

AAPL Newsletter

American Academy of Psychiatry and the Law



Winter 2024 • Vol. 49, No. 1

2023 AAPL Presidential Address

James Knoll, IV, MD: Seeking Balance in Forensic Psychiatry: A Tale in Three Parts

By Britta K. Ostermeyer, MD, MBA, DFAPA



Dr. James Knoll, IV, MD is AAPL's 49th President. He is Professor and Director of Forensic Psychiatry at Upstate Medical University in Syracuse, New York. He also serves as Upstate's forensic psychiatry fellowship training director and clinical director of the Central New York Psychiatric Center. At the 2023 Annual Meeting, he was introduced by his former forensic psychiatry fellows Drs. Dileep Borra, Vanesa Disla de Jesus, and Annette Liem.

Dr. Knoll's presidential theme was "Balance." He dedicated his presentation to his past, present, and future forensic psychiatry fellows, as fellows represent the future of forensic psychiatry. He also acknowledged that we are all returning from a pandemic that has changed our lives, our society, and our ways of viewing the world.

Dr. Knoll said that "balance" represents an opportunity for us to steady our footing, to reaffirm AAPL's resilience and dedication and excellence. He reminded the audience that "AAPL has stressed the virtue of balance in its preamble to its ethical guidelines. The 2005 Ethics Guidelines state: "Psychiatrists in a forensic role are called upon to practice in a manner that balances competing duties to the individual and to society." Dr. Knoll reminded us that former AAPL President Graham Glancy spoke of balancing: work with personal life; being thorough with being concise; and exercising objectivity with being persuasive.

In Part 1 of his address, Dr. Knoll spoke about the Tree of Knowledge. AAPL was wisely named after the fruit of the Tree of Knowledge, as its

primary mission is education. Over the decades AAPL has pursued its educational mission with impressive results, "creating a reputation for scholarship, forensic legal analysis, and service to the legal system and other systems." Dr. Knoll opined, "I believe it is important for AAPL to maintain its reputation as an organization striving for reliable, objective assistance to the courts. Yet, I also believe there's an important place for advocacy when it's thoughtfully and effectively done. The challenge will be in deciding which advocacy efforts to support. In any event, I suggest proceeding with great caution and care, in contemplation and selflessness, and also above all, please preserve the roots and the balance."

Dr. Knoll encouraged us to balance AAPL's educational mission with research efforts and to support AAPL's Institute for Education and Research (AIER). He added that AAPL's profound, thoughtful, and balanced ethical guidelines have sustained the organization to this day. Dr. Knoll also remarked that once the AAPL Tree of Knowledge was cultivated and improved, it changed society's perception of correctional psychiatry and completely changed the landscape.

Dr. Knoll spoke in Part 2 about the importance of teamwork. He spoke about technology and the "big data explosion" in medicine. Quoting the 2011 Harvard Medical School commencement address by Dr. Atul Gawande, who stated that "medicine's complexity has exceeded our individual capability as doctors," and that the best solution was to engage in teamwork. Dr. Knoll pointed out that those working in forensic and correctional settings must have effective teamwork, such as multidisciplinary

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Manuscripts are invited for publication in the Newsletter. They should be submitted to the editor via email to NewsletterEditor@aapl.org

The Newsletter is published in Winter (deadline for submission is November 15), Spring (deadline March 1), and Fall (deadline July 1).

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PRESIDENTIAL ADDRESS

Presidential Address

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threat assessment teams. Teamwork is going to be critical to effectively adapt to the accelerated rate of change that is coming. Dr. Knoll made a pitch to employ more teamwork in particular in forensic fellowships. He pointed out that fellowships across the country can assist each other by offering their strengths to other fellowships and vice versa, with the goal of leading to a more balanced learning experience. This would not only improve American forensic psychiatry but also correctional care. We are supporting each other and encouraging each other to get better and become better at forensic analysis.

Dr. Knoll went on to speak about the concerns related to body cameras as used by law enforcement. While such technology attempts to bring transparency and to refute inaccurate accusations, he cautioned that observer's judgements still vary. Observers inject their own subjectivity into what they see. If the clips are isolated, that can create bias. Dr. Knoll also questioned the use of video surveillance in psychiatry, citing a recent paper by former AAPL President Paul Appelbaum. Dr. Appelbaum and colleagues pointed out there was no evidence suggesting that better safety is achieved by video surveillance in inpatient psychiatric units. Dr. Knoll speculated that in the future, surveillance would likely employ artificial intelligence (AI), and concerns about impositions on privacy would have to be addressed. Dr. Knoll then spoke about the balance of personal privacy versus community safety, and showed the audience videos of local news interviews, one of a person who was OK with losing privacy in the interest of community safety, and a second of a person opposed to it. Dr. Knoll then urged us at AAPL to study digital evidence.

In Part 3, Dr. Knoll shifted gears

and spoke of his concern about the potential death of civil discourse. He reminded us about the importance of maintaining civility, a form of goodness, with gracious respect, thoughtful relating, and an active interest in common ground. He stated, "It is my opinion with reasonable Presidential Certainty that AAPL should be a paragon of civil discourse!" Dr. Knoll remarked that civil discourse is exemplified already in the roots of the Tree of Knowledge. He quoted from the biography of Dr. Ray Patterson by former AAPL President Ezra Griffith, which states, "Patterson insists that the specialist must develop thoughtful interaction with others, respectful curiosity about others, and a distinctive professional style reflecting commitment to justice and fairness for all." Dr. Knoll added, "This civility is already in our roots. All we need do is grow and nourish it. Tend to it and cultivate it. I fully believe AAPL can do this and do it well."

Finally, Dr. Knoll ended by emphasizing, in particular to forensic fellows, that the future for forensic psychiatry looks good, and reiterated that we have to utilize more teamwork to increase our effectiveness with the big data explosion. ☯

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Forensic Treatment, Ethics and Administration

Charles C. Dike, MD



The light shines in the darkness, and the darkness has not overcome it.
John 1:5 (NIV)

The media, including television shows and the movies, have popularized the term forensic, the mention of which conjures up images of brilliant professionals being examined and cross-examined in the courtroom. This glamorized picture intrigues the lay public and is great advertisement for our subspecialty, although many confuse forensic pathology with psychiatry. The American Academy of Psychiatry and the Law (AAPL) defines forensic psychiatry as a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory, or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment. A casual read would lead the reader back to the courts...applying clinical expertise in legal contexts.

But forensic psychiatry extends well beyond that. An even more critical role than court room antics is providing treatment to psychiatrically ill individuals involved with the criminal justice system. Here, there are no cameras, no flash, and no pomp and pageantry. Only skilled—and overworked—mental health professionals working hard to alleviate the suffering of patients housed in the extreme environments that are Departments of Correction (DOC) and forensic hospitals, especially maximum-security units.

Forensic psychiatric hospitals or hospital units within a DOC are not

regular hospitals, as the careful, even obsessive attention to safety attests. Safety measures include screening by police, metal detectors, or security wands, strict policies regarding items or visitors allowed in, and (often escorted) movement through reinforced metal doors. Dress codes that discourage staff members from wearing neckties, scarfs or other clothing articles that could be re-purposed as strangulation materials further emphasize the extreme nature of the environment of care.

Patients housed therein are saddled with the triple stigma of mental illness, dangerousness, and crime. They are often isolated from or ostracized by the society, including close family members and friends. They have limited or no access to social media or the internet. In short, they are trapped in darkness caused by their mental illness and crime. Staff members and other patients become their only family. Therefore, positive interactions with staff members are crucial, as they can be life-restoring. Staff members can bring a ray of light and hope to these seemingly hopeless individuals, paralyzed by their condition and circumstances. At the risk of their own safety, staff members hold these patients by the hand and guide them, one small step at a time, out of darkness into light. They are, indeed, agents of positive change. Staff members achieve this through kind attention, supportive and other forms of psychotherapy, rehabilitation activities, medication management, and behavior management techniques. Many staff members have sustained serious injuries in this process, and many struggle with encroaching darkness of their own from working in these extreme environments. Yet, most return to work as soon as

they can, placing themselves at risk all over again. These are the unsung heroes of forensic psychiatry.

How can facility administrators and the public express gratitude to them? How can they ensure that enough light is infused into the staff members themselves to motivate them to do the same for patients? An alert, responsive, and supportive administration goes a long way. For starters, administrators can demonstrate to staff that they understand the challenges of working in these environments by encouraging, equipping, and empowering them as they undertake the onerous task of rehabilitating severely mentally ill patients. Other administrative actions include: advocacy for establishment of a trauma-sensitive environment of care; adequate staffing to prevent burnout; and encouragement of time off for refreshment and reinvigoration. A stressed and burned-out staff is irritable and less tolerant with patients. At the extreme end, this may lead to patient abuse, as such staff members are more likely to respond to patient agitation with seclusion and restraint or other punitive measures. Effective scheduled supervision and debriefing following major incidents provides an opportunity for administrators to check the “emotional temperature” of the unit and apply interventions to defuse tensions. Adequate compensation of staff members goes beyond financial remuneration to include opportunities for educational advancement and career mobility, and public recognition for work done.

In conclusion, treatment of patients to alleviate suffering and restore health is at the core of medical practice – the bedrock of what it means to be a physician. Medical and psychiatric ethics state that: *A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.* Interestingly, AAPL ethics guidelines make little mention of psychiatric

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Standing on the Shoulders of Giants

Debra Pinals, MD



These are my first words for my first Newsletter column as the new Medical Director for the American Academy of Psychiatry and the Law (AAPL). I am excited to have been given the opportunity to serve in this role, and am looking forward to getting to know more AAPL members and to being helpful to the current AAPL President, Dr. Charles Dike, and his successors. I am also eager to work with our incoming Executive Director Dana Cooper, as our esteemed outgoing Executive Director, Ms. Jackie Coleman, passes the baton. In order to properly begin with this responsibility, however, it is important for me to first acknowledge the people upon whose shoulders I stand. Drs. Jonas Rappeport, Howard Zonana, and Jeff Janofsky have helped shape the position of the medical director for AAPL, each putting in years of hard work, and providing their perspectives and unique qualities that helped support AAPL since its inception. Each of these forensic psychiatrists have been role models to me, individually and collectively reflecting the values embodied in making AAPL the proud educational organization it is today. As I think of what each of them taught me over the years, I am humbled to be able to similarly impact others within AAPL. With nearly 2000 members around the country, and a lively educational program both in person and now online, our work as a professional organization with an educational mission has so much to offer, and the potential to continue to grow.

For this first column, I wanted to share with the readership some of my background and some thoughts that I

shared with the Council when I was being considered for this position. By way of background and introduction for those who do not know me, I have worked for years in various leadership positions within AAPL, including President. During my presidential year I launched the Women of AAPL (WAAPL) gathering at the Annual Meeting, to give voice to many of our members who wanted to come together and support one another. I have participated in the development of practice resources both for AAPL and the APA, and was named to chair the re-drafting in 2005 of the still-current AAPL ethics guidelines.

“The role of leaders is to maintain and model the vision and provide direction to others, and I hope to nurture attention to diversity in all aspects of the work of the organization, and to foster a culture of welcomeness.”

I was responsible for initiating, along with a hard-working committee, the first Maintenance of Certification (MOC) activities for AAPL. In my non-AAPL life, I have worked as a treating psychiatrist and a forensic evaluator, and have also served in state government leadership roles and in leadership roles in other psychiatric organizations. My current duties as Senior Medical and Forensic Advisor and Editor-in-Chief for the National Association of State Mental Health Program Directors (NASMPHD), and in Michigan as the Medical Director for Behavioral Health and Forensic

Programs and the Director of the Program in Psychiatry, Law and Ethics at the University of Michigan Medical School where I am also Adjunct Professor of Psychiatry, give me a unique perspective about leadership, and opportunities for mentoring that comes from that perspective. With that in mind, I invite members, including our more junior members, to reach out and connect.

With regard to AAPL itself, in my work supporting the President, Executive Director and Council, I hope to help the organization: (1) maintain stability, national representation, and financial viability through AAPL's core educational mission as a central theme; (2) foster a welcoming environment and supportive professional network that utilizes concepts of radical inclusion and attention to diversity; and (3) support adaptation and new growth. I commented in my application for this role that it is critical to help foster our organizational relevance and thrive. To that end, AAPL's original mission of providing sound education continues to give it valence for the practice of forensic psychiatry. There is simply no other place to go for the quality, variety, and depth of educational offerings that AAPL offers to the field. AAPL also serves a critical role offering a supportive network for forensic psychiatrists around the country. This has always been a perk of membership that is embedded in the richness of the organization that I hope to continue to develop as the medical director.

The role of leaders is to maintain and model the vision and provide direction to others, and I hope to nurture attention to diversity in all aspects of the work of the organization, and to foster a culture of welcomeness. As I write these words, there is much strife around the world; divisions in politics; marginalization of communities; and too many people with mental illness under correctional supervision

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Another Year of Change

Joseph R. Simpson, MD, PhD



AAPL celebrated its 50th anniversary in 2019. At the time of that year's Annual Meeting in October, which was held in Baltimore, as it

has been every ten years to recognize the city where AAPL was founded, no one had any idea that just a few months later, the world would be forever changed by a once-in-a-century global pandemic. The devastating effects of COVID-19 on millions of people are so well-known as to not require repeating here. In addition to the immense tragedy of lives lost, the careers and daily practice of essentially all healthcare professionals (HCPs) of any description were changed profoundly. Clinical and forensic psychiatrists were no exception, and are among those whose work has changed the most. Doctors, nurses and other HCPs working in areas such as pre-hospital care, emergency departments, intensive care units or surgery by necessity still carry on much as they did before, but in the mental health field, there has been a tectonic shift in terms of new opportunities for evaluation and treatment at a distance.

AAPL responded to the pandemic and the explosion in virtual communications capabilities with Annual Meetings held remotely in 2020 and 2021, and with the creation of an on-line arm for education, Virtual AAPL or VAAPL. VAAPL is now poised to become not only a key source of revenue for AAPL, but also to significantly expand the reach of our organization's educational content, providing access to valuable forensic courses (and Continuing Medical Education credit) without learners having to wait for, and travel to, an Annual Meeting,

Review Course or Chapter Meeting.

In 2023 the theme of change continued for AAPL. AAPL's third Medical Director, Jeffrey Janofsky, stepped down after ten years of exemplary service and contributions. His replacement is Debra Pinals, who is well-known to most readers as one of our field's most influential and accomplished leaders. Both Drs. Janofsky and Pinals previously served as AAPL President, in 2007-8 and 2012-13, respectively (as did founding Medical Director Jonas Rapoport, who was the first AAPL President back in 1969, and the second Medical Director, Howard Zonana, AAPL President in 1992-1993.)

Adding to the institutional turnover, AAPL's Executive Director, Jackie Coleman, has retired after 25 years, having been involved with our organization for nearly half of its existence. Although she will be sorely missed, fortunately for Mike Norko, Editor of AAPL's *Journal*, and his team, Jackie will continue as Managing Editor of JAAPL. If you attended the 2023 Annual Meeting in Chicago and had the opportunity to meet the incoming Executive Director, Dana Cooper, I'm sure that his enthusiasm and energy were very evident to you. Finally, another person who has been pivotal for AAPL, Mike Deegan, will also lay

down his walkie-talkie after 25 years of playing a key role in organizing AAPL Annual Meetings, making sure that presenters and attendees had everything they needed to get the most out of the meetings.

Dr. Janofsky provided some concluding thoughts on his tenure in his report in the previous issue of the Newsletter. In the current issue, you will find Dr. Pinals' first Medical Director's Report, as well as reflections from Jackie Coleman and Mike Deegan. Also within these pages are some photographic mementos of the bittersweet AAPL 2023 Annual Meeting.

As the upheaval of COVID-19 recedes and the world of healthcare settles into its "new normal," AAPL has clearly demonstrated its resilience and adaptability. So, although transitions are always a challenge, it is abundantly clear that AAPL will not only survive but prosper. As an organization it has and will continue to lead the way for the field of forensic psychiatry, thanks to the tireless work of people like Jackie and Mike, as well as Dr. Janofsky, and all the Presidents, Medical Directors, Council Members, Committee Chairs, Review Course faculty, and "rank-and-file" members who have contributed in ways large and small to making AAPL both the educational wellspring and the professional home for forensic psychiatrists in North America and beyond. ☪



Outgoing Executive Director Jackie Coleman and Medical Director Jeff Janofsky hug as incoming Executive Director Dana Cooper and incoming AAPL President Charles Dike look on.

Ask the Experts

Neil S. Kaye, MD, DLFAPA

Graham Glancy, MB, ChB, FRC Psych, FRCP

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

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

Q: In what circumstances is it appropriate to meet with a defendant or a defendant's family if they request to debrief with you after the verdict in a criminal case, after being engaged as an expert witness for the defense?



A. Kaye:

A great question often requires the answer be yet another question. This really great question demands a plethora of follow-up questions.

A complete answer requires employing a variety of perspectives and Dr. Glancy and I will attempt to shine some light on a least a few of these. Some simple and obvious questions include: who hired you, what if any duty do you have to the evaluatee or to the retaining party, does feedback constitute a blurring of the boundary between forensic and clinical work, what is the purpose of providing feedback and how might it be used, why does this party want to know, who would pay for the time, could disclosure harm anyone else even if unintended, when in the evolution of the case the request is made, is an appeal planned, is the requesting party

happy/angry/surprised/disappointed by the verdict, are they praising or critical of your work/testimony, have they been involved in the process prior to the verdict, and does family or anyone else have a right to such an audience?

The questioner tells us she was a defense expert in a criminal case but we don't know the outcome or if there will be an appeal. We have no idea why the request is being made or what are the expectations of the requesting party or if they are prepared to hear what you have to say.

"...if you were to tell an evaluatee that they qualify for an insanity defense, the lawyer may be placed in a position where they are in conflict with the evaluatee, because they have a different plan, for instance accepting a plea deal for time served."

With the myriad opportunities for appeals in the justice system, it is highly likely that I would decline the request, as partaking would undoubtedly muddy the waters for appeals, and would clearly cause you to have to decline any work in an appellate matter, which could potentially be a disservice to the original retaining party and/or to the defendant.

As for a duty, I believe you have one duty to the retaining party, a second and different duty to the evaluatee, and a third and still different duty

to the justice system. Accepting a fourth and again different duty seems burdensome and unnecessary. It is not uncommon, especially in high-profile cases to get requests for interviews by media after a jury has ruled, but caution is advised. Material that has been disclosed is public and might be a topic of discussion, but not everything you know or have learned during a case is actually disclosed in the course of a trial/case, and extreme care is needed to not breach confidentiality.



A. Glancy:

This is a complicated question, requiring a complicated answer. First, there is the question whether

it is ethical to give feedback in a forensic assessment. Second, there is the problem of whether it is within your retainer to spend time giving this feedback. Third, giving feedback is not a unitary concept and this requires elucidation.

Brodsky and Goldenson (1) suggest that giving feedback is consistent with the aims of trauma-informed principles, which is becoming part of an evolving forensic psychology. They also argue that it is consistent with the aims of therapeutic jurisprudence, increasingly a factor in forensic psychology and psychiatry. Giving feedback would presumably help an evaluatee develop insight and improve their well-being. This would need to be balanced against maintaining honesty and objectivity, a governing ethics principle. Giving feedback, I would posit, could mean changing from an assessor to a treater in mid-stream. This may confuse the evaluatee, and put one in the position of "wearing two hats."

The second point to make is that arguably your client is the retaining lawyer, not the evaluatee. Following this line of thought any feedback,

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Ask the Experts

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therefore, should be given to the lawyer, not to the evaluatee. The lawyer, as they see fit, may pass on the feedback to the evaluatee. One problem that might arise is that they may not deliver this as a mental health professional would deliver feedback, perhaps causing a negative effect. Another problem to consider is whether the lawyer has paid you to spend the extra time with the evaluatee delivering feedback. They may well feel that if the evaluatee requires therapy this should be paid for in the normal manner, for instance by healthcare funding or insurance. The lawyer may well be within their rights to say that, since you had billed ten hours for this case, they will only pay you for nine hours, since the last hour was therapy, which they did not request or condone.

It is also possible that you could attenuate an evaluatee's expectations by giving unwanted feedback. For instance, if you were to tell an evaluatee that they qualify for an insanity defense, the lawyer may be placed in a position where they are in conflict with the evaluatee, because they have a different plan, for instance accepting a plea deal for time served. In some circumstances, it may be best to allow the lawyer to decide how much feedback should be given, since they are taking the lead in the case.

Feedback is not a unitary concept. (1) One must consider *how much* feedback should be given to the evaluatee. For instance, reassuring an evaluatee by saying "you are doing fine" may be a lot of different from informing an evaluatee that they are endorsing rare symptoms and are therefore likely malingering. This may depend on the type of case. For instance, in a personal injury case, dealing with possible PTSD, at a certain point in your evaluation you should be prepared to answer the question of whether your assessment confirms the claimed psy-

chological injury.

In some cases, giving extensive feedback could affect further interviews, for instance by the psychiatrist on the opposing side, or by a psychiatrist for the same side. For instance, consider a case where an evaluatee with a diagnosis of schizophrenia sets fire to his house, killing his mother. You might assess him and give him the feedback that although you confirm his diagnosis of schizophrenia, you believe he does not qualify for an insanity defence because he told you that he was angry with his mother following an argument about how much money she retained from his welfare check. It is possible that defense counsel retains another forensic psychiatrist, and armed with this feedback, the evaluatee does not mention anything about his check during that interview. Or, following the assessment and feedback, when the defendant testifies in his own defense, he knows not to mention the welfare check. This could be analogous to coaching the witness, albeit inadvertently.

This does bring us to the other topic of *timing* of the feedback. Should you give feedback in the middle of an interview, at the end of an interview, the end of the session, following the formulation of your opinion or after the matter is settled? It could easily happen following the interview that you believe everything you are told and would likely support the position taken by the evaluatee. Having received collateral information sometime later, however, you could realize that what they told you was inaccurate or incomplete and you may come to a final conclusion not consistent with what you thought would be your initial opinion.

In this case, the evaluatee may feel deceived, and the feedback you gave them, in the best tradition of trauma-informed care, and to support their well-being, may well end up leaving them feeling deceived and betrayed. At the very least, any feedback should

be conditional on reviewing collateral information and coming to a final conclusion.

Take Home Points:

With the myriad of specific considerations needed to decide if one is willing to discuss a case with a defendant or the family after a jury verdict, it is impossible to declare a clear answer to the question of participation. There may be reasonable or even good grounds to be involved in such a discussion and a way to do this that is ethical, professional, dignified, and respectful of all parties.

The first step in addressing such a challenge is to be aware of all of the risks one may confront. This is a place where consultation with the retaining lawyer and a senior colleague with experience in this type of situation can be invaluable. Should one decide to proceed, go slowly, and divulge only the amount of information absolutely necessary to answer the question. There are times when less is more. ☯

References:

(1) S. L. Brodsky, J. Goldenson (2022) Feedback in forensic mental health assessment, *Journal of Forensic Psychology Research and Practice*, DOI: [10.1080/24732850.2022.2124140](https://doi.org/10.1080/24732850.2022.2124140)

Forensic Treatment

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treatment, focusing instead on forensic evaluation, consultation, and testimony. However, many forensic psychiatrists do provide treatment. They serve a critical function for patients even as they labor in the shadows of forensic evaluation and consultation for attorneys and the courts. The time has come to shine a bright light on the activities of these psychiatrists. It is time for AAPL to acknowledge more publicly this critical element of forensic psychiatry. ☯

2023 ANNUAL MEETING



2023 Annual Meeting Chairs Drs. Spanggaard and Kim



Incoming President Dr. Dike with the 2023 Charles Dike Scholars (and friend)



Poster Session



Poster Session



Early Career Breakfast



Outgoing President Dr. Knoll with some of his heroes:
Dr. Resnick, Dr. Dietz, and Mr. Conlon

2023 ANNUAL MEETING



AAPL members from Little Rock, AR, including Newsletter Photographer Eugene Lee, MD (r)



A light moment at the Annual Meeting



AAPL staff Jackie Coleman and Haley Burns



Current and past AAPL Medical Directors and Executive Directors



Dana Cooper and Jackie Coleman



On to the next adventure!

A Prescription for Disaster?

Stephen P. Herman, MD



The psychiatrist was called in to prescribe medication for a patient with Bipolar II Disorder. At first, he seemed well trained to be the consultant;

however, he relied solely upon family reports. He concluded the patient fulfilled most of the DSM-5-TR criteria for this diagnosis. The patient had a recent hypomanic episode after several depressions not controlled by traditional antidepressants. The psychiatrist ordered lamotrigine 25mg BID, and in one week increased the dosage to 50 mg BID.

There were three problems, however: the “psychiatrist” was not a medical doctor (he was a nurse practitioner who had signed on the line labeled psychiatrist); he never examined the patient; and the medication is not approved for those under the age of 13 -- the patient was 10 years old.

The child developed toxic epidermal necrolysis, although some dermatologists disputed this conclusion and were in favor of Stevens-Johnson Syndrome. The specific diagnosis was moot, because the child nearly died. (I hasten to add that most nurse practitioners do not work outside their scope of training. They are diligent, and their work is evidenced-based.)

But what about psychologists? Should they have the right to prescribe psychotropics? Several states already have or are pushing to have this privilege. Not unexpectedly, the American Psychological Association is lobbying in favor. On its dedicated website, there is a map showing details throughout the United States. (1) The organization maintains that even medical doctors, RN’s and PhD’s in psychopharmacology like the idea.

Their major argument is that mental

health services are so meager – whether inpatient or outpatient – that psychologists can effectively fill the void. And it *is* a strong argument.

The Arizona State Legislature currently has a bill, SB1457, that would allow psychologists the right to prescribe. (2) It was sponsored in the Senate by Thomas “T.J.” Shope. As of this writing, it is on hold in the House. Shope is a native Arizonan who is connected to IGA Supermarkets and the National Bank of Arizona. By virtue of sitting on various committees, especially Health and Human Services, he has been involved with abortion rights, sex trafficking, children’s health, gun rights, rules, appropriations, and other notable causes. In this state, the legislative season is short, and most politicians have other jobs. That does not automatically lead to conflicts of interests – although it might. He seems to be a decent man, who genuinely believes in psychologists’ prescribing authority.

Despite several allopathic and osteopathic medical schools in the Phoenix metro area, there is indeed a shortage of psychiatrists. A new medical school is being developed at Northern Arizona State University, in Flagstaff, which will include the education of all health science professionals, as well as one in Tucson. It’s likely, however, that a shortage of psychotropic prescribers will remain.

SB1457 would address this need. The bill states that a physician “*may* supervise” (italics mine) a licensed psychologist “who holds a conditional prescription certificate to prescribe psychotropic medication and any other medication approved by the United States Food and Drug Administration to treat mental disorders...”

And this is interesting: “[the psychologist has] completed a doctoral program in psychology from an accredited institution of higher edu-

cation of professional school, or, if the program was not accredited at the time of the applicant’s graduation, the program meets professional standards determined acceptable... [these psychologists can be trained in] clinical, counseling, educational or any other subject area in applied psychology... and can be accredited throughout the United States...”

There is also a section on malpractice insurance. However, there are no details about coverage or where to get it. Also, “A supervising physician is not liable for the acts of a psychologist under the supervising physician’s supervision unless the injury or loss arises from an act under direction and control of the supervising physician.” (I don’t know about you, but I find this a bit confusing and think this could be interpreted in different ways.)

There is no question about the lack of physicians trained in the use of psychotropics. In general, we have a clearer idea of the whole-body impact of these medications. No matter our specialty, we have trained long and hard to understand this. We appreciate the precarity of putting patients on these medications. We understand drug-drug interactions. We have become more attuned to carefully evaluating the claims of pharmaceutical companies. We understand the concept of off-label use. We *should* maintain the ability to keep up with general medicine and understand the strengths and pitfalls of certain peer-reviewed articles.

I am not in favor of granting psychologists prescriptive rights. We need to figure out another way to expand treatment in this imperfect territory. For example, the American Psychiatric Association has developed specific guidelines for telepsychiatry. (3)

Otherwise, we are wide open to danger. ☹

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Thursday Lunch Talk: Forensic Practice Before and After the Trial

By Ryan C.W. Hall, MD



AAPL member Dr. Raymond Patterson discussed his long and illustrious career in forensic psychiatry for the Thursday lunch presentation. With only a few slides, but with incredible warmth, wit and focus, Dr. Patterson covered some of the most pressing practical and philosophical problems he perceived the field of forensic psychiatry has dealt with over his career and likely will continue to deal with in the future. Themes touched on were balance, safety, honesty, understanding an individual's role, and advocacy for clinical care, professional standards, and collaboration with internal and external factors to achieve change. There was so much discussed in his presentation that it would be impossible to capture every nuance and point of subtext in his talk for this article. Some of the main points and themes are summarized below but unfortunately, some pearls of wisdom or insightful antidotes will be missed.

For those not familiar with Dr. Patterson, he obtained his medical degree from "THE" Howard University roughly 40 years ago (he noted that the "THE" is important, because one needs to take pride in one's educational institution on the witness stand in a manner similar to how a football

player does before a professional game). He has worked as a clinician and administrator of some of the largest and most influential forensic hospital systems in the country, such as Saint Elizabeth's in Washington D.C. and Clifton T. Perkins in Maryland. He has worked in correctional facilities, such as the Patuxent Institution in Maryland, and consulted to the Angola State Penitentiary in Louisiana. AAPL President Dr. James Knoll noted in his introduction for Dr. Patterson that Dr. Patterson is so

"...the line on the ground between himself and inmates in one correctional facility was known as the "deadline." The risk of his work was clear when an officer commented that it was called that because there were only three corrections officers for 200 inmates, and "if someone crossed the line, someone was likely going to be dead."

respected for his correctional work that he received the keys to both Angola and Patuxent. Dr. Patterson has consulted with federal, state, and city agencies, such as the US Marshals Service, the Secret Service, the United States Capitol Police, District of Columbia Police Department, and the Baltimore City Police Department. He has also consulted with organizations preparing for site inspections, as well

as doing site inspections for the Joint Commission. He is an individual who, no matter his position, has advocated for equitable access to medical and psychiatric treatment for inmates and patients. His efforts have been acknowledged with receipt of the 2019 Seymour Pollack Award from AAPL and the 2021 Yochelson Visiting Professorship of Psychiatry and the Law Award from Yale University.

Dr. Patterson started by discussing the early aspects of his career in institutions. He regaled the audience with many anecdotes and what he had learned from these experiences, which shaped how he carries himself as a forensic psychiatrist. He highlighted the notion of having respect for individuals, whether they are inmates/detainees, corrections "officers" (do not refer to them as just guards, because professional corrections "officers" do more than just "guard" detainees), or other health care personnel. Dr. Patterson discussed that one always needs to be aware of your surroundings. He highlighted this by discussing that he learned that the line on the ground between himself and inmates in one correctional facility was known as the "deadline." The risk of his work was clear when an officer commented that it was called that because there were only three corrections officers for 200 inmates, and "if someone crossed the line, someone was likely going to be dead." Dr. Patterson transitioned from that anecdote to remind new forensic psychiatrists and seasoned experts alike that there may be varying levels of professionalism in the institutions they find themselves in, and the individual is ultimately responsible for his or her own safety. If an evaluator does not like the set-up, it is up to them to address it. Even though you need to treat people with respect, you should never put your safety at risk by remaining silent.

Dr. Patterson then spent time talking about his work evaluating

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Patterson Lunch Talk

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institutions. He noted that one needs to be an advocate for positive change from within the role you occupy. If one is working with an advocacy group, a more outspoken activist role may be appropriate, but if one is employed by the system, an honest, straightforward approach, without dramatics, is often the best advocacy. This results in building trust, continued access, and greater ability to build collaborations to convey a message. For change to occur, a multidimensional approach is often needed. In the treatment realm, respect and understanding on how best to address concepts such as confidentiality for the individual and treatment team (patient, nursing, social work, administration, and even correction officers) are needed.

Dr. Patterson also strongly encourages those in administrative roles to listen to people who work in an institution and to have fair and reasonable expectations. He gave the example of a policy he reviewed which stated response time would be 15 minutes. He noted that he knew this was impossible, and so did every rank-and-file individual in the facility, because the mental health provider would have to clear five checkpoints, which could never be done within 15 minutes. He also noted that this response time assumed the mental health practitioner was immediately available, which almost never occurs with an incarcerated population.

Dr. Patterson also identified logistical challenges of setting up appropriate post-incarceration follow-up for both correctional facilities as well as treating public health systems. Given the problem of unexpected release (e.g., hard-to-predict parole board findings, good-time calculations, additional charges) and the unique needs

of a post-incarcerated population, it is not always easy to know exactly when and where follow-up should be accomplished. In addition, people in the federal system may be incarcerated hundreds of miles away from where they will be living upon release, creating additional challenges for establishing appropriate follow-up.

Dr. Patterson ended his talk by discussing some of the famous cases he was directly or indirectly involved in. He discussed John Hinkley; the “Shotgun Stalker;” and Zacarias Moussaoui. To highlight the notion of honesty and striving for objectivity, he gave the example that he was asked to do a news interview to profile the D.C. sniper while the perpetrators were still at large. Dr. Patterson noted that he declined the interview, since his only source of information at the time was the media itself, which he understood was not the same as having the full file that the active profilers in the case would have. He noted that one of his colleagues did do the interview, and predicted that the perpetrator was a single Caucasian male, who likely lived with his mother or aunt and was in his mid-to-late 30’s. Dr. Patterson noted that is likely what he would have said if he had done the interview based on the limited information he had available, and he would have been wrong, too (said with humor). This story was the perfect conclusion to his talk, because it highlighted his thesis that professional forensic psychiatrists need balance, an understanding of their role, and collaboration to best move the field forward. If one is looking for glory in the field of forensic psychiatry, you are not likely to find it, are not likely to make the profession more respected, and are not going to make the world a better place. However, treating people with respect and doing one’s job correctly will have an impact. ☺

Shoulders of Giants

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and at risk of arrest, houselessness, and early death. These very real issues impact the members of AAPL, who are doing work on the front lines whether in correctional settings, psychiatric emergency departments, or private offices. The work of forensic psychiatrists is hard, and can expose us to material that is not for the faint of heart, and yet we persevere and continue to work to provide the best opinions we can generate for courts and other third parties. The role of evaluators requires the utmost scruples, as the dignity of legal processes, and of the profession can rest on each one of us and the quality of our public work.

As I have progressed in my career, I continue to be inspired by the ability of people to come together as a team to develop important work as they themselves grow through these collaborative opportunities. AAPL is one of those incredible organizations that can truly serve as a professional home where we can work, learn, and grow together. I am excited to be in this role as Medical Director...and to let this partnership begin! ☺

Steven R. Conlon: How We Arrived Here: Cases that Influenced How We Respond to Violent Crime

By *Reneé Sorrentino, MD*



Mr. Conlon, Instructor at the FBI Behavior Analysis Unit at Quantico, Virginia, was AAPL's Friday Luncheon Speaker. Mr. Conlon has over 45 years of experience working with an elite group within the FBI that studies and consults with other agencies on violent crimes. His career has focused on understanding the motive, pattern, and rationale behind offending behaviors with the goal of prevention. Mr. Conlon's presentation provided an overview of several high-profile cases, illustrating his specific work with the FBI. Each case, as Mr. Conlon outlined, influenced the FBI's approach to future cases. For example, in the 1950s, a reporter for a news service who had been covering a high-profile case asked the Bureau to provide a list of persons they wanted to capture. This publication led to the "Top Ten Most Wanted" list we recognize today.

The emphasis on different acts of violence has varied over the decades. In the 1950s, the Bureau focused on bank robbers, followed by anti-government crimes in the 1960s and organized crime in the 1970s. The 1980s focused on sexual predators,

moving to crimes against children and white-collar crime in the 2000s. Terrorist acts have been the recent focus of the Bureau.

The role of psychiatrists as consultants to the FBI began in the 1950s with the case of George Metesky, "The Mad Bomber." Mr. Metesky planted bombs in New York City in the 1940s and 50s. Out of desperation, the NYPD asked James Brussel, MD, a psychiatrist who was Assistant Commissioner of the New York State Commission for Mental Hygiene, to develop a criminal profile of the bomber. Dr. Brussel's accurate profile led to the FBI's practice of criminal profiling, with the help of psychiatric consultants.

Mr. Conlon covered over 50 high-profile cases, starting with the Lindbergh Baby Kidnapping in 1932 and ending with recent public location shootings. Mr. Conlon identified

these cases as "a personal list of cases which influenced the work we do now." These included Charles Manson; Ed Kemper; the "BTK Killer;" John Wayne Gacy; Ted Bundy; Jim Jones; Timothy McVeigh; Ted Kaczynski; the kidnapping of Elizabeth Smart; Seung-Hui Cho; and Adam Lanza. They covered varied categories including serial killers; sexual sadistic killers; arsonists; priest offenders; stalkers; "angels of mercy" or healthcare killers; school shooters; bombers; police shooters; and presidential assassinations and attempts. In each case, he illustrated how understanding the offender's profile shaped the FBI's work. He explained how the publications of missing children evolved from 1980s advertisements on milk cartons to the Amber Alert system. He discussed recent technological advances, such as social media, and their role in investigating violent crimes. Mr. Conlon concluded with a proverbial "What's next?" suggesting advanced technologies like artificial intelligence may influence both the manifestation and the detection of violent crimes. ☯

2023 AWARD RECIPIENTS

Red Apple Outstanding Service Award

This award is presented for service to the American Academy of Psychiatry and the Law.

Britta Ostermeyer, MD, MBA

Golden Apple Award

This award is presented in recognition of AAPL members who are over 60 and who have made significant contributions to the field of forensic psychiatry.

Gary A. Chaimowitz, MB, ChB

Seymour Pollack Award

To recognize distinguished contributions to the teaching and educational functions of forensic psychiatry.

Susan J. Hatters-Friedman, MD

Park Dietz, MD, PhD: A Forensic Psychiatrist's Journey

By Karen B. Rosenbaum, MD



On Saturday, October 21st, 2023, AAPL luncheon attendees listened attentively and gratefully to the epic journey of renowned forensic psychiatrist and former AAPL president Dr. Park Dietz. Dr. Dietz graduated *cum laude* from Cornell University, earned MD, MPH, and PhD degrees at Johns Hopkins, and trained at Johns Hopkins and the University of Pennsylvania. At age 29, he became Harvard Medical School's youngest assistant professor. He was thrust onto the national stage as the prosecution's expert for the John W. Hinckley, Jr. trial in 1982 for the shooting of President Ronald Reagan and others. He left Harvard in 1982 for the University of Virginia, where he was eventually promoted to professor of law and professor of behavioral medicine and psychiatry. He founded Threat Assessment Group (TAG) in 1987, the world's first company devoted to workplace violence prevention, where he has trained or consulted to most of the companies in the *Fortune* 500. Upon moving to Newport Beach, California, he became clinical professor of psychiatry and biobehavioral sciences at UCLA, where he has taught for over 30 years. He consulted for decades to the FBI's

Behavioral Sciences and Behavioral Analysis Units. He coined terms such as "pseudocommando" and "family annihilator." He has consulted for movies and television. He has been an expert in numerous high-profile cases. He has trained and mentored numerous AAPL members over the years including myself.

After his unparalleled career was introduced by AAPL President James Knoll, Dr. Dietz began by encouraging that anyone can find a path, but it must be one's own path. He said that people often ask us, "How did you get interested in such things?" He traced his own interest to his family, which included multiple generations of medical doctors and health care practitioners, including grandfather, parents, uncles, and cousins. When he was a child, his father would show him surgical photos, including diseased organs, at the dinner table. His father was reverent about medicine, and from a young age Park was just expected to become a physician.

When he was sixteen, a friend confided to him that she had been raped by someone in their town, a teen who had been the first to sell switchblades, the first to have pornography, and the first to steal beer. Dr. Dietz shared that her confusion and pain had a profound impact on him, and he wanted to study the extremes of human behavior. He believed that understanding crime was the first step to controlling it, and to reducing the number of people who would be victimized.

At Cornell, he found himself interested in anthropology, sociology, and social psychology. When he learned that criminology was a discipline, he nearly veered away from medicine, until he stumbled upon the book *Forensic Medicine* by Keith Simpson, a professor at the University of Lon-

don, which contained shocking crime scene photos of decomposed human remains, wounds from all kinds of instruments, dead babies, and other difficult images. Dr. Dietz realized there was a path to work in both medicine and criminology.

As a medical student, he did as much of his elective work as possible in forensic pathology and forensic psychiatry and shadowed practitioners of each subspecialty. He traveled to London to meet Professor Simpson, who took him to a murder scene, the autopsy room, and then to tea. At the office of the Chief Medical Examiner of Maryland, he went to death scenes, attended autopsies, and worked on research projects regarding traffic injuries and murdered women. He was particularly interested in the work of Susan Baker, a pioneer in injury control research, with whom he collaborated on a study of drowning. He suggested to her that homicide and rape be viewed as intentional injuries and studied with the methods of injury control and criminal investigation. His focus was prevention, which helped his work with the FBI Behavioral Science Unit. He found that in case after case there had been "missed opportunities for prevention."

He concluded that compared to forensic pathology, forensic psychiatry offered the greater opportunity to understand crime, because it allows us to "dig deeper into criminal behavior and its emotional impact on families." He wanted to figure out why crimes occurred and left loved ones' lives shattered. He volunteered to help Herbert Thomas, editor of the *AAPL Bulletin*, (now the *Journal of AAPL*) by copy-editing accepted manuscripts. Dr. Thomas invited him to AAPL's 3rd Annual Meeting, where he met the leaders in the field, some of whom became his mentors and role models. During residency and fellowship he worked most closely with Jonas Rapoport and Robert Sadoff,

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Dietz Lunch Talk

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AAPL's first and second presidents. He said that it was through mentors and colleagues he met through AAPL that he was recommended to prosecutors in D.C. when they were looking for a forensic psychiatrist to examine Hinckley.

At Johns Hopkins, Jonas Rappeport facilitated Dr. Dietz's PhD research and mentored him through residency and beyond. Under the sometimes strict guidance of Paul McHugh, he studied the work of Adolf Meyer, the first Psychiatrist-in-Chief at Johns Hopkins Hospital from 1910-1941.

A Robert Wood Johnson Foundation Clinical Scholar while a forensic fellow under Dr. Sadoff at the University of Pennsylvania, Dr. Dietz led residents in conducting psychiatric disability evaluations in the homes of housebound applicants for benefits, an experience that opened his eyes to the lives of the less fortunate. The clinical scholars program helped with seed money for research. Although the program's focus was on public policy for healthcare, Dr. Dietz had other ideas, and spent his time at case conferences at the Philadelphia Medical Examiner's office and hanging out with Marvin Wolfgang, director of the Sellin Center of Studies in Criminology. Dr. Dietz explained that he did not have a "typical" Penn Medicine experience, but that senior mentors encouraged him to cross disciplinary boundaries and cultivate his own way of seeing the world.

On his first day on faculty at Harvard, he was assigned to figure out what to do with a man threatening to kill his boss at a local company, which sparked his interest in workplace violence. On his second day, he was asked to transform the notorious Bridgewater State Hospital into a teaching hospital. There, he saw that both patients and staff were getting injured, studied incident reports, and

found that most injuries were attributable to poor techniques used while attempting to subdue agitated patients. He presented his findings to the superintendent and was met with a cool response. Soon thereafter, correctional officers threatened to turn their backs if he were in need, if he interfered with their pastime of scheduling their injuries in time to take leave for their favorite sport seasons.

Another experience at Bridgewater taught him how to navigate bureaucracies. When he arrived, there were no computers or way to find out the charges of patients admitted there without pulling individual charts. When he asked if he could add the offenses to a log which included name and date of arrival, but not offense, he was told "No" because it had never been done that way. He looked at the new log book begun on the first of the year, copied the names of the first ten patients, pulled their charts in another building to find their charges, and returned to the admissions unit, where he drew a new column in the book and added the offenses while Dennis Koson, MD, his co-conspirator, distracted the correctional officers who kept the logs with fresh donuts. Humorously, he added that this experience made him realize he was not going to make a career within institutions.

Dr. Dietz said that we never know where the work we do may take us. An attorney representing the infamous "Torso Killer," Richard Cottingham, asked how often handcuffs and adhesive tape were used in sexual encounters in Midtown Manhattan and Bergen County, NJ. Dr. Dietz was offered a budget of \$10,000 to try to answer the question. He and a social worker flew to New York, initially attempting to interview sex workers they found through the *Village Voice*, but they would not talk to him. He eventually selected a random sample of "adults only" bookstores, compiled data and reported the findings to the

attorney. He submitted the quantitative part of his work for publication, and it was published, (1) followed by a blurb in *Psychology Today*, a meeting with Members of Congress, an interview at the White House, and appointment to the US Attorney General's Commission on Pornography. As he was publishing more on paraphilias and sex offenses, he was warned that it was "unsuitable" for a Harvard professor to write about such "dirty topics." He realized Harvard was another institution that may not be the best place for him.

He was still at Bridgewater when Hinckley shot Reagan, and he was 32 years old when he was asked to assemble and lead a team of experts. That team, consisting of Jonas Rappeport, Jim Cavanaugh, Richard Rogers, and John Monahan, visited the crime scene and the locations where Hinckley lived and stayed, reviewed all his past records, interviewed people who knew him and proximal witnesses, conducted multiple interviews with Mr. Hinckley, and inspected all the evidence, a new approach at the time. Dr. Dietz changed the landscape from a one-hour evaluation of criminal responsibility to 1000 hours. He said his terms "medical criminology" and "investigative forensic psychiatry" to describe this approach had not yet caught on, but that this sort of detailed work proved especially valuable to individuals seeking to apprehend criminals and to those trying the biggest cases of their careers. Moreover, these findings had implications beyond this individual case. For example, the press had reported President Reagan's travel itinerary that day, and Hinckley had a copy of it. This led the Secret Service to stop publishing the routes of presidents and details of their schedules.

Dr. Dietz recalled that the Forensic Psychiatry Clinic at the University of Virginia had video cameras mounted on the walls used to record all exam-

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How to Move Forward with Feedback: Tips for Psychiatry Trainees

Meghan Musselman, MD

Forensic Training of Psychiatric Residents Committee

As a forensic psychiatry educator and director of a forensics track in a general psychiatry residency program, I often focus on exposing psychiatry residents to forensic topics and opportunities during their residency training. While this has been effective in garnering residents' interest in the field of forensic psychiatry, these experiences are inadequate to fully prepare them for a forensic psychiatry fellowship. Forensic psychiatry fellowship is much more than learning about forensic psychiatric topics. It is about learning to interact with attorneys and judges, conducting forensic evaluations, learning how to write effective forensic reports and developing a mastery of the art of expert witness testimony. Feedback is inevitably an essential part of learning to be a forensic psychiatrist, and feedback in fellowship is and should be abundant. How effective that feedback is depends not only on the feedback giver but also the feedback receiver.

In academia, the topic of giving effective feedback is frequently taught, but we less often focus on how to effectively receive feedback. A 2017 scoping review on feedback in medical education found that over 97% of the articles reviewed focused on methods of feedback given to learners. (1) Yet, feedback can only be effective if it is internalized by the receiver. Why is there such a lack of focus on receiving feedback in academia? Maybe we erroneously believe that trainees take our feedback and run with it. The limited body of evidence on feedback reception however indicates that feedback is not always accepted by the recipient, and the integration of feedback is influenced by a variety of factors. (2, 3, 4) In this article, I will review three com-

mon barriers for integrating feedback and provide strategies for overcoming these barriers.

In their 2014 book, "Thanks for the Feedback: the Science and Art of Receiving Feedback Well," authors Douglas Stone and Sheela Heen identify three triggers that typically prevent individuals from internalizing feedback. The first trigger is the "truth trigger," which occurs when the feedback receiver believes that the content of the feedback is wrong or unfair. The second trigger is the "relationship trigger," which stems from the feedback recipient's perception of the feedback giver. The third trigger is the "identity trigger," which occurs when the feedback makes the feedback recipient question their identity and can lead to shame and defensiveness. (5)

Once a trigger has been identified, the natural next step is managing it. Many forensic trainees receive feedback on a forensic report such as, "Next time, I'd like to see more confidence in your opinion." Trainee A may view this feedback as helpful in accelerating her learning, whereas Trainee B internalizes, "This doesn't sound right. This is the first time I'm hearing that my reports are not good." Trainee B has experienced a truth trigger. The feedback seems to contradict what he has heard about his work in the past. What strategies can Trainee B use to work through the truth trigger?

- A. **Ask for clarity on the type of the feedback.** Was the purpose of the feedback for coaching, to accelerate learning, or was it an evaluation, telling Trainee B that he is behind his peers?
- B. **Attempt to understand the**

feedback giver's perspective. Trainee B could ask the feedback giver to see examples of confident writing and where his writing is falling short.

- C. **Learn about blind spots.** Trainee B should assess whether there is a gap between his perception of his writing and others' perception of his writing. Rather than dismissing his attending's feedback, he should consider whether the feedback is revealing a blind spot to him. He could ask a trusted colleague or mentor about the feedback he received.

Now imagine a scenario in which Trainee C has been told by her attending that she needs to improve her interviewing skills. Trainee C dismisses the feedback because the attending has a reputation of being overly critical. This is an example of a relationship trigger. The trainee has rejected the feedback because of her perception of the feedback giver. Trainee C ignoring the feedback and focusing on her perception of the feedback giver is called "switchtracking." We can impart Trainee C with strategies to help prevent switchtracking, in order for her to gain from the feedback from her attending:

- A. **Spot the two topics.** Trainee C can recognize that the attending never showing appreciation for the trainee is an issue and also that the trainee's interview skills are a separate issue.
- B. **Give each topic its own "track."** Trainee C can address her interview skills. Separately, she can express to her attending that would benefit from appreciative feedback as well.

In a third scenario, Trainee D meets with her program director for her semi-annual evaluation. She hears many positive comments but is struck

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Drugs in “Controlled” Correctional Settings

Jason Barrett, MD

Addiction Psychiatry and Correctional Forensic Psychiatry Committees

At the AAPL 2023 Annual Meeting, Ashley VanDercar MD, JD, Joseph Penn MD, Sanya Virani MD, MPH, and Abhishek Jain MD presented “Drugs in ‘Controlled’ Correctional Settings.” This panel was co-sponsored by the Addiction Psychiatry Committee and the Correctional Forensic Psychiatry Committee.

The learning objectives were to: recognize the covert nature of various illicit substances in correctional settings; appreciate system-based challenges in preventing and monitoring their introduction, manufacture, and trade; identify management strategies, such as testing and indicators of substance use; understand the impact on correctional treatment and forensic psychiatric examinations; and appreciate the balance of individual rights and institutional security.

Attendees were challenged to examine their awareness of contraband in controlled settings. Contraband was defined as “material prohibited by law, regulation, or policy that can reasonably be expected to cause physical injury or adversely affect the safety, security, or good order of the facility or protection of the public” (28 CFR § 500.1(h)).

Panelists described how drugs might be concealed using paper, fabrics, electronics, and even dead animals. Potential areas of entry into various controlled settings (e.g., forensic hospitals, prisons, jails) included: at intake and booking; interfacility transfers; staff (employees and contractors); visitors (professional and personal); drones; and “throw-overs.” Stopping the introduction of drugs can be extremely challenging, especially when New Psychoactive Substances (NPS), such as synthetic drugs, emerge quickly. A hierarchy of

the illicit drug system was presented, comprising enterprises, suppliers, and social sharing/trading.

There have been efforts at improving detection using drones to help with reconnaissance and surveillance efforts. Other measures have included mail scanners or allowing only digital mail; body scanners; and detection systems such as radar, electro-optical, acoustic, and radio frequency. It was highlighted that intoxication with NPS can lead to consequences including psychosis and violence. Additionally, there was attention given to legitimately prescribed psychotropic medications commonly targeted for abuse and diversion.

Attendees were asked to consider the effects of various drugs and the legal aspects of such effects as they might relate to forensic psychiatric topics, such as: the insanity defense, competency to stand trial, competency restoration, diminished capacity, and settled insanity. These substances could also play a role in correctional treatment and in cases involving a psychological autopsy. Causes for concern and further examination in this population include an unusual clinical presentation; information in medical records, or from recorded phone calls; or self-report from patients and evaluatees.

Panelists discussed amendments, administrative codes/policies, and potential obstacles to limiting drug use and entry into controlled environments. The use of urine drug testing was encouraged, with possible potential procedural and clinical challenges underscored. Additionally, substances outside of the “NIDA Five” (e.g., amphetamine, cannabis, cocaine, opioids, and PCP) often need specialized testing for detection, such as synthet-

ic opioids and synthetic cannabis, ketamine, bath salts, benzodiazepines, and buprenorphine.

Those working in carceral settings or forensic hospitals were reminded to strengthen relationships with custody staff toward a common goal. Improving retention of psychiatric providers in corrections was also identified as a potential factor that could improve continuity of care, and perhaps even help reduce the cycle of re-incarceration. Educators were invited to consider expanding core curriculums to include a correctional experience. The initiative would hopefully expand interest of trainees in this area.

In summary, those working in corrections should be aware that the list of NPS grows rapidly. NPS are easily smuggled into facilities and are often undetectable without specialized approaches. The goal of stopping their introduction into controlled settings may prove very challenging. Forensic hospitals may also be vulnerable to the entry of NPS if careful measures are not taken. Lastly, evaluators should be aware that substance-induced psychiatric symptoms of evaluatees can skew forensic evaluations and treatment. ☯

Disaster?

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The American Academy of Forensic Sciences Turns 75

David Annas, MD, MPH

Forensic Sciences Liaison Committee

The American Academy of Forensic Sciences (AAFS) held its 75th Anniversary Scientific meeting in February 2023 at the Rosen Shingle Creek Resort in Orlando. The AAFS annual meeting is the largest gathering of members of the forensic science community, with 11 disciplines represented. The Psychiatry & Behavioral Science section, while small, is active and growing.

Highlights from the program included AAPL member Brian Holoyda's presentation, "Forensic Psychiatric Implications of the Psychedelic Renaissance;" a team presentation by faculty from the Medical University of South Carolina: "The Aurora, Colorado, Movie Theater Shooting: The Significance for Forensic Mental Health Professionals;" and Dr. Anita Rajkumar's talk: "Forensic Pathology for Psychiatrists." Especially well-received was the interdisciplinary workshop, "Inside the Black Box: Psychiatry for Lawyers," (which will be offered again at the upcoming meeting in February, 2024) (1,2).

The AAFS Annual Scientific Conference provides a great opportunity to network with and learn from colleagues in other disciplines. One of the unique traditions of the conference is the evening session "The Last Word Society." Here, experts present interesting cases that have challenged forensic scientists for years. This year's presentations included an analysis of whether the mathematical genius Ettore Majorana faked his own death after selling a "Death Ray;" speculation on who actually killed Charles Lindbergh's baby; and the solving of Australia's coldest case, finally answering the

question, who was the "Somerton Man?" (1).

I was honored to present on the history of Forensic Psychiatry and of the Psychiatry & Behavioral Science section as part of the Interdisciplinary Symposium: "The Formation of the American Academy of Forensic Sciences." I introduced the topic with the story of the ancient Greek hero named Palamedes and how he cleverly uncovered Odysseus' malingering. Next, one can find early references to NGRI statutes from the first century BC. I reviewed England's contributions to the field from the 18th and 19th centuries, some of the landmark cases, as well as the formation of their Medico-Psychological Association in 1841. It was not long after this that the New York Medico-Legal Society formed in 1867, which would go on to influence numerous related fields.

The AAFS was founded in 1948. Dr. Val Satterfield served as the first section officer for the Psychiatry division two years later, and also became the first psychiatrist to be AAFS president, serving from 1957-1958. One of the most significant changes in the organization came when the term "Social-Behavioral" appeared in its definition of forensic science printed in the program for 1970 ("... the study and application of the sciences to the law, in the search for truth in civil, criminal, and social behavioral matters, to the end that injustice shall not be done to any member of society."). Future president Doug Lucas recalled the feverish debate that occurred on this subject: "The issues resulted in emotional discussions which caused the meeting to last well into the evening.

Debate was so intense that I was concerned that a few members might actually come to blows." In 1971 the membership voted to approve the executive committee's definition ("... the application of those portions of all the sciences as they relate to the law"). Thus, AAFS dedicated itself to being a more inclusive forensic science organization rather than strictly a "medico-legal" one. The Psychiatry division changed its name to "Psychiatry & Behavioral Science" in 1986, to signal more inclusiveness for psychologists, who had been accepted for membership the previous year. (3).

There has always been a close relationship and mutual respect between AAPL and AAFS. Several AAPL Presidents have served as AAFS Psychiatry & Behavioral Sciences Chair, including: Park Dietz, Robert Sadoff, Robert Weinstein, Richard Rosner, and Alan Felthous. The February, 2024 Annual Scientific Meeting will see former AAPL president Christopher Thompson take over as president of AAFS.

The 76th AAFS Scientific Program is entitled "Justice for All." All AAPL members are encouraged to attend the meeting in Denver, February 19th-24th, 2024. Please visit www.aafs.org for further information. ☪

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Paul J. Fedoroff, MD

By John M. W. Bradford, MBChB, DPM, FFPsych, MRCPsych, DABPN, DABFP, FRCPC, CM



On January 16th, 2023, Dr. Paul Fedoroff passed away peacefully in his home in Ottawa, Ontario, with his loving wife, Evelyn, by his side.

Since 2001, Paul had been Director of the pre-eminent Sexual Behaviours Clinic in the Royal Ottawa Health Care Group [ROHCG] through the Integrated Forensic Program at the Royal Hospital campus in Ottawa.

Dr. Fedoroff was a distinguished physician and researcher who contributed mightily to the clinical and academic mission of the ROHCG and the University of Ottawa. He was well-known for never turning away a patient, and had an exceptional interest in working with vulnerable people with intellectual disabilities. He was enormously proud of being awarded a recent research grant that allowed him to extend his passion helping forensic patients worldwide.

Paul was a full Professor of Psychiatry at the University of Ottawa, with cross-appointments to the Faculties of Criminology and Faculty of Law. He was Head of the Division of Forensic Psychiatry at the University of Ottawa. He was the first Research Director of the Forensic Research Unit at the University of Ottawa Institute of Mental Health Research (IMHR) and also Vice Chair of the Royal Ottawa Research Ethics Committee. He served as President of the Canadian Academy of Psychiatry and the Law (CAPL).

In 2012, Paul was named a distinguished fellow of the Canadian Psychiatric Association, a fellow of the American Psychiatric Association, and received the Bruno Cormier

Award for “Contributions to Forensic Psychiatry in Canada.”

The year 2015 was uniquely memorable for Paul: he was the president of the International Academy of Sex Research (IASR), and was named Specialist of the Year by the Royal College of Physicians and Surgeons of Canada. The same year, his work was recognized by the American Psychiatric Association (APA), which awarded the Sexual Behaviours Clinic the Gold Achievement Award, APA’s highest honour for excellence in academic clinical research programs in North America. In 2017, he was awarded the Earl L. Loschen Award for Clinical Practice from the National Association for the Dually Diagnosed (NADD).

It was no surprise that Paul had such an academic mind, as he was the son of Professor Sergey Fedoroff, fourth president of the Pan-American Association of Anatomy and the “father” of tissue culture, renowned for his ground-breaking research in tissue culture and nerve cell regeneration.

Born and reared in Saskatoon, Saskatchewan, Paul graduated with a Bachelor of Arts (advanced) in psychology from the University of Saskatchewan. He pursued medical school at the affiliated College of Medicine, subsequently serving as a Senior Clinical Fellow in Neuropsychiatry and a Clinical Fellow in Advanced Psychiatry at Johns Hopkins. There he was supervised by Dr. John Money, who is known for his research on gender and the theory of love maps. Although John Money mentored him, Paul disagreed with Money, who combined gender, orientation, and interest in a fused package of sexuality. Dr. Money proposed that once gender roles are “imprinted,” they are permanent and unchangeable.

Instead, Paul found that the current paradigm of human sexuality could shift away from Money’s 1950s love maps paradigm.

Paul found that sexuality has five distinct components with varying levels of mutability. These five components are genetics, gender, sexual drive, sexual orientation, and sexual interest. He found through research that pedophilic interests can change with treatment. Notably, there have been no hands-on re-offenses against children by patients treated at the SBC. He consequently believed that pedophilia is a sexual interest rather than a sexual orientation. Supporting this notion, his research found that treatment can be effective in changing sexual arousal towards children, as measured by plethysmography, for men who had pedophilic sexual interests.

Finally turning to forensic psychiatry in 1990, Dr. Fedoroff pursued a Clinical Fellowship in Forensic Psychiatry at the Clarke Institute of Psychiatry at the University of Toronto. As a staff psychiatrist, Dr. Fedoroff’s scope was prolific, working at Hopkins, Toronto Hospital, Whitby Mental Health Centre, and the Centre for Addiction and Mental Health (CAMH).

At AAPL in 2010, he became the chair of the Committee on Sex Offenders, while also serving as an AAPL councillor.

Under Paul’s leadership – he was the second director of the Sexual Behaviors Clinic (SBC) at the Royal Ottawa Mental Health Center – the SBC won numerous awards in addition to the APA’s Gold Achievement Award, such as the Innovation Award from Crime Prevention Ottawa (2018). This was particularly meaningful because it was awarded for his team’s work in preventing sex crimes in the community by treating those who are at risk of committing them.

Dr. Fedoroff was known for his

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Report of APA Assembly

Danielle B. Kushner, MD

The Fall 2023 APA Assembly meeting took place November 3-5, 2023 in Baltimore, Maryland. This was the first live fall Assembly meeting since the start of the COVID 19 pandemic.

Saul Levin, MD, MPA will step down from his position as CEO and Medical Director in 2024. He has served in these roles since 2013. The Board of Directors has appointed a search committee and hired a leadership consulting firm to lead the search for the next CEO.

In his report to the Assembly, Dr. Levin discussed recent APA advocacy successes and the annual APA Federal Advocacy conference that took place this September in Washington D.C. The legislative priorities of 2023 have included increasing the GME workforce, integrating behavioral health services, enhancing telehealth, and access to care for minority populations. Over the past year, the APA successfully advocated for increased reimbursement increases in the 2024 Physician Fee Schedule, including psychotherapy and complex patients, in addition to ongoing telepsychiatry advocacy.

Dr. Levin also discussed APA's recent financial challenges in 2023 due to a decrease in publishing numbers, a slow transition back to an in-person annual meeting, and less grant money. On the other hand, digital publications continue to be on the rise. Depending on the outcome of the upcoming 2024 Annual Meeting, the APA board will need to rethink goals of future meetings and potential restructuring. Dr. Levin concluded his remarks by emphasizing the organization's ongoing focus on Diversity and Health Equity.

APA President, Petros Levounis, MD, MA, discussed the theme of his presidency and the 2024 Annual Meeting, *Confronting Addiction from Prevention to Recovery*. He has initi-

ated four campaigns focusing on different aspects of addiction, one every three months during his term: vaping, opioids, alcohol, and technological addictions. These campaigns will be publicized through media outreach, special articles, interviews with major news outlets, and collaboration with other allied groups. President-Elect, Ramaswamy Viswanathan, MD, talked about his presidential priorities including enhancing the quality of care patients receive; fighting inadequately trained people encroaching into psychiatric practice; augmenting the psychiatric workforce; ensuring satisfactory work conditions and adequate reimbursement; promoting psychiatrists' wellbeing; and fostering trainees' professional development.

In addition to the executive reports, Tamara Campbell, MD, PsyD, Executive Director, Office of Mental Health and Suicide Prevention, Veterans Health Administration, provided an overview of VA mental health services and recent updates, including the National Strategy for Preventing Veteran Suicide; their ongoing telehealth expansion; "Whole Health" approach to care; PTSD academic centers of excellence, veteran's crisis lines; and Opioid Safety Initiative, among others.

Lastly, the Assembly discussed and voted on twenty Action Papers and seventeen new or updated Position Statements. Action Papers are a "product of an idea" and formulate members' ideas into actionable tasks that the Assembly can review, debate, and vote on. Action Papers of forensic interest that passed the recent Assembly included: *Promoting Guidelines for the Prevention of Patient Assaults on Mental Healthcare Employees*; *Removal of Exclusion of Electroconvulsive Treatment from Advanced Health Directives*; and *Opposition to*

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Farewell!

From Jacquelyn Coleman,
AAPL Executive Director

I have always loved the challenge of my career – the problem-solving, the urgency, the excitement of making things happen and the wonderful friendships that come from working with dedicated members to advance the organization's goals. Although I leave much of it with regret, there are other things I still want to do and have the peace to enjoy. As one who thought she might never retire, I realized what others have said to me is true – "you will know when the time is right."

The time is right and all that is left to do is to thank everyone who has been with me on this journey, who have taught me so much, and with whom I have been lucky enough to collaborate. ☺

From Mike Deegan,
AAPL Meeting Planner

It was a great quarter century of AAPL Meetings working alongside Jackie & Marie, Dr. Janofsky, Dr. Resnick, Dr. Scott and getting to know all the Presidents and many of our speakers who became friends. I stayed with AAPL as I said goodbye to others because every meeting was an adventure, I could bring great cost savings and expertise, and was always appreciated for what I did. I appreciate the opportunity that Jackie and AAPL gave me and surely will miss all the places we traveled together through the years. ☺

Danielle B. Kushner, MD

By Philip Candilis, MD



The chair of the AAPL Human Rights and National Security Committee is a transplanted Californian who openly admits to

seeking out the East Coast. Danielle Kushner grew up in Orange County with an appreciation for the relaxed environment, the people, and a medical school experience at the University of Southern California that nurtured talented “bookworms with interests” like her.

Medical school was a time that would reinforce Dr. Kushner’s community-mindedness with clinical rotations at LAC-USC Hospital (now LA General) in Los Angeles County’s underserved Boyle Heights neighborhood. But it was work at a child abuse clinic developed by a faculty mentor, and the chaotic, challenging evaluations in the psychiatric emergency room, that inspired a forensic psychiatry elective.

Having undertaken a History minor as an undergraduate, Danielle appreciated the writing in forensic evaluations, the clear difference from clinical work, and the opportunities to work in underserved areas. She rotated through the imposing Twin Towers Correctional Facility in Los Angeles, watching the intersection of “Law, Medicine, and Psychiatry play out in real life.” Dr. Kushner was sold on a career in forensic psychiatry.

Keen to be exposed to programs outside California, Danielle matriculated to Harvard’s Longwood residency, enjoying the variety of training sites, the Boston setting, and the supervision of AAPL luminary Tom Gutheil. Sitting in on Tom’s Psychiatry and Law Interest Group, Danielle found her interest in forensic educa-

tion kindled. Tom was “inspiring,” she relates, encouraging her to organize the Psych Cinema program at a time when medical humanities were making a resurgence. He encouraged her to explore AAPL alongside fellowship training.

Gravitating to the Big Apple to explore forensic programs with a strong clinical bent, Danielle chose New York University, where the public sector emphasis matched her professional sensibilities. She had already spent some time in Bellevue’s historic halls during medical school electives and was impressed by the dedication to public psychiatry. There she met fellowship directors Elizabeth Ford and Bipin Subedi. Danielle moved to the city approximately six months after Hurricane Sandy, seeing the traumatic aftermath of moving the hospital and patients just a few months earlier.

Friday morning discussions of law and ethics over coffee with Henry Weinstein were a particularly fond memory. Fellowship would be “the best year of training,” combining clinical, legal, correctional, and ethical issues. “I was especially enthused by my director Elizabeth Ford,” and “wanted to emulate her dedication, her passion for the correctional population, to inspire change, and treat patients with dignity and respect.” Danielle’s class would be Dr. Ford’s last at NYU, as she went on to lead Rikers Island mental health services.

Danielle would remain at Bellevue for a while longer, working on the inpatient forensic unit and appreciating its unique culture. It was ideal for her aspirations: a collective mission of academic and teaching interests. After 3½ years, she would move over to Correctional Health Services to re-join Drs. Ford and Subedi at Rikers.

Improving care through quality improvement became Dr. Kushner’s

avenue for effecting change: hospital referrals, metabolic monitoring, and effective prescribing of sleep agents all became tools for applying outcomes to critical elements of correctional healthcare. Attention to “psychiatric medication bridging” in particular, the connection between community prescribing at intake and in-house care, was a specific focus of her early efforts, reflecting the service’s attention to continuity of care. The capacity to turn quality improvement projects into formal academic research was not lost on Danielle, as she took on more teaching and advising of residents and fellows. A number of educational and service projects are currently being extended beyond program walls, namely hospital referrals, correctional psychiatry education, and pregnancy care.

In the same way that jail work offered Dr. Kushner a unique look at the tension between care and security, the tension between human rights and national security became a closely related professional interest. She had become fascinated with a project by UCLA’s Dr. Kristen Ochoa among immigration detainees that examined incompetence to stand trial (IST). At the time of the landmark *Francis* litigation, these detainees were being held for lengthy periods, reminiscent of what was ruled unconstitutional in the Supreme Court’s *Jackson v. Indiana* decision. The *Francis* ruling limiting IST detentions would underscore the vulnerability of incarcerated persons and recall Danielle’s fellowship experience conducting asylum evaluations with the organization Physicians for Human Rights. With asylum evaluations multiplying within New York’s fellowship consortium, Danielle became increasingly involved with AAPL’s Human Rights and National Security Committee, which she would come to chair.

The security focus of the committee centered increasingly on terrorism,

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A Bite at the AAPL: Workshop to Help Shape Our Organization

Ashley VanDercar, MD, JD; Abhishek Jain, MD; Ariana Nesbit, MD, MBE; Tobias Wasser, MD; Britta Ostermeyer, MD, MBA, DFAPA

Membership Engagement, Recruitment, and Retention (MERR) Task Force

How can we continue to sustain, review, and renew AAPL?

Exploring this question AAPL's Membership Engagement, Recruitment, and Retention (MERR) Task Force members held an interactive workshop at the October 2023 Annual Meeting in Chicago.

AAPL's MERR Task Force was created in 2021 by then-President Susan Hatters Friedman and chaired by Abhishek Jain. Its goal: recommendations for membership recruitment and retention; improving value for members; and increasing AAPL's profile outside the organization. Why now? The COVID-19 pandemic, and pivotal societal issues, have served as inflection points to reflect on personal, professional, and organizational values.

Workshop panelists provided background information to stimulate audience discussion. Tobias Wasser presented a history of medical societies, including the American Medical Association (AMA) and the American Psychiatric Association (APA). This helped contextualize AAPL among other organizations, such as being one of 126 Member Organizations recognized by the AMA House of Delegates. Ariana Nesbit summarized the current state of medical organizations. For example, the AMA had 10 years (2011-2021) of consecutive membership growth, followed by a decline during the COVID-19 pandemic. The importance of medical organizations as pillars of support for physicians, by way of networking, guidance, and advocacy for our interests, was highlighted.

Britta Ostermeyer discussed AAPL's history, including its first meeting with 74 charter members in

1969, recognition by the American Board of Medical Specialties in 2004, and its ongoing educational mission and support of research. Two decades of AAPL membership numbers were reviewed, including the recent dip (also experienced by the AMA and APA) that's now returning to a pre-pandemic membership of over 2,000. Throughout the workshop, video clips from past AAPL Presidents Paul Appelbaum, Renee Binder, Susan Hatters Friedman, and Jeffrey Janofsky added insights. Their observations included: medical organizations' increase in diversity and engagement with social issues; AAPL's movement from a sole focus on forensic examinations and expert testimony to greater focus on correctional psychiatry; AAPL's role in developing practice resources for forensic evaluations; and AAPL's participation with advocacy through amicus briefs and representation in the AMA, APA, and National Commission on Correctional Health-care (NCCHC).

Ashley VanDercar described a useful framework to help examine AAPL's future opportunities and obstacles. Nonprofit organizations can experience "life stages": 1) imagine and inspire; 2) found and frame; 3) ground and grow; 4) produce and sustain; and 5) review and renew. These stages are not cyclical, and failure can result in "decline and dissolution." (1) Live workshop audience polling indicated the audience thought AAPL is either in stage 4 "produce and sustain" (26%, n=6), or stage 5 "review and renew" (74%, n=17). Stage 4 is an organization's prime, where the goal is to sustain momentum, cohesiveness, and stability, and address challenges and conflicts. These issues – or the

changing world around the organization – may require shifting into stage 5 and considering what needs to be redesigned.

Dr. Jain presented preliminary findings from MERR's October 2022 AAPL Member Survey. Of 341 respondents (18.9% response rate), most described their satisfaction with their AAPL membership as excellent (41%) or good (44%). Three aspects stood out as important: 1) learning from meetings, publications, etc.; 2) networking; and 3) scholarly activity opportunities. Of 15 choices to optimize AAPL membership, respondents' top-ranked choices were: 1) more practice guidance/resource documents; 2) improved AAPL website; and 3) peer support/mentorship opportunities. Lowest-ranked were: creating a social media presence, and more advocacy. About 1 of 5 respondents (22%) had ever considered discontinuing their AAPL membership, citing issues such as: disagreement with organization's ideals/activities; cost/insufficient value; concerns about politicization; and loss of objectivity in search of advocacy. Further data analysis is pending.

In small group breakouts, workshop audience members discussed AAPL's unique role among other organizations, ways to improve, and current strengths. Responses were electronically submitted and discussed as a larger group. Participants praised AAPL's important focus on forensic psychiatry education, standards, and leadership. Better use of technology was highlighted as an area for improvement (e.g., online review course; website improvement; emailed acceptance/rejection decisions for Annual Meeting submissions). Other suggestions were: fostering a welcoming and inclusive environment for trainees and diverse colleagues; better defining and supporting careers in forensic psychiatry; mentorship in leadership; increasing AAPL's profile among oth-

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Attaining Competency: Becoming an Osteopathic Physician

Julia LaComb, DO Candidate, OU-HCOM Class of 2025



During my psychiatry rotation as a third-year medical student, I was assigned to a competency restoration unit at a state hospital.

Among my responsibilities were one-on-one educational sessions with a man accused of a sex offense and a diagnosis of mild intellectual disability. This experience provided me with an understanding of essential concepts in psychiatry, as well as unique insight into the intricate landscape of competence to stand trial evaluations and restoration. It also emphasized the importance of being able to meet individuals where they are to aid in that process.

In the United States, approximately 1% of the population has an intellectual disability (1, 2). Yet, in our criminal justice system, 23% of prisoners report symptoms of a cognitive disability (3). It is challenging to find accurate estimates of how many of these individuals meet criteria for a diagnosis of intellectual disability, both due to questionable self-reporting and inconsistent defining criteria (4, 5).

While IQ score alone does not lead to a finding of incompetence (6), intellectual disability may lead to a defendant being adjudicated incompetent to stand trial. This is often due to knowledge deficits and concrete thought process, which may render a defendant incapable of understanding their proceedings or assisting in their defense. These deficits may result in longer restoration stays compared to defendants with primary psychiatric disorders such as mania or psychosis (7). For competence deficits associated with intellectual disability, a

treatment approach termed competency attainment, emphasizing education over medication, is often the preferred method of achieving competence (8).

Such a model is exemplified by the Slater Method, developed at Rhode Island's Eleanor Slater Hospital (9). The Slater Method is a knowledge and understanding-based training aimed at providing adequate understanding, rather than rote memorization. This type of education has been shown to increase the likelihood of defendants with intellectual disabilities being restored to, or attaining, competence (8).

I provided my patient a type of individualized education that is loosely modeled after the Slater Method. Before doing so, however, I had to learn the content myself.

In the following weeks, our one-on-one sessions became an enlightening exchange. I was nervous, both about our meetings and about other patients casting curious glances through the windows of our glass-enclosed meeting room. However, I came to realize that my patient was just desperately trying to learn material that could, in theory, help him regain a sliver of control in his life. Witnessing his progress toward competency stirred conflicting emotions within me. I took pride in the progress he was making, and empathized with the challenges he was struggling to overcome. Yet, I also felt a sense of unease at extending sympathy to someone charged with that type of criminal conduct.

The truth of the allegations against my patient are a mystery for the courts to someday decide. Yet, in our sessions, I could see the impact of those allegations, and the adjudication of incompetence, in the uncertainty in his eyes. While I couldn't imagine life in his shoes, I could provide support

and education, rather than judgement.

Every patient has a unique story. My time on this rotation has offered a new perspective on establishing meaningful connections with patients, regardless of factors such as criminal allegations. Integrating forensic psychiatry into medical education provides an unparalleled learning opportunity. It allows students to deepen our understanding of a unique patient population and cultivate invaluable skills needed to provide compassionate and holistic healthcare. I believe this type of experience provides medical students with our own form of competency attainment – competency to one day serve as excellent physicians. ☪

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A Bite at the AAPL

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er professions; more interaction with other legal and forensic organizations; more objective data/research; and preventing expert work by unqualified practitioners.

In the large group, members referenced some strengths to continue building upon: education (e.g., the Annual Meeting); scholarly resources (e.g., Newsletter, Journal, Virtual AAPL); practice resources; chapter meetings (e.g., Midwest AAPL, Tristate AAPL); networking; and collegiality. The discussion underscored a desire for increased diversity and inclusivity.

One lively topic of discussion as AAPL's role with "advocacy." Comments ranged from the importance of how we define the term, to reminders of AAPL's past experiences (such as a 2001 death penalty position statement with subsequent organizational unrest). Opinions varied, with some citing a need to refrain from advocacy to maintain AAPL's cohesiveness, and others noting that our form of advocacy just comes in a different form, joining amicus briefs.

Participants referenced that the idea of advocacy, within our organization, has been associated with a loss of objectivity. Some suggested perhaps we should re-frame the concept of advocacy through our shared goal of "justice". As the workshop closed, panelist Dr. Wasser captured many audience sentiments, stating "we broker in an unjust world," and discussed potential educational roles for the organization as a form of advocacy.

No audience poll respondents viewed AAPL as being in a stage of "decline and dissolution." Participants added valuable input to help "produce and sustain" and "review and renew" our organization.

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The New York City jail system is one of the largest in the nation. Correctional Health Services (CHS)—a division of New York City Health + Hospitals—is the direct care provider for people in the City's custody.

CHS offers a rich and stimulating clinical and learning environment for psychiatrists interested in public health, correctional and forensic psychiatry, community psychiatry, trauma, serious mental illness, and systems-level change. Psychiatrists are matched to responsibilities that fit their clinical and professional interests and expertise. Experience working in correctional settings is not required; however, the ability to work closely, flexibly, and effectively with multiple other disciplines, including security staff, is critical.

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Dietz Lunch Talk

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inations, allowing him to study his own interviews and identify areas he could work on, like not asking leading questions or talking too much. He found this invaluable in minimizing bad habits he had picked up from clinical experiences such as working in the ER, where there is such time pressure that examiners adopt shortcuts. As a result of this experience, since 1982, he has sought to videotape every forensic examination he conducts. He strongly believes that videotaping the interview is the gold standard for maximizing transparency.

Dr. Dietz concluded with some of his unique experiences including visiting a gay bar that Jeffrey Dahmer had cruised, accompanying Elizabeth Smart and her mother in a police helicopter to locate the crime scene where she'd been held before it was obscured by snowfall, and saving children's lives during the Ruby Ridge standoff in Idaho. He spoke about the importance of mentorship including role modeling, guidance, instruction, providing opportunities, and the importance of interdisciplinary collaboration.

Dr. Dietz left the attendees with the unequivocal message that his work has been much more rewarding than anything else he could have possibly done with his career, and that the rewards far outweigh the risks and setbacks. With regard to finding solutions to dealing with angry people who may pose a threat he advised, "just behave like a decent human being," a message we can all take into any area of our lives. The audience responded with a standing ovation. ☪

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APA Assembly

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the Restriction and Criminalization of Appropriate Psychotropic Prescribing in Nursing Homes. Of note, the approved Action Paper entitled *Carceral Psychiatry* was co-authored by AAPL member Eugene Lee, MD, and requested that the APA develop a position on the use of the word "carceral" with respect to correctional psychiatry and medicine. It additionally asked the APA to develop a resource document to serve as a guideline on person-centered language for those incarcerated.

Position Statements approved by the Assembly included *Firearms Access: Inquiries in Clinical Settings*, which opposes legislation that prevents healthcare professionals from asking patients and others about firearms access and safety; *Police Interactions with Persons with Mental Illness*, which states that law enforce-

ment officers who respond to mental health crisis events should be trained to broadly recognize mental disorders to safely deescalate situations, prevent uses of physical force, and mitigate personal bias, and only be deployed only in situations where safety related issues require their presence; and *Abortion, Family Planning, Legislative Intrusion, and Reproductive Decisions*, which emphasizes elective and medically necessary abortions should remain as part of standard healthcare.

The 2023 Fall Assembly meeting concluded with a survey by the Assembly Restructuring Committee to help direct future change and initiatives.

The next Assembly meeting will occur during the 2024 APA Annual Meeting in New York, May 4th-8th. ☪

Faces of AAPL

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political violence that differs in a number of ways from non-political criminal charges. Danielle would draw on those differences to harness the expertise of a number of committee colleagues to develop an AAPL online course on terrorism evaluations. This in turn is developing into a written primer on the topic.

In contemporaneous professional efforts, Dr. Kushner joined her local APA district branch to support access to care for underserved groups and incarcerated populations. With long-time AAPL member Stuart Kleinman, Danielle re-invigorated the NY County Forensic Interest Committee, inviting speakers, communicating with local attorneys, and connecting with students interested in the field. Appointed AAPL's APA Assembly representative in 2018, Danielle works to clarify and present forensic matters to the APA Assembly. She is especially proud to be the first AAPL representative to receive AAPL support for an Action Paper to advance essential correctional education in residency programs. Now serving on the APA's Council on Psychiatry and the Law, Danielle describes an "amazing learning opportunity to make change and work with leaders in the field like Paul Appelbaum, Debra Pinals, and Rick Martinez." She has particularly enjoyed being reunited with Dr. Ford on the Council's Correctional Psychiatry subcommittee.

Dr. Kushner's next career chapter is as Associate Program Director of the NYU Forensic Psychiatry Fellowship. Her passion for educating and inspiring the next generation owes a lot to those AAPL leaders who did the same for her. ☎

How to Move Forward

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by one comment that she appears nervous during her mock trial testimony. She immediately thinks she will never be a good forensic psychiatrist. Trainee D has experienced an identity trigger, in which feedback led her to question her sense of identity and feel shame. We can impart Trainee D with several strategies to manage the identity trigger and gain utility from her program director's feedback:

- A. **Be prepared.** Trainee D knows she has a semi-annual evaluation coming up, so preparing can be helpful. She should consider how she typically responds to feedback. Does she typically get down on herself when given constructive feedback? If so, she can anticipate this in her program director meeting. Trainee D could also consider worst-case scenario feedback when preparing for her evaluation and what steps she would take to respond to it. The feedback she receives may then not feel so identity shattering.
- B. **Change the vantage point.** "Negative" feedback typically seems most devastating to the feedback receiver. Trainee D can take the feedback to a friend to get an alternative vantage point.
- C. **Shift from a fixed mindset to a growth mindset.** Instead of seeing her traits as fixed or set in stone, Trainee D should attempt to adopt a growth mindset, allowing her to view feedback as an opportunity for professional development.

The above examples illustrate how we as educators can help trainees gain from even imperfect feedback. By helping trainees identify feedback triggers and subsequently strategies for managing them, not only can we help trainees gain more from feedback, but we can help the feedback process feel more approachable and less daunting. This work should start long before fellowship, but is also critical to making the most of the forensic fellowship. ☎

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Attaining Competency

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In Memoriam

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research on assessing and treating individuals who had committed sexual offenses, as well as individuals who have problematic sexual interests, specifically paraphilic disorders. He was known for stating that a paradigm shift can change the way we view human sexuality, thereby changing how we approach the treatment of those with paraphilic disorders. Sexual interests could change through treatment, and his treatment approach was recognized in the media, as it was in academe. The details of his approach for problematic sexual interests are described in his leading-edge book from Oxford University Press, “The Paraphilias: Changing Suits in the Evolution of Sexual Interest Paradigms.”

Paul famously engaged in a debate with psychologist James Cantor on whether pedophilic disorder can be cured or can change, cogently addressing the logical fallacies that

influence traditional beliefs about the immutability of pedophilia. Paul’s stance towards treatment was that “Clinicians should inform patients there is no evidence that paraphilias, including pedophilia, cannot change.” Countering Cantor’s arguments about pedophilia as an orientation, Paul offered logical clarity:

There are several problems that arise from accepting the definition of pedophilia as an orientation. Referring to pedophilia (which is defined solely based on sexual interest in children) as an orientation (which is defined based on the gender of affection) confuses what is pathologic about the condition of pedophilia. It is not that the person feels affection toward children; it is that children sexually arouse the person... Because they equate pedophilia with orientation, commentators who claim that pedophilia is an untreatable condition often resort to arguments more applicable to homosexuality.

Paul lived his life to the fullest, whether organizing a fun gathering in his home with friends and colleagues, or cruising on the Seine River through Normandy. He was an extraordinary storyteller with an infectious smile and a witty sense of humour. He was extremely well-travelled, never saying no to an opportunity to visit a new city or country. He was equally in his element dining at Le Cinq in Paris with Evelyn or simply ordering KFC on a Friday evening. Paul had an eclectic love of all forms of music and attended countless concerts, but his love and knowledge of blues music was truly remarkable.

Patients, friends, and family will never forget Paul’s spectacular collection of ties that were, without a doubt, his signature. But Paul will be most remembered for his ability to be a healer, teacher, and educator – and an inspiration to all who knew him. ☪



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