

AAPL Newsletter

American Academy of Psychiatry and the Law



Fall 2021 • Vol. 46, No. 3

2021 Manfred S. Guttmacher Award

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



Established in 1975, the Manfred S. Guttmacher Award seeks to recognize outstanding contributions to the forensic psychiatry literature through a book, monograph, paper, or other published work or presentations at a professional meeting between May 1 and April 30 of the award year cycle. It is jointly sponsored by APA and AAPL. Awardees receive a plaque, \$1,000, and are invited to deliver an award lecture at the annual APA meeting.

The award is named for Manfred Schanfarber Guttmacher, MD, an American forensic psychiatrist. Dr. Guttmacher was born in 1898 in Baltimore, Maryland to German Jewish immigrants and died in 1966 in Stevenson, Maryland at the age of 68 from leukemia. Dr. Guttmacher was an avid writer and published several books on sexual offenses, psychiatry and the law, the mind of a murderer,

and the role of psychiatry in the law.

Congratulations to Debra Pinals, MD, and Lisa Callahan, PhD, who received the 2021 Guttmacher Award as authors of two articles on competency to stand trial issues, published in July 2020 in *Psychiatric Services*. Dr. Pinals is a former AAPL President and the current Chair of AAPL's Institute for Education and Research (AIER). She is also a Clinical Professor of Psychiatry and the Director of the Program in Psychiatry, Law, and Ethics at the University of Michigan. Dr. Callahan is a Senior Research Associate at Policy Research Associates, Inc. of the National Association of Counties (NAC).

In their first article, entitled "Challenges to Reforming the Competence to Stand Trial and Competence Restoration System," Callahan and Pinals discussed the crisis in the system that manages competence to stand trial

evaluations (CST) and competence restoration (CR). Many states are overwhelmed by increasing numbers of referrals and inadequate legal and clinical resources. The authors reviewed individual state responses in the management of CST and CR, identified barriers to the effective delivery of care and proposed potential areas of improvement. One of the primary areas of concern was identified as waitlists for competence-related services, which arise from many factors including a lack of resources and jurisdictional issues. The delay has led to successful class-action claims about access to evaluation and treatment. The need for data on competency-related factors is identified as a step towards improving the current challenges. To date, there are no comprehensive statistics on the number of beds in the US reserved for competency-related issues. Similarly, there are no empirically-derived practices for addressing competency restoration.

Pinals and Callahan concluded the paper with the identification of four areas identified as key CST system challenges: systemic data needs, access to care at the right level, expanding diversion options for individuals found IST, and expanded education of stakeholders. They recommend state and national reporting guidelines be developed to address the systemic data needs, concluding that the forensic mental health system should actively propose and implement solutions to these key challenges.

In their second article, entitled "Evaluation and Restoration of Competence to Stand Trial: Intercepting the Forensic System Using the Sequential Intercept Model," Pinals and Callahan discussed the grave challenges of persons suffering from serious mental illness, intellectual and developmental disabilities, or other serious conditions, who are subjected to long waits for admission to

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

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

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COVER STORY

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state psychiatric hospitals for competence-related forensic restoration services. Such defendants often do not have access to diversion programs, which leads to more negative outcomes. Although some communities are developing restoration services outside of state hospitals, state hospitals have remained the predominant default location for restoration services. Of note, restoration statutes often do not require consideration of a “least restrictive alternative.”

In order to achieve better mental health outcomes while still promoting public safety, Pinals and Callahan call for communities to develop local solutions by applying the Sequential Intercept Model (SIM) as a framework at various decision points during a defendant’s passage through the criminal justice system. SIM was originally conceptualized by Mark Munetz, MD; Patricia Griffin, PhD; and Henry Steadman, PhD, and is focused on advancing community-based solutions for justice-involved persons with mental and substance abuse

disorders in order to reduce their penetration into the justice system and to divert them for treatment into a robust community mental health continuum of care. Local community diversion-oriented actions can occur at various “intercepts” during a defendant’s journey through the justice system to redirect them to mental health treatment. In the SIM framework, Intercepts 0 and 1 can occur at the time of initial crisis and police responses; Intercepts 2 and 3 can occur at the time of first court appearances, during jail stays, and in specialty courts; and Intercepts 4 and 5 can occur during the time of jail stays until community release, which may include specialized probation for those released into the community and/or linkage to wraparound community resources. In particular, specialized case management and care coordination can improve mental health outcomes at this intercept.

Drs. Pinals’ and Callahan’s reviews identify a much-needed area of reform in the criminal justice system. Perhaps with the attention of the Guttmacher Award, their suggested interventions will be put into practice. ☎

A Message from the AAPL Executive Council:

We invite all AAPL members who read this to take a few moments to remember those who have passed away, lost loved ones, or otherwise suffered during the COVID-19 pandemic. The last year and a half has had effects on society, families and individuals to a degree that few have ever witnessed before.

We encourage everyone to take care of their physical and emotional health as much as possible as we look toward a brighter future.

AAPL 2021: Breaking Virtual Ground

Liza H. Gold, MD



I hope that most of you find yourselves reemerging from the limitations imposed upon us all by COVID-19. Many of us are still struggling

with loss, change and transition, but many of us are more hopeful about the future than we have been in some time and are cautiously re-engaging in our pre-pandemic lives. Inevitably, we are finding that those lives look somewhat different.

For AAPL, this means moving forward with Virtual AAPL (VAAPL): that is, taking on our educational mission through online technology. VAAPL Phase I has been a success. Since the first virtual Annual Meeting in 2020, AAPL has provided two online CME courses and one online CME panel. Dr. Charles Scott taught AAPL's inaugural and well-attended online course on Substance Use. Dr. Phil Resnick and Forensic Review Course faculty provided an Update, focusing on questions submitted before and during the online meeting. Dr. Ariana Nesbit-Bartsch, Co-Chair of the Early Career Development Committee, organized a panel on Starting a Private Practice in Forensic Psychiatry, coordinated to coincide with the ending of the academic year. The Early Career Development Committee has been encouraged to sponsor this panel as a yearly event with a changing roster of participants.

Two more CME courses are scheduled for 2021: Dr. Danielle Kushner, Chair of the Human Rights and National Security Committee, has developed a course on Forensic Evaluations in Terrorism Cases scheduled for August; Dr. Anthony Tamburello has chaired the development of a course to be presented in December on Correctional Psychiatry. Dr. Resnick and his faculty are also planning a three-day Forensic Review Course for September. And of course, our

Annual Meeting Program Chair, Dr. Renee Sorrentino, is already working with the AAPL Office to put together another excellent (but hopefully the last entirely virtual) Annual Meeting in October.

Online programming has included some free events for members only. Drs. Susan Hatters-Friedman and Renee Sorrentino have launched the one-hour CME series, Forensic Fridays. Their first "Ask-the-expert" Friday was held in June, with Dr. Thomas Gutheil sharing his expertise in evaluations in repressed memory cases. In July, Dr. Charles Scott spoke about forensic psychiatrists administering structured assessments. Additional Friday online lecture speakers scheduled through the rest of 2021 include Drs. Peter Ash, Renee Binder, Kenneth Weiss, and former AAPL Medical Director Howard Zonana.

"For AAPL, this means moving forward with Virtual AAPL (VAAPL): that is, taking on our educational mission through online technology."

AAPL also has held two members-only online town hall meetings, organized and sponsored by Dr. Charles Dike and the Diversity Committee. The first meeting addressed issues of increasing racial equity and diversity in AAPL; the second, with the assistance of Dr. Barry Wall, addressed LGBTQ issues. Both of these discussions resulted in practical suggestions for helping AAPL become a more welcoming and diverse organization. These suggestions are in the process of being worked into proposals to effect meaningful change.

I am also delighted to report VAAPL Phase II is nearing completion. The VAAPL Task Force, under

the leadership of Drs. Anne Hanson and David Burrow, will have selected an online learning management system (LMS) by the end of August. By the end of 2021, AAPL will be able to record and store our livestreamed programming and enter the new (for AAPL) world of on-demand learning. I thank everyone on this Task Force for the many hours they have contributed so AAPL can have many user-friendly, up-to-date, online CME educational options.

When we set out to develop VAAPL Phase I in 2020, I was confident that soliciting and developing high-quality content would be relatively straightforward. My confidence in our members' abilities to take their teaching and forensic expertise virtual was well-founded. To my mind, VAAPL Phase II has always seemed the greater challenge.

We will face the inevitable learning curve as we implement and integrate a user-friendly LMS. Some members will be extremely comfortable with this new technology; others may struggle to adapt. However, it is clearer than ever before that developing a robust, year-round, online learning system is integral to AAPL fulfilling its educational mission. As Gandalf stated at the Council of Elrond, "It is wisdom to recognize necessity."

The success of Phase II will require our members' help even more than did Phase I. First: As we integrate the new LMS and upgrade our website, we ask for everyone's patience. Disruptions and limitations due to the pandemic are still a part of many people's lives. Integrating new computer technology is challenging under even the best of circumstances, and there will undoubtedly be some frustrating moments for members and staff alike. Let's all commit to treating each other with respect and consideration.

Second: VAAPL offers multiple opportunities throughout the year to provide CME programming. Do you have an idea that lends itself to a podcast series? Do you want to develop a live and/or on-demand webinar? Can you suggest other types of CME activities now possible due to online learning

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Excited Delirium, Ketamine Use and Death During Police Restraint

Jeffrey S. Janofsky, MD



As medical director for AAPL, I represent AAPL on the American Psychiatric Association's Council on Psychiatry and Law (CPL). CPL performs

many functions for the APA including writing Position Statements and Resource Documents. CPL is also asked to provide consultation for other APA groups including the Assembly. At times CPL is asked to provide input to APA Government Relations regarding legislation that might be relevant to the APA.

In April 2021 CPL was informed that APA had been asked to give input to proposed legislation from Colorado Representative Joe Neguse's office to ban the non-hospital use of ketamine during arrest and detention for federal offenses. Representative Neguse has filed the bill in the House of Representatives as the Ketamine Restriction Act. (1)

The bill was generated after the death during arrest of 23-year-old Aurora, Colorado resident Elijah McClain in August 2019. Mr. McClain, a black man, was 0.3 miles away from his home when someone called 911 saying a person who was wearing a ski mask was walking down the street, was waving his arms and "looked sketchy." Several police officers arrived. There was no evidence of a crime and no weapon. Within one minute police attempted to restrain Mr. McClain using handcuffs and then bilateral carotid holds. Paramedics were called. Mr. McClain was in obvious medical distress. The paramedics protocol allowed them to administer ketamine after they diagnosed excited delirium in the field, without consultation with a physician. Paramedics then administered 500 mg of ketamine. Although Mr. McClain weighed 140 pounds at autopsy,

paramedics administered a ketamine dose for a 200-pound person, 50% more than should have been administered based on the protocol and body weight. Mr. McClain went into cardiac arrest and died several days later. (2)

Ketamine is a dissociative anesthetic that is an analog of PCP. It is sometimes recommended in the emergency medicine literature, but not the psychiatric literature, to treat acute agitation. UpToDate gives the following caveats for ketamine use in such situations: "While the use of ketamine for agitation is increasing, caution is needed until higher-quality evidence confirms the safety and effectiveness of this approach," and "Evidence suggests that ketamine can provide more rapid sedation than benzodiazepines and haloperidol, but its use may be associated with more complications including the need for endotracheal intubation." (3)

"EMS protocols around the country allow paramedics to administer ketamine in the field, without direct medical supervision after making a diagnosis of excited delirium."

The concept of excited delirium entered the literature in 1985 when Wetli and Fishbain first used the term in an attempt to explain sudden death in users of cocaine. (4) In 2009 the American College of Emergency Physicians published a white paper on their organization's Task Force on Excited Delirium. The Task Force Consensus Opinion was that Excited Delirium was "a real syndrome of un-

certain etiology. It is characterized by delirium, agitation, and hyperadrenergic autonomic dysfunction, typically in the setting of acute or chronic drug abuse or serious mental illness ...

The risk of death is likely increased with physiologic stress. Attempts to minimize such stress are needed in the management of these patients. Ideally, any necessary law enforcement control measures should be combined with immediate sedative medical intervention to attempt to reduce the risk of death. Sedation with various medications, including ketamine was a recommended treatment." (5)

Excited delirium has been used to explain in-custody deaths during police restraint and after Taser use. (6) Excited delirium is taught by police trainers as causing subjects to cause greater risk of physical harm to police officers because, "the usual tactics to detain a subject often don't work and the potential exists for the struggle to be elongated" and that persons with excited delirium are "far more violent than drunk subjects." (7)

EMS protocols around the country allow paramedics to administer ketamine in the field, without direct medical supervision after making a diagnosis of excited delirium. EMS services in Aurora, Colorado had such a waiver with many caveats including that agitation that is not thought to be "due to an underlying medical or psychological etiology" should be managed by police and that EMS personnel should not "engage in restraining people for law enforcement purposes." (Ref. 2, p. 67) Despite this caveat, ketamine was used to sedate Mr. McClain.

Citing an inadequate initial investigation that cleared responding police officers and EMTs, the Aurora City Council commissioned an independent investigation. The results of the investigation were highly critical of police behavior and found as well that the paramedics who administered ketamine did so without attempting to appropriately assess Mr. McClain and injected an inappropriately high dose of ketamine. (8)

In contrast to the American College

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Excited Delirium

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of Emergency Physicians position both the APA (after extensive discussion by CPL) (9) and the AMA (10) have endorsed policy statements stating that current evidence does not support excited delirium as an official diagnosis; that denounce attempting to justify police use of excessive force solely by an excited delirium diagnosis; and that state drugs like ketamine should not be used exclusively in a law enforcement setting as an intervention for an agitated individual without a legitimate medical reason and without appropriate supervision.

Mr. McClain's family has sued the City of Aurora and others in Federal Court under 42 U.S.C. § 1983 alleging multiple civil rights violations (Ref. 2, pp. 74-102). The case is currently in settlement negotiations.

After investigative reporting by the *Hartford Courant* in 1998 inpatient medical and psychiatric seclusion, physical and chemical restraint practices came under close scrutiny. (11) Although initially resisted by practitioners, the increased regulation and oversight generated from the investigations led to improved inpatient practice and better patient care. (12) I hope that the increased scrutiny of ketamine used as a chemical restraint by paramedics in the field will also lead to regulations that will improve patient outcome and eliminate in-custody deaths in restraint. ☯

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Committees: The Backbone of AAPL

Joseph R. Simpson, MD, PhD



Those who have read issues of this Newsletter in recent years may have a fair idea of how the organization works. Articles by the President, Execu-

tive Director, Medical Director, and Newsletter Editor not infrequently include discussions of the mechanics of AAPL's operations, or descriptions of components such as the Executive Council. AAPL Committees have been mentioned, and members encouraged to join, in those articles and in other pieces in these pages as well (see the Fellows' Corner in this issue, for example). Yet some may still be unclear about AAPL's Committee structure. What are these Committees, and what exactly do they do?

The first thing to understand about AAPL Committees is that they are actually of three types, as specified in AAPL's bylaws: Standing, Special, and Administrative/Member Services. The Standing Committees are critical for the day-to-day operations of the organization. They are the Budget, Education, Ethics, Membership, and Nominating Committees, along with the International Relations Program. The Committees falling in the Administrative and Member Services category include the Association of Directors of Forensic Psychiatry Fellowships, the Bylaws Committee, the Awards Committee, and the Rapoport Fellowship Committee, as well as the Editorial Board of AAPL's *Journal*.

The purpose of each Standing or Administrative Committee can be understood simply by looking at its title. In addition to them there are the Special Committees, which have now grown to 31. Most of these cover subtopics of interest within the field of forensic psychiatry, although a couple, such as the Maintenance

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Committees

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of Certification Committee and the Program Committee, serve AAPL's general educational mission. You can find a complete listing of Committees at <http://aapl.org/committees>. (Note that the AAPL website is currently being refurbished, and the links for the individual committees may not yet be active.)

Most people who are new to AAPL and want to get more involved join a Special Committee or two. These are a relatively low-pressure way to increase your engagement with AAPL. The true commitment-phobe may choose to "audit" a Special Committee by attending one of its meetings at an Annual Meeting without formally joining, as these proceedings are open to all AAPL members. But, once you find a Special Committee that sufficiently piques your interest, contact the Committee Chair, and then submit a request to the current AAPL President to be appointed to the Committee. The time window for these requests runs from October 15th to December 1st each year (this is the "open enrollment period," if you will).

Appointment to a Committee is for a three-year term; reappointments for additional terms are unlimited. The member must request reappointment from the Chair at the conclusion of each term (during the time window described above), if desiring to remain on the Committee. Recently, AAPL updated its rules regarding Special Committee membership. (1, 2) Reappointment is now based on attending a minimum of half the committee meetings held during the three-year term (e.g., at least two meetings if the Committee only met during AAPL Annual Meetings, or three if the Committee met at all AAPL Annual Meetings as well as at all Semi-Annual Meetings, which some Committees hold during the APA Annual Meeting.) In addition to this attendance requirement, in order to be approved for reappointment the member is expected to participate in at least one Committee activity during each three-

year term. The activities are: being a presenter at a Committee-sponsored presentation at an Annual Meeting; being an author on a Committee-sponsored AAPL Newsletter article; or contributing to the Committee's development of its slate of Maintenance of Certification questions.

These activities are really where the rubber meets the road for most Committees. They do perform other functions on occasion, such as providing specialized consultation to the AAPL Executive Council regarding topics which the Council may wish to address, and many serve a networking, referral and/or "listserv"-type function for their members, year-round. But the bread-and-butter of the Special Committees are the Annual Meeting presentations, Newsletter articles, and MOC questions. It is aspirational for each Committee to submit a presentation at an Annual Meeting at least every other year, and to publish one Newsletter article every year. In the last eight issues of the *Newsletter*, the number of articles per issue published under the auspices of a Special (or Standing) Committee, including joint submissions, ranged from five to eleven articles, hitting double digits twice. (The present issue is below average, with just two committee contributions.) I didn't do such an analysis for Annual Meetings, but Committee presentations are heavily represented there as well. There can be no doubt that AAPL's Committees play a huge role in delivering the high-quality educational content that brings most people to AAPL, and then retains them as members. This is of course not to discount the networking facilitated by the Committees, which can be another tremendous benefit. You can find out much more about the mechanics of AAPL's Special Committees, including rules for the Chairs, in current AAPL President Dr. Gold's AAPL Newsletter article in the Spring 2020 edition (2).

To wrap up this discussion, which has focused mainly on the Special Committees, I will point out that although technically there is no limit to the number of Special Committees an AAPL member can be a part of, for

most people it will be difficult to be an effective contributor if you spread yourself too thin by being involved with more than three or perhaps four committees at a time. Of course, this will vary with the individual, but given the expectations/requirements mentioned previously, if you're not yet a member of any committee, I would suggest that you start with just one or two. You can always switch to others later. ☺

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Life in AAPL as a Trainee: The Three Stages of Development

Ashley H. VanDercar, MD, JD



I have had the pleasure of attending AAPL meetings, and being involved with the organization, throughout my professional development as a

psychiatrist. As I am now finishing my forensic psychiatry fellowship, I've found it interesting to reflect back on the many ways that the organization has helped shape my career path and develop my knowledge base.

In thinking about these experiences, I have realized that there have been three stages of development that AAPL has taken me through: the development of curiosity, knowledge, and proficiency. Throughout these stages, there has also been a longitudinal theme of networking, which is a common trajectory for trainees. (1)

The first stage of development – the development of curiosity – occurred when I was a fourth-year medical student. I was on an elective forensic psychiatry rotation. I had two supervisors' individually approach me to tell me about "AAPL," and that their annual conference was taking place nearby that coming weekend. They both told me that I should attend. I scrambled to find weekend childcare and drove to Ft. Lauderdale. I attended a series of presentations, of which I still have vivid memories. My curiosity was sparked. A previous consideration about forensic psychiatry became a firm conviction, especially after the conference cocktail hour, where I felt like I had met my "people."

The second stage of development – the development of knowledge – occurred during residency. I had the good fortune of pursuing residency in a location with a strong forensics program, with faculty who were very willing to provide mentoring. Yet, AAPL was nonetheless a key aspect

of my development; in particular, committee involvement. Early on in residency, I joined two committees. The chairs of those committees took me under their wing, prompting me to participate in, and even chair, panel presentations and newsletter articles. With the guidance of more senior AAPL members, I gained the necessary knowledge to succeed on these projects.

The third stage of development – the development of proficiency – began during fellowship. It was during this time that I began practicing the skill set of forensic psychiatry. The knowledge provided in fellowship didactics and supervision was heavily supported by AAPL resources, including practice guidelines and JAAPL articles. This past year, although it was virtual, the content provided in the AAPL meeting took on a new perspective. No longer was it simply of academic and intellectual interest. It was practically useful. I could apply it, for instance, when determining whether an evaluatee with a Q'Anon belief was truly delusional, versus just espousing an Extreme Overvalued Belief.

Throughout all of these stages of development there has been an overarching longitudinal theme of networking. My primary professional network comes from my home institution. But it has been built upon by the members of AAPL, both those that I have met in the committees, and through the Rapoport Fellowship.

My experiences are not unique. They are the essence of AAPL and its mission. (2) Nonetheless, as I am writing this article to share my perception of how AAPL has helped me, I would like to use this forum to provide reflections and recommendations.

To faculty:

If you are in a position that involves the supervision of trainees, remember the importance of early AAPL involvement – both in terms of fostering both curiosity and knowl-

edge. Encourage your trainees, as well as medical students, to attend AAPL meetings. They don't have to attend the entire experience; just enough to get a sense of the content and the people.

If, after being exposed to AAPL, a trainee expresses additional interest, invite them to sit in on a committee. Be willing to give those who appear to have the drive and ability the privilege of taking control of projects. This is a formative aspect of career development. The trainee may not have the knowledge or expertise when they start the project, but with your guidance, they will.

To trainees:

If you are a medical student or trainee, I would first like to say welcome. The mere fact that you are reading this article means that you have an interest in forensic psychiatry – and you have found the right organization to nurture that interest. Please come to AAPL meetings, both while they are virtual, and once they return to being in person. When there, attend the social functions and network. Actively seek out mentors. Many AAPL members have self-identified as being willing to mentor trainees. The contacts you create will last and develop as you progress on in your career.

Once at the meetings, sit in on committees – and proactively ask to join one or two that appeal to you. Then, volunteer vocally and frequently to participate in, or chair, presentations and articles. Even if you feel as if the project is above your knowledge base, as long as you have committee-members willing to mentor you, you can rise to the challenge. Begin reading each AAPL newsletter and journal cover to cover. Use AAPL as a means to spark your curiosity, develop your knowledge base, and then provide you with proficiency as you launch into your forensic psychiatry career. ☯

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Ask the Experts

Neil S. Kaye, MD, DLFAPA

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

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

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

Q: Can you provide some advice on the potential liability faced by forensic experts?



A. Kaye:

We all learn the “4 D’s” of malpractice: a Dereliction of Duty, Directly causing Damages. There is a potential duty to the re-

taining lawyer, opposing counsel, the evaluatee, and to the legal system to do our work to an appropriate standard of care (SOC). The potential damages could involve harm to the evaluatee and or financial damages they suffer/incur because our work has failed to meet the SOC.

Civil litigation arises when a person is angry and believes that they were treated unfairly. Whenever one does a forensic evaluation, there is a high probability that one side will be unhappy with your opinion. Usually, cooler heads prevail and the parties recognize that by design, law is adversarial, and that suing an expert is unreasonable. Nonetheless, there are occasional lawsuits against an expert for acts of omission or commission in their work. These cases most often revolve around the issue of SOC and include the doctor claiming expertise beyond reasonableness or in a failure to do an exam/review of materials that would be consistent with the SOC and AAPL Guidelines for the specific evaluation.

One of the best protections against malpractice in the clinical world is the use of a second opinion consultation. These can even be done anonymously and by phone. As med-mal also involves deviation from the standard of care, checking with a colleague as to what they think makes it nearly impossible for a lawyer to accuse you of being ignorant of the standard, as you have a contemporaneous consult. It also makes it hard to paint you as the narcissistic, uncaring, callous, money-hungry MD....You don’t have to follow the advice the other doctor gives; you remain the “captain of the ship.”

“If you aren’t comfortable with the flow/logic of a case, or you need ideas/help with phrasing a nuanced point, don’t hesitate to contact a colleague for a second opinion.”

Here’s how it should be done: Just call the other doctor, or me (302-234-8950) and discuss the case. At the end, I’ll remind you to put a note in the chart that says the following: “Case anonymously discussed with Dr. Kaye.” That’s it! It is not necessary to detail what was discussed. You have documented that you got a second opinion so you’re covered (there has never been a successful med-mal case when a second opinion was obtained) and I am covered because you noted it was anonymous so I have no idea who this was about. Of course, there is still a place for in person, face-to-face second opinion consultations.

I am encouraging more forensic psychiatrists to take a similar approach. If you aren’t comfortable

with the flow/logic of a case, or you need ideas/help with phrasing a nuanced point, don’t hesitate to contact a colleague for a second opinion. Recently, one of the AAPL Committee listservs had a very interesting “group consult” on the question of whether or not a frightening delusion could be considered a trigger for PTSD. The group input undoubtedly helped a colleague crystallize their ideas and approach to a difficult and complex medical-legal matter.



A. Glancy:

In Canada, we have a national medical protective association (the CMPA), under the auspices of the Canadian Medical

Association, which deals with all medical malpractice cases in Canada. I was therefore able to ascertain that it is very rare for forensic psychiatrists to be sued in Canada. A recent case, however, is of particular interest. After a 20-year legal marathon, the Superior Court of Ontario finally ruled on a case styled *Barker v Barker*. (1)

This case involved 28 plaintiffs who were previously patients at a maximum-security hospital in Ontario (Penetang) between 1966 and 1983. The case involved the lead plaintiff Reginald Barker and two psychiatrists, one of whom was Dr. Elliott Barker, although they were not related. The pleadings stated that the use of some new programs, which were the brainchild of the doctors, to treat patients who were held involuntarily, having been found not guilty by reason of insanity, constituted a breach of fiduciary duty and were the cause of harm to the plaintiffs.

The doctors were working in an isolated, poorly staffed maximum-security hospital. In the setting of the ‘60s, where naked encounter groups, self-help movements and the use of

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Ask the Experts

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LSD were in vogue, they designed what they believed to be innovative, experimental treatments. In addition to the former influences, they studied Chinese brainwashing techniques and the work of Martin Buber, as well as what could be considered an idiosyncratic understanding of the therapeutic community approach.

In addition, although they did not explicitly reference him, a well-known and eminent psychiatrist at McGill University had also been using experimental techniques. Dr. Ewan Cameron had a theory that he could depattern patients, by which he meant using solitary confinement, sensory deprivation, sleep deprivation, the administration of LSD, and the use of repeated ECT up to three times daily, in order to remove anomalous and psychotic thoughts. His experiments were partially funded by the CIA and the Canadian government who were interested in understanding how brainwashing could be reversed. What was most pernicious was the fact that the patients were not informed of the nature of the experiments, the goals of the experiments, or in particular the possible harm that could be caused. (2, 3)

At Penetang hospital, similar techniques that involved long spells of naked encounter sessions, fueled by LSD and other mind-altering drugs, handcuffing psychopaths and schizophrenics together, and a plethora of other dehumanizing treatments were used to break down the defenses of patients. There was no clear plan to rebuild their defenses in any manner. The types and manner of treatments, and the privileges earned, were decided by so-called parent teachers. The experiments were nominally overseen by a hospital review board. They did not attempt to keep these procedures secret and in fact filmed documentaries, involved the press, and wrote a number of papers, some of which were published by scientific journals.

Anyone reading the aforementioned will not be surprised that the doctors and the state were found liable for

breach of fiduciary duty and assault and battery. The judge awarded significant amounts of damages by Canadian standards, including large punitive damages, which likely expressed his horror at the malicious, oppressive actions, which clearly offended the Court's sense of decency. (4)

Although these events occurred some time ago there are contemporaneous lessons to be learned. First and foremost is the concept of full and informed consent, which the court noted is even more important in circumstances where the patient is held involuntarily by the state, where the treatments are new and unproven, and where the impugned treatments are the subject of research. Other lessons, that likely apply to maximum security hospitals across the world, include the question of literal and metaphorical isolation, poor staffing levels, poor training for staff, and insufficient oversight.

“His experiments were partially funded by the CIA and the Canadian government who were interested in understanding how brainwashing could be reversed.”

Take-Home Points:

Just as in our clinical work, we are expected to adhere to a minimal *standard of care* in our work. Remember the ethical principle to strive for honesty and impartiality in reaching an opinion. Your most precious asset is your reputation. Doing the work honestly and ethically is the best protection available. Should you so desire, consultation with a colleague is always appropriate.

Also, for consent to be informed, it must never be coerced. Patients held involuntarily in hospital generally cannot give informed consent and generally should not be involved in experimental research, because it

would be very difficult for such consent to not be considered coerced. ☯

References:

- (1) *Barker v Barker*, 2020 ONSC 3746, (2020)
- (2) Lemov R: Brainwashing's avatar: The curious career of Dr. Ewan Cameron. Grey Room: 61-87, (2011)
- (3) Gillmor D: *I swear by Apollo: Dr. Ewan Cameron and the CIA-brainwashing experiments*: Eden Press, 1987
- (4) Cooper G: *Opinion of George Cooper, QC, regarding Canadian government funding of the Allan Memorial Institute in the 1950's and 1960's*: Department of Justice/Ministère de la justice, 1986

President's Report

continued from page 3

that we could make available to non-members or psychiatry residents? I strongly encourage our committees to undertake developing and sponsoring online educational opportunities.

If you have a proposal for online CME content, please contact Dr. Charles Scott, VAAPL Program Director, me or Dr. Anne Hanson (co-chairs of the Education Committee). If you think financial support would assist in developing your proposal or project, consider applying to the AAPL Institute for Research and Education for a grant. AAPL needs all of us to think creatively about the AAPL's new online post-pandemic future. ☯

SAVE THE DATE

AAPL 2022 ANNUAL MEETING

OCTOBER 27-30, 2022

SHERATON,
NEW ORLEANS, LA

RAPPEPORT FELLOWSHIP AWARDS, 2021-2022

Britta K. Ostermeyer, MD, MBA, and Susan Hatters Friedman, MD
Co-Chairs, Rappeport Fellowship Committee

The highly prestigious AAPL Rappeport Fellowship was named in honor of AAPL's founding president, Dr. Jonas Rappeport, MD. This fellowship offers the opportunity for outstanding senior residents with a dedicated career interest in forensic psychiatry to receive mentorship by senior forensic psychiatrists. Rappeport Fellows will receive a scholarship to attend the AAPL forensic psychiatry review course and the annual AAPL meeting, and a one-year mentorship by two Rappeport Fellowship Committee members. We wish to thank the AAPL Executive Leadership, the Rappeport Fellowship Committee members, and all Rappeport preceptors for their ongoing support of this superb training opportunity. The Rappeport Fellowship Committee and AAPL are excited to announce the 2021-22 Rappeport Fellows: Dr. Lawrence (Ren) Belcher, Dr. Austin Blum, Dr. Mario Moscovici, Dr. Amanie Salem, Dr. James (Alex) Scott, and Dr. Alexander Sones. Congratulations! Please join us in extending a warm welcome to our incoming Rappeport Fellows:



Lawrence (“Ren”) Belcher, MD

Dr. Lawrence (Ren) Belcher is a fourth-year resident at Massachusetts General Hospital and McLean Hospital where he currently serves as chief resident for the McLean resident clinic and co-chief resident for psychotherapy. He completed his undergraduate degree in political science at the University of Chicago, where he was elected to the Phi Beta Kappa honor society. After a post-baccalaureate program at Bryn Mawr College, he worked in clinical research and in community health, helping to open a federally qualified health center in his hometown of Detroit, Michigan. Dr.

Belcher attended the Pritzker School of Medicine at the University of Chicago, where he directed the Washington Park Children's Free Health Clinic and was elected to the Arnold P. Gold Humanism Honor Society. Dr. Belcher is a member of AAPL's Diversity Committee and Residency Training Committee and is a 2021 recipient of the Philip Resnick Scholar Award of the Midwest Chapter of AAPL. He has co-authored papers in JAAPL and the AAPL Newsletter. In 2022, Dr. Belcher will begin forensic psychiatry fellowship at University Hospitals Cleveland/Case Western Reserve University. His Rappeport mentors are Dr. Ariana Nesbit and Dr. Ryan Wagoner.



Austin Blum, MD, JD

Dr. Austin Blum is a fourth-year resident in the Department of Psychiatry and Behavioral Neuroscience at the University of Chicago, where he is also the Chief Resident in Consultation-Liaison Psychiatry. He earned a B.A. in history from Cornell University and a J.D. from Cornell Law School before graduating from the University of Chicago Pritzker School of Medicine. He has won several awards during his residency, including the American Psychiatric Association (APA)/APA Foundation Leadership Fellowship and the National Institute of Mental Health's Outstanding Resident Award, Honorable Mention. Dr. Blum is a member of two American Academy of Psychiatry and the

Law committees (Forensic Neuropsychiatry, Research) and serves on the APA's Council on Psychiatry and Law. His interests include the treatment of paraphilic disorders, legal and ethical issues in CL psychiatry, and the role of impulsivity in putative behavioral addictions (e.g., gambling disorder). He has recently published several papers and book chapters on these topics. In 2022, he plans to begin his forensic psychiatry fellowship at the University of California, Davis. His Rappeport mentors are Dr. Jackie Landess and Dr. Nathan Kolla.



Mario Moscovici, MD

Dr. Mario Moscovici is a final year resident at the University of Toronto, Canada. Prior to medical school at the University of Toronto, he completed an undergraduate degree in mechanical engineering and a master's degree in biomedical engineering. Dr. Moscovici decided on a career in forensic psychiatry and began working at the Centre for Addiction and Mental Health (CAMH) and at the Toronto South Detention Centre. Dr. Moscovici has a strong interest in research with a focus on aggression. He co-authored a book chapter for the American Psychiatric Association titled "Pharmacological Treatment of Antisocial Personality Disorder" and presented at the Canadian Academy of

Psychiatry and the Law annual conference in April 2021 on "prediction of violent incidents among CAMH inpatients using dynamic appraisal of situational aggression (DASA)." He has also previously co-authored a peer-reviewed publication on the Clinical Global Impression scale in correctional settings. In 2021, Dr. Moscovici will be applying and interviewing for a forensic psychiatry fellowship position. His Rappeport mentors are Dr. Sara West and Dr. Susan Hatters Friedman.

RAPPEPORT FELLOWSHIP AWARDS, 2020-2021



Amanie Salem, DO

Dr. Amanie Salem is a Chief Child Fellow at New York-Presbyterian Hospital. She earned a Bachelor of Science in Public Health and a Master of Public Health from Saint Louis University, where she was awarded the Outstanding Public Health Student Award and was inducted into Delta Omega, the Honorary Public Health Society. Dr. Salem completed her medical training at Kansas City University of Medicine and Biosciences in Kansas City, Missouri, graduating as a member of the Gold Humanism Honor Society. She completed her residency training at Saint Louis University where she was awarded Resident of the Month (twice), Outstanding Resident in Teaching, and was elected as Associate Chief Resident for Educational Activity. Dr. Salem has served on APA, AACAP, and AAPL councils and committees and presented at the annual conferences of these organizations. She was also awarded the APA SAMHSA Minority Fellowship Award and served as Vice Chair of this program. She received the Dr. Suzanne Munson Memorial Award by the New York-Presbyterian Hospital Department of Psychiatry and the National Institute of Mental Health. In 2022, she will begin Forensic Psychiatry Fellowship at the University of California-Davis. Her Rappeport mentors are Dr. Joe Penn and Dr. Brian Barczak.



James ("Alex") Scott, MD

Dr. James "Alex" Scott is a fourth-year resident at the University of Michigan. Born and raised in Cleveland, Ohio, he studied psychology at Furman University in Greenville, South Carolina and did medical school at the University of Cincinnati where he participated in basic and clinical research on traumatic brain injury and suicide rating scales. In residency, he has delivered grand rounds and written a manuscript on the historical development of the psychiatric interview as well as given lectures to psychiatry residents and undergraduate students at the University of Michigan on challenges in commitment proceedings and documentation in psychiatry. One of his interests is the interaction between police and persons with mental illness, and he authored a legal digest in JAAPL on this topic. He has assisted adjunct faculty members in evaluation, record review, and report writing for local criminal and civil cases involving police. He is currently researching historical trends in this area, and is participating in AAPL's Law Enforcement Liaison committee. He will be returning to Ohio in 2022 to complete a forensic psychiatry fellowship at Case Western Reserve University. His Rappeport mentors are Dr. Renee Sorrentino and Dr. Gary Chaimowitz.



Alexander Sones, MD

Dr. Alexander Sones is a fourth-year resident and the Chief Resident of Inpatient Psychiatry at UCLA. He graduated from the David Geffen School of Medicine at UCLA, where he was elected to the Alpha Omega Alpha honors society and twice received the Student Organization Award for Community Service. He completed his internship year at Harbor-UCLA Medical Center and served as the Chief Resident of Forensic Psychiatry. His career interests include the interactions of individuals with severe mental illness in the carceral system, early interventions for at-risk individuals with mental illness, and shifts in societal attitudes towards severe mental illness and the law. He serves as the primary psychiatrist for patients who have successfully been diverted from jail and re-entered the community via a county-wide criminal justice diversion program and on a separate forensic Assertive Community Treatment (ACT) team. He has published articles on forensic topics in *The Daily Journal*, California's leading legal newspaper. He is currently establishing a partnership between the UCLA Forensic Psychiatry Fellowship program and the UCLA School of Law in which forensic psychiatry fellows will be able to testify in mock trial cases conducted by the law students. In 2022, he will begin forensic psychiatry fellowship training at UCLA. His Rappeport mentors are Dr. Vivek Datta and Dr. Britta Ostermeyer.

What's in a Name? Disputes about Sexual Identity on a Child and Adolescent Psychiatric Unit

Luke Verret, MD; Hannah Scott, MD; Joshua Sanderson, MD;
Graham Spruiell, MD

Child and Adolescent Psychiatry and the Law Committee

Discussion of what later became known as Gender Dysphoria began in 1948 when renowned sexologist Dr. Alfred Kinsey was contacted by a woman whose male child insisted that he was in fact a girl. Dr. Kinsey referred the patient to Dr. Harry Benjamin, a noted German endocrinologist, who administered estrogen and referred the patient to a surgeon. In 1973, Dr. Benjamin, who dedicated his career to such patients, coined the term of art describing the feeling of incongruence, Gender Dysphoria.

In 1980, the DSM-III introduced the diagnosis "Gender Identity Disorder." Gender Identity Disorder was defined as an incongruence between one's anatomic sex and gender identity. In DSM-5, Gender Identity Disorder was replaced with Benjamin's Gender Dysphoria, defined by a marked incongruence between the gender assigned at birth and their experienced and expressed gender. This incongruence is considered a core feature of the diagnosis.

There are different, often conflicting ideas about sexual identity as it relates to the treatment of Gender Dysphoria. The following clinical vignettes are not from actual patients. Instead, they are "constructed patients" derived from a compilation of disputes involving sexual identity and the preferred use of a name and pronouns.

Patient A:

Brad, a 15-year-old patient, was admitted for depression and suicidal thoughts related to Gender Dysphoria. Brad expressed a preference for the name "Lacey" and the pronouns she, her, and hers. Lacey has a well-documented history of such feelings and beliefs, and her family and teachers have already begun using her preferred name and feminine pronouns.

Lacey has also enrolled in the pediatric adolescent clinic to consider hormone therapy. The treatment team agrees to use the name Lacey and the feminine pronouns after conferring with Lacey's parents and reviewing the medical records.

Patient B:

Three days later, Jacob, a 13-year-old, was admitted after expressing suicidal thoughts in the context of a disagreement with his parents about poor grades and the confiscation of his phone. Jacob has a history of ADHD but has never been hospitalized on a psychiatric unit. Jacob's intake evaluation reveals a long history of ADHD and oppositional behaviors at both home and school. He reports strained relationships with family and friends.

On the day after his admission, Jacob announced that he believed that he was meant to be a girl and requested that the staff refer to him as "Jackie" and use feminine pronouns. Jacob's parents provided collateral information confirming that Jacob had not previously discussed concerns about his sexual identity. Jacob's parents insisted that he should be referred to by his given name and masculine pronouns.

Discussion:

The conceptualization of the diagnosis of Gender Dysphoria and its treatments are evolving. Locally, Gender Dysphoria has become an increasingly common reason for admission at our child and adolescent psychiatric unit. A study from a community health center in Boston found that transgender youths have a higher probability of being diagnosed with depression and anxiety and have a higher rate of suicidal ideation, suicide

attempts, and (non-suicidal) self-injury compared to cisgender controls (1). With presentations increasing, challenges arise for psychiatrists that are difficult to traverse.

There is a spectrum of support that adolescents receive related to the family's acceptance of the diagnosis of Gender Dysphoria and the adolescent's stated preferences. In some cases, parents oppose both the diagnosis and the treatment of Gender Dysphoria, while other parents are supportive, as in Lacey's case. Lacey had a history of expressing symptoms of Gender Dysphoria and had parents and outpatient clinicians who supported her. In situations like Lacey's, there is an alignment that allow the treatment to advance.

It is more common for discussions of preferred name and pronouns to be testier. Sometimes, parents verbally express support for their child, while simultaneously resisting the child's request and preferences. In other instances, the parents oppose the adolescent's disclosure and wishes, and demand that the hospital refer to their child by their legal name. A particularly heart wrenching dilemma occurs when one parent agrees with the child while the other parent disagrees, threatening the marital bond and the integrity of the family. This leaves the treatment team in a precarious position, trying to avoid taking sides in a heated dispute while at the same time attempting to establish an alliance with the patient.

As a treating physician on a short-stay, adolescent psychiatric unit, it is desirable to rapidly build an alliance with the patient to make the most progress during a short hospitalization. For a patient who meets criteria for Gender Dysphoria, that typically translates into using a patient's preferred name and pronouns while recommending that others do as well.

But as with all therapies, there may be untoward effects. If the treatment team only considers the adolescent's wishes irrespective of parental wishes, this will add to the strain on both the family and the patient and can lead to a worsening of dysphoria that may

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Seeking Face Time: Can Video Calls Mitigate Risk?

Sherif Soliman, M.D.

Geriatric Psychiatry and the Law Committee

As I write this in June 2021, there is a sense of cautious optimism that the COVID-19 pandemic in the United States may finally be receding. I hope that remains the case when this is published in Fall 2021. The pandemic has been especially difficult for older Americans, who are among the most vulnerable to complications of COVID-19 and were most strongly urged to practice physical distancing. Skilled nursing and assisted living facilities closed their doors to visitors, who constitute an important lifeline for isolated older Americans. While many of us have begun to re-establish our social bonds, isolation had been a reality for too many older Americans before the pandemic and will continue to be a reality after the pandemic. The CDC reports that social isolation increases the risk of anxiety, depression, and suicide. Social isolation increases the risk of major neurocognitive disorder by 50%, heart disease by 29%, and stroke by 32%. (1) Isolation is also a key risk factor for elder financial exploitation and abuse.

One glimmer of hope that emerged from the pandemic was the increased use of video calling technologies to connect families and friends. Could these technologies play a role in reducing the risk of suicide or aggression among older patients? As forensic psychiatrists, we often focus on assessing and mitigating such risks in both clinical and legal settings.

I read with great interest a letter to the editor of *Psychiatry Research* authored by Padala and colleagues. (2) They describe a case of Mr. A, an 81-year-old man with major neurocognitive disorder due to Alzheimer's disease and hearing loss. He had been stable when receiving regular visits from his daughter. He exhibited agitation, pacing, and a loss of appetite when the visits were discontinued due to visitor restrictions designed to curb the spread of COVID-19. He

had difficulty communicating over the telephone due to hearing impairment. However, when they began video calls with his daughter, he was able to lip-read, and his daughter reported an increased sense of "connectedness." Staff noted improvements in his appetite and decreased pacing following a series of video calls. The authors concluded that video chat applications should be studied further in order to prepare for the next pandemic. While I think the clinical implications discussed are very exciting, I think that video calls may also have an important role to play in forensic psychiatry. While it remains to be proven empirically, it makes intuitive sense that an intervention that reduces isolation may reduce the sequelae of isolation, such as aggression and suicide. They could also reduce the risk of financial exploitation, since isolation is a substantial risk factor for undue influence and financial exploitation. In other words, these technologies may play an important role in the primary prevention of these negative outcomes.

Video calls are not only clinically helpful, but a potentially powerful tool in our risk mitigation armamentarium. By reducing isolation, this patient's agitation and anxiety were reduced. It is plausible to consider that reducing anxiety and agitation could also reduce suicide and violence risk in older patients. Of course, this is a single case and much more evidence is needed before we can conclude that video calls are a helpful tool in reducing isolation, suicide, violence, or other measures. In addition, there are many other factors to consider such as family dynamics, pre-existing conflicts, and the potential for a family member or acquaintance to use the calls to exert undue influence. Privacy concerns will need to be balanced against the need to protect vulnerable elders. Nevertheless, using video calls to reduce isolation is

an intervention with virtually no side effects. Further, the likely added cost would be minimal since virtually all facilities are equipped with wireless internet and hardware that is capable of supporting video calls.

Although much more study is needed, facilitating video calls with friends and family could become an important risk mitigation tool in forensic psychiatry. Video calls with family and friends could become a routine part of home health visits, as well as skilled nursing care. We routinely consider social isolation as part of our risk assessments for suicide and our assessments for the risk of undue influence. We must now consider ways to mitigate this modifiable risk factor. The technology that provided many with a lifeline to friends and family during the pandemic could become the lifeline for the millions that will remain isolated long after the rest of us have returned to our "normal" lives. ☯

References:

- (1) Centers for Disease Control and Prevention. Loneliness and social isolation linked to serious health conditions. <https://www.cdc.gov/aging/publications/features/lonely-older-adults.html>, accessed on June 29, 2021
- (2) Padala SP, Jendro AM, Orr LC. Face-time to reduce behavioral problems in a nursing home resident with Alzheimer's dementia during COVID-19. *Psychiatry Res* 288:113028. <https://doi.org/doi:10.1016/j.psychres.2020.113028>, 2020

SAVE THE DATE

**AMERICAN
PSYCHIATRIC
ASSOCIATION**

ANNUAL MEETING

MAY 21-25, 2022

NEW ORLEANS, LA

American Medical Association 2021 Special Meeting Highlights

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

The American Medical Association's (AMA) 2021 Annual Meeting was held as a special virtual meeting from June 11th through 15th, 2021. As with the previous two meetings, the special meeting was held virtually and focused on urgent business for the House of Delegates (HOD). Despite the platform, the meeting included the usual presidential speech and business of HOD. Delegates, alternate delegates, and others provided testimony on a variety of timely topics, ranging from COVID-19 to telehealth to social justice and public health.

AMA President Susan Bailey, MD, an allergist-immunologist from Texas, gave her final speech as AMA President and commented on the many challenges physicians faced during the preceding year and continue to face in their everyday practices of delivering high-quality care. Dr. Bailey gave a message of hope and resilience in medicine, talking about the hero's journey of physicians. "No one has shouldered more of this pandemic than our courageous colleagues on the front lines – brave men and women from every state who have gone above and beyond in service to their patients and communities." She noted that physicians are leading by example, and conveyed that "96% of practicing physicians have been fully vaccinated against COVID-19."

There was a call to remember those physicians lost to COVID-19. "You will remain in our heart and in our thoughts long after this pandemic is over." Beyond her speech, the AMA also recognized other members lost during the past year, including Paul O'Leary, MD, a child and forensic psychiatrist who was also an AAPL member and former Speaker of the APA Assembly. A fund has been established in Dr. O'Leary's name to recognize his contributions to organized medicine and contribute to future generations of

physicians.

Incoming AMA President Gerald E. Harmon, MD, a family medicine physician from South Carolina, continued the theme of the role of physicians as leaders in his inaugural speech. He emphasized that we are in a consequential time in American history. "We, too, are at war against seemingly formidable adversaries: the COVID-19 pandemic, which has led to the deaths of millions worldwide, and hundreds of thousands here at home, prolonged isolation and its effects on emotional and behavioral health, political and racial tension, and the immense battle to rid our health system—and society—of health disparities and racism." His speech captured many of the topics addressed during the week by the HOD.

The HOD debated and polished reports and resolutions on a wide variety of topics, including several that addressed behavioral health and forensic issues. Among topics addressed, a number of resolutions called attention to racial inequities in healthcare and efforts to diversify the workforce; scope-of-practice, including efforts to curtail the name change of physician assistants to physician associates; and support for world-wide equitable distribution of COVID-19 vaccinations and related supplies. The AMA took steps to research and advance practices for continued use of telehealth, especially around state licensure requirements and regulations.

Of particular interest to AAPL members, the HOD adopted a report stating that current evidence does not support the term "excited delirium" or "excited delirium syndrome" as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are set. Consistent with APA policy, the report also highlighted the risks of using ketamine and other sedative or hypnotic agents in out-of-hospital settings. AMA President Harmon said:

"For far too long, sedatives like ketamine and misapplied diagnoses like 'excited delirium' have been misused during law enforcement interactions and outside of medical settings—a manifestation of systemic racism that has unnecessarily dangerous and deadly consequences for our Black and brown patients."

Among other business, the HOD passed a resolution to support increased access to medication treatment for opioid use disorder for correctional facilities and persons in re-entry. In addition, the HOD considered discrimination against physicians treated for opioid disorder, emphasizing that one's condition does not equate with impairment and that appropriate treatment will help some physicians to continue to practice safely. In addition, referencing statistics that at least eight state legislatures introduced legislation in 2020 to criminally punish physicians who follow evidence-based practices in treating adolescents diagnosed with gender dysphoria, the HOD passed a resolution to oppose legislative efforts to criminalize or place other undue restrictions on gender-affirming care. The House also amended existing policy to advocate for the U.S. to pursue alternatives to immigrant detention centers to respect the human dignity of immigrants, migrants and asylum seekers who are in the custody of federal agencies.

The AAPL delegation was led by Barry Wall, MD, who provided detailed and thoughtful testimony in the reference committees. Dr. Wall was also elected to Chair the AMA Committee on Conduct at Meetings & Events.

The delegation is looking forward to resuming in-person meetings, especially as our two Young Physician Delegates, Drs. Sarah Baker and Katy Skimming, have not been able to attend an in-person meeting. The interim meeting of the AMA is currently scheduled for November 2021 in Orlando, Florida. You can find more information on the actions of the AMA House of Delegates at the 2021 Special Meeting at <https://www.ama-assn.org/about/house-delegates-hod>.[Ⓜ]

APA Assembly Updates

Danielle B. Kushner, MD

The Spring APA Assembly met virtually on April 24-25, 2021 prior to the online APA Annual meeting from May 1-3, 2021. The theme of the Annual Meeting was “Finding Equity Through Mind & Brain.” The conference marked the end of the presidential term of Jeffrey Geller, MD, and the start for Vivian Pender, MD. The theme of Dr. Pender’s presidency and new presidential task force is the Social Determinants of Mental Health.

In the Report of the Medical Director, Saul Levin, MD, MPA, discussed the organization’s recent administrative, political, and legislative updates. The APA continues to advocate for key legislative issues including the Resident Physician Shortage Reduction Act of 2021, expanding access to buprenorphine treatment, mental health parity, scope of practice, telehealth expansion, and outpatient insurance reimbursement, among others. The APA continues to encourage its members to engage in advocacy, most recently sponsoring the virtual 2021 Federal Advocacy Conference in June.

Through the COVID pandemic the APA has provided robust virtual educational programming and town halls on a wide range of topics. The APA Foundation specifically has continued to support mental health programming in various environments including schools, workplaces, faith-based communities, and legal settings. Of note, the Judges and Psychiatrists Leadership Initiative works to improve the judicial, community, and systemic responses to those with behavioral health needs in the criminal justice system through connections, trainings, and education. They recently cosponsored a report in October 2020 regarding rethinking competency to stand trial.

Dr. Levin additionally discussed APA’s continued efforts towards Maintenance of Certification (MOC) reform. In March 2021, the APA Trustees approved action items related to MOC. They stated that the APA

will work with the American Board of Psychiatry and Neurology (ABPN) to develop its own society-based alternative to MOC and acknowledged the National Board of Physicians and Surgeons (NBPAS) as a possible alternative to the ABPN’s MOC program. Of note, it also accepted a grant from ABPN to support APA educational programs, MOC products, and APA’s mental health registry. Additionally, the American Board of Medical Specialties (ABMS) recently released new draft Standards for Board Continuing Certification that will shape MOC programs for all ABMS boards, including the ABPN. It includes a proposal to change recertification “at intervals no longer than every five years.” APA is currently reviewing the impact of the change in standards and recommends for APA members to submit comments on the proposed changes to the APA.

The Presidential Report of Jeffrey Geller, MD reviewed highlights from his term focusing on the recent work on structural racism. The Presidential Task Force to Address Structural Racism led by Cheryl Wills, MD, produced actionable recommendations to the APA Board to help address this important issue over the past year. They included specific ideas to help increase diversity in APA leadership, campaign reform, education of members, fellow mentorship, meeting programming, and council projects, among others. In January 2021 the APA Board issued an apology for the history of racism in APA and Psychiatry. Furthermore, a Resource Document on Advocating for Anti-Racist Mental Health Policies is currently in progress.

Key Assembly forensic topics included the passage of an Action Paper advocating against the use of weapons by physicians employed by law enforcement. It focused on the recent expanded use of rapidly rotating batons in the Bureau of Prisons (BOP) and the dual roles of mental health providers as law enforcement

officers in the BOP. Two other approved Action Papers addressed bias in law enforcement and correctional staff through the development of APA policy to support employment fitness screenings and ongoing diversity and de-escalation trainings.

New APA Position Statements were approved on Interstate Licensure for Telepsychiatry, Racism and Racial Discrimination in Psychiatric Workplace, Condemning the Rise of White Supremacy Violence, Orchiectomy or Treatment with Anti-Androgen Medications as a Condition of Release from Incarceration, and Ongoing Need to Monitor and Assess the Public Health and Safety Consequences of Legalizing Cannabis. Additional edits of DSM-5 diagnoses were also approved in preparation for the next edition of the diagnostic manual.

The Council of Psychiatry and Law reported their recently completed Resource Documents on Non-Emergency Involuntary Medication for Mental Disorders in U.S. Jails, Mental Health Courts, and Safe Consumption Facilities, which have been approved by the Joint Reference Committee and are accessible on the APA website. The Council continues to work on ongoing projects through workgroups on child commitment, correctional topics, and addiction psychiatry.

Due to the ongoing COVID-19 pandemic the APA decided to hold all remaining 2021 meetings virtually and will not meet in person, including the 2021 Mental Health Services conference. The next APA Assembly meeting is scheduled during the APA 2022 Annual Meeting in New Orleans, May 21-25, 2022. The theme of the meeting is Sociopolitical Determinants of Mental Health. ☯

AAPL is pleased to announce the 35th Annual Rapoport Fellowship competition. Registration to the Forensic Review Course and 2022 Annual Meeting along with travel, lodging, and educational expenses are provided to the winners. Contact the AAPL Executive Office for details.

Prostitution and the Law

By Kavita Khajuria, MD

The trend towards legalization of prostitution in the United States (beyond regulated brothels in rural Nevada) surfaced again earlier this year, with New York City Mayor Bill de Blasio's move to decriminalize sex work. This was followed by New York Governor Andrew Cuomo signing off on a repeal of the law against "loitering for the purpose of prostitution," describing this as discriminatory against transgender women and non-white sex workers. (1) The Manhattan District Attorney subsequently announced that city prosecutors would not prosecute prostitution and unlicensed massages. (2) He then moved to dismiss approximately six thousand prostitution cases, nine hundred unlicensed massage cases, and over five thousand loitering-for-the-purpose-of-prostitution cases. (3) The D.A. argued that criminal prosecution would achieve the opposite of its intended effect, marginalizing the vulnerable, especially the LGBTQ community.

Some welcomed and supported this action, including the Legal Aid Society's Exploitation Intervention Project, the New York State Anti-Trafficking Coalition, and the Victims Services Agencies, who noted that the knowledge gained from speaking to survivors, advocates, and those with lived experience indicated disproportionate harm from these laws to Black, Brown, and East Asian women and girls, immigrants, and LGBTQ populations. (3) Counties in Maine followed suit, urging state lawmakers to decriminalize prostitution, arguing that it was time to acknowledge that the circumstances of human trafficking and sexual exploitation amounted to victimization that deserved support, not prosecution. (4) A bill was presented that consequently placed the focus on human traffickers and those who pay for sex, rather than those who engage in sex work. Supporters argue that legalization and regulation decrease danger, increase safety, and improve access to the legal system.

Not all agree. Some have cited the lack of culpability for out-of-state pimps who bring sex workers into areas where they would not face prosecution. (4) Others argue this may support establishments that provide or enforce sexual services under the guise of a new legal framework, namely massage parlors, nightclubs, and bars. The recent murders of six Asian women in Georgia, killed due to the perpetrator's apparent association of massage with sex work were a reminder of the dangers that face an entire group of workers (5). To complicate matters, many police forces in Canada do not enforce prostitution laws, but continue surveillance and monitoring of sex work establishments – an approach some describe as biased towards the detention and deportation of vulnerable migrants. (5)

Rudyard Kipling exaggerated only mildly when he called prostitution the world's oldest profession. Prostitution may be found in records as ancient as Mesopotamia, where priests engaged in sex to promote fertility in the community -- all women were required to perform "temple duty," with passing strangers expected to make monetary donations after utilizing their sexual services. (6) Today in the United States, sex work runs the spectrum from high-end escort services to high school pimps, with no demographic unrepresented. Almost all types of commercial sex venues exist to some degree, although the arrest trend has declined with the sexual revolution, with the availability of sex-work abroad, enhanced technology and online alternatives.

Solicitation and sex work are punishable in most U.S. states with a fine or jail, but penalties increase with recurrence, and may include suspension of a driver's license, vehicle seizure and forfeiture, and an unfavorable impact on immigration and professional licensure. In most countries, sex work is criminalized or controversial, with communities vacillating between seeing it as a threat to morality and a

source of exploitation. Objections to patriarchal legal systems, the commodification of women and other vulnerable groups, and violations of human rights all face the argument that prostitution should be ignored as a consensual act, with criminalization serving as nothing more than a mechanism of control. (7) Yet whether consent can be assumed under conditions of social and economic deprivation remains a difficult question for proponents of decriminalization. Moral and legal issues continue to inform this sensitive and complicated topic, and will likely continue to do so for years to come. ☯

References:

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- (7) Forestiere, A. To Protect Women, Legalize Prostitution. *Harvard Civil Rights - Civil Liberties Law Review*, October 1, 2019.

AAPL SPECIAL COMMITTEES

AAPL members interested in joining a Special Committee should contact and communicate exclusively with the Committee Chair. Requests to join Special Committees should be made to Special Committee Chairs between October 15 and December 1 of each calendar year. Requests for committee membership will not be considered after December 1. If members miss the "enrollment period" deadline one year, and are still interested in joining the Committee, they can ask the Committee Chair to put their names forward in the subsequent year's "enrollment period." Special Committee Chairs will forward their recommendations to the President no later than December 1. See page 17 for a list of special committees.

AAPL SPECIAL COMMITTEES

- Addiction Psychiatry
- Child and Adolescent Psychiatry and the Law
- Correctional Forensic Psychiatry
- Criminal Behavior
- Cross-Cultural Issues
- Developmental Disability
- Diversity
- Early Career Development
- Forensic Hospital Services
- Forensic Neuropsychiatry
- Forensic Training of Psychiatry Residents
- Gender Issues
- Geriatric Psychiatry and the Law
- Government Affairs
- Human Rights and National Security
- Judicial Action
- Law Enforcement Liaison
- Maintenance of Certification
- Media and Public Relations
- Private Practice
- Program
- Psychopharmacology
- Recovery
- Research
- Sexual Offenders
- Suicidology
- Technology
- Trauma & Stress
- Women's

What's in a Name

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decrease the likelihood of engaging the patient in future treatment. There is a very delicate balance specific to each patient and each parent that must be fully respected to avoid harm. Further complicating the matter is the fact that many states do not have specific statutes defining parental rights in this regard (2). The standard is considered “the best interest of the child,” which allows guardians to make decisions regarding matters of the child, such as education, religion, and medical treatments. But this becomes cloudier when considering whether parents legally have a right to insist that their child be referred to by their given name and corresponding pronouns.

Ultimately, it falls to the psychiatrist and treatment team to establish whether or not the patient has a diagnosis of Gender Dysphoria and to decide whether or not using preferred names and pronouns would be therapeutic for the patient. Competing principles include external factors such as diagnostic criteria, cultural beliefs, family beliefs, laws that protect parental authority, and laws that prohibit discrimination against patients with Gender Dysphoria. Internal factors include the psychiatrist's fiduciary responsibility to the patient, recognition that the patient is unique, and the duty not to harm the patient or the family.

Brad was admitted for depression and suicidal thoughts due to Gender Dysphoria. His diagnosis was well documented and supported by his family, school, and pediatrician. When Brad approached the treatment team with a request to be called Lacey and referred to by feminine pronouns, her diagnosis of Gender Dysphoria and requests were on a firm foundation. In that situation the competing principles were in alignment, and there was a path forward to provide treatment.

Jacob was admitted due to suicidal thoughts like Lacey, but suicidal thoughts were precipitated by anger at his parents for taking away his phone, not dysphoria or depression related to sexual identity. Additionally, there was no hint that he had concerns about

his sexual identity and he had never received a diagnosis of Gender Dysphoria. When Jacob approached the treatment team with the request to be called Jackie and be referred to using feminine pronouns, he may have been simulating Gender Dysphoria, but this is fundamentally different from having Gender Dysphoria. If he does not have Gender Dysphoria, then there is no reason to alter his name or pronouns.

Should Jacob's request be granted for other reasons? The way to determine whether there are other reasons to consider is to interview the patient and to get a better understanding about what “Gender Dysphoria” means to Jacob. It strains the imagination in this example because it is difficult to conceive of a therapeutic reason to agree to Jacob's requests. But what if we later discovered that he had told his teacher that he was a girl, and that his parents knew about it all along but deliberately concealed that information from the psychiatrist? In that scenario, Jacob's request would need to be reassessed based on this new information.

The cases above are relatively straightforward examples. As previously mentioned, the more difficult cases involve a legitimate diagnosis of Gender Dysphoria coupled with parents who vehemently oppose treatment of Gender Dysphoria, or parents who vehemently disagree with each other about authorizing treatment for the condition. As with more straightforward examples, the state of the science is such that there are no formulaic remedies, and each case should be considered individually and in detail. We broach this topic, not to offer answers, but with the hope of sparking the interests of others, as scientific evidence about the diagnosis and best clinical practices emerge. ☯

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- (2) Parental Rights. Parental Rights by State. Available from: <https://www.parentalrights.org/states/> Accessed Jun 16, 2021.

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