

AAPL Newsletter

American Academy of Psychiatry and the Law



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2022 AAPL Rappeport Fellowship Awards

Britta K. Ostermeyer, MD, MBA, DFAPA and Renee M. Sorrentino, MD, DFAPA

Co-Chairs, Rappeport Fellowship Committee



Pictured, left to right: Alyssa Beda, MD; Juliette Depré, MD; Bushra Kahn, MD; Jasmine McClendon, MD, MPH; Monika Pietrzak, MD, JD; Camille Tastenhoye, MD

The highly prestigious AAPL Rappeport Fellowship was named in honor of AAPL's founding president, Jonas Rappeport, MD. This fellowship offers the opportunity for outstanding senior residents with a dedicated career trajectory in forensic psychiatry to receive mentorship by two senior AAPL members. In addition, Rappeport Fellows will also receive a

scholarship to attend the AAPL Forensic Psychiatry Review Course and the annual AAPL Meeting. We wish to thank the AAPL Executive Leadership and the Rappeport Fellowship Committee members for their ongoing support of this training opportunity. At this time, the Rappeport Fellowship Committee and AAPL are excited to announce the 2022 Rappeport Fel-

lows: Dr. Alyssa Beda, Dr. Juliette Dupree, Dr. Bushra Kahn, Dr. Jasmine McClendon, Dr. Monika Pietrzak, and Dr. Camille Tastenhoye. Congratulations to you all! Please join us in extending a warm welcome to our incoming Rappeport Fellows!

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PRESIDENT'S COLUMN

"Do You Know What It Means to Miss New Orleans?": AAPL in 2022

Susan Hatters Friedman, MD



...*The Mardi Gras memories
 Of Creole tunes that filled the air
 I dream of oleanders in June
 And soon I'm wishing that I was
 there
 Do you know what it means
 To miss New Orleans...
 (Do You Know What it Means
 to Miss New Orleans, by Eddie
 DeLange & Louis Alter)*

Some of my favorite memories revolve around jazz. As Renee Sorrentino (1) wrote in her lovely JAAPL biography, I played jazz on my saxophone and clarinet long before I dreamed of being a forensic psychiatrist. 1989's *When Harry Met Sally* starring Billy Crystal and Meg Ryan was busy winning awards for its acting and comedy. But for me, the best part was the movie's soundtrack of jazz standards played by Harry Connick, Jr. In high school, my friend and I saw Dizzy Gillespie in one of his last shows—and with cheap student seats right up front where it feels like you're almost part of the band, and could see his iconic trumpeter cheeks up close. Our high school jazz orchestra took its annual trip to New Orleans. Walking through the French Quarter, down streets I knew from jazz charts—Basin Street Blues, Dauphin Street Blues—I finally got the answer to the question about how streets could inspire songs.

My favorite museum in Washington, D.C. is the National Building Museum. (A close second is the International Spy Museum.) It was in the National Building Museum that I first learned of the New Orleans

Habitat Musicians' Village. After the catastrophic flooding in New Orleans from Hurricane Katrina, working with Habitat for Humanity and thinking of the threat to New Orleans's musical heritage, co-founders (including New Orleans jazz musicians Harry Connick, Jr and Branford Marsalis) had a vision of building Habitat homes specifically for musicians. (2) The Musicians' Village came from hard work after catastrophe, and has become a thriving neighborhood, living the New Orleans cultural tradition. The Ellis Marsalis Center for Music is a community center, named after the New Orleans native legendary jazz pianist and patriarch. The Musicians' Village received the National Building Museum's 2010 Honor Award.

It is hard not to feel the music and energy pulsing in the vibrant city. It's easy to understand how the city has born so many jazz greats. In bustling New Orleans, the Jazz Museum has more concerts than there are days of the year. The Jazz Museum also displays the cornet that Louis Armstrong played.

Nicknamed Satchmo, Louis Armstrong, possibly the most well-known New Orleans jazz musician, was among the most influential jazz musicians in history. He was born into poverty in 1901. In 1913, after firing a pistol into the air on the previous New Year's Eve, he was sentenced to the Colored Waifs Home for Boys—where he learned to play cornet. He was charismatic and known for his stories, as well as his iconic voice and trumpet. A medical overuse syndrome bears his name; Satchmo's Syndrome, rupture of the orbicularis oris, can occur in trumpeters. He stopped playing trumpet for a year in 1935 due to symptoms, and the syndrome was named posthumously. (3)

Louis Armstrong's best-known song may be "What a Wonderful World." It was written by George David Weiss and Bob Thiele, recorded by Arm-

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AAPL in 2022

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strong in 1967, and finally inducted into the Grammy Hall of Fame in 1999. According to the Songwriters Hall of Fame, the song “was created in order to cut through the racial tensions of the 1960s but due to a lack of promotion, it did not succeed as a single on its first issue in the United States, although it topped the charts in many other countries.” (4) “What a Wonderful World” wasn’t a hit stateside until after 1987’s *Good Morning Vietnam*, in which the song was played over a montage of war-time video.

‘The Whole Truth: Recognizing Culture and Gender in Forensic Psychiatry’ is my chosen theme for AAPL’s meeting in New Orleans. The program committee has done a tremendous job selecting presentations for the meeting. As you will read in the Newsletter article by this year’s co-chairs, Ryan Hall and Karen Rosenbaum, we have three excellent luncheon speakers planned. Professor Bryan Stevenson is an attorney and an international leader in human rights. His *New York Times* bestselling book, *Just Mercy*, was adapted into a powerful film of the same name. Professor Ann Wolbert Burgess is a professor of forensic nursing and pioneer in behavioral profiling. She was an author of 1992’s *Crime Classification Manual*, and has written about her experiences in 2021’s *A Killer by Design*. The character Dr. Wendy Carr in the Netflix series *Mindhunter* is based on Professor Burgess. Dr. Gary Beven, our third esteemed speaker, serves as Chief of Aerospace Psychiatry at NASA Johnson Space Center. He has served as behavioral health and performance lead for 45 International Space Station expeditions, and can help us understand the final frontier. Each of the three speakers are pioneers and outside-the-box thinkers. I’m so excited to hear what each of them shares with us at AAPL.

As I write this, my final newsletter article as AAPL president, America is in the midst of televised public hearings on the January 6th riot.

COVID is not over, mass shootings continue, and war rages in Ukraine. Despite these challenging times, a lot of people at AAPL have been conceptualizing and working hard to realize the future of AAPL.

Since AAPL’s founding in 1969, both forensic psychiatry and our Academy have moved forward exponentially. All the while, AAPL has continued to be “dedicated to excellence in practice, teaching, and research in forensic psychiatry.” During his presidential year in 2019, Rick Frierson reflected on AAPL’s first 50 years, as well as the future of forensic psychiatry training. (5) A couple months later, COVID-19 was first identified, and our world changed significantly. AAPL then rapidly shifted to virtual meetings during the presidency of Will Newman, with Ryan Wagoner and Trent Holmberg as program co-chairs. Renee Sorrentino served as program chair for another excellent virtual AAPL meeting, during Liza Gold’s presidency.

During the pandemic, AAPL Council, committees (both regular committees and search committees), task forces, publications, and AAPL staff have used virtual platforms to communicate and move forward, working for the good of AAPL. Looking to the future, AAPL will have a fully operational virtual learning system, after much behind-the-scenes work from many folks to move forward with this. Charles Scott is leading the Virtual AAPL committee. It is our hope that Virtual AAPL presentations and sessions, continuing post-pandemic, will increase our learning, but also collaboration and connection among members.

This year, Beesh Jain has led the task force for membership engagement, recruitment, and retention (MERR), out of which many thoughtful ideas have come. Sandy Simpson and Gary Chaimowitz have been leading the task force for understanding disparities in evaluations and addressing our biases in forensic practice, rigorously reviewing this literature, and considering how these issues manifest in our practice and the ethical implications. It has also been a

busy year for search committees, led by Renee Sorrentino, Rick Frierson, and Aimee Kaempf. As you will be aware from mailings, searches have been conducted for the next AAPL Medical Director subsequent to years of Jeff Janofsky’s exceptional service to the organization, and for the next AAPL Review Course Director after decades of Phil Resnick’s dynamic teaching.

We’re excited to now return to in-person meetings. In-person meetings are important for gaining knowledge, but also for the formal and informal networking, the hallway discussions in between sessions spurred on by the learning from panels and workshops. Midwest AAPL held its March 2022 Minneapolis meeting in person and this was a first in-person meeting back for many of us. The energy of this vibrant group was restorative. It was so wonderful to catch up with friends, old and new.

New Orleans is a city renowned around the world not only for being the birthplace of jazz, but for its Creole and Cajun cuisine, its architecture, and its festivals, among other distinctions. “Do you Know What It Means to Miss New Orleans?” is a jazz standard first played by Satchmo, with Billie Holiday on vocals in 1947. Less than a week after 2005’s Hurricane Katrina, Harry Connick Jr. and Wynton Marsalis poignantly performed the song at NBC’s Concert for Hurricane Relief, to benefit the Red Cross Disaster Fund. (6)

If you recently attended the May APA meeting (also in New Orleans) like I did, you saw a city that we should be eager to return to in October. A city that, with much work after Hurricane Katrina, has flourished. We look forward to welcoming you, expanding our minds, and re-connecting in person at our New Orleans meeting. And all that jazz. ☺

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2022 AAPL RAPPEPORT FELLOWSHIP AWARDS



Alyssa Beda, MD

Dr. Alyssa Beda completed her psychiatric residency at the University Hospitals Cleveland Medical Center, Case Western Reserve University. She is currently in her Child and Adolescent Psychiatry Fellowship at the University of Maryland, Sheppard-Enoch Pratt Hospital in Baltimore, Maryland where she will serve as the Executive Chief during her second year. Her scholarly contributions include co-authoring a chapter on child murder by the mother in the 2021 SAGE Handbook of Domestic Violence and media reviews for the *Journal of the American Academy of Psychiatry and the Law*. At the 2021 AAPL annual meeting, she co-presented with Child and Adolescent Psychiatry Committee members, “Working with Justice-Involved Youth: Lessons from the Era of COVID-19.” She currently serves on the Child and Adolescent Psychiatry Committee and recently completed a year on the Maryland Regional Council for Child and Adolescent Psychiatry (MRCCAP) as a Fellow Delegate. She is a National Health Service Corps (NHSC) member with plans to begin work at a Federally Qualified Health Center in the D.C., Maryland and Virginia (DMV) region upon completion of her CAP fellowship. She plans to continue engagement in forensic opportunities throughout this time and beyond her service obligation. Her Rappeport mentors are Drs. Ryan Hall and Sara West.



Juliette Dupré, MD

Dr. Juliette Dupré is currently in her final year of general psychiatry residency at the University of Toronto. She is passionate about interdisciplinary research at the intersection of mental health, gender, and the law. As a medical student she was awarded the University of Toronto LEAD scholarship in recognition of her potential as an emerging physician leader. This scholarship allowed her to pursue a Master of Science in System Leadership and Innovation where she gained experience in quality improvement and policy analysis. She also completed a concurrent Master of Arts in Medical Anthropology focusing on the ethics of relating to suffering subjects. She has applied this learning to the forensic context by developing and piloting a program in Trauma-Informed Care for allied health professionals on the Women’s General Forensic unit at the Centre for Addiction and Mental Health. Dr. Dupré is completing a PhD in Gender Studies at York University, where she uses psychoanalytic theory to investigate the relationship between socially held beliefs about female gender, violence, and (in)sanity. Her doctoral research has been recognized at the national level with a Social Science and Humanities Research Council Doctoral Fellowship. Dr. Dupré hopes to continue her training in forensic psychiatry at the University of Toronto. Her Rappeport mentors are Drs. Gary Chaimowitz and Ariana Nesbit-Bartsch.



Bushra Kahn, MD

Dr. Bushra Khan is a fifth-year Clinician-Scientist resident psychiatrist at the University of Toronto. Dr. Khan is concurrently pursuing a Master of Public Health at the Harvard T.H. Chan School of Public Health as a prestigious Frank Knox Memorial Fellow. Dr. Khan serves as the Vice Chair of the American Psychiatric Association Public Psychiatry fellowship and is the immediate past-president of the Psychiatry Residents’ Association of Toronto where she championed anti-racism initiatives and developed the underserved curriculum. Dr. Khan’s research focuses on underserved communities initially in the context of individuals experiencing precarious housing and homelessness in addition refugee youth experiencing housing instability. More recently, Dr. Khan’s research examines forensic systems with respect to intersectionality with culture, syndemics, outcomes within carceral settings and forensic education. While in residency, Dr. Khan has published several first-author peer-reviewed papers and delivered international oral presentations at conferences including the APA, CPA and CAPL. She has worked professionally in healthcare evaluation at BORN Ontario and in language instruction at Tsinghua University in Beijing, China. Dr. Khan has received multiple accolades for her work with marginalized communities including the Canadian Sovereign’s Medal for Volunteers and the Hesselbein Global Academy Medal for Civic Engagement. Dr. Khan will be applying to forensic psychiatry subspecialty training in Canada in the 2023-2024 cycle. Her Rappeport mentors are Drs. Robindra Paul and Renee Sorrentino.

2022 AAPL RAPPEPORT FELLOWSHIP AWARDS



Jasmine McClendon, MD, MPH

Dr. Jasmine McClendon is a fourth-year resident at UC Davis. Prior to entering medical school, Dr. McClendon worked as a Program Supervisor for Court Appointed Special Advocates (CASA) of Los Angeles, a non-profit organization focused on advocating for children in the child welfare system. Dr. McClendon completed her medical training at Keck School of Medicine at USC in Los Angeles. She also completed an MPH at Johns Hopkins University, where she worked on brain injury, overdose, and substance use research projects. During residency she completed a forensic psychiatry elective as well as helped lead a forensic psychiatry mock trial lecture series for her resident colleagues. For two years she has served as a primary psychiatrist at a jail-based competency treatment program, gaining opportunities to provide expert testimony. Dr. McClendon is a member of AAPL's Resident Training Committee. She has authored publications in JAACAP and JAACAP Connect, with additional publications currently under review. Her publications focus on systemic juvenile justice issues, race, substance use, and neurodevelopment. Her career interests include the overlap amongst race, trauma, mental illness, and criminality; female-related psychopathy; and juvenile justice reform. Dr. McClendon is currently interviewing for a forensic psychiatry fellowship position. Her Rappeport mentors are Drs. Nathan Kolla and Joseph Penn.



Monika Pietrzak, MD, JD

Dr. Monika Pietrzak is a chief resident in her fourth year of adult psychiatry training at University Hospitals/Case Western Reserve University. She completed her undergraduate studies at New York University, graduating summa cum laude with a bachelor's degree in psychology and a minor in business studies. She then obtained her Juris Doctorate from New York University School of Law. After law school, she worked at a law firm in New Jersey for several years. She subsequently earned her medical degree from New York University School of Medicine. During her medical school and residency training, Dr. Pietrzak has pursued forensic psychiatry electives, scholarly projects, and teaching opportunities on forensic-related topics. She also serves on several forensic special interest groups and committees, including AAPL's Correctional Forensic Psychiatry Committee. She has been honored with the 2022 Resnick Scholar Award from the Midwest Chapter of AAPL based on her work. Additionally, she is a 2021-2022 Group for Advancement of Psychiatry Fellow. In 2023, she will begin her forensic psychiatry fellowship at Case Western Reserve University. Her Rappeport mentors are Drs. Jackie Landess and Britta Ostermeyer.



Camille Tastenhoye, MD

Dr. Camille Tastenhoye is currently a 1st year Child and Adolescent Psychiatry fellow at the University of Pittsburgh Medical Center, where she also completed her general adult residency. She will serve as Chief Resident for the CAP fellowship this upcoming academic year. She has been interested in forensic psychiatry since attending AAPL as a second-year resident and has since presented annually on topics including malingering and racial disparities in NGRI sentencing. She has completed various forensic rotations including working at a juvenile detention center and in a dedicated outpatient clinic for adjudicated minor sex offenders and arsonists. Her academic interests include radicalization of youth through social media, cults, and extremist groups. She has co-authored several papers related to forensic psychiatry, including a first-author paper in press with JAAPL reviewing the subculture of involuntary celibates. Dr. Tastenhoye has been very involved in her residency program throughout her time there. She worked closely with program leadership to create and implement a novel curriculum addressing inequities in psychiatric practice, which has been presented nationally at AACAP, AADPRT, and AAP. She plans to complete a forensic fellowship upon completion of her current fellowship and hopes to expand access to and awareness of forensic psychiatry for general residency programs. Her Rappeport mentors are Drs. Cathy Lewis and Ryan Wagoner.

The AAPL Rappeport Fellowship competition offers an opportunity for outstanding residents with interests in psychiatry and the law to develop their knowledge and skills. Winners must attend the Annual Meeting and Forensic Psychiatry Review Course. The 2023 AAPL Meeting will be held at the Chicago Marriott Downtown from October 19-22, and the Forensic Psychiatry Review Course will take place immediately prior from October 16-18. Travel, lodging, and educational expenses are included in the fellowship award, and a per diem will be paid to cover meals and other expenses. In addition, Fellows receive subscriptions to AAPL's major publications, the Newsletter and the Journal of the American Academy of Psychiatry and the Law.

Residents who are currently PGY-3 in a general program, or PGY-4 in a child or geriatric subspecialty training program and who will begin their final year of training in July 2023, are eligible. Canadian PGY-4 general psychiatry residents and Canadian PGY-5 child residents are eligible. Applications must be emailed to the AAPL Executive Office (office@aapl.org) no later than Monday, March 13, 2023.

The Equal Justice Initiative and Health Care Disparities

Jeffrey S. Janofsky, MD



At AAPL President Dr. Susan Hatters-Freidman's request, Dr. Megan Testa and I attended the Equal Justice Initiative's (EJI) Health Convening Program in Montgomery, Alabama on April 22nd, 2022. The EJI is a non-profit organization that was originally conceived to provide legal services to incarcerated persons. EJI was founded by attorney Bryan Stevenson, and its attorneys have won multiple appellate and US Supreme Court cases exonerating death row prisoners, and against unjustly harsh sentencing and abuse of incarcerated prisoners.

Bryan Stevenson will be a luncheon speaker at AAPL's October 2022 Annual Meeting in New Orleans. Some may remember that he previously spoke to AAPL as a luncheon speaker in 2010 on Re-evaluating Juvenile Culpability and Evolving Standards of Decency.

The Health Convening Meeting Dr. Testa and I attended has its roots in EJI's mission expansion into looking at disparities in US health care. EJI's Board members want to step outside of the courtroom and invoke the power of the narrative. Inspired by the work of EJI's late board member Dr. Paul Farmer's work with Partners in Health (PIH), EJI members believe individual and systems approaches to illness in impoverished communities is critical. Dr. Farmer's work in Haiti delivering HIV medications con-founded "many in the medical field who believed it would be impossible for poor rural people to survive the disease." (1) Mr. Stevenson spoke eloquently of Dr. Farmer's work and how he intended EJI's future work to focus on health equity issues, including helping to improve the transition

of psychiatric and medical care when incarcerated persons are released to the community.

At the Convening, health professionals from all over the US and several other countries met. EJI offered an open invitation for ideas from attendees on next steps, to build a network of professionals committed to health equity.

We heard from, among others, Dr. Luckson Dullie, PIH Executive Director in Malawi, one of the poorest nations in the world. Dr. Dullie oversees PIH efforts in Malawi to provide HIV tests and treatments and integrated care for patients. He has focused on hiring former patients, called "health navigators," both to provide income and to improve the perception of western medicine in the community.

We also heard from Dr. Selwyn Vickers, a surgeon who grew up in the US South's "Black Belt" and is now CEO of University of Alabama at Birmingham Health Systems and Dean of the UAB medical school. He spoke to us about the importance of adding equity measures into quality metrics telling us that a "patient's ZIP code is more important than their genetic code" in health care outcomes. Dr. Vickers believes that if we lessen health disparities health outcome improves both for society's haves and have nots, and that social determinants of health have more influence on outcome than medical determinants of health. He also emphasized the importance of recruiting minority persons into clinical research, and he described how he had helped to attempt to increase the participation of minorities in cancer-related research studies.

We heard from Anthony Ray Hinton, who served 30 years on Alabama's death row after being convicted on false testimony from a government ballistics expert. After years of court petitions to have the

evidence re-examined, it was shown conclusively that the bullets that killed the victim could not have been from the revolver found in Mr. Hinton's mother's home. Mr. Hinton was freed in 2015. He now works with the EJI to tell his story and has written a moving book, *The Sun Does Shine: How I Found Life and Freedom on Death Row*. (3)

I was also able to spend time in the EJI's recently opened Legacy Museum, on the American legacy of slavery. The museum sits on a former slave auction site in Montgomery. It traces the legacy of slavery from the transatlantic slave trade through the domestic slave trade, Reconstruction, and the 20th and 21st century issues of lynching, codified racial segregation, and the emergence of over-incarceration. I found both the content and presentation incredibly moving and informative, at the same level of my experience in the Washington and Jerusalem Holocaust museums. We have not fully confronted the legacy of slavery in America. A visit to the Legacy Museum is a good place for anyone to start.

So how can AAPL help? We already have a section in our own Resource for Prescribing in Corrections document, emphasizing how important continuity of psychiatric care is when prisoners are released. AAPL has focused on training psychiatrists to work in correctional settings. We also have an active Diversity Committee. AAPL has the deep expertise to help improve health disparities in correctional settings. ☪

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It Starts with the Nexus

Joseph R. Simpson, MD, PhD



All forensic psychiatrists are familiar with the term “nexus.” Legally speaking, it is defined as: “A connection or link, often a causal one.” (Ref.

1, p. 1070). Establishing a nexus, or demonstrating a lack thereof, is critical to most forensic expert work. In many cases, the difference of opinion between two experts hinges on this element of the case formulation.

To place the idea of a nexus in a forensic psychiatric context, consider the following actual case examples.

- A street gang member, Defendant A, took a firearm and drove, along with two of his associates, B and C, through the territory of a rival gang, looking for members of the latter gang. When they located one, Defendant A attempted to hand the weapon to B, instructing him to use it. However, neither B nor C would accept it. Defendant A then exited the vehicle and shot the rival gang member, killing him. The firearm used in the murder was never recovered. In the sentencing phase of his capital trial, Defendant A’s defense team sought to introduce evidence of cognitive dysfunction, but not severe enough to rise to the level of intellectual disability, which would have precluded a capital sentence under the *Atkins* decision. (2)

Based on the facts outlined, it would appear challenging to identify a nexus between Defendant A’s actions and choices in the crime and a cognitive deficit. Of course, I have provided only the broadest sketch, and one certainly might be able to think of ways in which Defendant

A’s overall cognitive or psychiatric profile may have been a mitigating factor at sentencing. The jury did not find cognitive impairment or any other factors persuasive, and sentenced the defendant to death.

- In a case involving three defendants accused of murder in the course of a robbery, one of the defendants, who had no prior mental health history, malingered psychosis, as demonstrated by (among other facts) recordings of his phone calls from jail. Expert A evaluated him and opined that he had schizophrenia and was incompetent to stand trial, while Expert B opined that he was malingering. At the jury trial to determine competency, the defense attorney asked Expert B if he was aware that the defendant had been shot in the past, or that he had post-traumatic stress disorder as a result of that event.

Here again, it is not clear what nexus the defense attorney was seeking to establish by bringing up prior trauma in a competency trial. The defendant was found competent to stand trial; he was subsequently convicted of first-degree murder and sentenced to life in prison without the possibility of parole.

- A man’s conviction for attempted murder was overturned on appeal on grounds of ineffective assistance of counsel. At his trial, no expert psychiatric testimony had been offered. The appeal was based in significant part on an expert report obtained after his conviction, which included a diagnostic impression of post-traumatic stress disorder. Although not explicitly discussed in the report or the appeal process, the circumstances of the case matched many of the characteristics of a catathy-

mic reaction, as described by Schlesinger. (7) There was a nexus between the defendant’s past history of sexual abuse and PTSD symptoms and his behavior in the instant offense, which, in the eyes of the appellate court, could have led a jury to conclude that he did not form the specific intent to kill; thus, a new trial was required.

I have reviewed the concept of the nexus in forensic psychiatry in some detail as a lead-in for a new type of article appearing in this issue of the AAPL Newsletter. AAPL member Hal Wortzel, MD contacted the Editors regarding the article about Jack Ruby’s epilepsy defense in the last issue. (4) He was concerned that the article did not make it sufficiently clear that in that famous case, the lack of a nexus to the crime, rather than the validity of frontal lobe epilepsy as a diagnostic entity, was the reason the defense did not succeed. We invited Dr. Wortzel, as well as the article’s authors, medical students Bao Nguyen and Brandon Simons and Associate Editor Ryan Hall, MD, to provide some additional thoughts for the benefit of the Newsletter readership.

We hope that you enjoy this new format and find the article useful and informative. In future issues we hope to publish similar dialogues or colloquia. You can give feedback on this, or any other Newsletter-related topic or issue, by emailing newslettereditor@aapl.org. ☎

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- (4) Nguyen B, Simons B, Hall R. Who Pulled the Trigger on Lee Harvey Oswald? Epilepsy or Jack Ruby himself? AAPL Newsletter 47: 13-14, 2022

Ask the Experts

Neil S. Kaye, MD, DLFAPA

Graham Glancy, MB, ChB, FRC Psych, FRCP

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

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

Q: If I keep doing forensic work and hang up my day job shingle, what are the pros and cons of doing only expert witness work and not being an active practitioner?



A. Kaye:

Ah, the elusive siren's call to abandon clinical work for the often more remunerative exclusive forensic practice. The

appeal of such a path is obvious: regular hours, no on-call, no patient behaviors to worry about, no office staff to manage, less overhead, no phone calls for prior authorizations, no prescription renewals or arguing with minimally trained gatekeepers to do what's right to help your patient.

But there are many potential downsides to taking such a path. For me, the enjoyment of working with a person and seeing them get better is irreplaceable. I took a sabbatical from clinical work many years ago and found I missed it terribly, so I returned. I can't imagine not being an active treating physician.

One of the benefits of earning income from various sources is the freedom to decline forensic cases that are uninteresting or in areas outside of your true expertise. If your

only source of income is forensics, you will be tempted to take cases that you might otherwise decline, which invariably creates its own level of stress. Also, do you really have a sufficient, reliable, and steady stream of good forensic referrals? What happens if changes in Workers' Compensation law are enacted, or a key referring lawyer retires?

Expertise is not just about knowledge but also, in many cases (especially med-mal), about being familiar with the treatment and the standard of care. One can get "rusty" without staying active in the trenches and lose one's real expertise. How comfortable would you be testifying about a patient who was on a medication you had never prescribed?

Some states require an expert witness to be in active clinical practice and set a threshold for such work (e.g., no more than 20% of your work is forensic). So, if you decide to just do forensics, you will need to be aware of laws in any state in which you are called that might be disqualifying. This is done to prevent the traveling "hired gun" scenario, an accusation which becomes harder to rebut if you do only forensics.

I have seen colleagues take this path as a step toward retirement. They may phase out their clinical work and then practice exclusively in the forensic arena for a few years. While that's not unreasonable, the same cautions noted above apply.



A. Glancy:

I have a personal aversion to answering a question with "Well, that's a good question," especially when trainees use this

phrase during cross-examination. When I received this question from a member, however, I have to confess I thought, "That's a good question."

It is an area that I must also confess to which I have not previously given serious consideration.

AAPL defines forensic psychiatry as "a medical subspecialty that includes research and clinical practice in the many areas in which psychiatry is applied to legal issues." There are a number of subspecialties included under the rubric of forensic psychiatry. These include correctional psychiatry, sexual behaviors, and forensic rehabilitation, including working in forensic hospitals. It is likely true that there are a number of forensic psychiatrists and other forensic mental health professionals who only do forensic expert work. It is my experience that many of them do maintain some clinical practice, although this is varied across North America.

In order to be qualified as an expert in forensic psychiatry, generally, the expert establishes that they have the requisite relevant, reliable training, experience, and skill.

Different jurisdictions have different practices, and it often comes down to the judge in a particular case. The Federal Rules of Evidence state that "a witness who is qualified as an expert by knowledge, skill, experience, training or education may testify" (1). AAPL discusses qualifications in their ethics guidelines, noting that "expertise in the practice of forensic psychiatry should be claimed only in areas of actual knowledge, skills, training, and experience". (Ref. 2, Para. V.) It is surmised that AAPL uses "and" deliberately in that sentence, implying that all these skills are required for a forensic expert (Meyer & Gutheil, 2017).

As Dr. Kaye has noted, in some jurisdictions, a certain amount of clinical work is necessary to be qualified as an expert. In the US, most states limit malpractice expert testimony (especially for a plaintiff) to psychiatrists with current clinical experience, often experience in the specific type of patient care being questioned (e.g., suicidal patients, inpatient psychiatry, patient diagnosis). In order to get some sort of consensus in this

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Ask the Experts

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area, I asked Dr. William Reid, an experienced forensic psychiatrist, past president of AAPL, and author of the book *Developing a Forensic Practice: Operations and Ethics Experts* (4), for his opinion on the subject. He advised me that:

Our usefulness to courts and our attractiveness to lawyers is based primarily in our psychiatric/medical backgrounds, not our forensic ones. It's true that being able to understand the lawyer's issues and translate clinical information into understandable legal (or jury) parlance is important, but it all rests on our credibility as psychiatrists first. The court needs *psychiatric* expertise, not *forensic* expertise. (Personal communication)

From a practical point of view, forensic practice can be complicated, difficult to organize, and stressful. It is sometimes a relief to be able to relax into routine clinical work for part of the week. Another scheduling problem is that if you take on multiple forensic cases, you may have to testify on multiple cases, and Murphy's Law states that these will all come in the same month.

Forensic practice also relies upon a referral base, which like in many other services, can be variable. I have spoken to consultants in many other fields, including top criminal lawyers, who upon finishing one or two big cases will suddenly have the negative cognition, "Will I ever get another referral?" This introduces self-doubt and panic and can be quite stressful. I have found, after 40 years in the field, that the answer has always been "Yes, but who knows?"

Various types of clinical work, however, do produce a steady flow of dependable work. For instance, a regular outpatient practice with reasonably dependable patients produces a regular income and occupies a certain portion of the week. Inpatient forensic rehabilitation

or correctional work also not only satisfies these goals but may also be inherently interesting and satisfying. In my opinion, this is one of the real advantages of the broader field of forensic psychiatry in that almost every day can be a little bit different and varied.

My advice to young forensic psychiatrists is to spend the first ten years of their career at an academic center if they have the opportunity to do so. This generally affords the opportunity to enjoy varied forensic psychiatric settings. It also provides the opportunity for teaching (an essential and rewarding thing in itself) and possibly research and academic writing. After these ten years, it is reasonable to take stock and make a decision on the future type of practice. They may want to stay in the academic setting, or they may consider different types of practice. It is much harder to go in the other direction. If a young trainee sets up in private practice and then, after ten years, feels unfulfilled or burnt out, it is harder to get a job in an academic setting—they have missed the boat.

Take-Home Points:

While it may be possible to do only forensic work, the reality is that most of us will not develop a sufficient referral base to make that possible. Further, the lack of clinical work begins to lessen your ability to claim expertise in a number of common areas that present in our usual scope of practice. There is such a need for good clinicians that in all good conscience, we can't recommend pursuing only forensic work, other than perhaps as a time-limited exit strategy to enter retirement. ☹

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AAPL in 2022

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civic-innovator-new-orleans-habitat-musicians-village/

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2022 MANFRED GUTTMACHER AWARD

AAPL congratulates Dr. Jens Hoffman and Dr. J. Reid Meloy on winning the 2022 Manfred Guttmacher Award for their book *International Handbook of Threat Assessment*.

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Rappeport Fellowship Retrospective: Rebecca Brendel, MD, JD

Ariana Nesbit, MD, MBE

In this continuing series, we explore the career paths of former Rappeport Fellows. The Rappeport Fellowship honors Jonas R. Rappeport, MD, who was AAPL's Founder (1969), first President (1969-71), and first Medical Director (1972-95). For this series, I had the opportunity to interview Rebecca Brendel, MD, JD, who was a Rappeport Fellow in 2003. Since her Rappeport Fellowship year, Dr. Brendel has emerged as a leader not only in forensic psychiatry, but also in general psychiatry, psychosomatic medicine, and ethics.

Dr. Brendel's interests in medicine, ethics, and the law date back to her undergraduate years at Yale College, where she earned a distinction in Philosophy. At Yale, she became interested in underlying justice considerations in medicine. After college, she earned both a medical degree from the University of Chicago Pritzker School of Medicine and a law degree from the University of Chicago Law School. During law school, Dr. Brendel worked with a mentor on reforming mental health law in the state. Specific topic areas addressed included surrogate decision-making, electroconvulsive therapy for incompetent persons, and civil rights issues for NGRI acquittees. Dr. Brendel described how her time in law school informed the work she ultimately went on to do as a forensic psychiatrist and policy consultant.

Although Dr. Brendel started medical school undecided about her future career, she now believes that, given the focus of her work in law school and early interest in ethics, it was "almost predetermined" that she would become a forensic psychiatrist. By her third year of medical school, she had become fascinated by psychiatry and saw how this career path would allow her to combine both practical and advocacy elements related to the law, while at the same time providing her with a deep intellectual community

and a broad spectrum of treatment approaches. During medical school, Dr. Brendel made the formative decision to complete clinical rotations at the Massachusetts Mental Health Center, where she met Dr. Thomas Gutheil and started attending his Program in Psychiatry and the Law meetings. Dr. Gutheil encouraged Dr. Brendel to volunteer on the Massachusetts Mental Health Center's Human Rights Committee, and she was appointed Chair of this Committee while still a medical student. She continued to serve as Chair throughout the majority of her psychiatry residency at Massachusetts General Hospital/McLean Hospital.

At the Program in Psychiatry and the Law meetings, Dr. Brendel met many early mentors, including Drs. Marilyn Price, Donna Norris, and Larry Strasburger. Dr. Strasburger—a close friend of Dr. Rappeport—encouraged Dr. Brendel to become involved in AAPL and to apply for the Rappeport Fellowship. Dr. Brendel attended AAPL for the first time in 2003 as a Rappeport Fellow, and recalled her experience as a Rappeport Fellow as being "hugely influential." She described how "a lot of people came out of the woodwork" to welcome her and the other Rappeport Fellows into the organization. She specifically recalled meeting Dr. Philip Meredith, connecting her to AAPL's Ethics Committee. This was a memorable meeting for her because her involvement with AAPL's Ethics Committee "opened up a whole host of lifelong connections and relationships." Dr. Brendel explained how the Rappeport Fellowship was not only helpful in connecting her to mentors, but that she also developed lasting, meaningful connections with her two Rappeport co-fellows, Drs. Susan Hatters-Friedman and Elizabeth Ford. Because of the bond that she and her co-fellows formed that year, they have been there for each other during "really pivotal moments" in

their careers.

Dr. Brendel's Rappeport Fellowship solidified her interest in forensic psychiatry, and she went on to complete a fellowship in Forensic Psychiatry at Massachusetts General Hospital. Immediately after fellowship, in 2006, she was appointed Assistant Training Director of the fellowship program. She was later promoted to Associate Training Director, which was a role she served in from 2008-2011. Throughout her career, Dr. Brendel has been focused on how psychiatrists can be engaged in public policy and psychiatrists' relationships to the state. Examples of how she has engaged in this work include her participation in the Massachusetts Probate and Family Court's implementation of a new guardianship law in 2009, and her participation in a working group to amend the Illinois Mental Health Code.

Dr. Brendel served as the Edmond J. Safra Faculty Fellow in Ethics at Harvard University during the 2006-2007 academic year. She is currently the director of Law and Ethics at the Center for Law, Brain, and Behavior at Massachusetts General Hospital, the director of the Master's Degree Program at the Harvard Medical School Center for Bioethics, and is an Assistant Professor of Psychiatry at Harvard Medical School. Early in her career, she found a niche in general hospital forensic psychiatry, and this focus carried her all the way to become the 2020-2021 President of the Academy of Psychosomatic Medicine. In addition, she is a distinguished Fellow of the American Psychiatric Association (APA), where she has been parliamentarian to the Board of Trustees, the Chair of the Ethics Committee, and the Chair of the Board of Trustees Ad Hoc Working Group on Ethics.

In May of 2022, Dr. Brendel will assume the role of APA President. Dr. Brendel is a long-standing member of AAPL's Ethics Committee, and considers this one of her primary professional homes and the source of many of her most profoundly transformative professional relationships: "In the

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Understanding Obsessive Compulsive Disorder Through a Forensic Lens

Reema Dedania, MD



On the cusp of finishing over a decade of higher education, I walked into a job interview at an Obsessive-Compulsive Disorder (OCD) clinic with

both relief and excitement. The day was anything but ordinary. Using an exposure and response prevention model of therapy for OCD, the clinic offered me a front-row seat to watch patients participating in therapy. Seeing gummy bears eaten off toilet seats and Bibles with “666” written all over them, and smelling the infamous “vomit jar” (not real vomit), were all included in my interview day experience. The clinicians actively participated in exposure work to facilitate an in-vivo experience for patients. Attendings going rogue? Sign me up!

The next two years, although challenging, enriched my understanding of the nuances involved in understanding a disease in which the interplay between thoughts and behaviors is at its core. Unbeknownst to me at the time, this experience primed my career as a forensic psychiatrist. Treating patients with a variety of OCD subtypes –including contamination OCD, scrupulosity OCD, and harm OCD –left me contemplating how to reconcile my own understanding of what constitute compulsive versus impulsive behaviors, and the relationship between OCD and impulse-control disorders.

Amongst the most distressed patients I worked with were those with pedophilia OCD (P-OCD), in which individuals have intrusive thoughts of being attracted to children and compulsions to extinguish those fears. Patients with P-OCD are not attracted to children. Rather, they have a debilitating *fear* that they might be, or a fear that if they are, they will be unable to resist an impulse to act. (1)

Marred not only by the intrusive, unwanted thoughts, patients often carry the weight of shame and guilt associated with the nature of the disease.

In general, those with OCD act compulsively with the sole intent of reducing or eliminating the overwhelming anxiety that they experience related to very specific unwanted thoughts. Although rare, some P-OCD patients with whom I worked had sought out pornographic content to demonstrate that they were not aroused by it, whether with the simple and more immediate goal of eliminating the anxiety associated with the thought, or with the broader and more self-probing goal of proving to themselves that they do not have sexual attraction towards children. In an effort to neutralize intrusive thoughts, they faced legal ramifications in the form of a conviction, loss of child custody, or mandatory sex offender registration.

When I left my job to pursue a fellowship at Case Western Reserve University, I did not anticipate that my clinical experience in OCD would dovetail with my new role as a forensic evaluator. The most pertinent areas in which my questions about OCD’s place in a legal framework have emerged are criminal responsibility and mitigation.

From *Rex v. Arnold* (2) in the 18th Century, establishing the so-called “wild beast” test, to the Insanity Defense Reform Act, (3) criteria for the insanity defense have shifted back and forth, incorporating various degrees of cognitive and volitional standards. The *Model Penal Code*’s formulation contains a volitional prong: “A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect, he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law.” (4) Under this standard, a defendant with OCD

could be found not guilty by reason of insanity when the disorder makes it difficult to do what the law requires, even if cognitively aware of the wrongfulness of their conduct. In subsequent years, many jurisdictions have sought to narrow the criteria by eliminating the volitional prong. After uproar over the John Hinckley verdict in 1983, the Federal government’s 1984 Insanity Defense Reform Act replaced the Model Penal Code statute with a purely cognitive statute. The variability of insanity defenses across jurisdictions is important in considering the key features of disorders such as OCD. (5, 6)

From a forensic standpoint, the following questions arise: how does (and can) the law provide a pathway for those with OCD to avoid criminal liability or mitigate their responsibility? How can we conceptualize other disorders that are linked by difficulties in controlling impulses, such as Intermittent Explosive Disorder or Pathological Gambling? Answers are generally not explicitly provided in the law, allowing a degree of interpretation by the forensic evaluator.

There are few cases involving a complete acquittal from criminal responsibility for defendants with OCD. In 2013, a High Court in India acquitted a juvenile with OCD after he murdered his mother. (7) Other cases have highlighted the fact that psychotic symptoms associated with OCD are sufficient grounds for a NGRI acquittal. In *R v. Ozipko*, (8, 9) Mr. Ozipko was charged with one count of second-degree murder and two counts of attempted murder. Dr. Lohrasbe, the forensic psychiatrist who evaluated Mr. Ozipko, determined that he had OCD symptoms since childhood, including repeated hand-washing, checking for locked doors, and mentally replaying thoughts. Dr. Lohrasbe noted that his preoccupations had an “obsessive quality, with his violent conduct being the culmination of several influences...including acute psychotic symptoms with horrific compulsions.” His OCD symptoms also included a preoccupation with the sequencing of letters, especially ‘Z’

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New Group Mentoring Initiative for Women AAPL Members

Jacqueline Landess, MD, JD; Sarah Baker, MD, MA;
Ashley VanDercar, MD, JD; Ariana Nesbit, MD, MBE

The AAPL Women's Committee, in collaboration with the Early Career Development Committee and others, will soon launch a small group mentoring pilot program, recently endorsed by the AAPL Executive Council. This pilot will focus on matching forensic psychiatry fellows and early career psychiatrists to mentorship groups that will meet on a bimonthly basis. The initial phase of the program will focus on women-centered mentorship. We hope to enhance membership diversity, retention, and recruitment by fostering an inclusive and welcoming culture and providing opportunities for networking, knowledge sharing, and scholarly collaboration.

Mentorship has been associated with increased research activity and career satisfaction among mentees. (1,2) Women professionals, in particular, benefit from mentorship, especially for leadership development. (3-5) This is critical because women – especially women of color, with disabilities, and who are LGBTQ – are far less likely to occupy management or “C-suite” positions. (6) This absence is not unique to corporate America: the gender gap exists within academic psychiatry as well. Most notably, only 9% of psychiatry department chairs are women, even though approximately 42% of academic psychiatrists are women. (7) In fact, women in academic medicine have lower mean starting salaries than their male counterparts. (8)

While traditional mentorship functions as a dyad, recent literature has described small group mentorship as a viable, dynamic, and engaging option for organizations and institutions to consider when exploring creative methods of relationship-building and career development. (9-11) This form of mentorship may be more accessible and less intimidating to younger psychiatrists and encourages peer-to-peer sharing and discussion of information,

attitudes, and opinions, as well as leadership development. (12) Small group mentoring is usually defined as one or two mentors leading groups not exceeding six mentees. The groups meet at regular intervals and discuss pre-determined topics of interest.

The existing literature clearly describes the benefits of small group mentoring. Participants in a two-year mentoring group for early-career faculty in the Psychiatry Department at the University of Toronto reported benefits including increased knowledge and enhanced feelings of collegiality and empowerment. (10) Another group mentoring program for female faculty and residents in the Emergency Medicine Department at the University of Indiana created a family leave policy and established a lactation space, thereby supporting women with families. (13)

Several organizations, including the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) and the American Academy of Child and Adolescent Psychiatry (AACAP) have seen the positive results of creating and implementing small group mentoring for their members. The ADMSEP model is a semi-structured approach for all members in which four to six mentees are matched with two mentors. They meet as a group on a bimonthly or quarterly basis. In AACAP, the small groups consist specifically of women mentors and mentees, and focus on leadership development.

For this pilot, we plan to recruit participants over the next six months with a target start date within the next year. In the initial phase, small groups will be led by two mentors and meet every other month to discuss topics like ethics, leadership, academic development, and work-life balance. Surveys will match mentors with mentees, measure participant satisfaction and other outcomes. Our

primary objective is to increase and retain the number of early career psychiatrists in AAPL.

If you are interested in becoming a mentor or mentee, please email Jacqueline Landess (jslandessmd@gmail.com) or Sarah Baker (sarah.baker@utsouthwestern.edu), co-chairs of the women's committee. Be on the lookout for further information at the October meeting. We welcome your involvement in this important endeavor. ☎

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Revisiting Human Trafficking: A Brief Review

Fatima Masumova, DO and Sanjay Adhia, MD
Human Rights and National Security Committee

Ms. T. is a 29-year-old woman from Guatemala, who at age three witnessed her family members being raped and killed by the right-wing military. After immigrating with her uncle to the US she was forced to cook and do chores under the threat of being sent back to Guatemala. Her uncle also used violence against her and accepted money from men who would rape her. She ran away and eventually pursued asylum. She was evaluated by a forensic psychiatrist, who opined that her Post-Traumatic Stress Disorder (PTSD) was exacerbated by trauma from trafficking, that her condition would deteriorate if she returned to Guatemala, and that the delay in filing for asylum was, in part, due to her PTSD symptoms.

Psychiatrists may encounter victims of human trafficking in clinical and forensic practice, including correctional settings. (1) These individuals would benefit from referral to services such as victim advocacy, social support, and the National Human Trafficking Hotline, although they may choose to decline assistance. Psychiatrists should be aware of the phenomenon of human trafficking because they may be called upon, either as a treating fact witness or expert witness, to provide testimony to explain victim behavior and symptoms. (2)

There are several types of human trafficking, including for forced labor; for sexual exploitation; for organ harvesting; and for forced criminal activities such as drug farming, theft, or forced begging. (3) Most common are trafficking for sexual exploitation or forced labor. (4)

In the US, sex and labor trafficking are defined in the Trafficking Victim's Protection Act of 2000 (TVPA). Sex trafficking is a "commercial sex act induced by force, fraud, or coercion." Additionally, sex trafficking encompasses acts in which a minor

is caused to perform commercial sex, even in the absence of force, fraud or coercion. Labor trafficking is "the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services" in order to force, coerce, or fraudulently induce an individual into slavery, involuntary servitude, or debt bondage. (5)

Traffickers use various recruitment strategies, such as offering jobs and promising citizenship in a destination country. Victims of sex trafficking are predominantly females; adult men are overrepresented in forced labor trafficking. Traffickers target vulnerable individuals such as immigrants, those who have financial needs or mental disorders, and children from dysfunctional families. (6)

Victims of sex trafficking are controlled by "pimps." Male pimps have been classified into types including "Romeo," also known as "Finesse," and "Guerilla." A "Romeo" has psychological control of the victim and can show affection, though he can also become physically violent. A "Guerilla" mainly uses aggression to control his victims. (7) Women can serve a variety of functions in sex trafficking of minors: A "Madam" manages a brothel and sets up prostitution "dates;" "Family" is an authority figure who provides a victim with a place to live and teaches safety strategies; "Handler" befriends minor victims and provides assistance creating online sex ads and transporting victims; "Bottom" or "Main Girl" works for a male pimp and has responsibilities such as training victims and providing discipline, including violence. (8)

Forced labor includes involuntary work in factories and on farms, as well as private households, usually under the threat of violence or punishment. Child laborers perform work that is hazardous to the health and development of a child, including

illegal drug or arms trade. Bonded labor involves demanding labor to repay a loan or service on undefined terms, with the value of victim labor becoming greater than the debt itself. Victims of labor trafficking can be threatened with deportation to keep them compliant. Perpetrators may isolate victims and move them to different locations to disorient and confuse them. (9)

Child laborers may be transported inside countries or across national borders. Trafficked child laborers may be involved in domestic labor, selling drugs, and being child soldiers. (10) In order to identify a possible victim of child labor trafficking, evaluators need to keep in mind international and domestic child labor standards. According to international standards the general minimum age for employment is 15, though light work can be performed starting at 13. In areas where the economy and educational facilities are not sufficiently developed, the minimum age can be lowered by one year. The minimum age for hazardous work is 18; it can be lowered to 16 under certain circumstances. (11)

In a medical setting, signs of possible trafficking include: Victims may have no insurance; offer to pay cash; have no identification documents; or show evidence of being involved in a controlling relationship, such as being accompanied by an individual who does all the speaking for them. (12) Giving scripted responses, living at a place of employment, physical injuries and work-related injuries may also indicate trafficking. (13)

Victims experience a variety of psychiatric and medical conditions. Depression, anxiety, and PTSD are the most common psychiatric problems reported. (14) Sex trafficking victims report more PTSD and Complex PTSD symptoms, as well as comorbid PTSD and depression. (15) Other consequences of sex trafficking include issues associated with pregnancy and sexually-transmitted infections. Victims of sex trafficking can experience skin branding, whereas victims of labor trafficking may have burns, deep cuts and other injuries.

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Faces of AAPL: Reena Kapoor, MD

Philip Candilis, MD



2022 has been a red-letter year for Reena Kapoor, MD, Associate Professor of Psychiatry and director of the forensic psychiatry fellowship at

Yale. Winner of the 2021 Red AAPL Award, Dr. Kapoor is president of the Association of Directors of Forensic Psychiatry Fellowships (ADFPP), the AAPL council representing the forensic fellowships. Majoring in Slavic Studies at Northwestern University, Reena was drawn to Tolstoy and Dostoevsky, whose dark tales provided early exposure to crime and punishment. The paradoxical twists of Dostoevsky in particular (e.g., “He has done me no harm. But I played him a dirty trick, and ever since I have hated him.” [*The Brothers Karamazov*]), shaped her understanding of guilt, anger, and hatred, and provided a foundation for a career in forensic psychiatry.

Well-travelled as a child to accommodate her parents’ careers, Reena got to know Saudi Arabia, India, the United Kingdom, and Bahrain, among others, developing a multi-cultural perspective that would influence her later work. She had traveled to 30 countries by the time she was a teen. Travel and the humanities offered a rich perspective, as Reena moved to the American Midwest from the Middle East in middle school. As different as life in Marion, Indiana was from Riyadh, Saudi Arabia, Reena appreciated being exposed to yet another culture and to veterans at the VA hospital where her parents worked, many of whom were as well-traveled as she. Her family lived on the hospital campus, so she grew comfortable with the medical and psychiatric conditions she would later study.

Travelling to Boston for residency after medical school in Chicago, Reena became a fan of big cities,

multi-site training, and clinical variety, graduating from the Harvard Longwood program with the feeling that she “could handle anything.” The idea of developing one’s sense of how to be a psychiatrist by *being* a psychiatrist was a powerful influence. She spent a 4th-year elective with Tom Gutheil at the famed Massachusetts Mental Health Center, shadowing Tom, reviewing cases, and cementing her forensic interests. Studying problematic sexual behaviors would become an outgrowth of this formative period, as would her interest in working with individuals with serious mental illness.

Dr. Kapoor’s fellowship year at Yale under the guidance of Howard Zonana would be “the best year of my training,” allowing her to be part of a community that was keen and expert without being pretentious. She had not intended to stay (family was still near Chicago), but could not pass up the opportunity to expand her academic interests while serving in the public sector. Work in court clinics and community forensics evolved into work in corrections, where the benefits of being “a decent doc and a decent human being” outweighed the stressful environment and approached “the closest thing to a calling” she had yet experienced. She would ultimately lead forensic services at the historic Whiting Forensic Hospital, overseeing a period of change and development that would intensify with the global pandemic.

Consultation to the US Department of Justice arose from a conference at Yale Law School, where a chance meeting with the head of the ACLU’s National Prison Project resulted in an invitation to serve in the oversight of correctional mental health nation-wide. The work provided an even greater opportunity to do good for marginalized persons about whom communities assumed the worst – if they thought about them at all. Reena viewed correctional oversight and consultation as an

extension of the patient care she had provided earlier in her career, serving her ultimate goal of improving mental healthcare in high-security settings.

Now as a fellowship director and president of ADFPP, Reena is moving to make the application and training process better “a little bit at a time.” Making future colleagues feel welcome as they enter the field is crucial, she says, to fostering lifelong membership in a diverse and intellectually rich professional community. Toward that end, she is championing initiatives to streamline the fellowship application process, improve communication between applicants and program directors, and share expertise between training programs.

Dr. Kapoor’s writing on cultural competence, race, and the treatment of marginalized groups provides the map for a profession working toward a deeper understanding of justice and equity. Whether providing a sobering critique of jail-based competence restoration or writing about the influence of Ezra Griffith on her professional development, her voice is critical to the development of a forensic professionalism that takes into account underserved communities.

AAPL, too, with the Red AAPL Award, recognized the importance of her perspective, noting the Community Forensics committee she founded with Merrill Rotter in 2015 and the development of a common fellowship application during her tenure with ADFPP. A former AAPL Councilor and Annual Meeting Program Chair, Reena served on AAPL’s strategic planning committee in 2021, mapping out the organization’s future and updating its mission statement to include explicit support for diversity and inclusion. After hosting the town hall meeting “Increasing Equity in AAPL,” Reena continues to serve on the Diversity Committee, encouraging the organization to become a professional home for forensic psychiatrists of all backgrounds, perspectives, and interests. ☪

Post-COVID Syndrome: Symptoms, Treatments, and Forensic Implications

Ryan C. W. Hall, MD; Tyler A. Durns, MD; Gregory Iannuzzi, MD
Psychopharmacology Committee

COVID-19 has left many questions and casualties in its wake. Although prevention and treatment of acute infection has been a top public health priority, long-term consequences from COVID-19 infection are emerging. In this brief narrative review, we will describe proposed symptoms of Post-COVID Syndrome, review suspected pathophysiology, discuss psychotropic medication as potential treatment, and consider the legal implications for off-label prescribing.

The concept of a post-COVID syndrome first emerged through support groups and online communities. (1) Although there is no clear consensus in the medical community, Post-COVID Syndrome generally refers to symptoms that continue or develop at least four weeks following acute COVID-19 infection. Hypotheses vary whether Post-COVID Syndrome is organic or psychosomatic. This bears similarity to controversies surrounding Gulf War Syndrome (2) and chronic Lyme Disease. (3)

Common symptoms reported by patients experiencing Post-COVID Syndrome include fatigue, dyspnea, cognitive impairment, chest and joint pain, palpitations, myalgia, smell and taste dysfunction, cough, headache, sleep disturbance, gastrointestinal and cardiac issues. (2) The pathophysiology underlying these symptoms remains unclear. Proposed mechanisms include tissue damage resulting from hypoxia, vascular changes, or immune system dysregulation such as adaptive autoimmunity, microglial activation, and maladaptive cytokine profiles. (1, 2) These mechanisms may particularly explain the cognitive sequelae from COVID-19 infection. Alternative explanations for cognitive symptoms include the possibility that encephalopathic changes occur at the time of acute infection.

Regardless of etiology, several risk factors for the development of Post-

COVID Syndrome have been identified. These risk factors include the severity of illness experienced during acute COVID-19 infection, early and significant dyspnea, a history of prior psychiatric conditions, and female sex. (2) In addition, the incidence of common psychiatric disorders such as depression, posttraumatic stress disorder, or exacerbation of obsessive-compulsive disorder may increase with COVID-19 infection. (2)

Treatments for Post-COVID Syndrome are under investigation, including those for similar diseases such as encephalomyelitis, chronic fatigue syndrome, and mast cell activation syndrome. (1) The angiotensin converting enzyme 2 (ACE2) receptor may provide a unique target for treatment of Post-COVID Syndrome. ACE2 receptors are highly concentrated in the lungs, heart, and brain glial cells. (2, 4) Activation of ACE2 receptors is suspected to contribute to encephalopathy, headache, cardiovascular accidents, and other features seen in both acute COVID infection and Post-COVID Syndrome. (4)

Supportive remedies and watchful waiting are the current treatments for the neuropsychiatric symptoms of Post-COVID Syndrome. Psychotherapy has been proposed to address maladaptive coping related to chronic fatigue. Other treatments mimic those used to treat “brain fog” or “chemo brain,” including repeated physical and psychological exercises, stress management techniques, promoting adaptive coping strategies, and medications such as methylphenidate, donepezil, modafinil, and memantine. (2) Treatment with selective serotonin reuptake inhibitors (SSRIs) may also be considered for commonly occurring comorbid psychiatric disorders, such as depression and PTSD. (4)

No medications have been approved by U.S. Food and Drug Administration (FDA) for Post-COVID Syn-

drome at this time. The FDA stamp of approval “implies that available evidence shows that a drug is safe and effective for the specific indication” (Ref. 5, p. 588). With no FDA approved medications, prescribing “off-label” remains the only alternative. Off-label prescribing introduces the risk of adverse effects without the FDA determination of safety or benefit. Nonetheless, off-label prescribing is a relatively common practice and accounts for 10-20% of all prescriptions written. (5) While a medication may not have FDA approval for a given indication, there may be peer-reviewed literature that supports off-label use.

Emerging literature may suggest a unique role for SSRIs in the treatment of acute COVID-19 infection, although the rationale and basis for efficacy is largely theoretical conjecture. This benefit is thought to be mediated via sigma-1 receptor signaling, which are important for viral replication. One of the SSRI’s which has garnered the most attention regarding its utility in treating COVID-19 infection is fluvoxamine. Fluvoxamine’s high affinity for the sigma-1 receptors may reduce clinical deterioration in some individuals infected with COVID-19. (6)

Other SSRIs share an affinity for sigma-1 receptors. The relative potency in descending order is: 1) fluvoxamine; 2) sertraline; 3) fluoxetine; 4) escitalopram; 5) citalopram; and 6) paroxetine. (6) Although sertraline has a strong affinity for sigma-1, it is suspected to function as a receptor antagonist, as opposed to fluvoxamine, fluoxetine, and escitalopram which may function as receptor agonists. (6) Fluvoxamine, fluoxetine, and escitalopram may also curtail infectious sequelae via their effect on nerve growth factor (NGF). (6) Serotonin and norepinephrine reuptake inhibitors (SNRIs) as well as mirtazapine possess relatively weak affinity for the sigma-1 receptor when compared to SSRIs. (6) However, there are other psychotropic medications with high sigma-1 receptor affinity, such as donepezil, typical antipsychotics (e.g., haloperidol), and ifenprodil, which is

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Curiosity, Courage, Compassion, and Other Lessons from My Interview with “The Other Dr. Gilmer”

Sherif Soliman, M.D.

Geriatric Psychiatry and the Law Committee

After completing his family medicine residency in 2009, Dr. Benjamin Gilmer began a new job at Cane Creek, a rural primary care practice in western North Carolina. He quickly explained to his new patients that he was not related to their prior physician, who was coincidentally also named Dr. Gilmer, Dr. Vincent Gilmer. Dr. Vince Gilmer was a beloved family physician. He often treated patients free of charge. That’s why everyone was shocked when on June 28th, 2004, Dr. Vince Gilmer strangled his elderly father to death, amputated his fingers, and dumped the body by the side of the road. To Dr. Benjamin Gilmer, the fact that they shared the same last name was an unfortunate coincidence that he would quickly explain. That worked on everyone except Benjamin Gilmer. As he heard stories of Vince Gilmer’s generosity and service to the community, he became determined to solve the mystery of why Vince Gilmer killed his father.

Dr. Vince Gilmer had sustained a serious head injury six months prior to the killing and, though he had recovered, had a brief period of transient global amnesia following the injury. He had also recently discontinued escitalopram. He argued, *pro se*, that his “brain wasn’t working,” which he attributed to SSRI discontinuation syndrome. He also exhibited tics, which were believed at the time to be malingered. He reported a history of sexual abuse by his father and alleged that his father had reminded him of the abuse and attempted to assault him before the killing. Dr. Vince Gilmer was convicted in Virginia and sentenced to life in prison.

Dr. Benjamin Gilmer was contacted by NPR reporter Sarah Koenig to record a story about the name coincidence for the NPR show *This American Life*. He initially declined but subsequently decided to enlist her

help in investigating the case. This led to an incredible journey that ended with Dr. Benjamin Gilmer spending more than a decade fighting for Dr. Vince Gilmer to receive a pardon and to receive appropriate treatment while in prison. Dr. Benjamin Gilmer met Dr. Vince Gilmer, first with Sarah Koenig, and then a second time with Dr. Steve Buie, a psychiatrist and the director of the Mountain Area Health Education Center residency program in Asheville, North Carolina. On observing Vince Gilmer’s movements, Dr. Buie raised the possibility of Huntington’s Disease. Genetic testing confirmed the diagnosis. While careful to point out that he did not attribute the killing to Huntington’s Disease, Dr. Benjamin Gilmer notes that it is one factor among several insults to Dr. Vince Gilmer’s brain. More urgently, Dr. Vince Gilmer was severely debilitated, with difficulty walking, speaking, controlling his impulses, and even recalling his cell phone number. Dr. Benjamin Gilmer sought out allies in the legal community and in the advocacy community. They prepared clemency petitions to three successive Virginia governors and were rejected each time, including by former Governor Ralph Northam, a neurologist. However, the story doesn’t end there. Governor Northam was sent an advance copy of Benjamin Gilmer’s book, *The Other Dr. Gilmer*; (1) and took the extraordinary step to reconsider the petition. On January 13th, 2022, Governor Northam granted Vince Gilmer a conditional pardon.

I had the opportunity to meet virtually with Dr. Benjamin Gilmer on June 25th, 2022. He graciously agreed to sit for a transcribed interview for this article on a Saturday morning. We had planned to talk for about half an hour but ended up having a far-reaching two-hour conversation

about mental health, the treatment of mentally ill patients in a system designed to punish, and the process of forensic mental health assessment. I was fascinated by his journey for justice, his compassion and his tireless advocacy on behalf of Dr. Vince Gilmer. I wanted to learn how this went from a mere coincidence, to what he described as “paranoia” that Vince Gilmer would get out and harm him, to insatiable curiosity, and ultimately to a fight for mercy. I included some of his insights, edited for clarity and minor transcription errors.

I began by asking the question every author on a book tour hears, “What’s your book about?” He responded:

My book is gosh, it’s about... That was the first question that my editor asked...and it’s sort of hard to put into a box because it’s a book that tells a story that’s firstly a deeply personal memoir. Secondly, it’s a medical mystery story about a murder. And thirdly, it’s a story about mental health and our shared cognitive fallibility. But most importantly, it’s a book about social justice. So, all those – the medical mystery and the murder and all that is, is an attempt to seduce the reader to be sensitized to these concepts. These deeper concepts of understanding our nature as humans and the fact that our brains so easily, as you know, so easily go awry. And what that means in terms of a general context of understanding each other.

Dr. Benjamin Gilmer told me that his journey began with curiosity, then fear and paranoia, and ultimately compassion and a sense of duty. He described meeting the other Dr. Gilmer as “transformative.” He said, “It not only transformed my limbic system, it transformed my heart.”

When I scheduled the interview, I had intended to write about the importance of remembering to consider neurodegenerative diseases. It quickly became apparent that simply

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Timely Updates from the Forensic Neuropsychiatry Committee

A. Persistent Neuropsychiatric Complications of COVID-19 Infection

By Dale Panzer, MD

Although several meta-analyses provide information on neuropsychiatric symptoms following COVID-19-related illness, persistent neuropsychiatric symptoms COVID-19 sequelae are not well-established. (1) Since we psychiatrists and forensic psychiatrists are increasingly encountering COVID-19-related questions, familiarity with this topic is very timely.

In a study by Badenoch et al., sleep disturbance (27.4%) was the most prevalent neuropsychiatric symptom, followed by fatigue (24.4%), objective cognitive impairment (20.2%), anxiety (19.1%), and post-traumatic stress (15.7%). (1) Rogers et al. reported a high prevalence of insomnia, fatigue, cognitive impairment, and anxiety disorders in the first six months after infection. (2) The prevalence of depression was 23.0%, headache 20.7%, anxiety 15.9%, and altered mental status was 8.2%. Of note, a Post-COVID-19 Neurological Syndrome (PCNS) has been formulated with symptoms including muscle pain and weakness, myopathy, sleep impairment, anxiety, depression, post-traumatic stress disorder (PTSD), dizziness, headaches, and anosmia. (3)

The neuroinvasive mechanisms of COVID-19-related illness are not well understood. There are reported cases of primary CNS invasion with encephalitis in patients with cerebrospinal fluid (CSF) containing COVID-19. (4) While cerebrovascular complications are uncommon, Shehata et al. reported a prevalence of over 1% of COVID-19-related cardiovascular sequelae, of which 60% were attributed to an acute ischemic stroke. (3) The increased stroke risk is believed to be due to hyperinflammatory/ hypercoagulable states and altered endothelial cell function resulting

from the viral infection.

At this time, there is no known specific treatment for patients with persistent neuropsychiatric COVID-19-related symptoms, other than standard symptomatic management. Based on available data, close monitoring of symptoms in COVID-19 infected patients for the development of persistent neuropsychiatric symptoms is indicated. (5)

A sampling of our AAPL Forensic Neuropsychiatry Committee members yielded that several have had persons with post COVID-19 complaints who presented for disability evaluations, in particular involving persistent cognitive impairment. Other forensic applications are anticipated. ☯

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B. Neuropsychiatry of Extremism

By Jacob Holzer, MD

The threat of extremist-based violence has increased in recent years. This increased threat has been triggered in part by precipitants, such as personal grievances, the political environment, and racism, as highlighted in a recent Department of Homeland Security Bulletin. (1) Extremist views comprise one of many variables that crystalize in an individual who may act in an ideologically-driven violent manner. (2)

Research findings support a neurobiological basis towards aspects of the complex underpinnings of extremism, including the important role of the Internet in interacting with external factors. (3) Research using functional magnetic resonance imaging (MRI) identified focal regions potentially related to social exclusion, radicalization, and a willingness to fight and die. These findings included hypoactivity in the dorsolateral prefrontal cortex, inferior frontal gyrus and parietal cortex. (4) Studies of variables such as emotional processing; socio-economic factors; and fear and stress, have shown a neurobiological basis for a separation between violent and non-violent extremists. (5)

A review article on “political neuroscience” found that individuals who were more ideologically extreme and willing to endorse violence, were more likely to struggle to complete complex cognitive tasks. Difficulty with strategic and complex cognition may push people to adhere to ideologies that simplify the world into neat categories. (6) A study of U.S. Air Force Academy cadets revealed that cadets who viewed religion as sacred and identified strongly with a religious group took greater risks in virtual combat situations when compared with less religious peers. (7) Taken together, these results suggest that a neurobiological basis is one layer in the complex construct of extremism and associated violence, with potential application to forensic psychiatry in criminal evaluations, consultation, and research.

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Pregnancy Termination: Medico-legal and Forensic Implications

Susan Hatters Friedman, MD; Nina Ross, MD; Jacqueline Landess, MD, JD; Karen B. Rosenbaum, MD; Katherine Michaelsen, MD; Ariana Nesbit, MD; Juliette Dupre, MD; Aimee Kaempf, MD; Richard Seeber, MD; Anna Glezer, MD

Gender Issues Committee

The Supreme Court's decision in *Dobbs v. Jackson* in June 2022 (1) illuminated the fractious and contentious divide between various sectors of the American public regarding abortion. Despite varying moral, religious, and ethical opinions, the decision has numerous medico-legal implications for patients and their physicians, which we will discuss in this article.

Contraceptive Rights:

Some legal experts have expressed concern regarding the potential implications of the *Dobbs* decision on other prior Supreme Court rulings, including those involving contraceptive rights. (2) In *Dobbs*, the Court held that the right to abortion is not a fundamental Constitutional right, in part because this right is not explicitly mentioned in the Constitution. *Roe* found abortion to be grounded in an individual's right to privacy, which stems from substantive due process protections under the 14th Amendment. Notably, the right to privacy is also not explicitly mentioned in the Constitution. Thus, other rulings that are also based on a right to privacy may be at risk of being overturned. One of these rulings is *Griswold v. Connecticut*, (3) which established the right to privacy and held that married couples had the right to use birth control.

Justice Samuel Alito wrote that, "Nothing in this opinion should be understood to cast doubt on precedents that do not concern abortion," explaining that abortion is different from other unenumerated rights because it destroys fetal life. Justice Alito added that *Roe* was "egregiously wrong" because the right to abortion is neither explicitly mentioned in the Constitution nor "deeply rooted" in

our nation's history and traditions. Given Justice Alito's assertion that the *Dobbs* decision does not foreshadow the overturning of other precedents, some constitutional law scholars proclaim that these concerns are "little more than baseless fearmongering." (4) However, others point out that many other unenumerated rights, including contraception, are similarly not mentioned in the Constitution nor "deeply rooted" in the history and traditions of the United States. For example, Paula Tavrow, director of the Bixby Program in Population and Reproductive health at UCLA said, "Nothing would prevent [The Supreme Court] from ruling subsequently on whether people have a right to birth control. For instance, they might decide that some people, such as adolescents or unmarried people, do not have the same right to birth control as other people." (5)

In fact, although one survey found that two-thirds (68%) of Americans believe that Americans should be provided with free birth control if *Roe v. Wade* was overturned, (6) some have expressed interest in seeing *Griswold v. Connecticut* overturned. (7) Furthermore, some methods of birth control, including emergency contraception and intrauterine devices (IUDs), have already been targeted by proposed legislation in several states because opponents conceptualize them as abortifacients. For example, last year, a Missouri bill attempted to ban IUDs and emergency contraception from Medicaid coverage. (4) Missouri's and Louisiana's "trigger ban" laws to ban abortion once *Roe* was overturned also include outlawing the Plan B morning-after pill. As Melissa Murray writes, "As red states line up to prohibit—and even criminalize—abortion, the crucial question will be,

'What counts as an abortion?'" (4) **Unintended Consequences and the Criminalization of Miscarriage:**

Many health care providers and advocates have expressed concerns about the impact of abortion bans on the care and treatment of people who lose pregnancies. By some estimates, roughly one in four pregnancies end in miscarriage. (8) Treatment of miscarriages and stillbirths often relies on the same medications and procedures used in abortions—and some recent abortion bans have already led to reports of less access to safe and timely treatment of miscarriages—causing clinician concerns about accusations of aiding an abortion, while other bans have explicitly targeted medications used both for abortion and treating miscarriage. (9, 10)

The pattern of prosecution of pregnancy loss in many states while *Roe* was in place and the experience of other countries that have implemented abortion bans support these concerns. In the US, though miscarriages are common and the causes may be unclear, prosecutors have charged individuals with feticide, manslaughter, reckless homicide, child abuse, and murder after having a miscarriage or stillbirth. (11) The individuals targeted are disproportionately low income and persons of color. (11) The prosecutions often rely on a variety of fetal harm laws that were originally framed as deterrents to crimes against pregnant women. Currently at least 38 states have fetal homicide laws. (12) The frequency of these prosecutions is also increasing. The National Advocates for Pregnant Women identified over 400 criminal cases and cases of forced medical interventions from 1973-2005—with 68 legal cases involving criminal charges related to pregnancy loss or neonatal death thought to have resulted from the pregnant woman's actions or inactions during pregnancy—and more recently, from 2006 to 2020 they identified roughly 1300 cases. (11, 13) The legal cases often focus on pregnancy loss where there is suspicion of drug use (most common) or other "suspicious" circumstances—physical trauma in

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Pregnancy Termination

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pregnancy (gun violence, car accident, fall, attempted suicide), declining medical advice (opting for home birth or declining a Caesarean section), or suspicion of self-managed abortions. (11, 14) Examples making it to the national news include the arrest and manslaughter charge of a woman who was shot in the abdomen during a fight, resulting in the loss of her pregnancy. (15)

International comparisons:

Internationally, abortion rights lie on a spectrum of legality, from complete prohibition with criminal consequences to elective requests within certain gestational limits. Despite these differences in legislation and potential criminal penalties for women seeking abortions, abortions continue to occur in every country across the globe. (16) There is a clear relationship between prohibiting and criminalizing abortion and an increase in unsafe abortions, which come with serious risks to the safety of the mother including death and complications due to sepsis, hemorrhage, trauma to the abdomen and genitals and permanent infertility. (17) According to the Center for Reproductive Rights, a human rights organization that tracks the status of reproductive rights globally, abortion is completely prohibited in twenty-four countries. (18) Women in these countries cannot access legal abortions for any reason, including to save a woman's life, to preserve her health, or in cases of incest or rape.

El Salvador has banned abortions since 1997, following lobbying from the Roman Catholic Church. (19) Amending its penal code, it criminalized seeking one's own abortion with a penalty of two to eight years in prison, aiding in abortion as a medical professional with six to twelve years and loss of medical license, and supporting a woman with abortion with a five-year sentence. (20) These laws are actively applied in El Salvador, including to adverse pregnancy outcomes such as stillbirths and miscarriages. (21) Modifications

to the Salvadorian constitution that designate life starting at conception in 1998 further meant that women can be charged with aggravated homicide, carrying a sentence of 30–50 years in prison. One-hundred and twenty-nine women were prosecuted for either abortion or aggravated homicide charges between 2000 and 2011, most in the context of presenting to medical care with obstetrical emergencies. (22) One additional effect of this criminalization is the separation of mothers from their existing children, a now widely recognized adverse childhood experience that is associated with significant negative physical and emotional health consequences. (23) These laws are noted to undermine physicians' ethical obligations of non-maleficence, interrupt the provision of medical care during obstetrical emergencies, and disproportionately impact women living in poverty and facing high rates of gender-based violence and adolescent pregnancy. (21)

In Poland, increasing restrictions on abortions have led to delays with interventions when problems develop with the pregnancy—even in a few cases resulting in the death of the pregnant woman—and delays in other healthcare for pregnant women—such as delays in life-saving cancer treatments. (24) With the notable exceptions of Poland and the United States, many countries across the globe are taking steps to increase access to safe and legal abortions. Colombia, Mexico, and Argentina have recently decriminalized abortion. Northern Ireland decriminalized abortion in 2019, followed by New Zealand in 2020. (18)

Safe Haven Laws:

Safe Haven Laws originated in Mobile, Alabama in 1998, and currently exist in all states. Under Safe Haven laws, mothers may relinquish their unwanted infant in a safe location. They remain anonymous and are not prosecuted if the baby is given up to staff at the appropriate location. Ages of the infant (e.g., up to 30 days old), as well as allowed locations for infant handoff, vary by state (e.g., fire station, police station, hospital). (25)

In many states, there are insulated safety boxes at these locations for a mother to anonymously relinquish her infant.

Safe Haven Laws have been referenced as a solution for women who have been unable to obtain abortions. For instance, during oral arguments in *Dobbs*, Supreme Court Justice Amy Coney Barrett inquired about Safe Haven laws as a solution to “the burdens of parenting”. (26) In reality, Safe Haven laws were created to decrease rates of neonaticide, not abortions. (25) In addition, it is not clear that if more women carry undesired pregnancies to term, they will seek out Safe Haven laws as a solution. For example, Texas had 172 infants relinquished under its Safe Haven Law since 2009; in comparison, 50,000 abortions were completed in Texas in 2021 alone. (27) Lastly, Safe Haven laws do not address the physical, psychiatric, and psychosocial ramifications that arise from carrying an unwanted pregnancy to term.

In conclusion, there are various ways in which the *Dobbs* decision may impact our practice as physicians and forensic psychiatrists. We should be aware of how criminalization of abortion in other countries has been associated with various negative outcomes, including the increased likelihood of a woman obtaining an unsafe abortion and delaying or not seeking healthcare during pregnancy.

It is also imperative to be aware of legislation, other than abortion bans, which may impact a patient's medical decision-making; this includes potential restrictions on contraceptive devices and medications. Forensically, there is the potential for increased prosecution of women who seek illegal abortions and/or physicians who perform them. Lastly, Safe Haven Laws have been offered as a solution to unwanted pregnancies but are not a panacea to this complex problem as some would hope. ☹

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Pregnancy Termination and Ramifications for Clinical Forensic Psychiatry

Susan Hatters Friedman, MD; Nina Ross, MD; Aimee Kaempf, MD; Jacqueline Landess, MD, JD; Richard Seeber, MD; Anna Glezer, MD; Katherine Michaelsen, MD; Ariana Nesbit, MD; Karen B. Rosenbaum, MD; Juliette Dupre, MD
Gender Issues Committee

In 1973, the United States Supreme Court held in *Roe v. Wade* that prohibiting abortion violated a woman's constitutional right to privacy. (1) In 2022, *Roe v. Wade* was overturned by *Dobbs v. Jackson*, when the Supreme Court ruled that prohibiting abortion was, in fact, constitutional. (2) Prior to the passage of *Roe v. Wade*, women in most states could obtain a legal abortion in very limited circumstances, including if a pregnancy was the product of rape or incest and if the pregnancy would cause serious mental or physical health sequelae. (3) In the wake of *Dobbs*, multiple state legislatures have indicated they will enact pre-*Roe* abortion laws or pursue even more restrictive legislation.

Patients with psychiatric illness will be inevitably impacted by these changes. Patients with psychiatric illness are more likely to exhibit poor contraceptive adherence, to have unplanned pregnancies, and to detect pregnancies later. (4) Pregnancy and the postpartum period are also times of vulnerability to psychiatric illness. (5) In addition, for those women seeking abortions, numerous legal, financial, and logistical barriers will now exist, including the illegality of abortion in some states and the inability of some women to travel out of state. In this article, we briefly discuss what is known about abortion and women's mental health. We then conclude with clinical considerations including an overview of informed consent and capacity, as ethical and legal questions may arise when treating women with psychiatric illness who desire abortions.

Although the field of research about abortion and mental health is rife with poorly designed studies, well-designed studies with proper control groups demonstrate that abortion is

not directly associated with mental health problems. (6-9) One such study is the Turnaway study, a landmark prospective study of hundreds of women who obtained, or were denied, an elective abortion. (8) The Turnaway Study lacked the methodological flaws of many other studies on abortion such as inappropriate control group comparison, lack of assessment of pre-abortion mental health, and lack of consideration of other confounding factors including the detrimental effect of stigmatization of abortion. (6, 7, 10) Decreased or no access to abortion may also adversely impact mental health. The Turnaway study observed that women who are unable to obtain a wanted abortion are more likely to face detrimental health outcomes, (11) to live below the poverty level, (12, 13) to stay in an abusive relationship, (14) and to have difficulty bonding. (13)

There are also significant implications in risk assessment and risk management after an unwanted pregnancy. As established in Resnick's landmark research, having an unwanted child is one of five motives for child murder by parents. (15) US mortality data from 1960-1988 research revealed that legalization of abortion was associated with a decrease in child homicide rates. (16) Longitudinally, states with stricter abortion policies had an increase in homicide deaths among young children. (17)

Consent and Coercion:

Informed consent forms the ethical, legal, and clinical basis of medical treatment. Over a century ago, in a case involving medical battery, Justice Cardozo wrote, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." (18) Based on

the principle of autonomy, informed consent is the process whereby communication between a physician and a patient allows the patient to make knowledgeable decisions about care. (19) Informed consent requires that the patient have medical decision-making capacity, that the physician disclose information relevant to the decision at hand, and that the decision be made on a voluntary basis, free of any coercion. (19) Given the time-sensitive and irreversible nature of abortion, the informed consent process is particularly important when a woman is considering whether to terminate a pregnancy, and it may be confounded by circumstances not encountered in other areas of medicine. These include socio-political controversies, conflicting views among stakeholders, religious beliefs, and intense emotional responses elicited among patients and clinicians. (19)

When a woman with mental illness or intellectual disability seeks an abortion or permanent contraception, medical decision-making capacity may be called into question. Though most women with psychiatric conditions retain capacity to participate in medical decision-making, this population may be particularly vulnerable to coercion. Psychiatrists should be aware of any biases that might impact reproductive health discussions they have with their patients and avoid any tendency to persuade or manipulate a patient's decision. (20) Whatever the woman's choice, it should be voluntary and free of any undue influence. (20) Clinicians should also be aware that most patients with psychiatric illness have capacity to make their own medical decisions. (21) When capacity to consent to an abortion is questioned, this capacity evaluation should be conducted as it would be for any comparable medical procedure. (21)

The post-*Dobbs* world presents legal risks for women seeking abortions as well as their medical providers. In Arizona, for instance, the attorney general recently announced the reinstatement of a pre-statehood law that bans all abortions and carries a penalty of up to five years in

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COVID-19 and the Mental Health Crisis in the New York City Jail System

Bipin Subedi, MD

Individuals with serious mental illness (SMI) are overrepresented in jails compared to the community (1). In addition, persons detained in jail have been shown to be more than five times more likely than persons in the community, and almost two times more likely than state or federal prisoners, to experience serious psychological distress (2). Jail suicide rates also suggest that factors unique to jail contribute to detained persons' suffering and adverse mental health outcomes. In 2019, national jail suicide rates were more than twice those of the community, and almost double state prison rates (3, 4).

There are several reasons why suicide is the leading cause of death in US jails, with a rate of about 49 deaths per 100,000 individuals in 2019 (3). Individuals enter jail with high levels of stress due to their recent detention, separation from family, disruptions in care, and loss of autonomy and access to usual outlets for coping. Uncertainty about the duration of detention and outcome of legal cases, coupled with the unpredictability and chaotic nature of the jail environment, often leads to additional tension and anxiety. These factors can exacerbate symptoms of an existing mental illness and lead to suicidal behavior; they can also induce psychological distress and self-harm in individuals without a history of mental health problems. Jail characteristics such as higher census, a census that is over capacity, and lower staff-to-detainee ratios are associated with suicide (3).

Understanding these challenges, New York City's Correctional Health Services (CHS) implemented a robust mental health system of care when it became the health care provider to people in custody as a new division of New York City Health+Hospitals in 2016. CHS substantially enhanced the mental health services available to incarcerated people by: hiring additional mental health professionals with a

focus on strengthening oversight and supervision; creating a strong, clinically-based suicide prevention program centered around early detection, individual risk assessment, and treatment planning, as well as close monitoring and investigation of all self-injury, regardless of severity; and establishing specialty units for individuals with SMI, which improved access to care and medication adherence and decreased injury due to violence.

Unfortunately, the COVID-19 pandemic destabilized New York jails in profound and impactful ways, at both the individual and systemic level. Since spring 2020, detained individuals have contended with extended court delays, restricted communication with family, friends, and attorneys, health concerns for themselves and for loved ones, and reductions in movement and daily activities. These ongoing and far-reaching disruptions in jail functioning have exacerbated the stresses on detained persons.

Since summer 2020, self-injury rates in New York jails have drastically increased compared to previous years. Although CHS has observed this trend across all housing areas and several age groups, the increase has been primarily driven by non-suicidal self-injury (NSSI) in non-SMI populations. The global increase in non-suicidal self-harm strongly suggests that systemic stressors induced this phenomenon. The fairly stable rate of self-injury among individuals with SMI through 2021 suggests that our interventions for these patients have been successful in mitigating harm to them.

Previously at a low baseline (the four-year period prior to 2020 saw one completed suicide), the rate of completed suicides has also increased significantly over the last several years, despite the rate of suicide attempts remaining stable. The increased rate of self-inflicted death amid overall increases in self-injury but unchanged rate of suicide attempts may be driven

by such factors as increased prevalence of intentionality, decreased availability of staff due to illness, or disruption in preventative safety and security procedures.

Since the pandemic began, CHS has taken significant additional steps to minimize psychiatric morbidity and mortality to our patients. These include: improving access to intake mental health evaluations; maximizing timely access to medication evaluations; creating a telephonic pathway for individuals to request mental health services; developing new central monitoring systems to identify and escalate high-risk individuals for intervention; creating additional mental health therapeutic housing areas; and instituting a lower threshold for referring and placing patients on suicide-watch observation. CHS has also provided education to clinical staff on suicide-risk assessment and to correctional officers on suicide prevention and the importance of taking all NSSI seriously.

While the significant increase in environmental and systemic stressors throughout the entire criminal-legal system during the pandemic has negatively impacted the people we treat, CHS staff will continue to utilize all the clinical interventions that have proven to be effective, and to develop additional interventions, in order to mitigate and manage the risks to our patients. However, it is crucial that all stakeholders recognize the inherent risks of involvement in the entire criminal-legal system up to, and including, any length of jail detention, especially during public health emergencies, and do what is possible to minimize the unnecessary, extended exposure of any individual to the jail setting. ☯

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A FORENSIC ROUNDTABLE

Editor's Note:

AAPL member Hal Wortzel, MD contacted members of the AAPL Newsletter editorial team regarding the "In the Media" column in the Spring 2022 issue, written by Bao Nguyen, Brandon Simons, and Associate Editor and "In the Media" Series Editor Ryan Hall, MD (1). Dr. Wortzel expressed concern that the brief article could potentially leave some readers with the impression that there was a sound scientific argument for Jack Ruby's crime being the result of a seizure, which was inappropriately rejected by an excessively skeptical jury. We asked the authors and Dr. Wortzel to continue the discussion here. Associate Editor Dr. Kaye and I decided to use editorial privilege to weigh in as well. We hope the readership finds what follows useful, and we welcome future suggestions for this type of dialogue – feel free to email newslettereditor@aapl.org.

Dr. Simpson:

Although we must always remember that "the plural of anecdote is not data," I have personally witnessed what I believe was a clear-cut example of violent behavior due to partial complex seizures. The aggression was either ictal or postictal. The incident fit all the parameters described by Nguyen et al. (1): the patient was male, older, and had had epilepsy for decades. He was admitted to an acute inpatient unit after a series of episodes involving him chasing a relative at home. I was a resident doing weekend call and was asked to respond to the outdoor recreation area. When the patient saw me in my white coat, he charged toward me, repeatedly trying to kick me in the shins as I backed away. As I was much younger then, I successfully avoided him until staff were able to convince him to walk with them back inside. Once back on the unit, he slumped over, lethargic, only able to speak in his first language. This went on for several minutes, until his English slowly returned, and he regained an alert level of consciousness. He was not ordinarily a violent individual and there was nothing to

indicate any element of malingering or secondary gain. So-called psychomotor epilepsy, with motor behavior that appears purposeful, is the most likely explanation for the patient's unprovoked aggression towards me, a complete stranger.

Dr. Wortzel:

While I appreciate this foray into forensic neuropsychiatry, and a fascinating chapter from its history, I am concerned that readers may get the wrong impression about the case of Jack Ruby and his seizure defense. While it certainly is true that the "epilepsy defense" is often greeted with skepticism, the case of Mr. Ruby arguably helped set that stage. In 2013 I wrote about instances where in expert testimony about emerging neurodiagnostic technology has failed the test of time. (2) The psychomotor variant of epilepsy alleged at Ruby's trial is now referred to as rhythmic temporal theta bursts of drowsiness, which, as described by Guttman, "as a type of epilepsy, has become a historical footnote." Beyond that though, Dr. Guttman explains that the defense's interpretation of Ruby's EEG as indicative of epilepsy was controversial even at that time. (3)

But debate about the EEG potentially misses a more important point, a risk we often encounter when experts engage in technical arguments about emerging technologies. Unfortunately, that very risk often serves as legal strategy - distracting triers of fact from clinical realities that the technology simply cannot overcome. In the case of Ruby, even if his EEG unequivocally established a diagnosis of epilepsy, that would still not prove that the behavior at issue was the consequence a seizure. Of course, persons with legitimate epilepsy diagnoses spend the majority of their lives making choices and engaging in volitional behaviors, which is why the phenomenology of seizures, and the specific behaviors under question, mandate the utmost scrutiny. Dr. Guttman describes testimony revealing the real problem with the epilepsy defense raised by Ruby:

"Doctor," the state's prosecuting attorney continued, "let me ask you a hypothetical question ... Suppose a person were standing on the edge of a crowd, had to make his way through at least one line of the crowd in order to draw a gun and shoot a moving man who is at least ten feet away when he first saw him, was a—made some explanation as 'you rat s.o.b., you shot the president' or 'you s.o.b.,' was immediately apprehended and within two minutes said something to the effect 'I intended to kill him' or—either that or 'I hope the s.o.b. dies' and then within three minutes said, 'I thought I could get off three shots, but you guys stopped me' or words to that effect. I'll ask you if, in your opinion, that person could have been suffering from psychomotor epilepsy at the time that he did the shooting?" The jurors watched intently as Frank [*an expert in neurology called by the prosecution*], seriousness of purpose indelibly imprinted on his face, said without hesitation, "No." (Ref. 3, p. 708)

There are cautionary tales of legitimate defenses going unheeded. But the case of Jack Ruby is a different kind of cautionary tale. There are also the potential consequences of "crying wolf," such as creating an atmosphere of cynicism that is difficult to overcome, even when real illness or injury is truly pertinent to the legal issues at hand. (2, 4)

Mr. Nguyen, Mr. Simons, and Dr. Hall:

We want to express our gratitude to the AAPL editorial team and Dr. Wortzel for their insights on our recent *Newsletter* article. Our intent was to revisit the 1964 *New York Times* story entitled "Ruby Trial Focuses Attention On Seizures and Their Effects" as a vehicle to discuss the current neuropsychiatric evidence and clinical basis for epilepsy-related aggression. Jack Ruby's trial was controversial at the time, with vary-

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Roundtable

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ing expert opinions being offered. (1) The constraint of a newsletter article format limited our ability to do a more thorough discussion about specific medical testimony and pitfalls of Ruby's defense. As such, we appreciate Dr. Wortzel's letter and this opportunity to expand upon the topic and our original piece.

Our aim was to neither dismiss nor bolster the legitimacy of the epilepsy defense. We wanted to highlight the complex medical investigations needed to establish a diagnosis and, more importantly, the challenges of causally connecting said diagnosis to the violent behaviors. In this regard, we fully agree with Dr. Wortzel's assessment about the volitional nature of Jack Ruby's behavior. We concluded our article with, "the more organized, complex and time-intensive the act, the lower the chance for a successful defense." (2) We would have liked to have had the space to have referenced or quoted Dr. Guttman's or others' work related to the cognizant and purposeful words and actions of Jack Ruby that made epileptic seizure-induced violence an extremely unlikely, if not an impossible, cause for his actions. (3) Dr. Wortzel's analysis of disrobing cases greatly reinforces the importance of examining the circumstances and means through which behaviors manifest to see if they are consistent and/or characteristic of an individual undergoing any sort of epileptic state. (4)

We are also appreciative of Dr. Simpson sharing his own personal experience with epileptic aggression and how to manage it. Responding to aggressive behavior during a seizure is often quite challenging, as portrayed in Dr. Simpson's anecdote. When patients with a history of violent behavior during seizures present during an ictal or postictal state, healthcare workers should take steps to protect themselves, such as being cognizant of how to best approach the individual, restricting access to throwable objects and avoiding wearing jewelry, neckties, and other

accessories which may be grabbed. Training staff who are likely to encounter epileptic patients to become proficient in recognizing and managing ictal aggression can be helpful in keeping both patient and staff safe in high-risk situations. (5) In part, this was why the Epilepsy Foundation's 2014 letter related to seizure-related behaviors and need to train individuals likely to encounter individuals with epilepsy (e.g., police) was referenced in the original article. (6)

For those interested on this topic, our newsletter article should be seen as a primer or a summary and not a definitive analysis. In that regard, we hope the initial article and this follow-up have been interesting and an educational starting point or refresher for general readers who may not be as familiar or active with this aspect of forensic neuropsychiatry.

Dr. Kaye:

As in most high-profile cases of the 1960's and 1970's, AAPL Member Emanuel Tanay, MD testified in the Ruby case. His book, *Passport to Life*, is a worthy read about his tenacity in saving himself and his family from the Nazis, and clearly that fearless resolve worked well in the courtroom, where he participated in the trials of Ted Bundy, Sam Shepard, and Robert Garwood. ☯

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Rappeport

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early days, we had these ethics dinners. These were the people who were thinking about ethics within systems and society, which is what I've always been interested in."

Dr. Brendel attributes much of her success to her training as a forensic psychiatrist. She described how one of the great strengths of forensic psychiatrists is their ability to learn how to change systems. She points to the tradition of women leaders in AAPL going on to become prominent leaders within other parts of psychiatry. With great enthusiasm, she additionally emphasizes the importance of "developing the network and mentorship. That's the theme!" We are proud to have a former Rappeport Fellow ascend to the role of APA President. We wish Dr. Brendel all the best in her challenging and exciting new venture. ☯

Mentoring Initiative

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American Medical Association 2022 Annual Meeting Highlights

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

For the first time in more than two years, the American Medical Association's (AMA) 2022 Annual Meeting was held in person from June 10th through 15th in Chicago, Illinois. This year marked the 175th anniversary of the AMA. With important topics, such as reproductive rights; diversity and equity in training and care delivery; firearm violence; and climate change among those being debated at the meeting, many delegates reflected on the evolution of AMA policies and important turning points in its history of advocating for patients and physicians. Although the meeting returned to an in-person format, use of technology to increase participation and promote safety due to Covid-19 was utilized to a greater extent than at previous meetings. Participants could attend sessions live or view sessions remotely, including the usual presidential speech and business of the House of Delegates (HOD).

The meeting took place shortly after the mass shootings at a school in Uvalde, Texas, a grocery store in Buffalo, New York and a medical facility in Tulsa, Oklahoma. With this, AMA President Gerald E. Harmon, MD, a family medicine physician from South Carolina, voiced a call for action to reduce firearm violence.

Gun violence is a plague on our nation. It is a public health crisis. And much of it is preventable. As we start this meeting, we are going to have a moment of silence for the victims of gun violence – including physicians and other health care workers who have been harmed – but first it's important for me, as your AMA president, to speak on this important topic. Almost every day in this country, we bear witness to the shocking brutality of weapons of war being unleashed on society ...

on elementary school students and movie theater goers ... on grocery store shoppers and people in houses of worship ... on physicians and health care workers in hospitals and clinics. This cannot be our new normal. Gun violence is out of control. Enough is enough.

Incoming AMA President Jack Resneck, Jr., MD, a dermatologist from the Bay Area, acknowledged the challenges that physicians have faced with Covid-19, and he spoke about the ongoing efforts of the AMA to support physicians through this time. He focused on ways that physicians have adapted to unexpected pressures, political partisanship, and health misinformation. He applauded physicians' continued ability to adapt and work to improve the health of their patients and communities, which will be needed as we face new obstacles. Like Dr. Harmon, he spoke directly about the public health crisis of firearm violence.

Delegates, alternate delegates, and others provided testimony on a variety of timely topics, ranging from restrictions that have been placed on physician practices to social justice to public health. Already mentioned was the attention to firearm violence at the meeting. Although the HOD had declared firearm violence a public health crisis, delegates of the 2022 meeting adopted new policy to support regulations on homemade "ghost guns," research for warning labels on packages of ammunition, and attention to the mental health impacts on school children who engage in active-shooter drills. Following release of the draft US Supreme Court opinion overturning *Roe v. Wade*, there was increased attention to reproductive health, and the HOD considered the impacts of restrictions and criminalization on those who provide reproductive health services. The HOD adopted policy that

explicitly recognizes healthcare as a human right, including access to safe, evidenced-based reproductive health services, such as abortion and contraception. The policy calls for the AMA to seek legal protections for patients and physicians against entities that seek to punish or criminalize reproductive health services.

Of particular interest to AAPL members, the HOD adopted policy that the AMA work with appropriate stakeholders to make evidence-based recommendations regarding the presence of weapons in correctional healthcare facilities. The impetus for this resolution is the requirement for law enforcement officers to carry a rapid rotation baton in some mental health units in federal correctional facilities. There has been concern that physicians, considered law enforcement officers in this setting, would have to comply even if they did not want to do so. The testimony favored assessment of the risks and benefits of physicians carrying weapons in correctional facilities.

Among other business, the HOD passed a resolution to call attention to the roll-out of 988 (National Suicide Prevention Lifeline) and advocate for adequate state and federal funding for the system. With concerns that many states have not allocated funding or resources for 988 a month before its start date, much of the testimony focused on the need for increased attention and access to suicide prevention in the wake of Covid-19 for both patients and as a resource for physicians. Further, delegates passed a resolution declaring that voting is a social determinant of health. The AMA also adopted policy to declare climate change a public health crisis that threatened the health and wellbeing of all; the policy directs the AMA to develop strategic plans to decarbonize physicians' practices and the healthcare sector.

The AAPL delegation was led by Barry Wall, MD, who announced that the 2022 Annual Meeting would be his last meeting as Delegate for AAPL. The Section Council on Psychiatry toasted Dr. Wall and his many years of service to the AMA and his tremendous contributions representing AAPL

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Report of APA Assembly

Danielle B. Kushner, MD

AAPL Representative to APA Assembly

The American Psychiatric Association (APA) Assembly meeting was held prior to the APA Annual Meeting on May 21-25, 2022 in New Orleans, Louisiana. The Assembly and Annual Meeting were the APA's first live events since 2019. The conference marked the end of the presidential term of Vivian Pender, MD. The theme of the meeting was Social Determinants of Mental Health which has been the theme of her presidency and presidential task force. Additionally, the APA hosted a smaller virtual Annual Meeting experience in June following the live meeting.

The Assembly meeting opened with a moment of silence to honor the passing of two past Assembly Speakers, Joseph Napoli, MD and Paul O'Leary, MD. The meeting followed with an Assembly Pledge focusing on respect and inclusion during the meeting.

In the Report of the Medical Director, Saul Levin, MD, MPA, started by remembering the members' lives lost in the COVID-19 pandemic and thanking the Assembly for their governance during the pandemic. He addressed APA's continuing efforts to address Diversity, Equity, and Inclusion (DEI) and thanked Natalie Gillard, founder of Factuality and current DEI Consultant to the APA.

Dr. Levin highlighted APA's continued advocacy efforts including scope of practice, mental health parity, collaborative care, and telepsychiatry at the state and national level. The new nationwide number for mental health and suicidal crises, 988, will go live in July. APA is working with states and district branches to develop local infrastructure. Dr. Levin reviewed the recent Ninth Circuit Court of Appeals review that reversed the decision of *Wit v. United Behavioral Health* in California. The APA subsequently filed an amicus brief and is collab-

orating with the American Medical Association (AMA) to fight for insurance carriers to follow general accepted standards of care.

APA updates were provided on current challenges that members face including safe prescribing, Maintenance of Certification (MOC), *DSM 5-TR*, licensing questions, and preservation of the patient/physician relationship. Of note, *DSM 5-TR* was released in March 2022. The new update includes fully revised text and new references, clarifications to diagnostic criteria, cultural changes, addition of Prolonged Grief Disorder, codes for suicidal behavior, and updated ICD codes.

The APA Foundation announced the Paul O'Leary Innovation in Psychiatry Award. Dr. O'Leary was past APA Assembly speaker, forensic psychiatrist, and AAPL member who died in May 2021. Melinda O'Leary, wife of Dr. O'Leary, along with their eldest daughter described his penchant for "big ideas" that led to the premise of the award.

Dr. Pender provided an overview of the work accomplished over the past year by the Presidential Task Force on the Social Determinants of Mental Health. Areas of focus included violence, poverty, adverse childhood experiences, racism, and climate change. Two key outputs included the development of an APA course for APA Fellows and the creation of a Caucus on Social Determinants of Mental Health.

APA President-Elect, forensic psychiatrist and AAPL member, Rebecca Brendel, MD, JD, reviewed her Presidential Theme entitled Roadmap for the Future, composed of three key areas: developing access and equity in mental health care and information, resources for mental health and workforce development, and strategic partnerships and leadership.

Other key Assembly topics included the passage of Action Papers

entitled Bolstering Services for Substance Use Disorders in Incarcerated Persons; Improved Awareness of the Impact of Psychiatric Diagnoses and Treatments on Military Members; and Strengthening Equivalent Pathways for Maintaining Board Certification. The last Action Paper requires the APA to uphold the National Board of Physicians and Surgeons (NBPAS) as an equivalent pathway to MOC by adding them to the list of affiliate organizations of the Council of Medical Education and Lifelong Learning and inviting them to any meeting that American Board of Psychiatry and Neurology (ABPN) is also invited. Another forensic Action Paper passed entitled Enhancing the Learning Experience about Jail and Prison Psychiatry in General Psychiatry Residency Programs, which was submitted by the current AAPL Representative to the APA Assembly and is the first Action Paper to be supported by AAPL Council. It has the APA advocate to the Accreditation Council for Graduate Medical Education (ACGME) Psychiatry Review Committee to require a correctional psychiatry experience (site visit, didactic, or rotation) in general psychiatry residency training and develop a correctional psychiatric curriculum for residency programs.

New APA Position Statements were Ongoing Need to Monitor and Assess the Public Health and Safety Consequences of Legalizing Cannabis and Impact of Structural Racism on Substance Use and Substance Use Disorders; along with revised Position Statements on Youth Substance Use; Mental Health Needs of Immigrants and People Affected by Forced Displacement; and Police Interactions with Children and Adolescents in Mental Health Crisis.

The Mental Health Services Conference is scheduled for October 13-14, 2022 in Washington D.C. The Fall Assembly meeting will be virtual in November 2022. The next APA Annual Meeting is currently scheduled for May 2023 in San Francisco, California. ☪

Understanding

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and ‘K,’ which he believed was related to “evil purposes.” He also experienced hallucinations, and “abnormal thinking when he spoke about experiences of a spiritual dimension,” and had “unravelling of logical connections.” Justice Schwann of the Court of Queen’s Bench for Saskatchewan acquitted Mr. Ozipko on the basis of insanity. The Court noted that while OCD played a part in his deficits, it was the combination of acute psychosis and OCD that resulted in a complete acquittal.

Although less successful as an insanity defense, OCD is frequently raised during the sentencing phase for mitigation. In *R v Grehan*, the Queensland Court of Appeal reduced the sentence imposed on a defendant with OCD who possessed over 44,000 images and 36 videos of child exploitation material. (8, 10) Expert evidence at sentencing showed that Mr. Grehan was “unable to curtail repeated obsessional thoughts and compulsive behaviors” and that his “offending behavior was maintained by his obsessiveness and ritualistic behaviors.”

Forensic psychiatrists, who may be asked to opine about mitigating factors for defendants with OCD, should be familiar with not only the relevant diagnostic criteria, but also how an individual’s intrusive thoughts and compulsions relate to the conduct constituting the offense. Obtaining a detailed account of any ritualizing behaviors, actions engaged in to alleviate the distress caused by obsessional thinking, and perceived consequences of refraining from engaging in such behaviors are important factors to relay to the court. Screening for disorders that frequently co-exist with OCD—such as Autism Spectrum Disorder (ASD), Major Depressive Disorder, and Attention-Deficit Hyperactivity Disorder (ADHD)—can help distinguish features of OCD from other comorbidities and add weight to the grounds for mitigation. In *R v Marson-Wood*, (8, 11) a forensic psychiatrist testified during the mitigation

phase for a defendant charged with 31 arson fires. Although the Court did not specify the nature of Mr. Marson-Wood’s specific OCD symptoms, it reduced his custodial sentence in consideration of his multiple psychiatric co-morbidities, including OCD, ADHD, ASD, anxiety, and depression.

Although few studies have investigated how frequently individuals with OCD act on their obsessions, there are emerging clinical models that are relevant to forensic psychiatrists, who may apply this understanding when assessing defendants for mitigation or criminal responsibility. One study examined the relationship between insight and volitional control. The study measured patients’ subjective sense of decreased control over their compulsions. The authors found that the experience of volitional control was not significantly related to the level of insight into the irrationality of their behavior. However, insight was found to positively correlate with control over obsessions. (12) Another study found that OCD patients were more impulsive than controls, demonstrated increased risky decision-making, and showed more biased probabilistic reasoning. Based on these results, the authors suggested that OCD may be conceptualized as a type of “behavioral addiction” with reward system dysfunction. (13)

As I near the completion of my forensic psychiatry fellowship, I am reminded of how our clinical expertise is the foundation of our role as a forensic evaluator. I am grateful for the opportunity to have learned about the nuances of OCD diagnosis and treatment prior to starting my fellowship. These experiences have conferred a deeper understanding of the relationship between volitional control, OCD, and criminal behaviors. And – I was able to walk away having eaten zero toilet-seat gummy bears. Win-win. ☺

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Human Trafficking

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(16) Trafficking victims may suffer from addiction, which can be a way for them to cope with trauma, though it can also be used by traffickers for exploitation purposes. (17)

Prior to the interview, appropriate security measures must be taken. The interview should be conducted in a safe space where the individual feels comfortable. One should attempt to inconspicuously separate the victim from the trafficker. The interview should be conducted in a nonthreatening and nonjudgmental manner, with regular breaks to allow the individual to regain composure. It is important to make sure that the interviewee has access to basic necessities such as food, clothing and medical care. (18)

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Human Trafficking

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After identifying a victim of trafficking, psychiatric and medical concerns need to be addressed in a timely manner. Legal issues, such as immigration status, must be acknowledged. The victim may need referral to a social worker for help with finding resources and temporary housing. With their consent, referral to a human trafficking hotline should be made. (19) Mandatory reporting laws pertain to children and individuals with mental disabilities.

Many trafficking victims meet criteria for special immigration options as a result of experiencing violence, blackmail, or other threats. Victims who are potential witnesses may be eligible for Continued Presence designation, which allows them to temporarily live and work in the US. T-Visa nonimmigrant status allows victims and their qualifying family members to remain for up to four years if they assist law enforcement in the investigation and prosecution of human trafficking or if they meet exemption criteria. Survivors of an eligible crime who experienced physical or emotional injuries can qualify for a U-Visa. (20) These remedies can provide protection from deportation, as well as a pathway to a green card or citizenship.

Lawyers may request help from forensic psychiatrists in human trafficking cases. Forensic psychiatric examination can demonstrate how the trauma impacted the applicant's ability to pursue the immigration application in a timely manner and how their life has been affected by this trauma. Additionally, the expert could opine as to the extreme hardship that would result from the loss of supportive services if the applicant is removed from the US. (21, 22)

To summarize, psychiatrists may encounter trafficking victims in their practice, and forensic psychiatric evaluation and testimony may be necessary in legal cases involving trafficking. Therefore, forensic psychiatrists should be familiar with this worldwide issue. ☯

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- ## Post-COVID
- continued from page 15*
- available in European and Japanese markets. (6)
- Informed consent is prudent when considering off-label prescribing. Physicians provide clinical information assuring informed consent of all prescribed medications (i.e., purpose of treatment, potential risks and benefits of treatment, risk and benefits without treatment, etc.). (6) Malpractice lawsuits filed regarding off-label prescribing are more often related to issues of informed consent than
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Post-COVID

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the mere fact that it was prescribed off-label. (5) Most courts have found that doctors are not liable for omitting discussion of a drug's "regulatory status." Instead, courts have identified that the designation of "off-label" is a "FDA regulatory term that denotes nothing about clinical risk or benefits" (Ref. 5, p. 590).

Current potential malpractice lawsuits regarding COVID-19 infection may be artificially suppressed. Many states and jurisdictions have passed legislation which prevents or limits lawsuits related to COVID-19. (7, 8) This indemnification is likely to end because the statute is based on a yearly renewal. Furthermore, Post-COVID Syndrome is covered by the Americans with Disabilities Act per guidance provided by the Office for Civil Rights of the Department of Health and Human Services, and the Civil Rights Division of the Department of Justice. (9) Therefore, we may soon see the emergence of malpractice or negligence claims related to the treatment of Post-COVID Syndrome.

In summary, Post-COVID Syndrome remains an emerging clinical entity with limited guidance for treatment, yet a potential role for psychotropic medications. Judicious informed consent empowers patients to make safe and educated decisions about their treatment and may protect treating providers from liability. Much remains to be determined regarding Post-COVID Syndrome and appropriate management in the scientific and legal arenas. ☞

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Curiosity

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discussing the importance of making the diagnosis would not do his story justice. Dr. Gilmer's lesson for forensic psychiatry is much more urgent: it's a plea for curiosity, compassion, and advocacy. While it is critical to maintain objectivity in a forensic psychiatric evaluation, we have a broader role outside of the evaluation to use our knowledge and training to advocate for better treatment conditions with corrections. Dr. Benjamin Gilmer suggested the possibility of collaborative, multidisciplinary forensic psychiatric evaluations. He pointed out that tumor boards were convened to determine the course of treatment for cancer patients and pointed out that decisions involving the death penalty or life in prison were at least as serious. However, he also told me that his book was not intended to be "prescriptive," rather it was intended to sensitize the reader to the plight of Dr. Vincent Gilmer and others suffering from severe

neuropsychiatric conditions in prison. When discussing his decision to advocate for Dr. Vince Gilmer, he said, "You know, I feel as if we've accepted the Hippocratic Oath. We can't just turn away; that's sort of our duty, is to advocate for others." ☞

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Timely Updates

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C. The use of information from passive health monitoring wearable devices in forensic settings

By Octavio Choi, MD, PhD

The increasing use of passive health monitoring wearable devices, such as Fitbits and Apple watches, as well as implanted medical devices such as pacemakers, have led to the increasing collection of enormous amounts of data with potential relevance to courts. (1) As an example, in 2016, a man with an implanted pacemaker claimed that he woke up in the middle of the night and realized his house was on fire. He further claimed that he spent the next few minutes frantically packing up essential belongings and fleeing his house. The police, who were skeptical of his account, received a search warrant to obtain data from his pacemaker, which contained a time-stamped record of his heart rate. Based on inconsistencies between the timing of the defendant's story and his recorded heart rate, in addition to other evidence gathered at the scene, the defendant was eventually arrested and charged with arson.

Such cases raise novel and interesting questions regarding balancing an individual's right to privacy with the state's legitimate purpose in protecting the public from criminal behavior. Legal issues in these cases revolve around confidentiality of medical information enshrined in HIPAA (Health Insurance Portability and Accountability Act (2)), the 4th Amendment's protections against search and seizure, and the 5th Amendment's protection against self-incrimination. For example, as health monitoring information becomes increasingly relevant and probative regarding individuals' mental states, at what point does such information constitute a "mental search space" analogous to a physical space, thus, requiring a search warrant to obtain? And at what point does such information become informative enough to be considered "self-testimony," which would be protected under the 5th Amendment?

These important questions have yet to be discussed and answered. ☞

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Pregnancy II

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prison for anyone aiding a woman in obtaining an abortion. (22) In the wake of the *Dobbs* decision, it will be important to continue to monitor reproductive healthcare needs, trends, and outcomes among women with psychiatric conditions, ensuring that patient autonomy is maximized and safeguarding against any coercive or abusive practices.

With the *Dobbs* decision, many states will likely retreat to pre-*Roe* abortion restrictions. These changes will undoubtedly impact women seeking abortions, which includes women whom psychiatrists treat. Thus, psychiatrists should be aware of existing research involving women's mental health and abortion and the limitations of this research. The most important predictive factor of a woman's mental health post-abortion remains her pre-abortion mental health status. Forensic psychiatrists should also be aware of potential individual and societal bias when asked to consider a woman's capacity to consent to an abortion, keeping in mind that most women with psychiatric illness retain capacity and that capacity assessment for an abortion is similar to an

evaluation conducted for any medical procedure. ☯

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AMA Meeting

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and psychiatry in the HOD. During his time as a Delegate, Dr. Wall served as Vice-Chair for the Section Council, served on reference committees, and chaired the AMA Committee on Conduct, among his many contributions. On a personal note, the AAPL delegation recognizes and greatly appreciates Dr. Wall's leadership, mentorship, steadfast professionalism, and the commitment that he displayed as Delegate for AAPL. He will be missed at future meetings.

The interim meeting of the AMA is currently scheduled for November 2022 in Honolulu, Hawaii. You can find more information on the actions of the AMA House of Delegates at the 2022 Annual Meeting at <https://www.ama-assn.org/about/house-delegates-hod>. 

Dear readers,

The Newsletter would like to honor recently deceased AAPL members in a biographical column similar to the Faces feature. If you have been particularly close to an AAPL colleague who has died, please consider memorializing them in a submission of up to 1500 words. Please email philip.candilis@dc.gov with any questions or submissions.

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Two Senior Forensic Psychiatry Positions in Connecticut

The State of Connecticut, Department of Mental Health and Addiction Services (DMHAS) is seeking an experienced and dynamic clinician to be the **Chief Medical Officer of the Whiting Forensic Hospital** in Middletown, CT. This nationally recognized forensic leadership role is offered in association with the Law & Psychiatry Division of the Dept. of Psychiatry at the Yale School of Medicine, and a successful MD candidate may be appointed as a State or Yale employee. Interested candidates may send CV to Charles Dike MD (charles.dike@ct.gov).

The Dept. of Psychiatry, Yale School of Medicine, is recruiting a psychiatrist for appointment at the Associate/Assistant Professor level, for a position as a **Consulting Forensic Psychiatrist at the Whiting Forensic Hospital** in Middletown, CT. Candidates must have a minimum of 5 years' experience in forensic psychiatry, with expertise in risk assessment/management. The primary clinical work assignment will be the CT DMHAS, with expected teaching of fellows and other trainees in forensic mental health. Interested candidates may send CV to Michael Norko MD (michael.norko@yale.edu).

The State of Connecticut, DMHAS, and Yale University are equal opportunity/affirmative action employers. Women, members of minority groups, persons with disabilities and in recovery, and protected veterans are encouraged to apply.



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