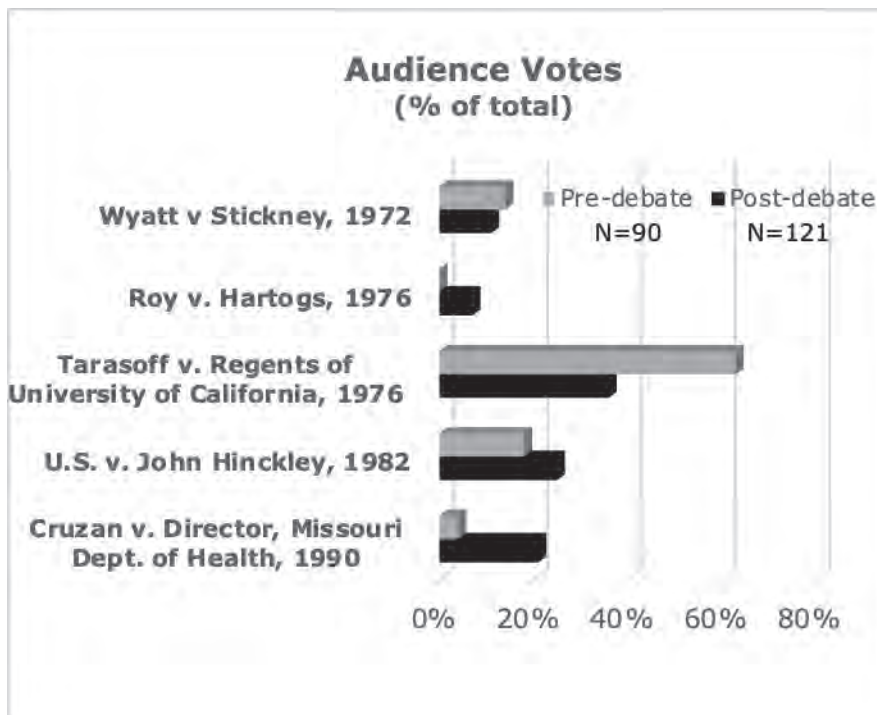
Susan Hatters Friedman, MD described how *Wyatt v. Stickney* revolutionized inpatient treatment by requiring individual treatment plans, humane environments for patients, and sufficient numbers of qualified staff. Her argument held the majority of those who thought that it was the most influential case in the pre-debate vote, and gained some new adherents in the final vote. Interestingly, all those who switched their votes to *Wyatt* were male (who comprised 60% of the audience).

*Roy v. Hartogs* was the clear underdog: prior to the debate, no one in the audience voted it the most influential case. But then Jacob Appel, MD, JD, MPH, MFA(x2), MA(x2), MPhil, came to the podium and pointed out that *Roy* peeled back the curtain of the consultation room for the first time, and allowed courts and medical boards to scrutinize behavior inside the psychiatrist's office. This had effects on all patients, not just a specific subgroup. It was the medical precursor of the #MeToo movement. His thoughtful argument swayed 7% of the audience to vote it the most influential case.

Alan Newman, MD, suggested that *U.S. v. Hinckley*, because of its enormous publicity, had a profound effect on the public's view of psychiatry, not just of forensic experts. His argument and animated slides more than doubled the votes for *Hinckley* from the pre-debate vote.

Richard Martinez, MD, MH, asked for an impromptu, show-of-hands vote that demonstrated that a significant majority of AAPL members agreed with the proposition that they were going to die. That,

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## XXXVIth International Congress on Law and Mental Health

*Kavita Khajuria, MD and Jagannathan Srinivasaraghavan, MD (Ashok Van) International Relations Committee*

The International Academy of Law and Mental Health (IALMH) held its XXXVIth Congress event in Rome, Italy from July 21-26, 2019, under the auspices of the Università degli Studi Internazionali di Roma and the Sapienza University di Roma. This was in collaboration with the Académie Internationale d'éthique, médecine et politique publique and the International Society for Therapeutic Jurisprudence.

Per its Mission Statement, the IALMH is founded on “the belief that issues arising from the interaction of law and mental health can be best addressed through multidisciplinary approaches.” Approximately 1350 delegates from 50 countries gathered at the Congress, with 270 panels, each with four to five presentations. Attendees included psychiatrists, psychologists, criminologists, sociologists, philosophers, researchers, lawyers and judges.

The Pre-Conference was held at the Sapienza University of Rome, one of the oldest universities in the world, founded in 1303 by Pope Boniface VIII. This was a full-day event with presentations on medical conscience/medical rights, complicity, medical ethics and new civil rights. The five-day conference was held at the University of International Studies of Rome. The breadth of sessions is beyond the scope of this article, but general themes included the changing landscape of mental health, claims and defenses in court, international perspectives on criminal responsibility, legal insanity in Europe & China, the United Nations Convention on the rights of persons with disabilities, mental health issues in Brazil, India and Japan, legislative impacts, mental health acts, gender bias in forensic psychiatry, female circumcision, battered women syndrome, the #MeToo Movement, neonaticide, filicide, juvenile delinquency, vulnerable pop-

ulations, incarceration, prisons and human rights, issues in law and aging, euthanasia and physician-assisted death, refugee issues, LGBT issues, trauma, wellness, terrorism, etc. A small number of sessions were held in Italian or French.

AAPL members have demonstrated long-term involvement with the IALMH. Dr. Thomas Gutheil (past president of AAPL) and Dr. Jagannathan Srinivasaraghavan (Honorary IALMH Fellow) both serve on the Executive Board. Numerous AAPL members presented on a variety of topics this year, including psychopathy and criminal responsibility in the US; forensic evaluation of PTSD; boundary violations in academic and professional psychiatry; sexual harassment in medicine; race and mass incarceration; practice resources for US corrections; psychotropic medications in incarcerated individuals; conspiracies and delusions; psychiatrists and physician-assisted suicide; crime causation theories; and female suicide terrorism.

The event was also an excellent opportunity to learn about Therapeutic Jurisprudence (TJ) and connect with members of its international community. TJ is a legal philosophy and multidisciplinary approach that invites one to examine “how laws, legal processes and the role of legal actors can improve (or harm) the well-being of people affected by the legal system.” TJ research and practice has underpinned many innovations in the legal system in many different areas.

Rome is an ancient city, rich in the arts, culture and history. Additional programs included a Pre-Conference Inauguration ceremony and a classical music concert accompanied by a soprano soloist. Another event was a concert at the majestic and world-famous Basilica di San Giovanni. Daily informal luncheons provided ample opportunity to connect and network

with international colleagues. Overall, the conference provided an excellent opportunity to present, learn, and network. Most notable was the degree of collaboration between professionals in mental health, law and perhaps most importantly, the humanities. The next International Academy of Law & Mental Health Congress will be held in Lyon, France in July 2021. ☎

## Medical Director

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dent for reappointment. Initiating a request for reappointment is the member's responsibility. Requests for reappointment to the President must come from the chair of the committee to the President directly. The President will not reappoint without approval from the Committee Chair.

- Reappointment for an additional three-year term will be based on an attendance minimum of half of committee meetings held within their three-year term and participation in at least one Committee activity.
- There should be no limit on the number of terms an AAPL member may serve on a Committee, and no limit on the number of Committees on which an AAPL member may serve.
- If possible, to be eligible to be appointed as Committee Chair, an AAPL member should have served at least one three-year term on the Committee.
- Special Committee Chairs should be limited to being Chair of only one Special Committee at a time.

So where will AAPL be headed in the next 50 years? Some members want AAPL to have an even greater direct advocacy impact, perhaps through direct lobbying. Others believe we should refocus on our educational mission by establishing a more vibrant web-based educational presence. I would appreciate your thoughts as current AAPL members. Please e-mail the AAPL office ([office@AAPL.org](mailto:office@AAPL.org)) and request that your email be forwarded to me. ☎

## Female Life Stages: What Forensic Psychiatrists Need to Know

*Susan Hatters Friedman, MD; Renée M. Sorrentino, MD; Sherif Soliman, MD; Nina Ross, MD; and Selena Magalotti, MD*  
*Gender Issues Committee and Geriatric Psychiatry and the Law Committee*

At the 50<sup>th</sup> Anniversary meeting of AAPL, the Gender Issues Committee joined with the Geriatric Committee to present about various topics within female life stages that forensic psychiatrists should be aware of, in order to complete evaluations in criminal, civil, and correctional work. Female youth, pre-menstrual dysphoric disorder (PMDD), pregnancy, postpartum disorders, and menopause were each discussed in turn.

Psychopathology is over-represented in incarcerated youth compared to the general population, and special considerations are warranted for incarcerated girls (1). Incarcerated girls have higher rates of depression, and the rates are increasing (2). Incarcerated girls also have higher lifetime suicidal thoughts and attempts compared to boys (3). Individuals with a history of childhood abuse, especially sexual abuse, are more likely to be arrested in their lifetime, and to have psychiatric symptoms including aggression. There is some evidence that girls in the juvenile justice system have higher rates of childhood sexual abuse than boys. A history of sexual abuse has been shown to be a predictor of criminal recidivism specifically for girls (4).

Throughout history, myths and taboos surrounding menstruation have perpetuated beliefs that aberrant behavior in a woman is the result of fluctuating hormones. Today, both the American Congress of Obstetricians and Gynecologists and the APA have developed overlapping but distinct disorders that qualify as premenstrual disorder. PMDD, introduced in the DSM-5, refers to the psychological and physical symptoms in the final week before the onset of menstruation, which lead to impaired function. Although 80% of women experience at least one psychological or physical symptom in the premenstrual period,

the prevalence of PMDD is 1.3-5.3% (5). PMDD is associated with depressive and anxiety disorders, and MDD is the most prevalent lifetime psychiatric disorder in women with PMDD (6). Cross-sectional studies have suggested a link between trauma and PMDD (7). Although personality disorders are not associated with PMDD, traits of impulsivity, anger, affect intensity, and lability were significantly associated with PMDD (6).

The American courts first considered premenstrual syndrome as a legal defense in the 1867 trial of Mary Harris, who was indicted for the murder of Adoniram Burroughs. (8) Harris and Burroughs dated for several years until he ended the relationship and began dating another woman. Harris subsequently killed Burroughs. She was found NGRI after a jury deliberation of 5 minutes. An expert testified “uterine irritability is one of the most frequent causes of insanity.” (8) Both the UK and France have found premenstrual disorders as grounds for insanity and mitigation. Subsequent reports have questioned the validity of such symptoms in relation to criminal behaviors. (9) Legal challenges to the PMDD defense include questions about the admissibility of the diagnosis including questions regarding the reliability of the diagnosis. Another critique of the PMDD defense is that it portrays women as unstable and perpetuates such stereotypes. (10)

Forensic psychiatrists may serve as experts in pregnancy-related civil cases or evaluate pregnant defendants or inmates, which requires a basic understanding of how to treat pregnant patients with psychiatric illness. While each case requires individual formulation, there are a few basic principles to keep in mind. Accurate characterization of the risks of treatment and the risks of alternatives is crucial. Physicians tend to dispro-

portionately consider the adverse events from errors of commission (i.e. prescribing a harmful medication) at the expense of minimizing the risk of adverse events from errors of omission (i.e. inadequately treated psychiatric illness) (11).

Psychiatrists should be aware of basic physiologic and metabolic changes that occur during pregnancy, which can affect medication metabolism and distribution as well as pregnancy outcomes. For example, prescribing a potentially teratogenic medication during the third trimester, after organs have largely formed, presents a much lower risk of teratogenesis than prescribing this same medication to a newly pregnant woman (11, 12). Psychiatrists also should inform patients of the likelihood of adverse pregnancy events and the severity of these events should they occur. Assuming the patient has decisional capacity, which the psychiatrist should determine, the patient then can decide on a treatment plan and provide informed consent (13). Documenting this treatment formulation and informed consent provide the best protection should a malpractice suit occur (13). Adverse pregnancy outcomes – and lawsuits – can result from both psychiatric medications and inadequately treated psychiatric illness.

The postpartum is the period of a woman’s life when she is most likely to suffer symptoms of mental illness. Sleep deprivation, hormone changes, role changes, and stress all play a part in the postpartum period. There is a discrepancy between the DSM and research regarding the length of the postpartum period, of which forensic experts should be aware (14). It is critical that postpartum depression, postpartum OCD, and postpartum psychosis be differentiated (15). As at any other time, untreated postpartum mental illness increases risks of negative outcomes. Mothers should be asked about thoughts of both infanticide and suicide (16). The forensic psychiatrist must also be aware that neonaticides and infanticides have distinct characteristics (17).

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## Entertainment Media Reviews: Fluff or Forensic Teaching Tool?

Karen B. Rosenbaum MD; Susan Hatters Friedman MD;  
Cathleen Cerny-Suelzer MD; Kenneth Weiss, MD; and Tobias Wasser MD  
*Forensic Training of General Residents Committee*

Entertainment media, including fictional and documentary films, have become more popular since the rise of internet-based television. The number of crime shows and other film series with forensic themes has risen significantly in the past decade. These shows and other forms of entertainment media illuminate the human condition. Given forensic psychiatrists' special ability to convey narrative, our field has a unique opportunity to highlight the behavioral dynamics at play in these series, which might otherwise be dismissed as evil or trivial, through scholarly writing.

In this presentation at the 2019 AAPL Annual Meeting, Dr. Rosenbaum introduced the concept of the "Rashomon Effect." As psychiatrists, we are always searching for the truth. This can be difficult as we cannot always trust the evaluatee, our narrator, to tell the whole truth. Denial or other psychological defenses can be a factor especially in the clinical setting. In the forensic setting, there is secondary gain as well as the usual psychological defenses. The Rashomon Effect describes the phenomenon when a story is told through varying viewpoints. It is named after one of the first movies to utilize this technique, the 1950 Japanese film *Rashomon*, by Akira Kurosawa. The film told the story of the death of a samurai and a sexual encounter from the perspective of four different narrators, each plausible but contradictory. The viewer does not know which narrative to rely on. Since then, this story technique has been used by many movies and television series, including the Showtime series *The Affair* (1), created by Sarah Treem and Hagai Levi. Each episode is divided into two parts, with the first part told from the point of view of one character, and the second from another main character's viewpoint. Where the characters

intersect is especially interesting as there are many differing details, both major (such as which character was responsible for saving a life) and minor (such as whether someone was wearing a revealing dress or a modest shirt). The first season is told retrospectively after a possible homicide. In the fourth season, a major character disappears, and when her body is finally found, her death is ruled a suicide. She had been in a relationship with someone who became violent.

*The Affair* was used to discuss intimate partner violence including its forms and etiologies. Another example of intimate partner violence and stalking behaviors in media is the Netflix series *You*, based on the novel by Carolyn Kepnes. In *You* (2) the main character, Joe Goldberg, who narrates in the second person, engages in stalking the object of his affection, Guinevere Beck, whom he meets when she wanders into his bookshop in Brooklyn. Instead of asking her out, he looks up her information online, finds her apartment, and watches her through her window for weeks before arranging a "chance" meeting with her. In order to control her, he tries to separate her from her friends by any means possible. When the body of one of her friends is found, her death is ruled a suicide. Both series had suspicious deaths that were ruled a "suicide," but there was no psychological autopsy performed. The ambiguity in both series demonstrates the potential value of psychological autopsy to differentiate between homicide and suicide. Both *You* and *The Affair* illustrate many forensic themes that could be useful in teaching students and trainees.

Dr. Hatters Friedman discussed medical child abuse (also referred to as Munchausen's by proxy or factitious disorder by proxy) and parricide as topics of teaching, using primar-

ily the HBO series *Sharp Objects* (3) (based on the novel by Gillian Flynn), Hulu's miniseries *The Act*, (4) and the theatrical release *Star Wars: The Force Awakens*. (5) Both medical child abuse and parricide are important topics for trainees to understand, yet both may be difficult to approach with standard teaching methods. The use of television and film may help broach the discussion about behaviors which some find so difficult to grasp.

In *Sharp Objects*, the protagonist and her sisters were victims of medical child abuse (for one of whom it was fatal). The abusive mother was realistically portrayed, as were the long-term effects of the childhood abuse. In *The Act*, a real-life case of medical child abuse and its eventual outcome of matricide was dramatized. In *Star Wars: The Force Awakens* (spoiler alert), Kylo Ren murdered his father Han Solo. Multiple similarities between Kylo Ren and real-life cases were discussed, and the concept of over-kill explored. Using these vehicles for teaching allows for discussion and interpretation of the research literature on these rare events.

Dr. Cerny-Suelzer gave an update of "From Dr. Kreizler to Hannibal Lecter: Forensic Psychiatrists in Fiction," (6) a collaboration she first worked on with Dr. Hatters Friedman, Dr. Sherif Soliman and Dr. Sara West for the 2010 AAPL meeting in Tucson, Arizona. Using frequent criticisms of forensic psychiatric experts and building on the work of psychiatrist film scholars like Irving Schneider and Glen Gabbard, Dr. Cerny-Suelzer and her colleagues came up with a typology of forensic psychiatrists as they are depicted in fictional works. The typology includes Dr. Evil, The Activist, The Hired Gun/Whore of the Court, The Professor, and The Jack/Jill of All Trades. With popular culture examples both old and new, Dr. Cerny-Suelzer illustrated how the typology can be used to teach psychiatry trainees at all levels and also the general public about myths, realities and misperceptions of forensic psychiatrists as experts and

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## After the Bell Rings: Addressing School Violence

Anne McBride, MD and Michael Kelly, MD  
*Child and Adolescent Psychiatry and the Law Committee*

The morning's forensic evaluation involves assessment of a detained 16-year-old boy who stabbed another student in the school cafeteria during a gang fight. In the afternoon on a children's crisis stabilization unit, two minors come in: a 13-year-old girl who wants to end her life after being viciously bullied on social media, and a 15-year-old boy who was brought in by law enforcement after his high school principal watched a social media post the student had made threatening a mass shooting/suicide.

School violence often grabs the attention of the nation, especially after catastrophic school shootings. While school shootings have profound effects on victims, families, and communities, school violence encompasses a much broader problem, ranging from bullying, physical and sexual violence on campus, to trauma off campus. Students spend a substantial portion of their young lives at school, making school safety paramount. Fortunately, we have a wealth of prevention measures to help maintain student safety.

For example, for the 16-year-old boy who stabbed another student, a formal violence risk assessment was conducted within the juvenile detention setting. Decades of research support the conclusion that using structured violence risk assessment instruments provides a more accurate violence risk appraisal than using an unstructured clinical judgment approach (1). Two of the most researched youth violence risk instruments are the Youth Level of Services/Case Management Inventory 2.0 (YLS/CMi 2.0) (2), which employs a risk-need-responsivity model, and the Structured Assessment of Violence Risk in Youth (SAVRY) (3), which utilizes a structured professional judgment model. Violence risk assessment allows the evaluator to systematically identify risk factors and protective

factors, integrate those factors with clinical judgment, determine an individual's acute risk for violence, and direct evidence-based interventions to lower that risk. Addressing dynamic risk factors is of critical importance for youth, because early intervention can substantially improve their developmental trajectories.

While risk assessment examines factors related to one's ongoing capacity for violence, threat assessment addresses targeted acts of violence. Similar to risk assessment, use of a systematic approach to threat assessment is a more effective method to assess targeted acts of school violence. In fact, following the 1999 mass school shooting at Columbine High School, the Secret Service partnered with the Department of Education to study 37 acts of targeted school violence that had occurred over the prior 26 years (4). Following this study, both agencies, along with the FBI (5), concluded that there is no reliable profile for a potential school shooter, and all three agencies advocated the use of a threat assessment approach when addressing targeted school threats. Schools can implement evidence-based structured threat assessment approaches, such as the Virginia Model for Student Threat Assessment, in response to a threat of violence by a student (6).

We also know from the research literature that most incidents of targeted violence at schools were planned, that other people had advance knowledge of the attacker's ideas or plans, and that most attackers behaved in ways that had caused concern in others prior to the violence. Individuals planning acts of violence often reveal clues to their intentions in a phenomenon that has been dubbed "leakage." In the FBI's 2018 report on active shooters in the U.S., the people most likely to observe concerning behavior or clues left by youth shooters were

student peers and school personnel, rather than family (7). Educating students about violence risk factors and fostering a school culture where students "look out" for each other can prevent campus violence. For instance, the 15-year-old boy who posted threats of suicide and violence on social media was identified by his peers, who expressed their concerns to school officials, which ultimately led to his being brought to the hospital for crisis services. Another critical intervention in this case was the restriction of access to potentially lethal means of self-inflicted harm and interpersonal violence – firearm restriction.

Firearm violence affects students both on campus and off. Firearm homicide is one of the leading causes of death in youth, and the number of youth who die of suicide by firearm each year is also alarming (8). We know that more than 30% of households with children have firearms (9). Studies show that firearm owners report feeling comfortable disclosing their firearm status to physicians, particularly when the discussion includes the risk association (10). Therefore, physician counseling on safe firearm storage (locked, unloaded, ammunition separate from firearm) is an easy and effective intervention to prevent future violence. In the case of the boy in crisis, a further step was taken when the local Sheriff's department issued a Gun Violence Restraining Order (GVRO), an option available in a minority of states to help limit access to firearms in individuals at substantial risk for harming themselves or others. In the case of an impulsive adolescent making substantive threats of targeted violence, such an intervention became an important preventative measure.

As our society becomes more media- and technology-oriented, it behooves us to stay aware of the platforms our youth are immersed in. For example, it is often helpful to incorporate a social media review when assessing a youth's risk of violence and/or suicide. We also must understand how far-reaching and consequential digital technology has become. For

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## Facing the Elephant in the Evaluation Room: Confronting Bias and Striving for Objectivity (Part I)

W. Connor Darby, MD and Robert Weinstock, MD  
Ethics Committee

AAPL ethics guidelines highlight the importance of psychiatrists adhering to the principles of honesty and striving for objectivity:

“When psychiatrists function as experts within the legal process, they should adhere to the principle of honesty and should strive for objectivity. Although they may be retained by one party to a civil or criminal matter, psychiatrists should adhere to these principles when conducting evaluations, applying clinical data to legal criteria, and expressing opinions.” (1)

The idea that forensic psychiatrists, like all individuals, are inherently biased was originally articulated by Bernard Diamond. (2) AAPL Ethics Guidelines recognized this concept when it replaced a previous requirement to be “unbiased” with the guidelines of adhering “to the principle of honesty” and to “strive for objectivity.” (3) Thus, AAPL considers it essential to strive to reach an objective opinion despite recognition that we can never be completely free from biases. But the question remains, how do forensic practitioners pragmatically deal with bias and the ethics dilemmas it presents?

When we talk about bias within the context of forensic psychiatry, some obvious examples of unethical behavior may come to mind. There is the “hired gun” who is biased in favor of the retaining side for financial reasons and distorts her opinion to please the attorney who hired her, thus, in her mind, increasing the likelihood of repeat business and a lucrative career.

But the “hired gun” can also come in the form of the forensic psychiatrist who accepts cases to pursue some perceived ideological agenda and is willing to distort his opinion to accomplish or further this cause. Consider the two following hypotheticals: 1) the forensic psychiatrist who

only testifies for the defense at the penalty phase of capital cases and is willing to distort his opinion because he believes capital punishment is a terrible societal injustice; and 2) the forensic psychiatrist who only testifies for the prosecution at the penalty phase of capital cases and is willing to distort her opinion because she believes these defendants pose an incredible societal danger. In both of these cases, the forensic psychiatrists are “hired guns” and behaving unethically not because they choose to work exclusively for one side (i.e., the defense versus the prosecution), but rather because they choose to distort their opinion as a means to an end. Testifying exclusively for one side could be ethical, as long as the forensic psychiatrist never distorts her opinion and strives to be as objective as possible.

While the above examples illustrate the pernicious effects of conscious bias displayed by the “hired guns,” the more prevalent and insidious unconscious bias may lead to problematic and unethical actions as well. AAPL Guidelines identify this concern in the Commentary section under Section IV. Honesty and Striving for Objectivity:

“Being retained by one side in a civil or criminal matter exposes psychiatrists to the potential for unintended bias and the danger of distortion of their opinion. It is the responsibility of psychiatrists to minimize such hazards by acting in an honest manner and striving to reach an objective opinion.” (1)

Unconscious bias presents a major challenge for forensic psychiatrists aspiring to be as ethical as possible, since by definition it is not recognized by the practitioner herself. How do we combat something that we are blind to? One strategy is to identify

areas of potential unconscious bias, increase awareness and humility that we are all susceptible to particular biases despite our intent not to be, and employ methods that attempt to mitigate detrimental effects of such unconscious bias.

One such area of unconscious bias that jeopardizes objectivity occurs when a psychiatrist in a forensic role aligns herself too closely to being in a treatment role, guided by traditional physician ethics principles. Paul Appelbaum’s solution to this problem, which in certain cases may reflect a practitioner’s unconscious bias to favor evaluatees, was to delineate principles distinct to forensic psychiatrists: truth-telling and respect for persons. Appelbaum asserted that these principles should govern a forensic psychiatrist’s ethical behavior in advancing justice, rather than the beneficence and non-maleficence that govern the behavior of a treating psychiatrist, whose goal is always to advance the patient’s health and welfare. (3)

Appelbaum further elaborated that truth-telling is composed of both subjective and objective components, which can be applied to the conscious and unconscious bias problems in our field. (4) The “hired gun” has conscious bias to favor one side. She distorts her opinion and is subjectively not telling the truth (i.e., she is dishonest). AAPL Ethics Guidelines offers clear instructions to not violate subjective truth-telling that may be related to conscious biases to serve the retaining attorney: “Psychiatrists should not distort their opinion in the service of the retaining party.” (1)

On the other hand, the forensic psychiatrist who has unconscious bias to favor the defense or prosecution regardless of the reason (e.g., ideological, financial, desire to help or please the retaining attorney, victim, victim’s family, defendant, plaintiff, society) may unintentionally approach the case in a way that is likely to yield an opinion aligned with that bias, and in doing so is failing to reach an appropriate level of objective truth-telling. AAPL Ethics Guidelines elaborate on practical methods forensic psy-

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## Fifty Years Post-Powell: Addiction and Culpability

Ashley H. VanDercar MD, JD; Abhishek Jain MD;

Corina Freitas MD, MSc, MBA; and Elie G. Aoun, MD  
Addiction Psychiatry Committee

For over two centuries there has been a debate over whether addiction is a “choice” or a “disease.” Medical organizations have increasingly defined addiction as a disease, often describing it as a relapsing brain disorder characterized by loss of control over substance use. Yet, the legal system is mixed in its view on the relationship between addiction and volition. With recent decriminalization movements, rising opioid overdose deaths, and improved understanding of the neuroscience of addiction, this growing debate on substance use and volition has significant societal and judicial implications. (1)

A critical turning point in this debate occurred in 1962, in *Robinson v. California*. The United States Supreme Court found that a California statute making it illegal to be “addicted to the use of narcotics” was unconstitutional. The Court held that the statute was cruel and unusual, noting that it criminalized an illness (addiction) “which may be contracted innocently or involuntarily.” (2)

For a short while thereafter it looked like there might be a new doctrine of criminal responsibility, as applied to persons with substance use disorders. (3) In 1966, in *Driver v. Hinnant*, the Fourth Circuit found that as the “chronic alcoholic has not drunk voluntarily” the application of a statute criminalizing public intoxication was unconstitutional. (4) That same year, in *Easter v. District of Columbia*, the D.C. Circuit similarly invalidated a public intoxication statute, noting that “[o]ne who is a chronic alcoholic cannot have the *mens rea* necessary to be held responsible criminally for being drunk in public.” (5)

This liberalization of criminal responsibility came to a halt in 1968. In *Powell v. Texas*, with a closely divided ruling, the Supreme Court upheld a Texas law criminalizing

public intoxication. (6) Five of the nine justices agreed that Texas’s law was constitutional. However, only four signed onto the rationale: that while it is unconstitutional to criminalize *the status* of being an addict, it is permissible to criminalize *the act* of drinking. Justice Byron White, in a concurring opinion, acknowledged the profound implications if the court were to absolve defendants of criminal responsibility whenever a crime involved “compulsions” that are “symptomatic” of a “disease.” However, he stated that if Mr. Powell had demonstrated that “resisting drunkenness [wa]s impossible” and that he was homeless, with no place to go except a “public place,” the application of the public intoxication statute would be unconstitutional.

Justice White’s concurring opinion became relevant in July 2019 in *Manning v. Caldwell*. *Manning* involved a 19<sup>th</sup>-Century Virginia statute that made it illegal for the “habitual drunkard” to consume, purchase, or possess alcohol. The plaintiffs were, as described by the court, “homeless alcoholics.” The Fourth Circuit Court of Appeals invalidated the Virginia statute. The crux of their holding was that the statute was unconstitutionally vague. However, they also found a “viable claim” in the argument that the statute was cruel and unusual, as “the Eighth Amendment cannot tolerate . . . the targeted criminalization of *otherwise legal* behavior that is an involuntary manifestation of an illness.” (7)

The *Manning* court relied on *Robinson* and *Powell*; in particular, Justice White’s concurring opinion. They did this through the “Marks Rule,” which is from a 1977 Supreme Court case in which the Court held that when there is a fragmented ruling (like in *Powell*) with “no single rationale . . . the [Court’s] holding . . . may be viewed as that position taken by those Members who concurred in the judgments on the

narrowest grounds.” (8) The Fourth Circuit interpreted this to mean that they should rely on Justice White’s concurring opinion, with its focus on volition and homelessness.

The *Manning* opinion was narrow. It focused on otherwise legal behavior that is criminalized only for people with a disease. Despite this, it is an interesting case. It is reminiscent of the *Driver* and *Easter* cases that tried to extend *Robinson* to acts associated with the status of addiction.

Shortly after *Powell* was decided in 1968, a commentary in the American Bar Association Journal noted: “the legal profession stands ready to herald ‘a due process concept of criminal responsibility’ when the medical profession has evidenced ‘the disease concept of alcoholism.’” Leroy Powell was not the right defendant and 1968 was not the right year.” (3) As the conceptualization of addiction as a disease becomes more established, and we begin to understand the still uncertain relationship between addiction and volition, it is possible that jurisprudence will return to the state it was in between the *Robinson* and *Powell* decisions.

Today, when considering intoxication defenses, we are primarily left with the doctrines of insanity and *mens rea*. Jurisdictions differ considerably in how they treat these concepts. (9) In general, intoxication does not excuse criminal behavior, though courts may consider limited circumstances such as involuntary intoxication (e.g., a “spiked” drink or unusual reaction to a prescribed medication) or settled insanity (e.g., a mental disturbance resulting from substance use which has become permanent) as a potential defense.

Some courts allow evidence of intoxication to negate the *mens rea* of a specific intent crime (e.g., “I was so intoxicated I didn’t actually *intend* to kill the victim”), potentially lowering the severity of the charge and subsequent punishment. Additionally, all states now have drug courts, offering sentencing alternatives for individuals with a substance use disorder. While these courts vary in terms of eligibility

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## Madison v. Alabama: Forensic Neuropsychiatry and the Supreme Court

Nina Ross, MD and Vivek Datta, MD, MPH  
Forensic Neuropsychiatry Committee

“What is your view on the significance of the MRI evidence?” (1)

-- Chief Justice John Roberts,  
during Oral Argument in *Madison v. Alabama*

In what is sure to become a landmark case in forensic psychiatry, in *Madison v. Alabama* the US Supreme Court considered the competency to be executed of a man with vascular dementia. At issue were (A) whether the Eighth Amendment’s prohibition against cruel and unusual punishment applies to defendants condemned to death who have no memory of the alleged offenses, and (B) whether the same prohibition prevents the state from executing a prisoner with dementia or another cause of cognitive dysfunction such that he cannot remember the crime for which he was convicted or understand the circumstances of his execution.

In *Ford v. Wainwright*, the Supreme Court ruled that imposing the death penalty on a prisoner who is insane after sentencing does constitute cruel and unusual punishment. (2) In *Panetti v. Quarterman*, the Court further clarified that a prisoner who, due to mental illness, lacks “rational understanding of the reason for [his] execution” cannot be executed. (3) Both of these cases involved delusions secondary to psychotic illness. *Madison v. Alabama*, which the Supreme Court decided on February 27<sup>th</sup>, 2019, considers the case of a prisoner with vascular dementia. In 1985, Vernon Madison shot and killed a police officer. He was convicted of murder in 1998 and sentenced to death. While awaiting execution, he developed vascular dementia which resulted in severe memory deficits, blindness, urinary incontinence, and slurred speech. His cognitive deficits resulted in an inability to recall the crime for which he received the

death penalty. Because he could not remember his crime, his lawyers petitioned Alabama state courts in 2016, arguing that his lack of ability to recall his crime renders him mentally incompetent, as he does not have a rational understanding of the reason for execution. Alabama argued that Mr. Madison’s ability to state the rationale for the punishment, even if he cannot recall the crime itself, renders him competent to be executed.

Madison then sought *habeas corpus* relief in the federal courts, and the Eleventh Circuit Court of Appeals ruled that he was incompetent to be executed. In *Dunn v. Madison* the Supreme Court reversed, finding that the state court’s determinations of law and fact were “not so lacking in justification” as to give rise to error “beyond any possibility for fair-minded disagreement” as required under the Anti-terrorism and Effective Death Penalty Act of 1996. (4)

In January 2018, Madison, now scheduled for execution, petitioned in state court for relief with new evidence that the court-appointed expert whose testimony was previously relied on (Dr. Kirkland) had been suspended from the practice of psychology. The state court reaffirmed his competency to be executed and Madison was granted *certiorari*, this time on the constitutional issues surrounding his claim.

In a 5-3 majority opinion (Justice Kavanaugh was not involved in this case) penned by Justice Kagan, the Court ruled that an inability to recall a crime does not preclude someone from receiving the death penalty, but dementia could be the underlying reason someone lacks a rational understanding for their reason for execution, which could form the basis for a constitutional prohibition against execution as outlined in the Court’s earlier decision in *Panetti*. Ultimately, they

vacated the decision and remanded the case to the Alabama courts for a re-evaluation of Mr. Madison’s competency in light of their opinion.

This case is particularly interesting from a neuropsychiatric perspective, as it is another example of the increasing significance of neuroscientific evidence in the courts. Previously, in *Roper v. Simmons*, the court considered neuroscientific evidence regarding the developing adolescent brain in ruling the death penalty unconstitutional for minors. (5) Madison repeatedly drew the Justices’ attention to his documented MRI evidence of cerebrovascular disease to support the case that he had cognitive dysfunction, which rendered him incompetent to be executed. In doing so, he was likely attempting to assuage the Court’s concern that anyone might invoke amnesia for the crime to avoid the death penalty, whereas Madison had demonstrable evidence of “brain damage” to support his assertion of incompetency. In fact, the use of brain imaging and neuropsychological testing was central to Madison’s petition, in which he argued that these technologies demonstrate an “evolving landscape of evidence allowing courts to adequately review maladies that could give rise to incompetence.” (6)

In 2016, there were 2,814 prisoners under sentence of death in the United States, over 500 of whom were over the age of 60. (7) The most recent US Bureau of Justice estimate of the length of time spent on death row is 15½ years. (8) Given this aging population, the consideration of dementia in competency to be executed is likely to become increasingly relevant. With the development of new imaging modalities including amyloid-PET and tau-PET imaging for the diagnosis of dementia, we suspect the courts will continue to be faced with attempts to redefine criminal and civil competencies through neuroscience. In *Madison*, the Supreme Court opened the door to dementia-based challenges to carrying out a capital sentence, but stopped short of ruling it unconstitutional for any prisoner with dementia to be executed. (9)

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## Updates from the Association of Directors of Forensic Psychiatry Fellowships

George D. Annas, MD, MPH  
ADFPF Committee

The Association of Directors of Forensic Psychiatry Fellowships (ADFPF) Committee meeting at the 2019 Annual Meeting in Baltimore was well-attended, with approximately 50 attendees representing over 30 programs. The meeting included many discussions and debates – some new and some very old, in regard to improving the primary education of forensic fellows and the challenges of recruitment. The good news includes the fact that there was no bloodshed over the discussion on whether or not forensic psychiatry should join the Match® system.

Dr. Octavio Choi announced that he has started a new fellowship program at Stanford, with a special area of focus for applicants interested in neuroscience and its use (and misuse) in the courts. He will start with his first fellow in July of 2021. Dr. Janofsky announced that less than 10% of AAPL members had contributed to the AAPL Institute for Education and Research (AIER). He urged all members to get the word out and encourage colleagues to contribute (the suggested amount is what you charge for one hour of your time doing evaluations). (1, 2) The committee also voted unanimously to renew the office positions of the Chair, Vice Chair, and Secretary (Drs. Richard Martinez, Annette Hanson, and James Knoll, respectively).

Drs. Reena Kapoor and Bipin Subedi updated the committee on the diligent work they have been doing in regard to creating a universal application that aspiring fellows could download from the AAPL website, fill out, and then send out to the programs they were interested in. Based on the feedback they had received from the directors prior to and at the meeting there appeared to be a consensus that this was an achievable goal. The attendees agreed that each program could still

ask for additional information after receiving a “universal application” from a candidate, and those with specific institutional application requirements in place could continue to use their own forms and process. Dr. Kapoor also noted that she had researched the requirements for programs to adopt the Electronic Residency Application Service (ERAS®), which would be a potential option down the road. The pros and cons were debated, and there were still many who felt the electronic system had its drawbacks for applicants, such as cost and the impracticality for those who only wanted to apply to a handful of programs.

Dr. E.J. Keisari, PGY-4 and Chief Resident at the University of Connecticut announced a research project he is working on, involving obtaining data from fellowship directors about their applicants and the challenges of recruitment. Once this project is finished, a potential future one is a survey of current and recently-graduated fellows to determine their opinions on the application process and potential improvements for the future. Although most programs have exit surveys regarding their graduates’ experiences and future plans, much of the data on applying to fellowships thus far has come from the side of the programs more so than the applicants themselves. Dr. Martinez reminded the committee that for residents interested in learning more about applying for forensic fellowship positions, there was an article in *Academic Psychiatry* on this topic. (3) Although it is a contemporary article, an updated version may be in the works.

A significant portion of the meeting was devoted to a discussion led by the Chair in regard to improving the process for fellowship applicants. While it appeared that there was no consensus for the programs to ultimately enter the

Match system, it was acknowledged that one potential advantage of this would be to prevent programs from pressuring applicants to sign on to a program early and before the applicant had finished his or her interviews. This has been an age-old problem and an issue debated at many ADFPF meetings. In an attempt to limit this, after a vote was held with near-unanimous support, a rule was adopted stating that no program would start interviewing prior to April 1<sup>st</sup> of the preceding calendar year, and no program would give an applicant a deadline for acceptance prior to May 1<sup>st</sup>. Offers to internal candidates were not subject these rules.

While there have been similar rules and guidelines such as these before, many programs have broken them without consequence. Further discussion included the manner in which such rules might be enforced in the future. One member suggested – in a true sign of the times- that the violators be “publicly shamed.” However, few thought this would be effective without the use of a pillory. Since it was soon apparent that we lacked the budget for such a device, the debate was shelved for the time being. Sadly, there was no suggestion to bring back the practice of dueling with pistols, but there is always the semi-annual meeting, next April! ☺

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### Calling all Forensic Fellows:

The Newsletter is actively recruiting Fellows to write a column for the Fellows’ Corner. This is a unique opportunity to share your views and experiences during your Fellowship year.

If you are interested, please send an email to [newslettereditor@aapl.org](mailto:newslettereditor@aapl.org).




## 13 Reasons

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online) reporting on suicide often was deemed to be sensational and negative in nature. For example, the study found print media often printed articles with high visual impact (front page and use of photographs of or near the location) with online media showing greater noncompliance with tonal aspects of the media guidelines, such as using inappropriate terminology. On the other hand, online media, and especially social media, have been shown to be a positive influence by connecting struggling individuals to places to receive professional help, as well as providing resources such as suicide prevention hotlines, through text and chat programs. (14) Media have also brought more awareness to the topic of mental health and suicide, with good examples being Logic's song "1-800-273-8255" (the number of the National Suicide Prevention Lifeline) and YouTube pop culture reporter "Ian from What Culture," who frequently ends his videos with a discussion of the importance of mental health and getting help if needed.

Ultimately, it is not surprising that Netflix has faced backlash for *Thirteen Reasons Why*. It has tried to respond to the criticism. More than two years after releasing the first season, Netflix has deleted the graphic suicide scene at the end of the first season. (15) Feedback from experts like Christine Moutier, MD, chief medical officer at the American Foundation for Suicide Prevention, was what Netflix claimed prompted the change. In addition, the show now comes with extensive trigger warnings, resources for parents to discuss difficult themes with their children, and a video featuring the show's stars encouraging people to seek help if they are having trouble. While these changes have been applauded by mental health and other organizations as a positive change, (16) the show still remains edgy and controversial in how it addresses other themes, such as its depiction of a graphic rape and a school shooting. It will be interesting to see if additional changes will be made, or will some degree of edginess

and controversy be deemed necessary for the work to maintain its artistic message and identity. 

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*continued from page 23*

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## Media Reviews

*continued from page 19*

consultants to law enforcement.

Dr. Weiss traced the history of forensic themes in cinema, from the earliest depictions of Biblical scenes (e.g., the slaying of Abel and the near-filicide of Isaac by Abraham) through a variety of 20<sup>th</sup>- and 21<sup>st</sup>-Century cinematic renderings of psychiatrists and their patients. He encouraged the use of media in teaching, using clips from the classic movie *My Cousin Vinny* to teach about the justice system. Dr. Weiss explained the importance of media reviews by forensic psychiatrists, using his own reviews as examples of how viewing and writing about media can improve our sensitivity and empathy in clinical work.

Finally, Dr. Wasser, the editor of the media and book review section of the *AAPL Journal*, discussed the process of submitting reviews to the *Journal*, gave some recent examples and underscored why this is an important area for forensic psychiatrists to pursue if they have an interest. Recently, given the emphasis in popular culture on streaming media, the *Journal* has renewed its efforts to include media reviews in this section of *JAAPL*. Reviews typically center on three potential themes. The first is television programs or movies with prominent forensic themes, such as the Netflix series, *Mindhunter*, a series focused on the work of the FBI's Behavioral Science Unit and in particular the interplay between two FBI agents and an FBI psychologist trying to understand the minds of serial killers. The second theme is media with forensic connections, but not solely focused on forensics, such as the HBO documentary, *Neverland*, (7) describing the accounts of alleged victims of child abuse at the hands of the late Michael Jackson. Finally, the third theme is reviews which describe media that identify creative forensic themes within non-forensic content, such as reviews identifying ideas of patricide woven into the *Star Wars* series. These reviews can also be used

to help teach students and trainees about forensic psychiatry in a creative and interesting manner. (8)

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### Ethics

*continued from page 21*

chiatrists should employ to strive for objective truth-telling that could be interpreted as ways to avoid potential pitfalls related to unconscious biases:

"Psychiatrists practicing in a forensic role enhance the honesty and objectivity of their work by basing their forensic opinions, forensic reports and forensic testimony on all available data. They communicate the honesty of their work, efforts to attain objectivity, and the soundness of their clinical opinion, by distinguishing, to the extent possible, between verified and unverified information as well as among clinical 'facts,' 'inferences,' and 'impressions.'" (1)

Confirmation bias, or the tendency to search for, interpret, and favor information that affirms a particular hypothesis, is a serious landmine that threatens the objectivity of a forensic practitioner's work and the credibility of the entire profession. *AAPL Guidelines* recognize this problem and suggest the partial remedy of obtaining all the relevant information and performing due diligence to demarcate whether this information is

verified or not. That is, forensic psychiatrists should not stop prematurely, for whatever reason, in collecting additional evidence which may conflict with their initial hypothesis. (8)

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## AAPL Votes

*continued from page 16*

Dr. Martinez argued, made *Cruzan v. Director, Missouri Dept. of Health* the case with the greatest influence on the greatest number. His argument garnered the largest increase of the audience from the pre-debate to post-debate, 17%.

Depending on the particular strategy one uses to analyze the voting results, each participant was the most successful. But the real winners were the audience, who were treated to an educational and entertaining evening. And now the debate as to which is the most influential Landmark Case since *AAPL* was founded is finally settled. (8)

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## Steven A. Young, MD

*continued from page 8*

outreach, and provides crisis management to posts. Often medical officers are the initial responders in the wake of unexpected situations, both natural and man-made. Travel, email and videoconferencing are core elements of the practice model. Sometimes boundaries can be blurred during a crisis, as help can arrive in many forms and from both federal and private agencies. RMOP help “comes in many flavors,” but a core element is the “post visit” following a crisis. He has been asked to perform many non-physician duties that support an embassy’s goals, including supporting a presidential visit, speaking to a local school, and participating in a documentary about embassy life. Sometimes just knowing where the bathrooms are can make someone an important contributor!

Dr. Young chose the issue of family advocacy as an example of a forensic issue common to both DOS and private practitioners to illustrate the similarities of the issues we all face. DOS has a specific set of policies and procedures addressing the approach to these cases. These policies are available to the public (<https://fam.state.gov/fam/03fam/03fam1810.html>) and are very similar to those that inform stateside Department of Child and Family Services evaluations. Like domestic programs, the DOS version combines both medical and law enforcement components. All cases are reviewed at the Washington level and interventions can include local care, medical evacuation, and in rare cases, criminal prosecution through the Department of Justice.

Dr. Young described a “typical day” and said that it often included a variety of both clinical and administrative tasks. Patient care is always job number one, but for an RMOP that can mean a mixture of telemedicine, email, phone calls, and in-person visits. Internet-based tools like online/mail order pharmacy programs allow more efficient care even in very austere settings. As the sole mental health

providers in their regions, RMOP’s plan future post visits and coordinate with Washington on various issues including emergent situations both at the individual patient and embassy-wide level. When an acute problem emerges – anything from earthquakes to terrorist attacks – the RMOP is a key source of information on the ground for decision makers in Washington. Their unique knowledge of their region and the individuals at each embassy put them in the best position to both offer care and coordinate additional resources that may arrive as a crisis unfolds.

Dr. Young also discussed the difficulty of balancing patient needs with the needs of the organization. At times, the needs of the patient, the embassy community, and/or Washington do not completely align. In this sense, forensic psychiatric skills become very valuable, as most forensically-trained practitioners have some degree of training and experience in scenarios where there are competing needs. Unexpected problems can arise. Dr. Young provided a particularly poignant example of an embassy being evacuated and employees refusing to leave without their pets. The RMOP had to negotiate with the families and the Air Force to come to some middle ground to allow the evacuation to succeed. Embassies are small communities, and like many small-town psychiatrists, RMOPs can find themselves facing the occupational hazards of being somewhat ostracized and lonely. Embassy social events can become mine fields if unhappy or very sensitive patients are also in attendance.

In conclusion, Dr. Young offered that, “*a career in foreign service presents many challenges and opportunities. The dual agency role is a constant tightrope. Creative solutions to finding care are often a must. Forensic psychiatric issues arise frequently but are not necessarily identified as such. A forensic background can be very useful in many situations in terms of assisting both patients and leaders with a structure to think about complex problems.*”

After a standing ovation, Dr. Young respectfully answered several questions, some of which were politically charged due to concerns about the ever-evolving American political situation. He pointed out that the Department of State has existed since the time of Thomas Jefferson, and that employees do their best to serve the American people regardless of political affiliation, and will always continue to do so. ☺

### NCCHC Board Elects New Officers and Names New CEO

Juvenile health care expert **Robert (Robby) Morris, MD, CCHP-P**, was elected as new chair of the NCCHC Board on October 13. Dr. Morris is professor emeritus at the UCLA Department of Pediatrics and represents the Society for Adolescent Health and Medicine on the Board.

The Board also elected:

- **Joseph Penn, MD, CCHP-MH**, University of Texas Medical Branch and UTMB Correctional Managed Care, as chair-elect.
- **Carolyn Sufrin, MD, PhD**, Johns Hopkins School of Medicine, as secretary
- **Nancy White, MA, LPC**, Truman Medical Center Behavioral Health, as treasurer

All terms run through October 12, 2020.

In addition, NCCHC veteran and former vice president of meetings and education **Deborah Ross, CCHP**, has been named CEO. Ross has expanded educational programming and outreach, leading NCCHC to be recognized as the premier educational provider in the field.

## Female Life Stages

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It is also increasingly important for forensic psychiatrists to competently assess and treat women in older adulthood. Menopause is defined by the World Health Organization as “the permanent cessation of menstruation resulting from the loss of ovarian follicular activity.” (18) Perimenopause is “the period immediately prior to the menopause (when endocrinological, biological, and clinical features of the approaching menopause commence) and the first year after menopause.” Up to 85 % of women experience symptoms during perimenopause. Symptoms include vasomotor symptoms (e.g. “hot flashes”), irritability, decreased libido, and vaginal dryness. The treatment of anxiety and depression during this period consists primarily of SSRIs and SNRIs. The Harvard Study of Moods and Cycles found that perimenopausal women had twice the risk of a first major depressive episode (19). Hormone replacement therapy has been helpful, particularly for vasomotor symptoms; however, it is important to weigh the risks and benefits carefully.

It is critically important for forensic psychiatrists to understand the unique treatment needs of women in correctional and state hospital settings. Assessment and care should be trauma-informed and should take into account the patient’s unique history, medical conditions, preferences, and goals. Forensic psychiatrists should also advocate for humane conditions in correctional facilities including (when appropriate) contact with family and children, appropriate medical care, and policies that limit intrusive searches by male officers to emergency situations (20). ☞

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## Powell

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criteria and implementation, they generally take the approach of treatment over punishment.

In summary, over the past half-century, society and the criminal justice system’s views on addiction and volition have swung between addiction as “choice” and “disease.” Though a movement toward decriminalization and treatment has taken shape, there continues to be a debate on addiction, intoxication, and criminal responsibility. Forensic mental health professionals must remain aware of this ongoing debate, and of jurisdictional differences. ☞

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## Physician Advocates

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“doing,” but also typically include training sessions and education about health policy issues.

- 5) **Encourage membership and involvement in local, state, and national professional organizations:** It can be helpful for faculty to foster the connections between a trainee and those who are active in professional organizations. Trainees can sit on committees, which is an excellent opportunity to learn and network. Being involved also opens the door for trainees to be exposed to a community that develops bills, provides testimony about mental health law, and writes amicus briefs, amongst other activities.
- 6) **Encourage trainees to meet with their legislators:** It is easy to look online to find the name of one’s local state senator or representative. Though it may seem intimidating at first, legislators are happy to meet with constituents to discuss issues pertinent to the region they represent. Meetings can be set up locally with legislators when they are in town. Forming such relationships provides an opportunity to serve as a resource in the future when pertinent issues arise.
- 7) **Teach trainees to be mindful of potential risks:** Health policy advocacy is satisfying work but physicians must keep in mind that the time they spend will not be compensated. Further, if a physician publically states their opinion on certain issues, this could be perceived as a potential bias of the physician and may be used in cross-examination in a courtroom situation. Additionally, it is important to educate trainees that when they partici-

pate in health policy advocacy they are representing their own opinion and not the organization by which they are employed. A psychiatrist must not appear as if they are speaking on behalf of their institution, unless they have been given express permission to do so.

Overall, health policy advocacy allows psychiatrists to go beyond the individual patient, instilling health in the profession as well as to larger groups of individuals with mental illness. Psychiatrists can use their knowledge to give a voice and fight for positive change for vulnerable and underrepresented people with mental illness in our communities. Health policy advocacy allows psychiatrists to invoke positive change beyond our limited geographic reach. With all of these benefits in mind, I think with fostered interest during training we can engender a notable increase in forensically trained psychiatrists participating in local, state, and national advocacy efforts. It is important that we teach trainees that we can all make a difference, we just have to start. ☯

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## School Violence

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the 13-year-old girl considering ending her life due to online bullying, it is important to consider how cyberbullying extends the reach of school bullying beyond school grounds, making it widespread, rapid, and often permanent. When it comes to individuals perpetrating online bullying and harassment, child forensic psychiatrists are increasingly asked to assess youth who get into legal trouble for engaging in digital dating abuse, accessing child or underage pornography, or the relatively common phenomenon of “sexting.” Understanding new media and technology can help to prevent future harm, particularly when physicians begin counseling youth and their families on appropriate and inappropriate digital media use.

School violence is a problem that is broad in scope despite the rarer instances that garner much attention in the media. Mental health professionals play a critical role in keeping our schools safe by assisting school administrators, teachers, law enforcement and courts using evidence-based practices to address and prevent future violence. ☯

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## 2019 Presidential Address

*continued from page 12*

plore forensic psychiatry and to gauge forensic interest. Dr. Frierson stated, “My recommendation is that AAPL must continue to oppose changes in general training that would impinge on the time devoted to forensic training of general residents and that could hinder the development of resident interest in forensic psychiatry. We must be vigilant to new proposals so that we can respond if needed... When I talk about professional advocacy that is what I mean.”

Challenge #4 pertains to producing quality forensic psychiatrists. Many programs may not adequately prepare their graduates for independent practice. In some instances, graduates have never performed core forensic evaluations. Since ACGME requires procedural proficiency in criminal responsibility evaluations, Dr. Frierson urged the identification of the core skills and competencies that forensic psychiatrists are expected to possess and perform so that judges and attorneys know what to expect when hiring forensic psychiatrists.

Finally, Dr. Frierson presented Challenge #5, regarding the best way to assess the quality and competen-

### SEEKING PSYCHIATRISTS AND PSYCHIATRY FELLOWS TO PARTICIPATE IN A RESEARCH SURVEY

Clinical psychology doctoral candidate is conducting research regarding clinician decision-making in Sexually Violent Predator (SVP) evaluations. Experience with SVP evaluations is not necessary in order to participate.

The study should take approximately 10 minutes to complete. Participants may enter a drawing to win one of ten \$100 Visa gift cards.

To participate in the study, please access the link below:  
[https://iup.co1.qualtrics.com/jfe/form/SV\\_ct0ZjoseYrZnQ0d](https://iup.co1.qualtrics.com/jfe/form/SV_ct0ZjoseYrZnQ0d)

Please contact Victoria Hauth at [bdxv@iup.edu](mailto:bdxv@iup.edu) with any problems accessing the study or if you have questions regarding the research. This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the protections of human subjects (phone 724-357-7730).

Thank you for your help,  
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cy of forensic psychiatry graduates. Although fellows are adequately prepared to pass the forensic specialty board examination, we do not know how that ability correlates to the ability to adequately perform forensic evaluations, write forensic reports, or provide expert testimony. Dr. Frierson contemplated alternative ways of measuring graduates' competencies, including peer review of forensic

reports, review of testimony, and/or hypothetical vignettes to assess a candidate's ability to identify missing key information needed to form a forensic opinion.

In closing, Dr. Frierson emphasized that moving forward over the next 50 years, “AAPL should continue to honor the vision of its founding members: to foster the provision of quality education in forensic psychiatry. ☞

## MUSE & VIEWS

### Snitches in the White House

- In 1992, President George H.W. Bush became concerned about the weight of his dog, Ranger, who often received treats while living in the White House. To combat this problem, President Bush sent a memo to all White House staff informing them not to provide any treats to Ranger. The memo also stated, “All Civilians and Kids are specifically instructed to ‘rat’ on anyone seen feeding Ranger.”

[https://www.cracked.com/article\\_26803\\_5-huh-white-house-facts-history-class-never-mentioned.html](https://www.cracked.com/article_26803_5-huh-white-house-facts-history-class-never-mentioned.html)

Submitted by Ryan Wagoner, MD

## 2020 Rappoport Fellowship Competition

The American Academy of Psychiatry and the Law is pleased to announce the 33rd Annual Rappoport Fellowship competition. Named in honor of AAPL's founding president, Jonas R. Rappoport, MD, the fellowships offer an opportunity for outstanding residents with interests in psychiatry and the law to develop their knowledge and skills.

Winners must attend the Annual Meeting and Forensic Psychiatry Review Course, in order to win the award, short of extenuating circumstances of which AAPL is notified in advance.

The meeting will be held in Chicago, IL from October 19-21, 2020. Immediately prior to the Annual Meeting, Fellows will also attend AAPL's Forensic Psychiatry Review Course, an intensive, comprehensive overview of psychiatry and law. At the Annual Meeting, Fellows are encouraged to attend the many excellent educational sessions, and to meet with AAPL preceptors, who can assist them in exploring interests in psychiatry and the law. Travel, lodging, and educational expenses are included in the fellowship award, and a per diem will be paid to cover meals and other expenses.

Residents who are currently PGY-3 in a general program, or PGY-4 in a child or geriatric subspecialty training program and who will begin their final year of training in July 2020, are eligible. Canadian PGY-5 general psychiatry residents and Canadian PGY-6 child residents are eligible. We will accept two nominations from each residency program. Please contact the AAPL Executive Office for more information or visit our website at [www.aapl.org](http://www.aapl.org).

## UC DAVIS SCHOOL OF MEDICINE

### DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

*Health Sciences Assistant/Associate Clinical Professor – Division of Psychiatry and the Law* to serve part time as supervising and teaching attendings of forensic psychiatry fellows, general psychiatry residents, and medical students who provide care for individuals in general population and on the inpatient psychiatry unit. The applicant(s) will direct care to individuals who are in jail custody and provide training to non-psychiatric mental health professionals through the onsite didactic lecture series. As a faculty member of the Division of Psychiatry and the Law, the applicant (s) will be provided at least 20% time to engage in forensic psychiatric evaluations with administrative support provided for case management and billing. The applicant (s) will provide direct supervision on forensic psychiatry fellows' cases and will be encouraged to join the forensic psychiatry fellowship training program as a didactic instructor. Applicant(s) have opportunities to engage in research, scholarly, or creative activities derived from and in support of their clinical teaching, professional and service activities. Requirements include a medical degree, board certification in general psychiatry, a California Medical license (or eligibility for licensure in the State of California) in addition to teaching and supervisory experience for residents, fellows, and medical students. Completion of ACGME Forensic Psychiatry Fellowship and Forensic Psychiatry Board Certification are preferable. Experience supervising child psychiatry residents/fellows, general psychiatry residents, and medical students is preferred.

Applications should be submitted by January 10, 2020 for initial consideration. However, the position will remain open until June 30, 2020 or until filled. Qualified applicants should upload a Letter of Interest, Curriculum Vitae, Statement of Teaching, along with contact information for 3 to 5 references online at: <https://recruit.ucdavis.edu/JPF03236>.



Oregon Health & Science University (OHSU) has an outstanding opportunity for a BC/BE forensic or general psychiatrist for clinical work, teaching, and research at Oregon State Hospital (OSH). We offer a unique 80/20 schedule which, upon approval, allows faculty one day per week to pursue academic projects. Opportunities include competency and insanity evaluations, court testimony, medical student and resident supervision, patient care, and, depending on skill and experience, a possible administrative position. The Oregon State Hospital is a robust institution with ample support from the state in its goal of providing high-quality care and forensic evaluations in a state of the art facility. The leadership teams of OHSU and OSH provide strong support for professional development and career advancement.

Academic rank begins at the level of assistant professor and may be higher depending on credentials and experience. We provide competitive pay and benefits, which may be substantially supplemented with voluntary call at OSH's twin campuses.

We invite your interest in this unique and rewarding opportunity.

If you would like more information, please contact Maya Lopez, M.D. We look forward to hearing from you.

Maya Lopez, M.D., Administrative Chief, Oregon State Hospital  
[lopezst@ohsu.edu](mailto:lopezst@ohsu.edu)



**AAPL Newsletter**  
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