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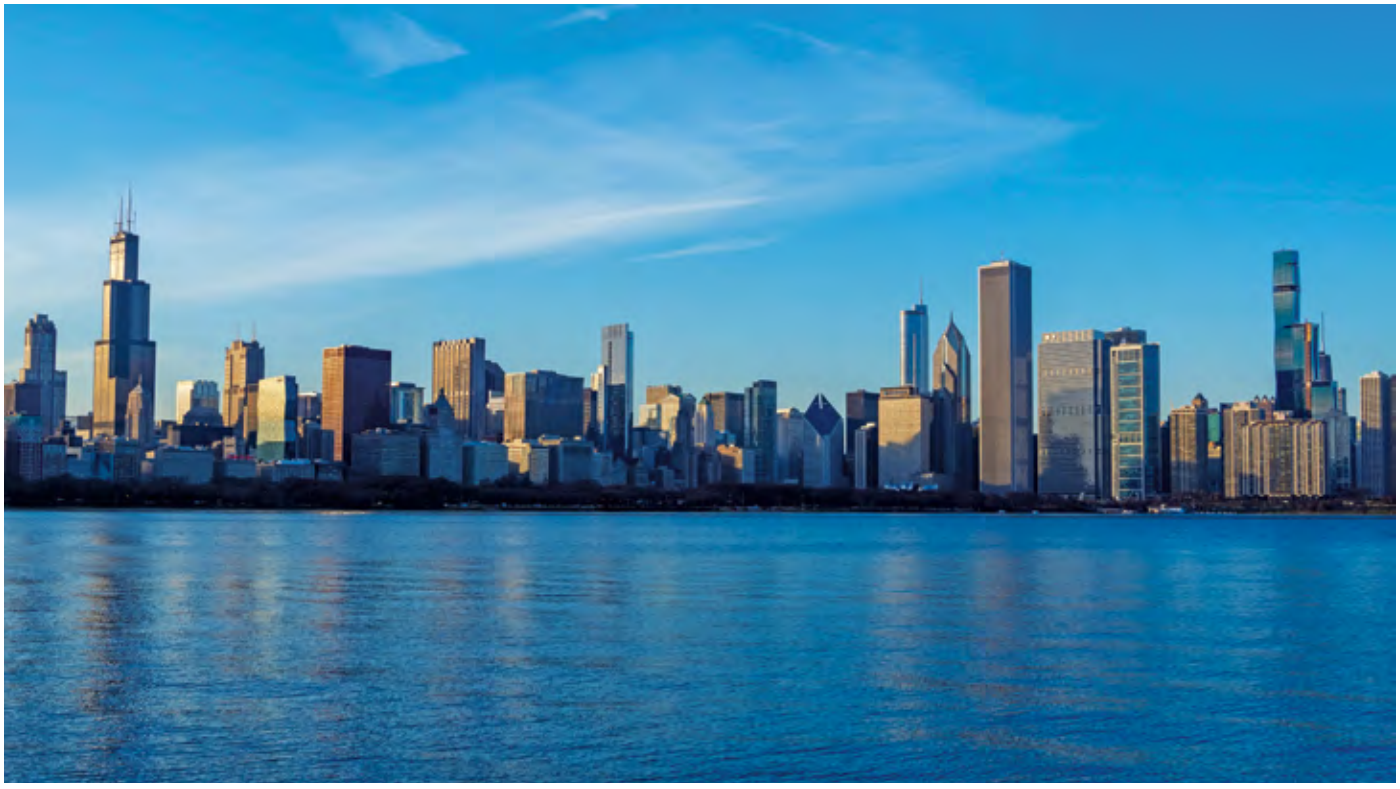
54th Annual Meeting: Balance

Melissa Spanggaard, DO and Jungjin Kim, MD
Program Co-Chairs



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The 54th Annual Meeting of the American Academy of Psychiatry and the Law is once again returning to the Windy City, Chicago, on October 19th-22nd, 2023. President James Knoll's theme for the Annual Meeting is *Balance*. In his President's Column in the Winter 2023 issue of this newsletter, Dr. Knoll outlined his rationale for choosing this oft-overlooked value as the central theme as follows:

> "Balance is an understated value with multiple connotations including stability, as well as a means of discerning and judging. Balanced judgment requires an awareness of differing viewpoints while maintaining objective rationality. AAPL has stressed the virtue of balance in the preamble of our ethical guidelines, noting the importance of balancing competing obligations to individual and society. The forensic psychiatrist confronts balance routinely and in a variety of areas. In expert work, thoroughness must be balanced with conciseness. In daily work, personal life must be balanced with career… I propose adaptation and stability may be promoted via the use of teamwork, technology, and returning to a balancing touchstone when necessary."

Dr. Knoll elaborated on the importance of teamwork, touchstones, and the need to search for balance as we strive to thoughtfully and meaningfully respond to our rapidly changing socio-cultural environment. To that end, we sought the wisdom and experience of three exceptional minds as our distinguished Luncheon speakers: Dr. Park E. Dietz, Steven R. Conlon, and Dr. Raymond F. Patterson. We believe these speakers not only represent excellence in their fields, but they are also enduring models of balance in their careers.

Dr. Park Dietz is a past president

(continued on page 2)

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COVER ARTICLE

54th Annual Meeting

continued from page 1

of AAPL and a pioneer in the field of forensic psychiatry. Over his distinguished career, he has consulted or testified in some of the highest profile US criminal cases. Dr. Dietz has authored hundreds of articles on topics relevant to forensic psychiatry. He is the founder of the Threat Assessment Group, Inc. (TAG), which specializes in analyzing and managing threatening behavior and communications.

Steven Conlon is a seasoned veteran of criminal behavior analysis. He has devoted over 45 years in law enforcement and is currently an Instructor at the FBI Behavior Analysis Unit at Quantico, Virginia. This is an elite group within the FBI that studies and consults with other agencies on violent, sometimes perplexing crimes. He will take us through an enthralling journey of a wide array of thought-provoking and occasionally strange and disturbing cases that have influenced the modern conception of behavioral analysis.

Dr. Raymond Patterson is a celebrated forensic psychiatrist with some 40 years of experience in the field. He has been able to achieve an impressive balance between consultative forensic expert work and being a leader in forensic and correctional healthcare. He has devoted much of his time and great skill to "combating the negative effects on individuals experiencing extended stays in prisons and forensic psychiatric facilities." (1) He has served in many forensic and correctional leadership positions in large forensic systems. Dr. Patterson has been a consultant to the U. S. Secret Service, the U. S. Marshal Service, the District of Columbia Police, Baltimore City Police, and the US Capitol Police. One of his enduring missions has been to advocate for equitable access to medical and psychiatric treatment.

In addition to these distinguished speakers, we will have a wide array of exciting and educational panels and presentations. The submissions for this meeting have been coming in fast and in record numbers. We hope the various threads of the selected talks will converge into the central theme of balance and our organizational mission of truth-seeking. The co-chairs are very grateful for the Program Committee's hard work in helping determine which submissions will be accepted. Please do not be discouraged or take it personally if your submission is not selected this year, and consider making another submission next year. Please also be aware that upon the submitting author's request, the Program Committee's grades and comments will be provided.

Chicago is an exciting town with excellent food, architecture, art, history, and much else to experience. We look forward to seeing you there!

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Analysis of Motive in Forensic Psychiatry

James L. Knoll, IV, MD

Introduction

On what basis can we infer mental states? (1) The profundity of this question took up permanent residence in my mind beginning in my early training in forensic psychiatry. To date, there is a paucity of research and guidelines for inferring a defendant's mental state for the purposes of a forensic psychiatric evaluation. In dissent in *Kahler v. Kansas*, Justice Stephen Breyer wrote: "mental illness typically does not deprive individuals of the ability to form intent. Rather, it affects their *motivations* for forming such intent." (emphasis added) (2) The courts often depend upon forensic psychiatrists to analyze and testify about motive in a manner that is ethical, reliable and cognizant of limitations. Motive focuses on why a person engages in criminal conduct, and is distinct from intent, which focuses on a specific state of mind required for liability. Motive is a key component of affirmative legal defenses and has been a traditional consideration at sentencing. It plays an important role in multiple disciplines relevant to forensic psychiatry including law, criminology, psychology, and philosophy. Because evidence of motive often provides the basis for inferring a requisite state of mind, it is necessary to adopt a methodology for motive analysis that is reliable and objective.

Understanding Motive

Jurists as far back as Bracton believed that a finding of "bad motive" was essential for criminal liability. (3) A simple definition of motive is: the cause that moves people to induce a certain action. (4) Motive derives from the Latin word *motivum*, meaning "moving cause" – that which moves a person to commit a certain act. (5) The Greek origin derives from the word *moveo*, meaning "that which moves." (6) Thus, from ancient times, "motive" denotes the dynamic factor that encourages the individual to behave in a way that satisfies a specific need. (7) In criminal investigation, motive is a key element used to classify and analyze crimes. (8) From a psychological perspective, motive is the impetus giving rise to purposeful behavior. (9) Motives can be thought of as arising from a combination of beliefs and desires. When a desire exists along with the belief that a certain action will satisfy that desire, an action-desire is said to arise. (10)

"Motive focuses on why a person engages in criminal conduct, and is distinct from intent, which focuses on a specific state of mind required for liability."

The philosopher David Hume believed that motivation consisted of two elements – passion and reason – which are roughly comparable to desire and belief. In other words, "passions drive people," and reason steers the "driving force of the passions." (11) Consideration of Hume's desire-belief theory of motivation is a helpful starting point for the analysis of motive in forensic psychiatry. Desires may be affected by psychotic symptoms such as delusions. For example, in 1800, James Hadfield attempted to assassinate King George III. (12) Hadfield's desire was to precipitate the second coming of Christ. His belief was that he would bring about his own judicial execution. Thus, motivating desires and beliefs depend upon sensory input and cognitive processing, both of which may be impaired by hallucinations, delusions, and disorganized thinking.

Upon considering the criminology literature, detectives conducting homicide investigations rely heavily on motive for providing a context for why the murder occurred. Motive is established through careful analysis of objective facts such as crime scene evidence, witness testimony, victim characteristics and situational circumstances of the offense. (13) In US criminal law, there is no requirement to prove motive to reach a verdict. However, motive may be shown by the prosecution to prove that a defendant had a plausible reason to commit the crime. Motive is distinct from intent in criminal law. The traditional legal distinction between the two is that motive is *why* defendants act, and intent is whether defendants wanted to act and what they wanted to do. (14) Intent is defined as a determination to perform a particular act for a specific reason. (15) Thus, intent is a conscious objective or purpose, and in criminal law is synonymous with *mens rea*.

It has been argued that motive is not necessarily a different mental state from intent but can be conceptualized as a sub-type of intent. (16) In this manner, motive is the "ulterior" intention, or the intention behind the intentional act. When one acts with a motive, one has the belief and desire to further some end. (17) The rationality of a defendant's motive becomes crucial in the eyes of the fact finder. (18) Jurors are more likely to perceive defendants as sane when the prosecution presents evidence of a strong, reasonable motive. (19) In contrast, evidence of an irrational or

(continued on page 20)

Physician Non-Compete Agreements

Jeffrey S. Janofsky, MD

As a forensic psychiatrist I am frequently asked by about-to-graduate trainees and in-practice psychiatrists for advice on how to deal with employment contracts. My initial suggestion is to seek counsel from an attorney who is expert in employment law in the state where the physician will be employed. I also recommend that the psychiatrist be especially careful about non-compete clauses that may be embedded in a long employment contract.

A physician non-compete agreement prohibits a physician from practicing medicine within a certain geographic area for a certain time period after leaving their current position. They may be included in a physician's initial employment contract or may be added as a new requirement to maintain employment. The alleged goal of these agreements by employers of physicians is to protect the time and resources invested in developing the physician, as well as building a patient base.

However, non-compete agreements also limit individual physicians' ability to negotiate for increased pay. Non-compete agreements may also limit career mobility and may lead to physicians feeling trapped in their current positions, which can be detrimental to their job satisfaction and overall well-being.

Non-compete agreements may be anti-competitive and could lead to higher healthcare costs. By restricting competition among physicians, healthcare organizations may be able to charge higher prices for their services, which can be detrimental to patients who are already struggling to afford care.

The specific terms of a non-compete agreement vary depending on state law. Some agreements may prohibit a physician from practicing within a specific radius of their former employer, while others may restrict them from practicing in the same city or state. The duration of the non-compete agreement also varies, from six months to two years.

Physician non-compete agreements have become a contentious issue in the healthcare industry, with some states taking steps to limit or ban their use. California, North Dakota and Oklahoma ban non-compete agreements generally. Colorado, Massachusetts, New Hampshire, Rhode Island and New Mexico have made physician non-compete agreements non-enforceable. (1)

"A physician non-compete agreement prohibits a physician from practicing medicine within a certain geographic area for a certain time period after leaving their current position."

Other states have passed statutes that do not ban physician non-compete agreements but attempt to balance the interests of employed physician vs. the organizations they join. (1)

In a letter to the Federal Trade Commission (FTC) on February 7th, 2020 the American Medical Association (AMA) took the position that AMA's CJA opinion 11.2.3.1 on Restrictive covenants is, "consistent with the majority of states where courts enforce post-employment non-competition agreements in physician contracts so long as those agreements protect a legitimate business interest, are reasonable with respect to duration and geography, and are not otherwise against public policy, of which patient choice may be a consideration in some jurisdictions. (1) The AMA noted that it has "a large and diverse membership" including employed physicians as well as physician practice owners or managers who may have varying perspectives. The AMA emphasized that if an employer of a physician uses a non-compete agreement, it must be for the employer's legitimate business interest. Thus, the AMA did not recommend that the FTC use its rulemaking with respect to non-compete agreements in physician employment arrangements.[1] The AMA does state that physicians in training should not be asked to sign non-compete agreements as a condition of entry into a residency or fellowship program. (2)

In contrast to the AMA's position, The American Bar Association has long taken the position that it is unethical for attorneys to enter into non-compete agreements. (3)

The American College of Emergency Physicians (ACEP) has been a leading physician professional organization lobbying against non-compete agreements. As I write this, the ACEP is responding to the proposed regulations in part by gathering input from its physician members on how non-compete agreements have affected physician practice. (4)

The APA does not have a position statement or resource document on psychiatrist non-compete agreements. The Opinions of the APA Ethics Committee does contain a statement which emphasizes that concerns about patient solicitation "cannot supersede the continuity of appropriate and adequate patient care. (5)

In July 2021, the White House issued an executive order that directed the FTC to develop new rules to limit

(continued on page 21)

Look Before You Leap

Joe Simpson, MD, PhD

When forensic psychiatrists graduate from training and start practicing, they encounter new types of cases and situations that they were not exposed to during fellowship. Starting out, it is natural to feel a sense of pressure or urgency to not say no to business, and a desire to please the attorney or other client, in order to preserve potential future opportunities. However, there are times when accepting a case is more trouble than it's worth. In this issue's Ask-the-Experts column, Drs. Kaye and Glancy provide a fascinating discussion of the ways in which bias, positive or negative, can behoove us to decline a case. As they point out, it is wise to think in advance about the types of cases one does not want to get involved with.

Every forensic psychiatrist should reflect on the types of work they are and are not willing to do. There may be whole categories of cases that you do not have an interest in, or where you realize you would not be objective. Or perhaps you doubt whether the task requested is a suitable use of forensic psychiatric expertise. Some examples follow.

Defense attorneys may ask a psychiatric expert to testify regarding the mental condition of a witness in a criminal case, or a plaintiff making an accusation in, for example, a harassment case. (I am not referring to cases where the plaintiff is suing for damages on the basis of psychiatric injury; in such cases the nature, origin and causality of the alleged psychiatric diagnosis are proper subjects of inquiry.) In the type of case I have in mind, the goal of the defense is to impugn the credibility of someone slated to testify based on their psychiatric condition, whether it be a substance use disorder, personality disorder, or psychosis. In crude terms, the message they want to convey to the finder of fact is something along the lines of, "You can't believe what that methamphetamine addict says he saw at the time of the crime; he's out of touch with reality." Personally, I have always declined this type of case, as being outside what I think is suitable for forensic expert testimony. But certainly, others might disagree.

Another example from the criminal sphere is working with *pro per* (also known as *pro se*) defendants. If you accept such an appointment, there is typically not an attorney involved. You will end up either working with a court-appointed investigator, or else directly with –and for – the person whom you have been hired to evaluate. This is a very difficult situation, for multiple logistical and ethical reasons which I won't flesh out here. The easiest solution is to simply not get involved with *pro per* defendants. But if every psychiatrist were to take that stance, it is hard to avoid the conclusion that some of those defendants would be deprived of the opportunity to proffer legitimate and valid expert testimony critical to their defense.

A third example is when the defense wants to put forth an unusual or unorthodox argument. Without going into detail, a defense lawyer once asked me to work on a murder case where the defense's theory did not include a DSM-recognized diagnosis. I was aware of an expert in town who specialized in the type of defense being contemplated. When I asked the attorney why he wasn't hiring that expert, he replied that prosecutors had figured out how to counter that expert now, so he wanted someone new. This was another red flag telling me that if I took the case I would be getting into some ethically murky waters, so I declined. It smacked too much of gamesmanship for me to feel comfortable.

Finally, turning to the civil forensic realm, there are times when one's decision about a case hinges on information not known until after the case has been accepted. Back when smartphones and social media were starting to explode in popularity in the latter part of the 2000s, I accepted a fitness-for-duty case in which the evaluee was described as having a depressive illness. However, when I contacted him, it was immediately clear that he had some type of delusional process. He directed me to videos he had posted online, consisting of him in a mockup of a TV studio, auditioning for a role as a news anchor or host, in which he espoused a conspiracy theory. The case was not as had been advertised, and I had no interest in being incorporated into this man's delusions as one of the evildoers keeping the truth from being revealed, or being mentioned by name in his online rants. So, I withdrew; as forensic experts, we are under no obligation to see every case through to its conclusion regardless of the potential personal or professional risks.

In conclusion, it is prudent to think beforehand about the scenarios that would lead you to decline a case. And, if things take an unexpected turn after you accept, the best option may be to terminate your involvement in order to minimize your risks.

Ask the Experts

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

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

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

Q: Can you discuss counter-transference and forensic evaluations?

A. Glancy:

Joe, a 63-year-old man, tells you, in his heavily accented English, how he worked on a construction site for 45 years, and every day he came home, and his wife tormented him, belittled him, and verbally abused him. As he tells the story, you cannot help but feel sorry for him. He then tells you about the day that he came home and decided he had had enough, decapitating his wife and setting fire to the house. Your emotions significantly change as he tells you in detail about this horrible event.

It has been nearly 40 years since Alan Stone, who sadly died recently, challenged forensic psychiatry, arguing that forensic practice struggles to straddle two ethical systems, which is damning. (1) He noted that as physicians, if we empathize with the patient, we may twist justice or distort the truth; on the other hand, if we serve the needs of the justice system, we may harm the patient. Paul Appelbaum proposed to clean the slate from the ethics of therapeutic medicine and offered that truth-telling and respect for persons are sufficient to keep our primary duty to justice or a third party in check. (2) Ken Appelbaum suggested using what he called "forensic empathy." (3)

With my colleagues at the University of Toronto, we proposed introducing the concept of detached concern, as described by Halpern, for use in forensic psychiatry. (4) We argued that this concept allows a forensic psychiatrist to search for truth without the over-identification and impaired judgement that can result.

"...if the forensic psychiatrist hears the "elevator summary" of the case and recoils in disgust and anger, they should consider whether it is ethical for them to take the case."

In the case of Joe above, it can be seen that initially, perhaps, a positive countertransference could affect the objectivity of the forensic psychiatrist. Later in the interview, as one perhaps recoils in horror, negative countertransference may affect the search for the truth. For the purposes of this article, I will assume that negative or positive countertransference may result in bias. As far as I know, this is an untested but intuitive hypothesis. Nevertheless, being aware of and measuring the level of detached concern may preserve the forensic psychiatrist's assessment role, which requires striving for objectivity and honesty.

This problem should dictate whether a forensic psychiatrist takes the case at the initial entry point. For example, if the forensic psychiatrist hears the "elevator summary" of the case and recoils in disgust and anger, they should consider whether it is ethical for them to take the case. On the other hand, and perhaps this is a little more contentious, if the forensic psychiatrist feels that they *must* help to get this person acquitted, they should also think long and hard about whether to take the case.

A. Kaye:

Without getting bogged down in the exact definition of countertransference (it's doubtful that two analysts would ever agree to the same definition), let me approach this question as: "How do I deal with the feelings I have toward a particular evaluee/case?" Obviously, these feelings could have either a positive or negative valence; both warrant recognition and management.

It is perfectly normal to have feelings about a case. These usually begin as soon as the first contact is made with the referring party. In some instances, you may be so affected as to desire a certain case because of possible personal gain (e.g.: it's a high-profile case and it will make you famous) or your own opinion about the topic (e.g.: death sentence) is such that you want to further your cause/political desire to change the law through participation in the litigation.

Both of these create potential minefields. Other common "hot zones" are child sexual abuse or the risk of siding with one spouse in a divorce/custody battle. Some of these topics are significant enough to cause the forensic psychiatrist to refuse the case outright. I know of two forensic psychiatrists who have sadly experienced the suicide of a child, so they won't take med-mal cases involving suicide. The bottom line: if you know you have a bias that is going to influence

(continued on page 7)

Ask the Experts

continued from page 6

your opinion, it's best not to take the case in the first place.

There is almost no forensic matter that doesn't involve the risk of countertransference affecting one's opinion. I try to begin the analysis by asking myself is it the person, what they did, or something about the legal system itself that is causing my reaction? The latter is often a neglected topic, but as an example, I turn down most family court work as I think that trying to solve interpersonal relationship problems via litigation is rarely the best approach. In my many years of working in the system, it seems to me that rarely does anyone "win," especially the children. If my feelings about the issue itself (usually an especially heinous criminal behavior) would impair my ability to be impartial in my assessment, I decline the case. I stopped doing capital cases for personal reasons.

I don't usually develop any feelings about the person until I have seen them face-to-face. Most evaluees don't elicit much in the way of personal feelings in me, but it does happen occasionally. It is usually related to my perception of the person's limited capacity for empathy or obvious malingering. I manage my feelings much as I do in my clinical work, by remaining neutral and being careful to not share. Remember though, positive feelings are just as problematic as negative feelings, and often harder to identify. If you "like" the person and "hope" they get their disability approved, that should be a red flag.

Recently, I did an evaluation in a criminal case where I thought the charges, while appropriate, carried a significant mandatory minimum sentence that was out of proportion to the actual risk posed by the defendant. But, I also really disliked the defendant, despite sympathizing with the behavior (to which they fully admitted). I decided to seek consultation from a trusted colleague. Their feedback was very helpful. My colleague told me they were surprised that I was so sympathetic to the defendant, knowing my own personal feelings about the criminal behavior and other views shared by the defendant. That feedback confirmed for me that I had managed to not allow my negative feelings about the person to taint my opinion about the criminal behavior itself, and made writing my report much easier.

"There is almost no forensic matter that doesn't involve the risk of countertransference affecting one's opinion. I try to begin the analysis by asking myself is it the person, what they did, or something about the legal system itself that is causing my reaction?"

Take Home Points:

The AAPL Ethics Code discusses the need to strive for objectivity and impartiality. Awareness of one's own feelings about the topics we address and toward the people we evaluate is key in working to the ethical standard to which we are pledged. Seeking collegial consultation is always an option and often very helpful.

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Seeing Red

Stephen Herman, MD

A matador's small red cape is called the *muleta*. His larger cape is the *capote*. The *capote* has magenta on one side and gold or blue on the other. An estimated 250,000 bulls are killed yearly in bullfights in Spain, France, Portugal, Mexico, Colombia, Venezuela, Peru and Ecuador. (1)

Prior to meeting the matador, the bull is stressed by transport to the ring. Picadors on horseback use spiked lances to repeatedly stab the bull in the neck. The lances tear the bull's muscles and tendons. Sometimes, this additional stress causes internal bleeding.

The matador waves his red cape with menace. But things are not what they seem. It is the waving of the capes that anger the bulls, for the bulls are colorblind!

What does this have to do with "red flag laws?" These laws are hoped to neutralize shooters before they act. It is as if venom were removed from the fangs of a rattlesnake. The kindly snake warns, but if unheeded, it pounces. So, the theory goes, take away someone's guns *before* they do damage.

By convention, red means STOP. Red flag laws have been passed in jurisdictions across the United States. In 2014, the FBI published *A Study of Active Shooter Incidents in the United States Between 2000 and 2013.* (2) Findings included:

- The trend over the study period showed a steady rise. In the first half of the years studied, the average annual number of victims was 6.4, but that average rose in the second half of the study to 16.4, an average of more than one incident per month.
- Of the 160 incidents studied, 64 (40.0%) would have met the criteria to fall under the federal statute passed in 2012 which defines mass killing as three or more killed in a single incident. Of the 64, 39 of these mass killings occurred within the final 7 years studied.
- Study results also indicate that, of the 11 defined location categories, the majority of incidents – 45.6% of the 160 – occurred in an environment related to commerce. The second most common incident locations were in educational environments (24.4%), and the study results established that some of these incidents involved some of the highest casualty numbers.
- Study results provided added clarity on instances where law enforcement appeared to be most at risk…though law enforcement responded to a large number of school incidents, no law enforcement officers were killed or wounded when responding to a school incident. However, in 45 of the 160 incidents where law enforcement did engage a shooter, law enforcement suffered casualties in 21 (46.7%) of the incidents, resulting in 9 officers killed and 28 wounded.
- The study did identify some shooter characteristics. In all but 2 of the incidents, the shooter chose to act alone. Only 6 female shooters were identified.
- 12 of 14 shooters in high school shootings were students at the schools, and 5 of the 6 shooters at middle schools were students at the schools.

The constitutionality of red flag laws has been debated. (3, 4) Many legislators believe these laws do not have to involve people who are mentally ill or have a criminal record.

The problem is, on what basis are the guns removed? Who decides? Is it a father or mother, mental health professional, next-door neighbor, follower of social media? If the person is a mental health professional, what training has she/he received? Is the person a psychiatrist or other medical doctor, nurse practitioner, clinical social worker, licensed associate counselor, behavioral technician, school guidance counselor, life coach?

Could Sandy Hook have been prevented? Adam Lanza shot and killed his mother, who tolerated his increasingly bizarre behavior. Then he went to his former school, initiating his killing spree. The school was later purposely destroyed by the town. Could anyone have predicted that a six-year-old boy in Newport News, Virginia would shoot his teacher? Should parents or guardians be arrested for failing to lock away guns and ammunition?

The purpose of this column is to raise questions. The answers, to paraphrase Bob Dylan "are blowin' in the wind."

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Gender Dysphoria, Forensic Psychiatry, and the Right to Treatment

Richard Seeber, MD

Since 2020, legislation which would restrict access to gender-affirming medical care for youth, and in some cases, young adults, has been proposed in a majority of US states. While many of these legislative battles about youths' access to gender-affirming care have been well-covered in the press, academic medical journals, and on social media, comparatively less has been published regarding transgender inmates' access to gender-affirming care.

An estimated 6000 transgender and gender-diverse people are incarcerated in state and federal prisons in the United States. (1) Transgender and gender-diverse people are incarcerated at a significantly higher rate than the general population, with approximately one in six transgender people being incarcerated in their lifetime. (2) Psychiatric disorders, particularly depressive and anxiety disorders, are also significantly more prevalent among transgender and gender-diverse people than in the general population. (3) Despite a small representation of the total incarcerated population in the US, transgender and gender-diverse inmates are an important population who deserve the attention of forensic psychiatrists.

Inmates rely upon the carceral system to provide evaluation, diagnosis, and treatment for medical concerns, from hypertension to colon cancer to major depressive disorder. Transgender and gender-diverse people may experience clinically significant distress concerning incongruence between their experienced gender and sex assigned at birth, social constraints placed on their expression of gender identity, and they may meet DSM-5-TR diagnostic criteria for gender dysphoria. As with other medical and psychiatric concerns, transgender and gender-diverse inmates depend on the prison system to access gender-affirming care for management of gender dysphoria. While the inclusion of gender dysphoria in the DSM may be viewed as pathologizing gender diversity, its inclusion carries an important implication for transgender inmates, as a medical diagnosis entails medical treatment.

In 2022, the World Professional Association for Transgender Health (WPATH) published its eighth edition of its standards of care (SOC-8) for the health care of transgender and gender-diverse people. These standards offer recommendations for the evaluation and treatment of transgender and gender-diverse people, including recommendations for the provision of gender-affirming hormone therapy and surgical treatment where indicated, safe housing within institutions without segregation or isolation, and the application of these standards of care regardless of whether a transgender person is incarcerated or not. (4) Of note, when considering professional standards for gender-affirming care, the courts have consistently looked to WPATH standards.

WPATH SOC-8 guidelines recommend that professionals evaluating transgender and gender-diverse people for physical gender-affirming treatment be licensed healthcare providers, ideally with at least a master's degree in their clinical field, with competence in the evaluation of gender dysphoria and incongruence, co-occurring mental health concerns, and capacity to consent for gender-affirming medical and surgical treatment. Should such care be requested, evaluators should recommend it only if the experience of incongruence between gender identity and physical characteristics is clinically significant and enduring. Evaluators should also consider whether other mental and physical health concerns are present that may impact either a person's experience of gender dysphoria or the treatment thereof. The role of social transition – living congruently with one's gender identity in social settings – should be discussed with the evaluee. In addition, any steps that were taken to socially transition, for instance by changing one's name, pronouns, or legal documents, may provide helpful collateral in supporting the duration of the distress caused by gender incongruence. Further, evaluators are advised to assess capacity to consent to any proposed physical treatment, including a discussion of the potential impact such treatment may have on their ability to reproduce. To this end, surgical procedures involving removal of gonads are advised only after a person has taken gender-affirming hormone replacement therapy for at least six months. (4)

Forensic psychiatrists who are knowledgeable about the evaluation and medical care of transgender and gender-diverse people would be uniquely qualified to conduct evaluations of mental health concerns, capacity to make medical decisions, and social factors impacting mental and physical health. In caring for gender-diverse people, research suggests physician education about gender-affirming care is important; however, recognition and reduction of physician implicit bias against transgender people is perhaps even more important than didactic knowledge. (5) Thus, forensic psychiatrists who conduct evaluations or offer treatment recommendations for transgender and gender-diverse people in forensic settings should not only be knowledge-

(continued on page 22)

Online Radicalization: What Forensic Psychiatrists Need to Know

Douglas Brennan, MD; Ariana Nesbit, MD; Ambar Faizi, MD
Early Career Development Committee

The shift to virtual workplaces and online school during the COVID-19 pandemic strengthened social media platforms. With quick dissemination of information, it became more difficult to properly vet posted information, and easier for groups who have historically operated on the fringe of society to promulgate their ideologies. Given this new landscape, many forensic psychiatrists will at some point evaluate or treat a person who is a member of an extremist group. Therefore, it is important to be able to recognize radicalization, know where to obtain information on radicalized groups, and understand how to approach risk assessment and management.

Radicalization is the process by which an individual is introduced to an ideological message and belief system that encourages movement away from mainstream beliefs toward extreme views. Radical interpretations of mainstream political or religious doctrines typically foster the promotion of violence to achieve social, religious, or political change. Online radicalization often occurs gradually, with repeated viewing of content which resonates with individuals who tend to align with extreme views. As individuals engross themselves in this content, they develop an altered sense of reality and extreme views no longer seem radical to them. With the development of relationships with others who support extremist views, they may begin separating from those who do not share their beliefs. Increased online interactions with like-minded individuals and mounting insularity from existing social contacts further perpetuates an inclination towards violence. Desensitization to violence, perceived or real grievances, feelings of superiority, moral outrage, and willingness to commit violence to further a cause may spur an individual from resonating with radicalized ideology to committing acts of violence.

> *"There are many biased and unreliable sources, and accessing this information is not without risk. Generally, psychiatrists should avoid sites that require an email address to access their material because it may be misused."*

If a forensic psychiatrist suspects their patient or evaluee may be part of an extremist group, they must determine whether the person's beliefs are delusions or extreme overvalued beliefs. The *DSM 5* specifies that delusional beliefs are "not ordinarily accepted" by an individual's culture or subculture. In contrast, an extreme overvalued belief is defined as "one that is shared by others in a person's cultural, religious, or subcultural group". (1) Extreme overvalued beliefs are held by members of many different subcultures, including religious extremists (e.g., Jihadists), cults, conspiracy theorists (e.g., QAnon), and others such as Sovereign Citizens and Incels. The distinction between delusional and extreme overvalued beliefs is important, because the management of the two differ. More specifically, while delusional beliefs may be treated with antipsychotic medications, extreme overvalued beliefs will not respond to medications but rather may be managed by strategies such as separation from others who share similar beliefs.(2) One clue that may help distinguish delusions from extreme overvalued beliefs is whether the patient is able to identify the origin of the belief. Unlike those with delusional beliefs, who are unlikely to provide a logical origin for the beliefs, those with extreme overvalued beliefs are usually able to point to a specific website or interaction with a group of people who share their beliefs. (3) Psychiatrists should also consider whether the patient is exhibiting other psychiatric symptoms (e.g., hallucinations) that would suggest that the belief is more likely to be psychotic.

Given that the appropriate management of an individual with an extreme belief depends on the etiology of the belief, psychiatrists should have general familiarity with the more common subcultures. However, psychiatrists may not know where to obtain reliable information on these groups. There are many biased and unreliable sources, and accessing this information is not without risk. Generally, psychiatrists should avoid sites that require an email address or other personal information to access their material because it may be misused. For example, the Oath Keepers group actively solicited prominent members of society—including physicians—in order to bolster their legitimacy. The Oath Keepers' membership list was recently leaked and was found to have 81 persons who are holding or running for elected office, 373 current law enforcement officers, and 117 active-duty military members. (4) In many cases, when contacted by the media, people on this list disavowed membership. (5) One county sheriff reported that he accessed the Oath Keeper website for educational purposes and merely provided his name, yet was later listed as a member, with potentially disastrous career conse-

(continued on page 23)

An Update on Gabapentin as a Potential Controlled Substance

Mihaela Kancheva, MD Candidate, UCF Class of 2024; Ryan C. W. Hall MD Psychopharmacology Committee

Gabapentin is an anticonvulsant medication first discovered in the 1970's, receiving FDA approval in 1993. (1, 2) It has been approved for postherpetic neuralgia, with expansion to some other neuropathic pain conditions (e.g., diabetic, fibromyalgia, spinal cord injuries), adjunct therapy for the treatment of partial seizures in epileptic patients, and moderate to severe restless leg syndrome. (1, 2) It is also used off-label for myriad other conditions, including general neuropathic pain; as a muscle relaxant; for postmenopausal hot flashes; essential tremors; anxiety; treatment-resistant depression and mood disorders; irritable bowel syndrome; alcohol withdrawal; postoperative analgesia; nausea and vomiting; migraine prophylaxis; headache; interstitial cystitis; social phobia; generalized tonic-clonic seizures; pruritus; insomnia; PTSD; and refractory chronic cough. (1)

Gabapentin passes through the blood-brain barrier to act directly on receptors. It is thought to limit release of excitatory neurotransmitters, and has an indirect effect on other neurotransmitters, such as serotonin. (1, 3) Despite its similar chemical structure to GABA, gabapentin is not believed to directly bind to GABA-, GABA-, or benzodiazepine receptors. (3) Instead, it is believed to function through voltage-gated calcium channels, especially alpha-2-delta-1 receptors, that inhibit excitatory neurotransmitter release at the presynaptic junction. (1, 3)

A 2019 AAPL Newsletter article noted growing concerns about gabapentin becoming a potential drug of abuse, especially when used in conjunction with opioid medications. (4) At the time, medical communities in the United Kingdom, Scandinavia, and Germany had raised questions regarding abuse potential, while in the United States, the state of Kentucky had placed the drug on the State Schedule V list in 2017. (4, 5) This started to place gabapentin on similar footing to the related medication pregabalin, which has always been in Schedule V. While literature was beginning to show abuse potential for gabapentin, this was limited mainly to patients with pre-existing substance abuse problems, with the risk in patients without a history of substance abuse still relatively low when used in a low-to-moderate dosing range. (4, 5)

Since 2019 there has been a growing trend to further control the prescription and distribution of gabapentin. By November 2020, seven states had made it a Schedule V drug (Alabama, Kentucky, Michigan, North Dakota, Tennessee, Virginia, and West Virginia), and 11 states and the District of Columbia require prescription monitoring for it (Connecticut, Indiana, Kansas, Massachusetts, Minnesota, Nebraska, New Jersey, Ohio, Oregon, Utah, and Wyoming). (5) Literature has further started to define a potential gabapentin abuse profile, such as using for euphoria (e.g., a "cocaine-like high", "marijuana-like high"), potentiating the intoxicating effects from opioids, as well as for the sedation or sleep effects. (2, 4, 5)

In February 2022, the nonprofit group Public Citizen filed a petition with the FDA and DEA to try to get gabapentin listed as a federal scheduled substance. (4) The petition is based on a study finding that gabapentin causes euphoria, which intensifies with increased dosage, and an FDA report warning of respiratory depression. (2, 6) Overall, the group argues that patients should have access to medications for pain control that do not put them at increased risk for substance abuse. Public Citizen also argues that gabapentin is frequently prescribed for multiple off-label uses, as noted above, which could further increase abuse potential. This is particularly relevant for psychiatry, since many of the off-label uses being investigated in the medical literature pertain to psychiatric conditions or symptoms (e.g., alcohol abuse, insomnia, anxiety, adjunct for mood disorder).

The most recent DEA fact sheet (3) for gabapentin raises concern for increasing adverse outcomes related to misuse. For example, the DEA fact sheet cited the 2020 annual National Poison Data Center (NPDC) report by the American Association of Poison Control Centers (AAPCC), which found a total of 135 fatalities involving gabapentin in 2020, compared to a combined total of 168 fatalities from 2012 to 2016. For 23 of those 135 fatalities, gabapentin was the primary cause of death. Although fatalities were increasing, the number of poison center calls from 2017 to 2020 were remaining relatively constant, at about 22,000 calls a year. There were 7,214 calls related to just gabapentin in 2020. For single-agent calls in 2020, gabapentin was associated with seven deaths, 178 outcomes classified as medically "major," 832 outcomes classified as "moderate," and 1,441 outcomes classified as minor. The DEA also noted that in a cohort of 503 adults who reported "nonmedical" use of pharmaceuticals in Kentucky, 15% reported that they use gabapentin to "get high". (3) This was a 165% increase from a sampling a year prior, and a 2,950% increase from a 2008 sampling. Therefore, it is not surprising that some substance abuse treatment centers are starting to include education related to gabapentin on their webpages and advertise

(continued on page 25)

Asylum Evaluations

Collin Shumate, MD; Robert Polo, MD; Matthew Motley, MD, PhD; Mikel Matto, MD; Michael MacIntyre, MD; Jacob Appel, MD, JD, MPH
AAPL Human Rights and National Security Committee

Thousands of refugees to the United States apply for asylum protection each year (1). Many have suffered severe physical or psychological abuse or torture and seek clinical evaluations to support their claims in court. Forensic psychiatrists possess distinctive skills that render them highly suited for conducting such evaluations and may wish to serve as *pro bono* evaluators (2, 3). This unique opportunity provides a needed service that can be personally and professionally rewarding.

A. Basics of Asylum

Individuals granted asylum are entitled to a number of benefits, including a path to citizenship and permission for immediate family members to migrate to the U.S. (4, 5). To qualify for asylum, an individual must meet the legal definition of a refugee as outlined in the United States Refugee Act of 1980. This involves establishing that the individual is unable or unwilling to return to their country of nationality due to "persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion." Applicants must apply from within the United States and within one year of arrival (2). Under a policy enacted in 2019, some candidates for asylum applying at ports of entry on the United States-Mexican border, but originating in third countries, may be required to remain in Mexico until their court hearings.

An individual may apply for asylum *affirmatively* if they are not actively engaged in removal proceedings. Affirmative proceedings are carried out in a non-adversarial setting where an asylum officer reviews the application, performs an interview, and makes a determination (2). If an individual is actively engaged in removal proceedings, they can seek asylum as a defense against removal, or *defensively*. This process takes place in immigration court. The government is represented by counsel who argue the case for removal, but asylum seekers often represent themselves as the administrative hearing does not entitle the asylum claimant to free representation (2).

B. Role for Psychiatrists

The opinion of a medical professional can play a significant role in strengthening a case for asylum (6). As medical professionals, psychiatrists can perform diagnostic evaluations and discuss the presence of mental illness and its relationship to the persecution or fear of persecution reported by the applicant. Even if an evaluation does not reveal a mental illness or mental health symptoms, an evaluator can educate the court on how a person's resilience, or the court's perceived lack of symptoms, does not necessarily negate a claim that abuse was experienced. A psychiatrist might also opine on how mental health symptoms impair an applicant's ability to adhere to the requirements of the asylum process, such as the requirement to apply within one year of arrival to the U.S. From a clinical perspective, a psychiatric evaluator may also provide guidance to the court to help the evaluee obtain appropriate care throughout the process.

Forensic training is not a requirement for conducting asylum evaluations, but forensic psychiatrists are particularly qualified to perform them. The evaluation itself is similar to many trauma-based forensic evaluations and the evaluator is expected to produce a report, typically in affidavit format. While the requirements of the evaluation and affidavit may vary based on the asylum clinic or the sponsoring agency, the forensic psychiatrist's experience and training make the process more intuitive. This general familiarity with the forensic setting may also make forensic psychiatrists more comfortable in providing opinions on other distinctive psychiatric-legal issues that can arise during the process.

C. Volunteering

Physicians interested in volunteering their services can sign up through Physicians for Human Rights (PHR), which matches attorneys seeking asylum evaluations for clients with qualified providers. PHR's Asylum Network includes student clinics at nineteen medical schools and also has close affiliations with a number of independent clinics (for a list of clinics, go to https://www.phrstudents.com/asylum-clinics). The Society of Asylum Medicine offers both resources and support to clinicians.

Prior to conducting an evaluation, volunteers generally attend a daylong training session to familiarize them with distinct aspects of the asylum evaluation and process. Notably, the interview can often be conducted via a virtual platform because it is a mental health assessment.

Several specific concerns should be addressed with an asylum clinic when one volunteers. First, depending on the site and the nature of the evaluation, the provider may be required to hold a license in the jurisdiction where the evaluation occurs. Second, whether or not one's malpractice insurance will cover such evaluations may depend upon the nature of the policy and the location of the evaluation. The answer to both of these questions may depend upon whether the state or the insurer defines these

(continued on page 24)

AAPL Practice Resource for Prescribing in Corrections

Anthony Tamburello, MD, CCHP
Correctional Forensic Psychiatry Committee

I am proud to be a part of AAPL, which has been my principal resource for education in forensic psychiatry, as well as the principal conduit for sharing what I have learned along the way. According to the AAPL website, listed goals for the organization include "facilitating the exchange of ideas and practical clinical knowledge;" "developing guidelines for education and training in forensic psychiatry;" and "stimulating research in forensic psychiatry." (1) Illustrative of these aims, AAPL has published numerous practice guidelines, including Ethics (2005); Competency to Stand Trial (2007); Forensic Evaluation of Psychiatric Disability (2008); the Insanity Defense (2014); and Forensic Assessment (2015). (2)

Since 2017, documents organized by AAPL to promote the goals of the organization are referred to as practice resources, which do not require compliance with Institute of Medicine standards for practice guidelines. While this change of labelling improves the agility of AAPL to provide these documents, it by no means compromises quality. Each practice resource is reviewed by the AAPL medical director, with opportunity for commentary from membership. Authorship is retained by the writers, which promotes engagement and participation by membership. AAPL practice resources include an update to Forensic Evaluation of Psychiatric Disability (2018); (3) an update to the Forensic Psychiatric Evaluation of Competence to Stand Trial (2018); (4) and Forensic Training in General Psychiatry Residency Programs (2019) (5), with more in the works.

The AAPL *Journal* published the original version of the Practice Resource for Prescribing in corrections as an online supplement in 2018. (6) The authors promoted this document via presentations at AAPL annual meetings and with the National Commission for Correctional Health Care (on which AAPL has representation). In 2019, Glancy and colleagues collaborated to publish a version of the document applicable to Canadian facilities. (7) It was exciting to see the reach of our work broaden.

The American Psychiatric Association suggests that for practice guidelines, anything older than five years is considered out of date. (8) We thus aspired to periodically update this document to reflect the current state of knowledge. I am not sure where the time went, but in the early days of the pandemic, Dr. Jason Ourada (one of the earliest supporters of this work in the Correctional Psychiatry Committee) reached out to ask about starting an update, with particular interest in developments in addiction medicine. He was right. Considerable new literature had emerged relevant to our work in carceral settings, and not only for the treatment of substance use disorders. Borrowing from one of my favorite movies, I reached out to the task force, declaring that it was time to "get the band back together."

Though some of our original group had retired, most were happy to return, including past AAPL presidents Drs. Jeffrey Metzner and Graham Glancy, systems experts Drs. Joseph Penn, Elizabeth Ford and Michael Champion, and Correctional Psychiatry Committee Chair Dr. Elizabeth Ferguson. Dr. Todd Tomita, a major contributor to the Canadian version, was a welcome addition to our task force, solidifying the international reach of our project.

We quickly learned that since our last comprehensive review of the literature (circa 2016), scientific progress in correctional medicine has been impressive. Every section from the original document required substantial revision, though readers will notice the most changes in the sections on emergency psychiatry, ADHD, and substance use disorders. To broaden the applicability of the document, sections are now included on medication management of gender dysphoria; the delivery of psychiatric care (including medication) in a public health emergency; pregnancy and lactation; and mental health watch in jails and prisons. Our revision uses person-centered language wherever practicable.

If you are reading this article, I hope that you are asking what this can do for you. The practice resource is quite literally a resource for you, a product of hundreds of hours of work, informed by many years of collective experience, at no cost to you. This was a labor of love. We did this not only to improve the quality of care for patients in jails and prisons, but also to inspire others to pursue work, teaching, and research in these settings.

To residency and fellowship directors: consider using the practice resource for recommended or required reading for those rotating through correctional settings. Encourage curiosity about questions not answered by the current state of the literature, which may lead to scholarly projects. To administrators and medical directors in jails and prisons: consider using the practice resource for orientation of new prescribers or for the ongoing training of current employees. To those interested in research: consider using this as a starting point to identify gaps in the knowledge base. To those currently working with incarcerated persons: download a copy and use it for a reference (as I do).

(continued on page 25)

From Mentee to Mentor: Lifelong Teaching Requires Lifelong Learning

Michael MacIntyre, MD; Deirdre O'Sullivan, MD; and Emily Keram, MD
Early Career Development Committee

The transition from trainee to attending is one of the more difficult along the lengthy path of a medical career. Though the stress of studying for board exams may be in the rearview mirror, one suddenly has ultimate responsibility for day-to-day decisions. After years of always having a supervisor or attending nearby, it is challenging to adjust to being in charge. This transition is made even more challenging when the next stage involves responsibility for the growth and development of others in the field. That is, becoming a mentor.

The word "mentor" derives from Homer's epic poem *Odyssey* (1) When Odysseus left for the Trojan War, he placed his son Telemachus in the care of his trusted friend Mentor. When Mentor wasn't completely up to the task, the Goddess Athena appeared in Mentor's likeness to provide Telemachus guidance instead. In its original meaning, the term "mentor" denotes two specific tasks: The first is to act *in loco parentis*. In the role, the mentor looks after their mentee's professional growth and well-being, while serving as a role model for essential functions, such as developing collegial relationships, hewing to professional ethics, and managing work-life balance. The second task is to impart the higher-level knowledge and skills of one's profession.

Some conceive of these functions as providing psychosocial support through role modeling and offering career support, including providing work that stimulates skill development. (2) Effective mentoring allows for deep, equitable learning with social transformative value. (3) Though not everyone may be interested in the role, there are significant benefits to becoming a mentor, including greater productivity, career satisfaction, and personal gratification. (4)

The reader may have some intuitive sense of what makes someone a good mentor. You might think of those in your life who have helped shape your own journey. You understand how they communicated with you, taught you, and motivated you. However, remarkably little research exists on what objectively defines good mentorship in a medical career, and almost nothing focuses on forensic psychiatry. Similarly, little work focuses on how to become a good mentor.

> *"Training rarely addresses becoming a mentor, and we are often left to simply mirror our own mentors for lack of other options...There is no one-size-fits-all approach to developing mentorship skills."*

Like any other step in the career pathway, we believe becoming a good mentor involves acquiring knowledge and skills that can be practiced and continuously honed. Unfortunately, mentorship is a journey often undertaken without much guidance. Although descriptions of the process of mentoring are available, less is written describing the knowledge and skills that make one effective in overseeing that process. (4) Training rarely addresses becoming a mentor, and we are often left to simply mirror our own mentors for lack of other options. Mentorship is full of challenges, such as addressing differences in backgrounds and experiences or navigating limitations and boundaries within a mentor-mentee relationship. There is no one-size-fits-all approach to developing mentorship skills. We offer the following advice to guide the transition to the mentorship role.

First, being a good mentor requires specifically paying attention to mentorship. You're already taking this step. Since mentorship concepts vary, it is essential to reflect on your personal approach to mentoring. Do not assume mentorship "just comes naturally" or simply develops with experience. Rather, reflect on your relationships with your mentors and your mentees. Consider what works, what doesn't, and adjust your approach as needed. Become familiar with theories of mentorship and incorporate them into your work with mentees.

Second, continue your relationship with your own mentors. Though the mentor-mentee relationship will evolve, you can turn to your mentors throughout your career. While your own mentors may help you with practice development or difficult cases, you can also discuss the challenges that arise with your own mentees. You may be pleasantly surprised when your mentor seeks your consultation and guidance in their relationships with new mentees as well.

Peer mentoring can be a remarkable tool. By regularly engaging with others at your career stage, a peer mentoring relationship may develop, allowing for formal or informal engagement, collaboration, communication, support, and risk-taking without any hierarchical element. (3) Your peers frequently have similar experiences and challenges, making it easier to relate to each other and have frank discussions about the profession, including the process of becoming a mentor.

You can expand your peer and mentor network by getting involved

(continued on page 21)

Contemporary Issues in Forensic Psychiatric Ethics and Dr. Alan Stone's Legacy

Ariana Nesbit, MD, MBE
Ethics Committee

AAPL Ethics Committee members have long heard from forensic psychiatry fellowship directors that they would benefit from additional resources for forensic psychiatric ethics training. To address this need, a workgroup of the AAPL Ethics Committee has been planning a project titled "Contemporary Issues in Forensic Psychiatric Ethics." We are excited to announce that this project recently received a grant from the AAPL Institute for Education and Research (AIER).

"Contemporary Issues in Forensic Psychiatric Ethics" has expanded beyond its initial vision as a resource for forensic trainees. The current aims and objective are (1) to provide an educational resource on forensic psychiatric ethics for not just forensic trainees but also other AAPL members; and (2) to record for posterity first-hand accounts of the thought leaders who have shaped the field of forensic psychiatric ethics, including discussions of their theoretical approaches in their own words. To accomplish these goals, current AAPL Ethics Committee members will interview approximately 15 experts in the field of forensic psychiatric ethics using a videoconferencing platform. The interviews will feature both thought leaders who shaped forensic psychiatric ethics from its origin to current times, as well as emerging thinkers who are at the cutting edge of the field and considering the most pressing current dilemmas. Each interview will last 10-15 minutes. The interviews will be consolidated into two or three longer videos to be published on the AAPL website available to all members.

Among the questions to be considered are:

1) What were the most significant ethical issues in forensics when you entered the field?
2) What ethical issue or issues have you been most actively involved in? How did you become interested in this topic?
3) What do you see as your contribution to forensic psychiatric ethics, and how is your role related to the work of others in the field?
4) What do you see as the challenges ahead for forensic practice from an ethical perspective?
5) In light of recent discussions about how we should go about trying to strive for objectivity in our work while practicing within an imperfect system, how would you apply your theories and experiences to the current struggle?
6) Given how the field has evolved over time, would you modify your theoretical approach?

AAPL Ethics Committee members will also provide an accompanying annotated bibliography with selected papers from each interviewee.

From the conception of the workgroup, we knew that one of the thought leaders we wanted to prioritize was Dr. Alan Stone. At AAPL's 1982 Annual Meeting he gave a keynote address entitled, "The Ethics of Forensic Psychiatry: A View from the Ivory Tower." This speech criticized forensic psychiatry's ethical standards, argued that psychiatry was burdened with hidden moral biases, and asserted that psychiatrists did not have a place in court (1). His address was later described in *JAAPL* as having "reverberations on a national scale" (2) and provoked many—including the forensic psychiatrists who will be interviewed by our workgroup—to react and provide legitimacy to forensic practice.

On January 22nd, 2022, the workgroup reached out to Dr. Stone, eager to start our interview series with him. Sadly, we found out the following week that we were too late: Dr. Stone passed away at his home in Cambridge, MA, on January 23rd of laryngeal cancer. To honor Dr. Stone's memory and lifetime contributions at the intersection of law, psychiatry, and morality, a panel was presented at AAPL's 53rd Annual Meeting in New Orleans titled, "Remembering Dr. Alan Stone and his Impact on Forensic Psychiatry." The panelists included Drs. Rebecca Brendel, Paul Appelbaum, Michael Norko, Richard Martinez, Howard Zonana, Robert Weinstock, and Phil Candilis – all of whom were influenced by Dr. Stone. Dr. Loren Roth provided a written statement. The panel was videotaped and will be posted on the AAPL website along with the other interviews and accompanying bibliography.

As discussed during this panel, and as we hope to demonstrate further with our interview project, forensic psychiatric ethics has evolved substantially over the past 40 years. Even Dr. Stone—one of the fiercest critics of forensic psychiatry—conceded in 2007 that forensic psychiatry's "ethical terrain…seems less a hazardous wasteland than it did 25 years ago". (3) As we move into a new era of social and racial influences to tackle, it is important for forensic psychiatrists be knowledgeable about their ethics. During this new era, it is critical that we understand our field's history and learn from our founders how our guid-

(continued on page 24)

American Medical Association (AMA) 2022 Interim Meeting Highlights

Jennifer Piel, MD, JD, Delegate; Patricia Westmoreland, MD, Alternate Delegate; Sarah Baker, MD, Young Physician Delegate; Kathryn Skimming, MD, Young Physician Delegate

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The Interim Meeting was held in-person November 12th through 15th in Honolulu. Delegates, alternate delegates, and guests debated issues including reproductive healthcare, daylight saving time (DST), treatment of transgender athletes, and firearm violence.

President Jack Resneck addressed the House of Delegates (HOD). Building on his speech at the Annual Meeting last June, he discussed the AMA's role in advocating for physicians experiencing burnout after the COVID-19 pandemic and in the midst of Medicare payment cuts and burdensome prior authorizations. He also called out the proliferation of medical misinformation and its impact on gender-affirming care and health equity.

In the aftermath of the Supreme Court Decision in *Dobbs v. Jackson Women's Health Organization*, Dr. Resneck also condemned the politicization of healthcare:

> I can't sugarcoat how dangerous it is for physicians to know that governors, legislators, state attorneys general, and law enforcement are all perched on their shoulders in exam rooms, waiting to judge decisions we make in partnership with our patients. It's getting mighty crowded with all those folks squeezing into our exam rooms! We didn't pick this political fight, but we will stand up for our patients, for the policies of this House, and for our profession.

Dr. Resneck stated that the AMA had filed briefs in a dozen state and federal courts, met with the White House, and testified before Congress on the risks to patients in the post-*Dobbs* era. He also emphasized the ruling's disproportionate impact on low-income and marginalized communities. Later in the meeting, delegates adopted policy opposing physicians being held criminally or civilly liable for pregnancy loss resulting from medically necessary care and advocated for greater insurance coverage for reproductive healthcare. They also voted to amend AMA ethics guidance to make clear that physicians must have latitude to treat patients, including abortion services, in accordance with professional judgment, even if the letter of the law limits needed care.

Dr. James Madara, Executive Vice President and CEO, discussed the AMA's 10-year strategic plan. He described the three strategic "arcs," chronic disease, professional development, and removing obstacles that interfere with patient care, and explained that each was driven by advocacy, equity, and innovation. He provided examples of work done in each. These included AMA Ed Hub, a collection of 9000 online educational resources; and Health2047, a Silicon-Valley-based innovation firm supporting startups with potential to improve the practice of medicine.

Health equity, especially in training, continued to be a major focus; the HOD passed policies to enable AMA to work with stakeholders to expand pathway programs to help students from historically marginalized racial and ethnic groups enter the medical field. They also supported policy that encouraged training programs, from medical schools through fellowship programs, to work towards more equitable and transparent recruitment and selection processes.

Other timely debates arose throughout the meeting. For example, in light of the Senate Passing a bill to make DST permanent, the House of Delegates heard testimony from sleep medicine experts about the cardiovascular morbidity associated with DST. These experts testified that Standard Time better aligns with our natural circadian rhythm. After hearing this testimony, the HOD voted to support the end of DST.

Many items discussed at the meeting were relevant to forensic psychiatry. After previously declaring firearm violence a public health crisis, the HOD voted to support research examining sources of illegally possessed firearms and methods to decrease their prevalence. Delegates also voted for the AMA to work with stakeholders to develop evidence-based recommendations to mitigate the effects of firearm-related violence.

The HOD also adopted policy opposing mandatory testing and specific hormonal guidelines for transgender athletes and affirmed that athletes should be able to compete in alignment with their gender identity. Delegates supported Medicare parity for mental health and substance use disorders and adopted policy to advocate for civil and criminal immunity for possession, distribution and use of drug paraphernalia intended for harm reduction. They also voted for the AMA to collaborate with the World Health Organization to implement destigmatizing terminology in ICD-10 and future ICD iterations.

Of particular interest to AAPL members, the HOD adopted policy to develop model legislation to establish a minimum age of 14 for juvenile justice jurisdiction in the United States. This is in alignment with the United

(continued on page 22)

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

Henry S. Levine, MD, and Joel M. Silberberg, MD

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

In the last issue of the Newsletter, Bill Reid and Carla Rodgers shared their reflections on retirement from forensic psychiatric practice in an article entitled "RIP: Rest in Peace or Retire in Productivity? Part I." In this second installment, we outline some of the more "brass tacks" aspects of reducing one's clinical or forensic practice, or simply retiring.

First, the "thinking about it" piece of the puzzle. The most important consideration for many of us who have thought about retirement is, "Do I dive in, or just dip my toes in the water?" Research on preservation of intellectual capacity as we age may be relevant. There is a growing body of evidence that maintaining cognitive stimulation, in addition to physical conditioning, contributes to ongoing mental and physical health.

Forensic psychiatrists are not immune to the reality that for most physicians, "medicine is a jealous mistress." Many of us have, by virtue of the demands of our practices, delayed or abandoned satisfying pursuits outside of medical practice. We may not have engaged with family and leisure activities as vigorously as did peers. To forensic psychiatrists in this category, "diving in" to retirement may be as shocking as a polar plunge.

In this instance the "toes in the water" approach may be preferred. Fortunately, forensic psychiatric practice allows many opportunities for part-time work. Private practitioners can be more selective about cases they take. Institutions that employ forensic psychiatrists, especially those with budgetary constraints, may welcome psychiatrists who switch from full- to part-time. Providing services in local jails, teaching at academic institutions, or doing "prn" evaluations for disability insurers or government programs may be options. Remaining active in professional organizations such as APA and AAPL is an additional way of maintaining personal and professional ties. At the same time, the "toe tester" can try out the temperature of long-fantasized-about but seldom-indulged-in activities: in our cases, studying a foreign language, cooking, building a family tree, and playing golf and bridge. Others we know have studied music, taught non-medical subjects at colleges, started new physical training routines, or started to meditate.

Some of us have, in parallel with their careers, remained active in non-medical worlds. For us, just diving into retirement may make more sense. We may be able to easily transition from forensic practice to spending more time and effort in "extracurricular" activities.

For both the toe testers and the divers, there are some considerations that merit attention, whether cutting back or cutting out of practice. Thinking about how to keep and maintain access to records of one's clinical practice, how long to keep staff beyond one's moving out of practice, considering state laws regarding maintenance of clinical, forensic, and business records, and making arrangements for collecting remaining receivables all merit deliberation. You may need to cancel your malpractice insurance but at the same time arrange for tail coverage. If you have a "practice will" (a document recommended by the APA and other professional associations), changing its provisions to fit your new status may be necessary. Consider notifying referral sources that you will be less available, or in the case of "divers," unavailable. We advise offering referrals, and younger AAPL members will welcome this gesture.

There is also a long list of agencies and organizations that you should notify when closing a medical practice, including state licensing authority, professional membership organizations, insurance carriers for your office policy, third-party payers, tax authorities, whoever maintains your website and online presence, answering service, post office, DEA, specialty board(s), and those from whom you lease offices and office machines.

Clinical patients merit special consideration and appropriate lead times to terminate and transition. Office staff may need emotional support for their transition out of your practice. Thought should be given to compensating unused sick time, vacation time, pensions, and other employment benefits. You'll need to deal with your telephone message, business credit cards, bank accounts, prescription pads, and any drug samples in your possession.

Given the complexity of issues in withdrawing from practice, consulting an attorney experienced in professionals' retirement considerations is often very helpful. The APA also has materials and guidance specific to closing a medical practice.

Dropping back from medical practice often engenders a variety of unexpected and negative emotions, such as loneliness, guilt, loss of self-esteem, and embarrassment. Talking with colleagues or a therapist can help ease the transition. In any event, whenever and however you make the transition, we wish you a happy swim.

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(continued on page 24)

VIRTUAL AAPL ("VAAPL") LAUNCHES!

Charles Scott, M.D.

As the first appointed Chair of the VAAPL committee, I wanted to encourage submissions for our new online platform. Below are some frequently asked questions about VAAPL and how to submit an abstract. VAAPL represents a terrific way for you to reach a large audience outside of the annual meeting. The VAAPL committee looks forward to receiving your submissions and seeing you online!

What is "VAAPL"?

VAAPL is a new AAPL Committee that was created in 2021 to help provide online learning for AAPL members during the course of the COVID-19 pandemic. AAPL has recognized that providing ongoing online education represents a positive membership benefit and will continue to provide online education on a continuing basis. The VAAPL Committee functions in a similar fashion as the AAPL Program Committee in soliciting, reviewing, approving, and scheduling educational activities. However, VAAPL functions to coordinate virtual educational experiences whereas the AAPL Program Committee functions to coordinate in-person educational experiences at the annual AAPL meeting.

How do I decide whether I should submit my educational proposal for the annual in-person meeting or for VAAPL?

Where you submit your educational proposal is a personal choice and there are benefits of presenting in either format. The in-person meeting may allow for more natural audience interaction whereas virtual presentations may allow a wider audience to attend as onsite registration and attendance is not required. If you submit to one format and your submission is not accepted, then please consider submitting your proposal to the other format. Fortunately, VAAPL will allow more of our members to present as there are a limited number of timeslots for presentations at the annual meeting. As many outstanding submissions are often not accepted for the annual meeting, VAAPL provides an additional avenue for members to educate other members.

Who decides what submissions for VAAPL are selected?

VAAPL consists of committee members appointed by the AAPL President. These committee members review all submissions in a process that parallels how the AAPL Program Committee reviews submissions for the annual meeting. Committee members independently rate each submission and work with the VAAPL Chair and Education Committee in deciding which submissions best meet the needs of AAPL members and address identified learning gaps.

What types of presentations are recommended for VAAPL?

VAAPL allows a wide variety of virtual presentations, ranging from panels, courses, town halls, and one-hour presentations from senior AAPL Members. Because workshops typically require significant interaction between the instructor and audience, this format may be less conducive for VAAPL presentations.

How often are VAAPL online presentations?

VAAPL is striving to have at least two online educational opportunities a month. Therefore, the VAAPL committee will solicit, review, and select online submissions on an ongoing basis.

Is there only one day of the week when VAAPL presentations can occur?

There is no particular date or time that a VAAPL presentation must occur. Because these presentations are virtual, we ask those who submit to consider dates and times that may work best for our membership across the various time zones.

Will I get CME's for attending a VAAPL presentation?

Yes. AAPL works with its accrediting organization to ensure its members receive CME's and VAAPL follows the same process for awarding CMEs as conducted for the educational presentations at the annual meeting.

How do I submit a VAAPL presentation?

Go to the AAPL website at aapl.org. Click on the tab titled "VAAPL" and follow the instructions.

NCCHC Releases New Edition of Standards for Health Services in Juvenile Facilities

(Chicago) – The 2022 edition of NCCHC's Standards for Health Services in Juvenile Detention and Confinement Facilities is now available. A Juvenile Standards Task Force, which included physicians, nurse practitioners, nurses, and mental health experts from around the nation, worked for more than 18 months on this update to the 2015 Juvenile Standards.

The revision brings the Juvenile Standards up to date with best practices for evidence-based care of youths, and also into alignment with NCCHC's 2018 Standards for Health Services in jails and prisons. "Not only does this revision reflect our current understanding of trauma-informed care, which is critical for supporting youths who are involved in the justice system, but it also acknowledges the disproportionate confinement of minority youth," says Joseph Penn, MD, CCHP-MH, chairman of the Juvenile Standards Task Force.

"Issues of special concern in juvenile correctional health care settings – such as self-injury, self-mutilative behaviors, and suicide attempts; LGBTQI youth; substance use; medicolegal issues such as use of restrictive housing, emergency psychotropic medication, and seclusion and restraint; cultural competency; ethical issues; and mandated reporting – receive attention in the standards."

The standards reflect new knowledge gained over the last seven years, especially in the areas of supporting youth with adverse childhood experiences (ACES), such as abuse, neglect, and trauma. Dr. Penn notes, "It is now widely accepted that kids and teens are not just small adults and need to be treated appropriately. In the right circumstances, juvenile detention is an opportunity for a good diagnostic evaluation in a safe environment and can be the beginning of effective therapies to help them avoid risky choices as teens and adults."

Dr. Penn recommends that any facility holding youth use the new Standards. "No matter where a youth is housed – jail, juvenile detention, or immigration detention – following NCCHC's standards will give appropriate guidance and avoid poor outcomes for staff and youth alike."

NCCHC Standards are a vital resource that provide the framework to ensure that systems, policies, and procedures are in place to produce the best and most effective outcomes. Compliance with these nationally recognized standards helps ensure that facilities provide constitutionally acceptable care and provides a pathway for continuous improvement.

NCCHC accreditation surveys of juvenile facilities will assess compliance with the new Juvenile Standards starting July 1, 2023. As of May 1, the Certified Correctional Health Professional (CCHP) exam will reference the 2022 juvenile health standards.

For more information about the standards, visit ncchc.org/juvenile-standards.

AAPL Awards Committee Seeks 2022 Nominations

The AAPL Awards Committee is interested in receiving nominations by June 1 for the following awards:

Red AAPL; Golden AAPL; Seymour Pollack Award; Amicus Award; and Howard V. Zonana, MD Best Teacher in Forensic Fellowship Award.

For descriptions of the awards, please go to aapl.org/awards. Send your nominations to Charles Scott, MD,Chair of the Awards committee at clscott@ucdavis.edu.

President's Column

continued from page 3

unreasonable motive increases the likelihood that jurors will see defendants as insane.

Motive was explicitly defined by the Missouri Court of Appeals in *State v. Willis*. (20) The case involved introducing evidence of a forged life insurance policy where the accused would obtain financial gain as a result of the death of the victim. The prosecution sought to introduce this evidence as relevant to the establishment of a motive. In *Willis*, the court defined motive as: "the moving course, the impulse, the desire that induces criminal action on the part of the accused." Motive is explicitly recognized in hate crimes, in that it is an element of the offense and must be proven to establish liability. (21) Concerns about identifying motives include obtaining sufficient evidence, the presence of mixed motives and the difficulty of determining a defendant's internal mental state. (22) Such concerns about the reliability of inquiries into motive may be mitigated by the fact that most standards do not require full excavation of all motives. Indeed, the "ability to focus the inquiry on a single motive streamlines hearings and simplifies jury instructions." (21)

Motive in Forensic Psychiatry

Motive may be relevant to multiple areas of forensic psychiatry, including the insanity defense, diminished capacity, diminished responsibility, psychological autopsies, psychological factors affecting sentencing, and threat assessments. The AAPL practice guideline for forensic psychiatric evaluation of defendants raising the insanity defense state that the forensic psychiatrist's testimony may "address the effects of the illness on behavior generally and on *motivations* other than the defendant's insanity." (emphasis added) (23) Colorado's insanity test states that a mental disease or defect must render the defendant "incapable of distinguishing right from wrong with respect to" the act, but that "care should be taken not to confuse such mental disease or defect with moral obliquity, mental depravity, or passion growing out of anger, revenge, hatred, or other motives." (24)

Research has suggested that defendants who commit homicides without apparent motive are more likely to be psychotic than defendants with clearly identifiable motives. (25) Case studies analyzing motiveless homicide and psychopathology have characterized offenders without motive as irrational, erratic and angry. (13) When offenders with psychosis do have motives, they are more likely to kill family members and have a motive of retaliating for a perceived wrong or injustice. (26) It is within a defendant's genuine delusions and the behavioral evidence created at the time of the offense that motives will be found. What is needed is a reliable method of analyzing the motivating delusional beliefs within the context of the behavioral evidence relevant to the offense. An approach that maximizes objectivity, reliability and acknowledgment of limitations would help standardize and improve the accuracy of motive and mental state determinations. Candeub (1) and Morse (27) suggest that logic, common sense, analysis of behavioral evidence and inference are critical tools for exploring motive.

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continued from page 20

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Medical Director

continued from page 4

the use of non-compete agreements. The order also encouraged the Department of Justice (DOJ) to challenge the use of non-compete agreements that are overly broad or unfair to workers. (6)

On January 5th, 2023, the FTC issued its Notice of Proposed Rulemaking that would prohibit all employers from imposing non-compete agreements on workers. The Biden Administration believes that non-compete agreements reduce worker's wages, exploit workers and hinder economic liberty. The proposed rule would require employers to rescind existing non-compete agreements. (7, 8)

In his February 2023 State of the Union address, President Biden highlighted the national problem with non-compete agreements by highlighting the Executive order stating, "We're banning those agreements, so companies have to compete for workers and pay them what they are worth." (9)

Banning non-compete agreements might become a game changer in medicine, allowing individual physicians more power to bargain with employers and more flexibility in changing jobs, while staying in the same community.

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Mentee to Mentor

continued from page 14

with committees at AAPL. This will allow you to interact with people in all stages of career development and be exposed to different styles of educating and mentoring.

Third, practice mentorship. Be proactive and choose to mentor. If you are at an academic center, make yourself available to medical students, residents, or fellows. Follow through on any offers and respond to those who seek your mentorship. Explore your mentee's unique personal career goals and look for opportunities to benefit these ambitions. If there is no easy access to trainees near you, AAPL has trainees of all levels looking for mentorship.

Finally, accept that mentoring involves constant self-assessment and improvement. No one will ever become the perfect mentor. Not every interaction with a trainee will lead to a lifelong, fulfilling mentor-mentee relationship, and not every mentor is the right fit for every mentee. However, each will be a new opportunity to help you better understand what works in your approach to mentoring and help you be more adaptable to various personalities and learning styles.

Caring about the quality of your mentorship already makes you qualified to become an excellent mentor. We hope our advice provides some guidance in this challenging and highly rewarding journey.

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Mentee to Mentor

continued from page 21

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AMA

continued from page 16

Nations' recommendation to increase the age from 12 to 14. The AMA also passed policy promoting that board certification processes should offer an independent, external assessment of knowledge and skills for both initial certification and recertification. Members of the psychiatry delegation testified that the ramifications of this new policy should be studied, as growing numbers of APA members are considering joining alternative board certification programs such as the National Board of Physicians and Surgeons, which would not meet the standards in this new AMA policy.

This meeting was Alternate Delegate Patricia Westmoreland's first meeting with the AAPL Delegation. The delegation also said goodbye to Jeff Akaka, former APA delegate to the AMA, and Louis Kraus, a delegate from the American Academy of Child and Adolescent Psychiatry and former Chair of the AMA's Council on Science and Public Health.

The AMA Annual Meeting is in June in Chicago. You can find more information on the actions of the House of Delegates at the 2022 Interim Meeting at https://www.ama-assn.org/about/house-delegates-hod.

Fellows' Corner

continued from page 9

able about gender-affirming medical care but also critically examine and challenge any implicit biases they might hold towards gender-diverse people.

Given the significant psychological benefits transgender and gender-diverse people derive from receiving gender-affirming care, WPATH guidelines recommend the provision of such care without delay where indicated. (4) Put differently, someone diagnosed with gender dysphoria who requests gender-affirming medical care should be granted access to treatment so long as they are able to provide informed consent. In cases where standard-of-care treatment for gender dysphoria is constrained, transgender inmates depend upon judicial recourse. Often, transgender inmates will seek relief from such limitations under the Eighth Amendment, citing their restriction from gender-affirming care as cruel and unusual punishment.

In *Estelle v. Gamble* (1976), the United States Supreme Court held that a treatment's deprivation must be "sufficiently harmful to evidence serious indifference to serious medical needs" to qualify as cruel and unusual punishment. Showing such indifference requires both:

1. A prisoner demonstrated a serious medical need and that the prison administered inadequate medical treatment; and
2. The prison was deliberately indifferent to the prisoner's demonstrated need.

A serious medical need may be shown by a physician diagnosing a medical concern requiring treatment. Inadequate medical treatment included treatment that is not "commensurate with modern medical science" and not "of a quality acceptable within prudent professional standards." Additionally, an inmate must show that the prison "knew of and consciously disregarded a substantial risk of serious harm to the inmate's health or safety". (6)

Over the past two decades, transgender and gender-diverse inmates have prevailed in securing gender-affirming medical care when the aforementioned two-pronged *Estelle* test was applied. For instance, in *Fields v. Smith*, a 2005 Wisconsin statute restricting state inmates from accessing gender-affirming care was ruled unconstitutional under the Eighth Amendment. (7) Cases involving an inmate's right to access gender-affirming surgery have been inconsistently decided, with some (e.g. *Kosilek v. Spencer)* being decided against the inmate, but others (e.g. *Norsworthy v. Beard*) being decided in favor of them.

Studies have demonstrated that gender-affirming hormone therapy (8) is associated with increased quality of life, decreased depression and anxiety, and that gender-affirming surgical treatment (9) is associated with decreased psychological distress, decreased nicotine use, and decreased suicidality. Given the benefits of providing gender-affirming care and risks of withholding it, forensic psychiatrists should outline both when providing opinions related to access to care. As with all forensic evaluations, the evaluator should consider alternative motivations to an individual's request for transgender treatment. These may include housing preferences, access to preferred canteen items, or a potential path to release as some institutions may not be equipped to meet the needs of a transgender individual. Additionally the distress experienced by a gender diverse individual may not be related to gender issues at all, but rather the result of other psychiatric disorders or environmental stressors. In conclusion, forensic opinions regarding the health

(continued on page 23)

Fellows' Corner

continued from page 22

of gender-diverse people should be rooted in evidence-based principles outlined by WPATH.

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Acknowledgement:

I thank Dr. Renee Sorrentino for her mentorship and thoughtful review of this submission.

Online Radicalization

continued from page 10

quences. (6)

Rather than rely on an Internet search engine's results, we recommend starting with these open-source websites that do not require a log-in:

US Government sites: FBI (https://www.fbi.gov/investigate/civil-rights/hate-crimes); Dept. of Justice (https://www.justice.gov/hatecrimes; https://www.justice.gov/hatecrimes/resources). Non-government site: Anti-Defamation League (https://www.adl.org/).

Research on the association between various extremist beliefs and violence is lacking due to the heterogenicity both between different extremist groups and different members within each subculture. Given this lack of research, it is difficult to identify specific risk factors for violence in this population. (7) However, acts of mass violence are often inspired by online communities, and perpetrators of mass violence often see themselves as "agent[s] to advance a particular cause or belief system". (8) There is also evidence that conspiracy theorizing is associated with an increased willingness to act violently, especially when the person is paranoid and/or angry. (9) Additional research into specific risk factors for violence in this population is necessary because general risk factors do not always apply to individuals who commit acts of mass violence. For example, mass shooters often do not have histories of past violence. (10) As we await such research, forensic psychiatrists should focus on general practices of violence risk assessment, including considering the magnitude and likelihood of future violence, as well as the imminence of the threat. During this assessment, the psychiatrist should keep in mind their local regulations regarding their duties to warn and protect. (7)

As part of the risk assessment, the psychiatrist should assess the individual's commitment to the belief and related subculture and how far down the pathway to violence they are. For example, have they casually researched the subculture and related beliefs online? Have they posted on relevant websites? Have they participated in protests or rallies? Have they started planning violence, or committed extremist belief-inspired crimes? (3) Psychiatrists should consider other general risk factors for violence and mass violence, especially dynamic factors such as substance use, fixation on feelings of injustice, social stressors, social isolation, anger, and access to weapons. (7, 10)

This article is meant to provide forensic psychiatrists with a starting point when they encounter a situation where extreme beliefs are espoused. However, it is important to acknowledge that, although some mental disorders may increase susceptibility to radicalizing influences, violent extremism is not itself a psychiatric condition. Some authors have argued that, although psychiatrists often are asked to participate in if not lead efforts at countering violent extremism, that this is the "psychiatrization" of what is really a "complex interplay of individual, social, and societal factors". (11)

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continued from page 23

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Contemporary Issues

continued from page 15

ing principles evolve as we reconsider our roles inside and outside the courtroom. The AAPL Ethics Committee would like to extend our sincere gratitude to the AIER Committee for their financial support of this important project.

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Asylum

continued from page 12

evaluations as providing medical care—which some do not. Finally, providers should clarify whether they will be expected to be available to appear in court to elaborate upon the findings in their affidavits and what such availability entails. For example, a provider physically unable to travel to court or who is uncomfortable with virtual testimony should inform the clinic of these limitations in advance so that expectations can be adjusted accordingly.

D. Conclusions

There is an increasing number of asylum evaluation clinics being developed across the country. This surge is accompanied by a continued demand for clinicians willing to provide *pro bono* evaluations. The forensic community is uniquely suited for this important and rewarding work. Forensic psychiatrists often find the process of writing reports much more intuitive and familiar than their non-forensic colleagues. Program directors or other educators may consider integrating asylum evaluations into their residency or fellowship curriculums, particularly if their institution has an associated asylum evaluation clinic. Many participants value the opportunity to impact the lives of asylum applicants so significantly through a very limited commitment of time and derive incredible satisfaction from advocating for this community of persecuted individuals in need.

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Gabapentin Update

continued from page 11

"Treatment for Neurontin Addiction". (7)

Although there is a movement for scheduling gabapentin, there has also been some pushback. Most notably, the American Medical Association (AMA) passed a resolution at its 2022 Annual Meeting entitled "Oppose Scheduling of Gabapentin D-120.927". (8) The resolution explicitly states the AMA's intent to "actively oppose" the placement of gabapentin in Schedule V, with an official letter sent to the Commissioner of the FDA. One of the concerns discussed at the meeting was that scheduling gabapentin may discourage the use of this relatively safe non-opioid treatment option for pain, and could indirectly result in more inappropriate or illicit substance use. The AMA also acknowledged that further study of off-label uses, risks, and benefits of gabapentin in both the general population and in people with substance use disorders is warranted.

As can be seen with this update, there has been a trend for gabapentin to be made a controlled substance. There is significant debate on the pros and cons. Given the general national concern over prescription drug misuse, there is likely going to be additional legislation and regulation of gabapentin, which could impact how this medication is used in the general population, as well as in forensic settings such as jail, prisons, and state hospitals.

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AAPL Practice

continued from page 13

I am very grateful to past and present co-authors for their generosity, AAPL medical director Dr. Jeffrey Janofsky for his thoughtful review, the AAPL members who took the time to review and comment on our draft, the AAPL Council who supported this project, and Dr. Michael Norko who saw this project through to publication. We certainly hope that the field will continue to progress, and that future versions will be needed and welcomed. I invite comments, questions, and suggestions.

The AAPL Practice Resource for Prescribing in Corrections (2022) may be found at: https://jaapl.org/content/50/4_Supplement/S1. (9)

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Deadline: June 1, 2023

ISAAC RAY AWARD

Description: The Isaac Ray Award, established in 1951, recognizes a person who has made outstanding contributions to forensic psychiatry or to the psychiatric aspects of jurisprudence. It is a joint award of the APA and the American Academy of Psychiatry and the Law that honors Isaac Ray, M.D., one of the original founders and the fourth president of the American Psychiatric Association.

Eligibility: Outstanding contributions to forensic psychiatry or to the psychiatric aspects of jurisprudence.

Nomination Requirements: Letter of nomination (sent with consent of candidate); nominee's CV; supplemental letter from a second nominator

Deadline: June 1, 2023

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One Regency Drive
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Joseph R. Simpson, MD, PhD, Editor