Applying AAPL Ethics and Mission in Forensic Treatment

Charles C. Dike, MBChB, MPH

The increased visibility of the patients' rights movement in medicine in recent years has left the erroneous impression that patients and their physicians are on equal footing in the physician-patient relationship. The reality is that vulnerability of patients in this relationship leaves them at the mercy of health care professionals. This is most acute in psychiatry, where patients reveal aspects of their inner being to their psychiatrist, including strange beliefs they would never disclose to their closest friends and family members, whereas psychiatrists, in contrast, reveal close to nothing of themselves to patients. Additionally, distortions of reality can strip patients of social mores and basic humanity and sometimes cause them to commit crimes. American Academy of Psychiatry and the Law (AAPL) scholars have espoused the values of treating evaluees professionally and with compassion and respect while upholding their dignity and humanity. These worthy forensic psychiatric writings, however, have unfortunately not always transitioned into the clinical treatment of forensic patients. Reports of patient abuse by staff in psychiatric hospitals, including forensic psychiatric hospitals, remain rampant. Using real-life examples, I apply forensic psychiatric ethics to patient care and offer suggestions of practices and policies that would enhance treatment of patients and decrease the potential for patient abuse in psychiatric hospitals.

J Am Acad Psychiatry Law 53(1) online, 2025. DOI:10.29158/JAAPL.250001-25

Key words: forensic treatment; ethics; psychiatric hospitals; advocacy; administration; education

In March 2017, a whistleblower alerted the state police working for the Connecticut Department of Mental Health and Addiction Services that a patient was being abused at the state maximum-security psychiatric facility. On reviewing the video installed to observe the patient's room, the police found multiple examples of abuse of the patient by staff members over several weeks.[1] These included staff members putting a diaper on the patient's head, throwing food at him, pouring water over him, putting salt in his coffee, kicking him, physically restraining him to the bed by straddling him between their legs, and placing a wet mop on his head after cleaning the floor.[1] Even more shocking was the fact that these staff members knew or should have known they were being recorded. Approximately 37 staff members were implicated, and they later resigned, retired, or were terminated. Nine of them were charged with cruelty to persons and disorderly conduct.[2] Several agreed to plea deals; one of them was found guilty by a jury at trial and subsequently imprisoned.[3]

Incidents such as this are unfortunately not rare or bygone. In July 2022, three staff members joined a patient to beat another patient to death at Twin Valley Behavioral Health Care, a center for forensic psychological evaluations in Columbus, Ohio.[4] In February 2024, a camera caught a mental health technician grabbing a patient by the shirt, throwing him to the floor and punching him in the stomach at Choate Mental Health and Developmental Center (Choate) in Illinois.[5] Investigations preceding the installation of cameras at Choate had identified 20 employees as being charged with felonies on suspicion of patient abuse.[5] In an earlier incident reported in *The New York Times* in 1983, nine staff members were indicted by the Justice Department on charges of beating and abusing patients at a Pennsylvania state institution for the mentally retarded.[6] The authors of the news article

Published online February 11, 2025.

Dr. Dike is Professor of Psychiatry, Yale School of Medicine, New Haven, Connecticut, and Medical Director, Connecticut Department of Mental Health and Addiction Services, Hartford, Connecticut. Address correspondence to: Charles C. Dike, MBChB, MPH. E-mail: charles.dike@yale.edu.

Disclosures of financial or other potential conflicts of interest: None.

believed the indictments were "the first Federal criminal civil rights prosecutions brought against employees of mental institutions for patient abuse" (Ref. 6, p 10). The article quoted the Assistant Attorney General William Bradford Reynolds, head of the department's civil rights division, as saying, "This should give a clear message across the country that abuse of patients will not be tolerated. . . I fully recognize that employees of mental institutions have difficult and demanding jobs, but they cannot abuse citizens who are among the most defenseless in our society" (Ref. 6, p 10). Unfortunately, not much has changed since 1983, given the examples described earlier.

Stories of abuse have dogged psychiatric institutions across the country with reports of sexual or physical abuse or neglect.[7,8] These troubling events invite deep scrutiny and raise several questions, such as why these abuses happen, how many people know of an abuse incident but keep silent, if hospital leadership are aware or complicit in the abuse, and what could have prevented these incidents. Although the abuse often involves mental health aides and the nursing staff, psychiatrists who are identified as leaders of treatment teams and hospital administrators cannot escape blame altogether. This article extends my thinking about the ethics duties of members of the American Academy of Psychiatry and the Law (AAPL) and the concern forensic psychiatrists ought to have for forensic treatment facilities and those they serve. It invites AAPL members to pay attention to what transpires in treatment settings. By applying AAPL ethics, as proposed in impressive and copious articles written by AAPL scholars, and the mission as espoused by AAPL, this article presents recommendations likely to decrease the chances of patient abuse in forensic psychiatric institutions. Of course, most psychiatrists in forensic treatment settings, as well as staff from other disciplines, are not AAPL members and are therefore not bound by AAPL ethics guidelines. Forensic psychiatrists, however, can model these ethics principles to other disciplines and paraprofessional staff. Although the examples presented and discussions focus heavily on forensic psychiatric hospitals, the recommendations proposed will apply to psychiatric units in prisons and jails and in general psychiatric hospitals.

Evolution of AAPL Ethics

From the moment Alan Stone[9] challenged AAPL with his provocative comment that psychiatrists had no business operating in the legal arena because the risk of bias, for the defendants or the legal system, was too high, AAPL scholars have engaged in a vigorous academic exploration of what it means to be an ethical forensic psychiatrist. They have also established ethics guidelines for its practice that have continued to evolve through the years.[10] Paul Applebaum's thoughtful response to Alan Stone, which promoted truth seeking and justice in forensic evaluations[11] in lieu of treatment and care, deviated from the medical ethics principle of caring for the patient, a central obligation of physicians. This set the stage for subsequent ethics principles of forensic psychiatry that centralize the evaluee. Griffith and Baranoski[12] identified forensic psychiatric report writing and oral presentation and performance in court as two key practice elements of forensic psychiatry; this further solidified the understanding of forensic evaluations as the primary function of forensic psychiatrists. In forensic psychiatric scholarship, forensic psychiatric clinical treatment was overshadowed, to be mentioned in passing. There are, however, hopeful glimpses of change. Griffith and Griffith[13] provided a recent eloquent discussion of human dignity in forensic treatment; this is a commendable example of a much needed focus on forensic treatment. If forensic psychiatry is a vocation as observed by Norko, "wherein we are present to and give witness to suffering, where we regularly exercise empathy and compassion in all aspects of the work" (Ref. 14, p 20), forensic treatment must emerge from the shadows and take its rightful place alongside forensic evaluations and testimony.

Narratives and Cultural Formulation

In forensic treatment, it is not uncommon for individuals to be defined by their crime, whereas little attention is paid to the human being. Not much effort is expended to understand how the patients drifted from being fellow human beings to individuals referred to as criminals by the public and some clinicians. Several questions come to mind.

> Do clinicians care about the life histories, experiences, and social factors that created the circumstances that made the individual vulnerable to developing severe mental illness and subsequent criminal behavior?

> Do clinicians seek to understand the psychological and sociocultural truth about forensic patients and their behavior, a curiosity Griffith asserts must be fueled by a profound respect for a person?[15]

Is there a sincere effort to engage in a cultural formulation[15] of the patients to appreciate who they are and what motivates them?

What narrative do clinicians apply in describing these individuals? (As Griffith and Baranoski observed,[12] our work is not simply informative but meant to persuade audiences one way or another.)

Do clinicians ask the question trauma specialists encourage clinicians to ask: what happened to this person rather than what the person did?

Case Example

The example described below shows how the ethics principle of respect for persons, through thoughtful and less disparaging narratives and appreciation of our shared humanity, could be applied in a forensic inpatient treatment environment.

Situation

Male patients on a maximum-security psychiatric hospital unit engage in power struggles in the shower room every morning during morning routines. Fights about who goes first and for how long often lead to at least one patient being in restraints or locked in seclusion for safety on most mornings.

Psychiatrist's Proposed Solution

After much reflection and discussion with staff regarding a solution for this vexing problem, the psychiatrist proposed that creating a desired activity in the morning and inviting only patients who have been free of aggression could solve the problem. A 30-minute news group where hot coffee is served to the patients after the morning routine appeared to be the perfect activity. Hot coffee was the main attraction. This was at a time when only decaffeinated coffee was served to patients and, even then, only at specified times. Regular coffee was erroneously believed to increase the risk of patient aggression and was therefore prohibited for patients, but not for staff who drank real (regular) coffee in patients' presence.

Outcome

The psychiatrist scheduled a community meeting to discuss the plan with patients. The psychiatrist informed them that only patients who were free of aggression in the past 12 hours will qualify for the news and coffee group. Patients enthusiastically supported the plan, including the qualifying condition.

Having secured the patients' support, the psychiatrist came in early to discuss the plan with third-shift staff members who would prepare the coffee early in the morning and get patients ready for the group. Staff members listened patiently to the plan. After a brief period of silence, a staff member spoke up for the group: "I am sorry doctor. We do not serve coffee to criminals."

Here, the staff's chosen narrative of the patients is that of criminal, the patients being defined by their crime and not their human condition. The staff did not see the patients as members of their community who should be served as brothers and sisters as recommended by Griffith.[16] Their crime had justified their loss of basic respect that should be accorded to all human beings.

Psychiatrist's Response

After the psychiatrist recovered from the shock of the staff's response, he rolled up his sleeves and invited some patients to assist him in making the coffee. Aware that the patients had kept to their end of the bargain and there had been no restraints or seclusion in the past 12 hours (including during the morning routine), the psychiatrist determined that the news and coffee group must run. Patients were excited to be asked to assist with making the coffee as they had done for years in the past, before their crime. The first news group was a huge success. Patients discussed the morning news in real time with each other while drinking coffee, a normal routine they had lost on account of their institutionalization. The psychiatrist continued making coffee with the patients daily for seven business days, during which there were no restraints or seclusion, a finding that surprised the staff.

Staff members subsequently agreed to take over the coffee making and preparation of the patients for the news group as the behavior modeled by the forensic psychiatrist had yielded a favorable outcome. A positive outcome was the breaking of the myth surrounding regular coffee and aggression.

Compassion

In Norko's commentary[17] exploring the notion that compassion is at the core of forensic psychiatry, he refers to Griffith's exhortation that the use of narratives to describe a subject of forensic evaluation should involve compassion and to the extension of

that notion by Candilis, Martinez, and Dording[18] to make the case for a "compassionate professional," who is drawn into multiple aspects of the subject's suffering. As defined by Swinton[19] and quoted by Norko,[14] compassion occurs when one has a deep awareness of the suffering of another accompanied by a desire to bring relief. In proposing a moral foundation of forensic ethics that is based on compassion, Norko reminds us that compassion plays a central role in many faith traditions. Indeed, Karen Armstrong, a former Roman Catholic nun turned historian of religion, was surprised to find that compassion was the common core of all religions.[20] Compassion is summarized by the Golden Rule, "Do unto others as you would have them do to you" (Luke 6:31). According to Norko,[17] empathy and compassion are the tools of presence, both in forensic treatment and in forensic evaluations.

Case Example

The following example demonstrates the application of compassion in forensic treatment.

Situation

A unit in a maximum-security psychiatric hospital had 10 males and one female. The female patient had a half bathroom (no mirror) in her room but shared the shower room with the men. A time was set aside for the female patient to use the main bathroom alone for shower and grooming. Unfortunately, she often spent what was considered an inordinate amount of time doing her makeup, to the frustration of both the male patients and staff members working hard to de-escalate the increasingly distressed men. She was often forcibly removed from the bathroom, causing her significant agitation and behavioral dysregulation that would sometimes lead to locked seclusion or restraints. Self-grooming by taking time to apply her makeup was very important to this patient, but other patients did not appear sympathetic. Staff members were unsure how else to proceed as installing a mirror in her room was out of the question because it could be broken and used as a dangerous weapon in a maximum-security psychiatric hospital.

Psychiatrist's Response

The psychiatrist convened a meeting with the female staff members and invited the chief nursing officer of the facility. The psychiatrist then posed the following questions to them:

> Is it a reality that one woman may spend what may be considered an excessive amount of time applying makeup in the morning before leaving her home?
>
> Do you know of anyone who does so in the community, maybe a family member?

As the majority responded in the affirmative, the question shifted to how we can accommodate similar needs for this woman, albeit a patient in a maximum-security setting. Staff members were now excited and motivated to find a solution.

Outcome

After some brainstorming by the staff, they agreed that a nonbreakable plexiglass that would serve the function of a mirror could be installed in the patient's room. It worked and the patient was very grateful. Here, application of the Golden Rule elicited compassion in the staff members, changed the dynamic, and led to a positive outcome.

Shared Humanity

The ravages of severe mental illness may rob individuals of their humanity,[21] even as they may increase the risk of interaction with the criminal justice system. Steiner[22] described the case of a college roommate who was one of the stars in college and an intelligent and charismatic natural leader. Years later, her mental illness transformed her life into one of poverty, squalor, and psychosis. When she was brought by the police to the hospital where Steiner worked, Steiner remarked, "It was a tragedy really, and I knew it. The nurses, doctors, and social workers who cared for her saw the illness, but could they appreciate the tragic dimensions of it? Katherine's old self and new self were so cutoff from each other – family members not being allowed to see her now, and treaters not able to know what she had been" (Ref. 21, p 472). Therein lies the challenge of forensic treatment: how to recognize the humanity of individuals caught in the dual stigmas[23] of severe mental illness, with its attendant destruction of personhood, and illness-driven criminal behavior.

Case Example

Recognition of patients' humanity encourages their treatment with the respect and dignity they deserve. Here is an example demonstrating that in psychiatric treatment.

Situation

Patients in a maximum-security psychiatric hospital were often referred to as brutes and animals who should be treated as such. Some staff members used even more derogatory terms to describe them. This is critically important because, as the English adage goes, "give a dog a bad name and hang him." Referring to human beings as brutes or animals may justify abusive conduct toward them. The question of how to humanize the patients in the eyes of the clinical staff plagued the unit psychiatrist for months.

Psychiatrist's Response

The psychiatrist asked family members of patients to send photos of the patients as babies, toddlers, elementary and high school children, playing sports, or while engaged in ordinary activities ahead of treatment planning meetings. The psychiatrist, with the help of staff, then created a collage of these photos and hung them in the treatment room for a couple of days before the treatment planning meeting.

Outcome

Staff were shocked to see the change that had befallen the patients as a result of their illness. Seeing the photos at various stages of a patient's life suddenly struck staff members to the core; they could see themselves or their family members in the patients. Gradually, the patients were no longer brutes or animals but human beings. Griffith's quote comes to mind; the emphasis is on a commitment to serving our neighbors fairly and respectfully, seeing them as members of our community and serving them as brothers and sisters.[16] In other words, connecting to our patients as human beings drives us to do our work professionally and humanely.

Professionalism

According to the Oxford Learner's Dictionaries,[24] professionalism is the high standard that you expect from a person who is well trained in a particular job. In offering a robust view of professionalism, Candilis, Martinez, and Dording[18] recognize the conflict between forensic and clinical roles and propose a model of forensic ethics that synthesizes both roles. As argued by Martinez and Candilis (Ref. 25, p 385), "Merely to accept one's primary duty to the criminal justice system as it exists now is to negate a large part of forensic professionalism. . . a robust professionalism for forensic psychiatry cannot ignore our physician backgrounds or our diverse personal histories." Candilis further identifies[26] the habits and skills associated with the ethics precepts of professionalism as keeping professional expertise up to date, learning different approaches to ethics problems, choosing among ethics theories or solutions, balancing individual and societal claims, following the profession's historical narrative, protecting vulnerable values, and aspiring to improve the profession. Robust professionals, in Candilis' view,[26] are sensitive to vulnerable evaluees (and patients, in my opinion) and integrates personal, professional, and community values in their work. This includes protection of vulnerable persons (and understanding their narratives). Robust professionals working in forensic treatment facilities are conversant with pressures of legal concerns as they apply to their patients' situation and treatment, as well as the medical ethics that guide their professional practice. Candilis submits that robust professionalism applies in forensic treatment facilities where vulnerable and economically disadvantaged patients receive care because it embodies principles such as respect for persons, utilization of cultural formulation in care, and engagement of patients with openness and transparency.

Many psychiatrists who work in forensic treatment settings, however, have not gone through a forensic fellowship program and may not be aware of the ethics principles discussed by AAPL scholars. Being board certified in general adult psychiatry or a subspecialty of psychiatry other than forensics does not help in this regard either. To address this problem, I offer the proposal discussed below.

Proposal

AAPL should develop a certification for psychiatrists working in forensic treatment settings. Such certification, Certified Forensic Treatment Specialist (CFTS), with its affiliation to AAPL, will enhance the professionalism and reputation of psychiatrists in these settings through mentorship, education (continuing medical education (CME)), and engagement, and provide a professional home for them. Benefits to AAPL include increase in membership and generation of revenue. As the certification becomes more broadly recognized, it could potentially encourage psychiatrists to work in forensic facilities during which time they would become eligible for the certification and establish

a connection to AAPL. Eligibility criteria and requirements for CFTS would be fleshed out by a workgroup whose recommendations will be debated, edited, and finally approved by the Executive Council of AAPL. The workgroup will discuss any potential roles for the American Psychiatric Association (APA) or other organizations in establishing the certification. Enhancement of professionalism in the psychiatrists will benefit the patients they treat and model professional behavior to the staff members they work with, thereby decreasing the risks of abuse in the institution.

Advocacy

Discussions about advocacy provoke strong reactions in AAPL members. AAPL's mission is "to promote excellence in forensic practice policy, to provide and support educational activities, and to foster research that enhances knowledge about forensic psychiatry while building a diverse and inclusive body of forensic psychiatrists."[27] It is silent on advocacy. There are indications, however, that younger AAPL members and recent graduates of forensic psychiatric training programs seem to favor involvement of AAPL in advocacy for social justice concerns, but to many of their senior colleagues, advocacy is a toxic word. AAPL, of course, engages in a form of advocacy by participating in *amicus* briefs when matters important to forensic psychiatry are involved. AAPL's reluctance to embrace advocacy on a wider scale is informed in part by concerns of accusations of bias when an AAPL member offers opinions on a topic on which AAPL has publicly advocated. Although debates regarding AAPL's involvement in advocacy activities are healthy, there should be no debate about AAPL's involvement in advocacy as it pertains to the forensic treatment space or in the education of fellows.

Advocacy in Forensic Treatment

In terms of forensic treatment, AAPL can and should advocate for access to effective biological and psychological investigations and treatment of forensic patients. Availability of behavioral, neuropsychiatric, sex offender, or other specialized evaluations and treatment are often challenging in forensic settings. Additionally, AAPL can and should advocate for improvements in social conditions that affect individuals in the criminal-legal and mental health systems,[28] such as appropriate housing, employment, education and training, and access to transportation and health care. Challenges confronting forensic patients include landlords' reluctance or refusal to rent apartments to felons and employers' reluctance or refusal to hire felons.[29] These have direct impact on access to health care because most Americans access health care through health insurance provided by their job. Thus, for forensic patients, social determinants of health are also social determinants of justice.[30]

Therefore, forensic psychiatrists should recognize the ethical imperative of advocating for these services and any other service that would likely prevent incarceration and reincarceration. Advocacy for just and equitable treatment of individuals in the legal system should not be debatable or controversial, nor should advocacy for high-quality, patient-centered care in forensic settings, destigmatization and decriminalization of mental illness, alternatives to incarceration, and humane treatment and rehabilitation of incarcerated individuals.

Advocacy for Education on Social Justice

AAPL's mission statement encourages support for educational activities. Although forensic psychiatrists practice in the criminal legal system, which can be unjust and discriminatory, these matters are not typically on the educational curriculum of fellows and therefore are not taught or formally discussed in fellowship training. Questions and healthy debates have arisen regarding the role of forensic psychiatrists in maintaining the disparities in the system. Understanding the contexts in which forensic psychiatrists practice will nurture adherence to the crucial AAPL ethics guidelines of striving for objectivity in a criminal legal system that is neither objective nor just. Disparities in policing, sentencing and incarceration, as well as embedded biases in forensic assessment tools, including actuarial tools used for vital evaluations, are prime areas for education and discussion. Discussions of the experiences of minority groups (racial, ethnic, sexual orientation, and people with different abilities) in our criminal legal system would enhance the education of fellows. Understanding the context in which forensic psychiatrists practice and factors that lead to unequal outcomes will not only enhance forensic evaluations but will also improve forensic treatment, as it may engender less bias and foster a more humane care.

Administration

Management of forensic patients can be quite challenging, as most have severe and refractory

psychiatric disorders and are dangerous. Characteristics of these forensic patients can mirror those of nonpsychiatric individuals in prisons, including intimidation, violence, exploitation, and manipulation of others.[31] Clinical administrators should resist attempts to admit individuals whose dangerousness is solely the result of antisocial personality or criminal behavior, as their presence is likely to disrupt the therapeutic milieu of care.[32] Therefore, keeping and maintaining safety in the environment of care is crucial. A safe and secure environment allows for effective treatment interventions and decreases the risks of patient abuse as described earlier.

Clinical administrators should be aware that incidents of trauma in both patients and staff are high[33] and therefore should advocate for trauma-sensitive environments of care.[34] Such environments decrease agitation, frustration, and aggression in patients, thereby decreasing the likelihood of patient abuse. Adequate staffing levels and regular and adequate staff training on de-escalation and behavioral intervention techniques, as well as effective supervision of staff, are essential. These and other resources needed for providing the standard of care for forensic patients should be at the top of the administrator's advocacy list. Attention to the resources and interventions that would enhance patient care is an ethical imperative.

Clinical administrators should also be alert to the culture of the environment of care and work to foster a culture that expects respect and compassion for all, disavows violence in speech and behavior (including via inscriptions on clothing), and encourages respectful speech (for example, no foul language or name calling). Equally important is a culture of accountability and close monitoring of the facility for early detection of patient abuse and prompt response.

Conclusion

Forensic psychiatry has come of age. Through professionalism, expertise, research, and close attention to ethics practices, forensic psychiatrists have demonstrated their worth and earned respect among their physician colleagues in all clinical care settings and in the criminal legal arena. Although AAPL ethics are robust and AAPL scholars continue to engage in fruitful discussions to address evolving societal norms, they have largely focused on the evaluative aspects of forensic psychiatry, including report writing and testimony in court or other legal and quasilegal arenas. Relatively fewer discussions have focused on the application of these ethics guidelines in forensic psychiatric treatment settings. Ongoing reports of patient abuse at these settings suggest that unethical practices are at play. These incidents forcefully demand our attention, as forensic psychiatric treatment has been in the shadows for far too long. Course correction is sorely needed. Forensic psychiatrists, employing AAPL ethics guidelines and adhering to the mission of AAPL, can serve as intermediaries in this process by modeling appropriate behavior to other staff members. It is time for forensic psychiatric treatment to attract the attention it deserves from AAPL, including vigorous discussions regarding forensic treatment ethics. Our patients (and staff) deserve no less from us.

References

1. Collins D. Staff accused of abuse at state-run hospital claim immunity [Internet]; 2018. Available from: https://www.norwichbulletin.com/story/news/crime/2018/05/07/staff-accused-abuse-at-state/12295437007/. Accessed August 18, 2024
2. Salzo V. 9 staffers charged with abusing patient at Whiting Forensic: State police [Internet]; 2017. Available from: https://patch.com/connecticut/middletown-ct/9-staffers-charged-abusing-patient-whiting-forensic-state-police. Accessed January 6, 2025
3. Mill J. Jury finds Whiting nurse guilty of patient abuse [Internet]; 2019. Available from: https://www.middletownpress.com/middletown/article/Jury-finds-Whiting-nurse-guilty-of-cruelty-13741421.php. Accessed January 6, 2025
4. Teller SE. Patient, staffers charged in mental health facility beating [Internet]; 2024. Available from: https://www.legalreader.com/patient-staffers-charged-in-mental-health-facility-beating/. Accessed August 17, 2024
5. Hundsdorfer B. A security camera caught an employee beating a patient. It took 11 days for anyone to take action [Internet]; 2024. Available from: https://www.propublica.org/article/illinois-choate-employee-camera-caught-beating-patient. Accessed August 17, 2024
6. Associated Press. Workers indicted in patient abuse. The New York Times [Internet]; 1983 Nov 4. Available from: https://www.nytimes.com/1983/11/04/us/workers-indicted-in-patient-abuse.html. Accessed August 17, 2024
7. Barnett B. Addressing sexual violence in psychiatric facilities. Psychiatr Serv. 2020; 71(9):959–61
8. Jina-Pettersen N. Fear, neglect, coercion, and dehumanization: Is inpatient psychiatric trauma contributing to a public health crisis? J Patient Exp. 2022; 9:23743735221079138
9. Stone AA. The ethics of forensic psychiatry: A view from the ivory tower. In Stone AA, editor. Law, Psychiatry, and Morality. Washington, DC: American Psychiatric Press; 1985. p. 57-75
10. American Academy of Psychiatry and the Law. Ethics guidelines for the practice of forensic psychiatry [Internet]; 2005. Available from: https://aapl.org/ethics-guidelines. Accessed January 6, 2025
11. Appelbaum PS. A theory of ethics for forensic psychiatry. J Am Acad Psychiatry Law. 1997 Sep; 25(3):233–47
12. Griffith EE, Baranoski M. Oral performance, identity, and representation in forensic psychiatry. J Am Acad Psychiatry Law. 2011 Sep; 39(3):352–63
13. Griffith EEH, Griffith VAS. Clarifying human dignity in forensic practice. J Am Acad Psychiatry Law. 2024 Mar; 52(1):61–70

14. Norko MA. What is truth? The spiritual quest of forensic psychiatry. J Am Acad Psychiatry Law. 2018 Mar; 46(1):10–22
15. Griffith EE. Ethics in forensic psychiatry: A cultural response to Stone and Appelbaum. J Am Acad Psychiatry Law. 1998 Jun; 26(2):171–84
16. Griffith EE. Personal narrative and an African American perspective on medical ethics. J Am Acad Psychiatry Law. 2005 Sep; 33(3):371–81
17. Norko MA. Commentary: Compassion at the core of forensic ethics. J Am Acad Psychiatry Law. 2005 Sep; 33(3):386–9
18. Candilis PJ, Martinez R, Dording C. Principles and narrative in forensic psychiatry: Toward a robust view of professional role. J Am Acad Psychiatry Law. 2001 Jun; 29(2):167–73
19. Swinton J. Beyond kindness: The place of compassion in a forensic mental health setting. Health Soc Care Chaplain. 2013; 1 (1):11–21
20. Popova M. Compassion and the real meaning of the Golden Rule [Internet]. Available from: https://www.themarginalian.org/2015/01/08/karen-armstrong-compassion/#:~:text=Compassion%20is%20aptly%20summed%20up,attitude%20of%20principled%2C%20consistent%20altruism. Accessed August 20, 2024
21. Jenkins TA, Robison M, Joiner TE. Dehumanization and mental health: Clinical implications and future directions. Curr Opin Behav Sci. 2023; 50:101257
22. Steiner J. A college reunion in the psychiatric emergency room. Psychiatr Serv. 1998; 49(4):471–2
23. Tremlin RC, Beazley P. A systematic review of offender mental health stigma: Commonality, psychometric measures and differential diagnosis. Psychol Crime & L. 2024; 30(2):125–49
24. Oxford Learner's Dictionary. Professionalism [Internet]. Available from: https://www.oxfordlearnersdictionaries.com/us/definition/english/professionalism. Accessed January 6, 2025
25. Martinez R, Candilis PJ. Commentary: Toward a unified theory of personal and professional ethics. J Am Acad Psychiatry Law. 2005 Sep; 33(3):382–5
26. Candilis PJ. The revolution in forensic ethics: Narrative, compassion, and a robust professionalism. Psychiatr Clin North Am. 2009; 32(2):423–35
27. American Academy of Psychiatry and the Law. About the organization [Internet]. Available from: https://aapl.org/organization. Accessed January 6, 2025
28. Nishar S, Brumfield E, Mandal S, *et al*. "It's a revolving door": Understanding the social determinants of mental health as experienced by formerly incarcerated people. Health Justice. 2023; 11(1):26
29. Hameroff E. Addressing incarceration as a social determinant of health. Am J Nurs. 2023; 123(6):8
30. McCausland R, Baldry E. The social determinants of justice: 8 factors that increase your risk of imprisonment [Internet]; 2023. Available from: https://theconversation.com/the-social-determinants-of-justice-8-factors-that-increase-your-risk-of-imprisonment-203661. Accessed August 20, 2024
31. Coid J, Ullrich S. Prisoners with psychosis in England and Wales: Diversion to psychiatric inpatient services. Int'l J L & Psychiatry. 2011; 34(2):99–108
32. Wasser T, Dike CC, Norko M. The forensic unit. In Sharfstein SS, Dickerson FB, Trivedi H, editors. Textbook of Hospital Psychiatry, Second Edition. Washington, DC: American Psychiatric Publishing Inc; 2022. p. 211-28
33. Dike CC. Management of forensic hospitals. In Griffith EEH, Norko MA, Buchanan A, *et al*, editors. Bearing Witness to Change in Forensic Psychiatry and Psychology Practice. Boca Raton, FL: CRC Press; 2017. p. 219-33
34. Menschner C, Maul A. Key ingredients for successful trauma-informed care implementation [Internet]; 2016. Available from: https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf. Accessed August 17, 2024