AAPL Newsletter

American Academy of Psychiatry and the Law

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Forensic Psychiatry Review Course: October 21-23, 2013
AAPL 44th Annual Meeting: October 24-27, 2013
Del Coronado, San Diego, CA

Suicide by Cop

Manuel Lopez-Leon MD, MACPsych
Chair, Committee on Liaison with Forensic Sciences

Self-destructive subjects seeking an easy exit can get law enforcement agents and innocent bystanders killed. Suicide by cop (SBC) is a method of suicide that occurs when a subject engages in threatening behavior which poses an apparent risk of serious injury or death, with the intent to precipitate the use of deadly force by law enforcement against that individual.

Peter I. Collins, MD, member of the American Academy of Forensic Sciences (AAFS), explained the evaluation of situations in which an individual may be engaging in SBC. Dr. Collins is an Operational Psychiatrist who has worked with the Royal Canadian Mounted Police assisting in setting up their Behavioral Science Section and with the Ontario Provincial Police (OPP) doing criminal profiling, threat assessment, and performing polygraphs. He assists the OPP in undercover strategies, interviewing confidential informants, source development, counter-terrorism, and developing investigative strategies. Dr. Collins is frequently involved in acute SBC situations and has participated in the largest scien-

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2013 Guttmacher Award Announced

Alec Buchanan, MD, PhD, and Michael A. Norko, MD, MAR, will receive the prestigious Manfred S. Guttmacher Award at the Annual Meeting of the American Psychiatric Association and the Semiannual Meeting of the American Academy of Psychiatry and the Law in San Francisco, CA, in May 2013.

The award, which was established in 1967 and first awarded in 1972, is co-presented by the American Psychiatric Association and AAPL, and honors outstanding contributions to the literature of forensic psychiatry in the form of a book, monograph, paper, or any other work presented at a professional meeting or published between May 1, 2011 and April 30, 2012.

The book for which the two are being honored is: Buchanan A, Norko MA (eds.): The Psychiatric Report: Principles and Practice of Forensic Writing. New York: Cambridge University Press, 2011.

The lecture "The Psychiatric Report: Inquiries and Praxis" is at 2:30 p.m. Sunday, May 19 in Room 132/133, Moscone Centre North - Exhibit Level.

American Academy of Psychiatry and the Law

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Manuscripts are invited for publication in the Newsletter. They should be submitted to the editor via email to charles.dike@yale.edu.

The Newsletter is published in January (deadline for submission is November 15), April (deadline February 1), and September (deadline July 1).

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Suicide by Cop

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tific publication related to suicide by cop. We were honored to have him speak at our committee's annual Forensic Sampler.

The term "suicide by cop" has become popular recently, and is frequently used in the media and pop-culture. Although the phenomenon has existed probably since the beginnings of the history of law enforcement, it was first described in news accounts from 1981. The first scientific publication came about in 1985, but the use of the term did not come about until the early 2000s. The phenomenon has existed for decades, if not for more than a century, because it wasn't necessarily immediately apparent. In contrast, Dr. Collins pointed out that nowadays, even the subjects in question utilize the term "suicide by cop" in about a third of the cases.

"... individuals who commit suicide by cop are more ambivalent about living rather than having intent of dying, and death is seen as an end to their perceived misery."

Dr. Collins was involved in one of the largest methodological studies in SBC along with his colleagues Kris Mohandie, PhD, and Reid Meloy, PhD. He reported that individuals who commit suicide by cop are more ambivalent about living rather than having intent of dying, and death is seen as an end to their perceived misery. These individuals see life through dark glasses, have constricted thinking, and see the future as a prolongation of their suffering. Often times, these individuals are more likely to respond to attempts to be dissuaded from their act by helping them be aware of alternatives rather than by trying to make them happy.

SBC is a highly effective method of completing suicide. Law enforcement agents are trained shooters and often use lethal force if they believe an individual is dangerous towards them or others. Since these individuals want to die at the hands of the police, they create scenarios that will draw enforcement agents' attention to them. They may create a confrontation and escalate the situation with threats. They frequently have weapons, and in some cases they may have fake weapons, or even feign having a weapon. The presence of a weapon increases the probability that agents will lethally shoot the subject.

Dr. Collins is frequently called to help the OPP deal with different situations as they are still developing. He stated that in about a third of the calls he receives, the individual actually makes open demands to be shot by the police. Dr. Collins described several factors that help him determine the severity of the situation. For instance, if the subject has just murdered a significant other, particularly if it's in the context of domestic violence, it is a high-risk situation. If the individual seems to have developed complicated plans such as barricading him/herself, it is also likely that the situation will become highly volatile if law enforcement agents break the barricade. Dr. Collins reported that responders to these situations unfortunately have learned from bad experiences that subjects state that they will only give up to a specific person or ranking officer. It is highly dangerous for negotiators to give in to these types of demands because often times the subjects end up shooting the person they asked for to ensure that other agents respond with lethal force.

Some of the demographic facts that Dr. Collins and his team of investigators found out were discussed. His research included the review of files of 25 police departments. He pointed out that statistically, these types of events are more common in

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Paranoia in Forensic Psychiatry

Charles C. Dike MD, MPH, FRCPsych

In the shadow of Newtown, drowned by the cacophony of voices regarding gun control, something ominous is unraveling. On April 3, 2013, yet another top law enforcement officer was shot and killed, this time in West Virginia. The officer, Sheriff Eugene Crum of Minto County, was gunned down in a parking lot following his crackdown on drug dealers. Coming on the heels of the assassination by gunfire of district attorney Mike McLelland of Kaufman County, Texas, and his wife in their home on March 30, 2013; of Tom Clements, director of Colorado prisons, in his home on March 19, 2013; and of Mark E. Hasse, assistant district attorney, Kaufman County, Texas, on January 13, 2013, a counter revolution appears to be afoot. Criminals have now declared a war against law enforcement officers and have gone toe to toe with the officers to prove a point, a bloody point; to scare them away from doing their jobs so the criminals may run haywire and hold the country hostage. Why they have decided to embark on their dastardly act at this time in history with the backdrop of a vigorous gun debate gripping the country is unclear. The big question generating much discussion is how to keep law enforcement officers and their family members safe.

It was also a critically important discussion, albeit a slightly different one, years ago when I was a forensic psychiatric fellow; what mailing address we should list in APA/AAPL's database, whether we should refuse to give a home address to these bodies even if they assured us the address would not be made available to the public, and whether or not we should delist ourselves from the phone book or Yellow Pages (yes, those things used to exist!). The goal of course, was to erect a barrier or construct a wide moat between us forensic psychiatrists and the dangerous defendants and patients we come in contact with on a regular basis. The idea was to become invisible to (or untraceable by) the defendants or patients outside of the work environment or the courthouse. No one, of course, raised the issue of us arming ourselves with sophisticated weapons to protect ourselves should these undesirable elements break through the dense fog around us. I wonder if that did not come up because our discussion was happening in New England or because the issue of gun control was not hot at the time. I recall, however, that there was a general belief that forensic psychiatrists needed to have a healthy dose of paranoia to keep themselves and their family members safe.

For me, this paranoia was initially reinforced during fellowship when I testified on a case of an individual accused of murder. As I walked out of the courtroom after my testimony, the defendant's family members charged at me in a threatening manner, encircled me and angrily asked me why I had made such comments about their relative. It was a scary scene indeed that got me wondering if I had made the right choice of pursuing forensic psychiatry. For many weeks thereafter, I was hypervigilant, scrutinizing everyone around me, as well as the environment, closely, wondering when and where the defendant's relatives would spring from to cause me harm.

Threats from patients found NGRI and subsequently residing in a forensic psychiatric facility or the Department of Correction are not uncommon, especially when a patient believes that he/she is unjustly kept in custody due to the psychiatrist's report or testimony. Threats such as "When I get out, I will find you, F—- your wife and children and then F—— you up!" evoke the most emotional reaction and concern in psychiatrists, because unlike their counterparts in general psychiatric hospitals, most of these patients have shown a capacity for violence.

The heightened level of alertness and concern discussed in fellowship gradually wore off with time, however. Worse still, attempts at hiding one's residence and private phone number fell victim to the openness of the World Wide Web. It is by far easier to locate people on the internet these days than ever before, a reality that has rendered all defensive maneuvers somewhat irrelevant. In this climate, it is easy to be seduced by the argument advanced by some that one needs an armory of guns at home and on oneself to defend self and family. There is evidence however, that possession of guns may only provide a false sense of hope, and may not protect one from a determined criminal. According to the New York Times of April 1, 2013, district attorney Mike McLelland, a former army officer who served the army for 23 years, including service in Iraq during Operation Desert Storm, carried a gun at all times (even while walking his dog, apparently) after the killing of assistant district attorney, Mark E. Hasse. Mr. McLelland had been reportedly confident of being able to protect himself and take the fight to the enemy, citing his military background. Unfortunately, it was not to be as assassins tracked him to his home and tragically murdered him and his wife.

So then, how is a forensic psychiatrist supposed to protect him/herself from aggrieved defendants/patients who might be seeking revenge for perceived injustice? It seems the only solution is the mantra that has worked for Alcoholics Anonymous all these years…total submission to a higher power.

Forensic Psychiatrists and the Unique Window onto the World

Debra A. Pinals MD

On December 14, 2012 a devastating tragedy at Sandy Hook Elementary School took place, involving a school shooting and a deceased perpetrator. From that event, there remain so many questions that haunt society and perhaps will never be answered to anyone's complete satisfaction. When events like these occur, rare as they are, the focus often results in a desire to find a cause, and with that, questions about mental illness surface. In the aftermath of the Sandy Hook killings, and other incidents of firearm-related violence this past year, forensic psychiatrists around the country have been asked to participate in media interviews, task forces, workgroups, public commissions, legislative testimony, and community conversations, just to name a few.

The specialty of forensic psychiatry is unique, and it offers a unique perspective for others. Practitioners in the field can rely upon collective years of general clinical mental health experience. Some have additional child and adolescent psychiatric skills. Some have other subspecialty training, such as in addictions, or geriatrics. In addition, forensic practitioners can be viewed as specifically trained individuals who can provide thoughtful input into complex questions that the world sometimes turns to us to address. Questions for which a forensic psychiatric response may be sought include topics such as mental illness and violence, approaches to risk assessment, the legal regulation of psychiatric practice, and the psychosocial impact of laws, such as laws pertaining to firearm access. As the questions flood in, we remind ourselves and others about notions of privacy, the risk of stigma and concerns relevant to any laws that might inadvertently create a collateral consequence of dissuading people with mental illness from accessing needed services.

These are all weighty topics, and ones that require constant personal learning. Learning itself can come in many forms, and it is during times like this, when so many questions are being asked, that I have again been reminded of the critical importance of our organization as a whole. In speaking with colleagues, we have bounced ideas off each other to explore questions and local responses related to recent events. Through the AAPL Journal, we can read the latest to help ascertain best approaches to knotty problems.

"... it behooves us to partner together to continue to pursue knowledge, skills, and experience that can help shed light where there may be dark shadows."

Even outside the political questions being posed, it is not uncommon for me to reach out to an AAPL colleague, or for one to reach out to me, to ask a basic question about some small nuance of forensic psychiatric practice. It is thus through AAPL that networks are created. Curbside consultation is just a phone call or email away. What do you do if two lawyers call you about taking the same case? What does "restoration" mean for someone who has chronic hopelessness and suicidality when she thinks about her serious criminal charges? What type of cultural consultation might be helpful when a defendant is evidencing a religious transformation that might involve delusions? How do you set up a contract with a new disability insurance company? These were questions that came across my desk in the last three months, and there were many others. The network within AAPL allows for these questions to be asked—and answered.

Members of AAPL hear repeatedly that the organization was built with a mission to educate its members, and now, as much as ever, the need for this education is just as strong. The topics seem to be getting broader as our scope of practice evolves. We have moved from thinking about evaluation work for third parties, to understanding more about correctional psychiatry, specialty court services, re-entry programming, and legislative impact on practice issues, such as legislation related to firearm access that implicates actions on the part of psychiatrists. I recall when starting in the organization that my main focus was to identify the ways in which I could improve my evaluative skills-one case at a time. As I have grown in my career, and taken on responsibilities that look beyond one defendant at a time and focus also on systems, the organization and the Annual Meeting have provided me with a wealth of information upon which to rely. I am thrilled that we have a Research Committee and that our posters each year have improved in their research focus and presentation of data hot off the press. I would encourage our members to continue to submit these types of presentations and to continue to establish mechanisms to pursue research on forensic topics.

Within the AAPL governance structure, we are in the midst of several projects to help in advancing the knowledge of the members beyond research presentations. We are looking into online maintenance of certification self-examination, and questions have come in from several members and committees to help build our exam. We are reviewing and revising practice guidelines. We are looking at ethics opinions to help members with frequently asked questions. We are working on research and educational product development through our meetings and in partner-

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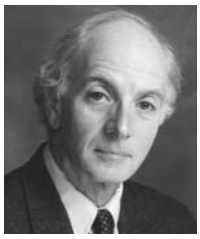
Sandy Hook – Mental Health and Gun Laws

Howard Zonana MD



On December 14, 2012 a 20-year-old young man shot his way into the school and quickly killed twenty children (5-7 years old) and six adult staff members at the Sandy Hook Elementary School in Newtown, CT. Immediately before, he had shot and killed his mother at their home. Within 15 minutes of the 911 call; he committed suicide by shooting himself.

The weapons he carried were a .223 caliber Bushmaster XM 15 – E2S rifle, a 10 mm Glock handgun and a 9 mm SIG Sauer P226 handgun. A 30 round magazine was recovered with the rifle along with a large quantity of unused ammunition. A shotgun was found in the car along with three other rifles in his home. The assault rifle was the primary weapon.

As of this date there have been no official reports clarifying what mental disorder, if any, Adam Lanza was diagnosed with. His brother was described as saying that Adam was "somewhat autistic" and friends of his mother reported that Adam had been diagnosed with Asperger syndrome, disorders not typically associated with violence.

This tragedy has galvanized a large local and national debate. The level of discussion has risen with a number of our members participating on both levels. The major areas are legislative proposals involving:

1. Guns and gun trafficking, assault weapons, large magazine bans and background checks.
2. Mental illness treatment needs, reporting laws and outpatient commitment.
3. School safety

The blending of the mental health issues and the gun control in the U.S. is problematic for mental health treatment. The press highlights shootings by the mentally ill, so that most people can name incidents that were the result of individuals with major mental illnesses. This has the effect of distorting the amount of violence actually perpetrated by the mentally ill. The public thinks it is much higher than the 4% it actually is. This lack of clarity and objective thinking highlights the emotional response for the victims and evokes demands for quick fixes.

There is general agreement that mental health services are highly fragmented and not well integrated with other medical services. The Mental Health Parity Act has so many loopholes that insurance companies have not provided the expected coverage, and thus true parity remains largely unimplemented, even though along with the Affordable Care Act, it has the potential to add 30-60 million people to the mental health roles and access.

> *"During a trial, unless the prosecutor can prove the seller knew the buyer was in one of those prohibited categories, there will be no conviction."*

Fragmentation is also illustrated by the fact that across the country hospital emergency rooms are filled with psychiatric patients needing admission, but no beds are available. With deinstitutionalization of the mentally ill from 1955-1980, the Community Mental Health Centers Act of 1963 was supposed to fund local facilities to care for the discharged mental patients housed in the large state facilities. That funding was aborted in the Reagan era. Hospitals presently have little or no incentive to open additional psychiatric beds, since they are not cost effective in the way that surgical beds are. Connecticut's mental health budget does somewhat better than many other states for the uninsured with serious mental disorders, but the insured with more marginal incomes often have a harder time finding services in a timely manner.

Of interest is that the debates in the Connecticut legislature since Sandy Hook have revolved around broader reporting statutes for the mentally ill deemed dangerous. Connecticut does not have a formal Tarasoff[1] (duty to protect potential victims from patients that have made actual threats) statute, although the Connecticut Supreme Court has intimated that it would likely recognize a Tarasoff duty if there were an identifiable victim or class of victims. Such a bill is now under discussion. Connecticut's present confidentiality statute also permits disclosures by the psychiatrist if there is evidence to suggest that the patient represents an imminent danger to self or others.[2] A second proposal is to pass legislation to permit outpatient commitment. Such legislation had been proposed three to four times in the past, only to be defeated. Connecticut does have outpatient commitment for insanity acquittees. Outpatient commitment is controversial and while a number of states have passed such statutes, many do not implement them and a number like New York do not permit forced medication.

Although the gun issues are generally separate from the mental illness needs, there is some overlap since the NRA simplifies the issue by endorsing removal of guns from the mentally ill as a solution for the whole problem. It now cites the mentally ill in jails or prisons as appropriate targets for gun restriction, upon their release, insinuating that the mentally ill pose a greater risk of violence than the general population. Connecticut has a statute that blocks the court committed mentally ill from owning a weapon for at least a year. In addition, it allows anyone to file a complaint so

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Not A Time For Logic

Jacquelyn T. Coleman CAE, Executive Director

As I write this, the Connecticut General Assembly has just approved what is supposedly the most significant gun control measure in the country, and the President is coming here this afternoon to raise the question why the Congress can't get the job done on gun control.

It's been a disheartening time for those who advocate for anything to do with mental illness and people with mental illness. It's an inadequate bill in many ways, too excessive on some points and completely ignoring others. It was forged from compromise on an emotionally challenging issue where everyone wants to claim they had a part in fixing the problem, except the only problem people (well, most people) can agree on is that 26 were killed in Newtown, Connecticut on December 14. After that, it gets a lot hazier.

I can't remember a time in my life before this when I have been involved in so many conversations about mental illness with so many different types of people. Some of those conversations have required great self-restraint on my part.

First, I regularly experience the problem of holding two competing thoughts in my head at once and trying to argue for both of them at the same time. As almost everyone has heard, the Sandy Hook shooter does not appear to have a record of treatment for mental illness. On the other hand, if legislators want to fix some things that are wrong with the mental health delivery system, why not let them? Now, try to write testimony that says both those things at the same time.

Second, focusing on the mental illness part, the things that would help people with mental illness appear to center on money, and there's none of it. It appears there would be more if the third party payers were living up to their responsibilities. As Pat Rehmer, Connecticut's Commissioner of the Department of Mental Health and Addiction Services pointed out, public sector patients right now have access to more comprehensive services than patients covered by private-sector plans. Attempts to put into law various provisions that would make it harder for the third-party payors to evade claims are apparently too specific to burden them with, since "things change." But even in the public sector there isn't enough money to go around and we're not supposed to talk about that with a serious deficit looming.

Third is the stigma. It's palpable. I'm sure you've heard it on the national level. We have experienced it here in the drafting of the gun bill. The things that have been discussed are outpatient commitment, which Connecticut does not have currently; mandatory reporting by psychiatrists of patients who are likely to become violent; reporting of voluntary admissions to psychiatric hospitals that will then be used to affect eligibility for gun permits; mandatory mental health screening of all children at certain age levels. While most of those things did not make it into the bill, there are still proposals floating around and we have a couple more months to go before the legislature adjourns. Many items were swept into a study task force, so the argument against hasty decision-making did have an effect. But I felt the pain of the President of NAMI-CT, who spoke at the Mental Illness Media Awards presentation at the Capitol in March: "Just because people do crazy things doesn't mean they are crazy."

I felt bad that he, a person who has experienced mental illness himself, had to resort to stigmatizing language to make his point, and yet sometimes, in order to get on the same level as the person we are speaking with, we have all had to do it.

We've all tried to find ways to explain the difference he describes. I'd say we haven't gotten very far. One person said to me: "This legislation is infringing on my second amendment rights. Why can't they just identify those people who are mentally ill and put *them* away?"

Yes, my head really is going to explode.

Unique Window

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ship with the activities at the AAPL Institute of Education and Research.

The time since the October meeting has already flown by, and by the time this newsletter article is published, submissions for the next meeting will already be under review. Our upcoming Program Chairs, Drs. Stuart Anfang and Barry Wall are going to be putting together an amazing program. We will once again be convening to enhance our knowledge and network with peers.

For individuals to sustain membership in a national organization, a serious financial commitment must be made. The organization must therefore be able to turn that individual investment into a way for a member to personally profit, if not monetarily, then professionally. I have found this investment to be well worth it…and I hope that our members do as well. If not, we want your suggestions to help improve what the organization can do.

In the meantime, we will continue to be part of the complicated fabric that is related to the aftermath following the events that took place at Sandy Hook. We know that there are problems with some of the automatic and simplified linkages that have been made between firearm related violence and persons in mental health treatment. We know that potential proposed actions and legislation are likely to be complex, with both benefits and risks. We also know that there are limits to what we know and what we can offer as guidance. Nonetheless, our important role in the national dialogue has been made clear, and it behooves us to partner together to continue to pursue knowledge, skills, and experience that can help shed light where there may be dark shadows.

Ask The Experts

Robert Sadoff MD
Neil S. Kaye MD

Neil S. Kaye, MD, and Bob Sadoff, MD 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. Please address some of the issues and challenges to be confronted as a forensic practice grows and becomes more time consuming.

Sadoff: I found a number of issues when my forensic practice grew and consumed more time. Perhaps the most important one for me was the need to reschedule treatment patients when I was scheduled to testify in court. Not only was it a burden on the patient to change his/her usual time, but often the case was continued at the last minute, so I had no patient and no court appearance. That was the major reason I decided to stop treating patients and commit exclusively to an expanding forensic practice.

In addition to court demands that affected the patient, the growing forensic practice also involved traveling from home base to other parts of the country and even to other countries. Travel involved not only forensic cases, but lectures and forensic meetings that took me away from treatment patients. It was neither fair to them nor to me always rescheduling and shuffling.

A growing forensic practice often meant conflict in schedule for court time as well. One cannot be in two places at once; one has to assign priorities to different cases and which to attend and which to reschedule. I can recall having 3 cases in 3 states on the same day. I had to testify in New Jersey in a personal injury case in the morning, a federal criminal case at noon in Pennsylvania and a malpractice case in Maryland in the late afternoon. That is too much to do in one day. I can also recall seeing eleven different defendants in three different jails in one long day. That is also too much for one person.

Traveling to different places on demand can also be very challenging. One cannot always predict how long the case will go and how to accommodate all demands by various judges and attorneys who need the expert in court at a designated time. This brings us to sharing cases with other experts when the demands become excessive. Attorneys usually want the expert they choose and not a "substitute." However, I found it to be very important for young forensic psychiatrists to be mentored (not partnered with) by an older experienced psychiatrist who can introduce him/her to new attorneys.

"Forensics requires a serious commitment, can be very time consuming and will undoubtedly affect a clinical practice."

In some cases, I was able to refer attorneys to other psychiatrists who had a particular expertise in psychopharmacology, sex offenders, or addiction matters and could be of more help to the lawyers. In Pennsylvania, we have tort reform laws for malpractice cases that prohibit a psychiatrist from testifying against a colleague unless the expert practices in the same field: i.e., is treating inpatients or in a particular area as the defendant. Since I no longer treat patients, I am now precluded from testifying on liability in psychiatric malpractice cases and refer all to those colleagues with forensic experience who are still treating patients. I also feel that to minimize harm I will refer women involved in sexual abuse or harassment cases to female forensic experts and children to child and adolescent forensic psychiatrists.

Kaye: This provocative question brings to mind the words often attributed to Confucius: "A smart man knows what he knows, a smarter man knows what he doesn't know."

Since I graduated medical school in 1984 the practice of medicine and indeed the entire health care delivery system of our country has changed dramatically. All of these changes affect my practice and hence my expertise. In order to be a competent expert, one must first be an excellent clinician. As time goes on, it becomes more difficult to claim expertise in areas where one is no longer practicing.

One of the great changes has been in the delivery of inpatient mental health where most inpatient hospitalizations are being managed by hospitalists while outpatient work is managed by outpatient psychiatrists. It is possible to stay abreast of inpatient standards even if one is not actively treating hospitalized patients, but it would be unwise to simply believe that the processes and standards have not changed in the last decade. While no longer doing inpatient work myself, I have made it a point to visit inpatient units regularly and I am actively involved in writing the laws for our State that govern inpatient hospitalizations. This allows me to stay current and to comfortably present myself as an expert, as I am well aware of what is actually occurring.

Similarly advances in psychopharmacology can prove challenging to an expert who isn't really an active treater. I was in a case where the

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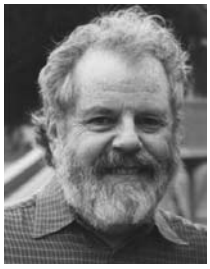
The Ten-Year-Old Killer of Riverside, California

Stephen P. Herman MD



About two years ago, Joseph Hall, age 10, shot his sleeping father, a neo-Nazi, in the head. The criminal case dealt with whether this juvenile knew the difference between right and wrong. The judge reported Joseph engaged in certain activities before and after the killing, indicating that he understood what he was doing and, therefore, was guilty of second-degree murder. As a result, the child could be held in state custody until he is 23. The ruling, not unexpectedly, is being appealed by the public defender.

Joseph was no angel even before the killing. According to the *New York Times*, he had regularly beaten his sister and stepmother, stabbed classmates with pencils and tried to strangle a teacher with a telephone cord. He was impulsive, and bit, kicked and scratched other children.

Joseph frequently witnessed neo-Nazi meetings at his house. He saw guns – including the murder weapon – watched his father's associates give each other the Nazi salute, and knew members of the Ku Klux Klan. He was very proud of his brand new belt with a Nazi insignia. His father was the regional director of the National Socialist Movement.

The child was thrown out of several schools and was eventually home-schooled by his stepmother. He was often beaten by his father.

There is no indication that any social services were involved or that the child received mental health treatment. A psychologist testified at the trial that Joseph had been frequently abused at home, including probably having been sexually abused. The prosecutor argued Joseph's father was a good man, despite his affiliation with the neo-Nazi movement.

In a videotape, the child said he had gotten the idea to kill his father after watching an episode of *Criminal Minds* in which a boy killed his abusive father and was never punished.

His sister said Joseph had been planning the shooting for days. One issue reported as motivation for the killing was that the child feared his father was planning to divorce his stepmother, with whom he was very close.

The judge's decision was appalling and indicated complete lack of understanding of what competency means for a 10-year-old. There is no indication that this was explored in pre-trial hearings. Although the sentencing had not occurred at the time of this writing, Joseph could become the youngest inmate in the State Division of Juvenile Justice. One can only imagine what a decade of incarceration might do to this child. It would be yet another form of abuse.

> *"In a videotape, the child said he had gotten the idea to kill his father after watching an episode of Criminal Minds in which a boy killed his abusive father and was never punished."*

Several years ago, I had the opportunity to work with a legal team defending a 9-year-old girl who had stabbed to death her best friend. They had had an argument over a rubber ball. "Jenny" grabbed a kitchen knife and stabbed her friend in the heart. The child died almost immediately.

Jenny grew up in a New York City project which was a regular scene of violence. Jenny witnessed her mother in physical altercations with neighbors, drug users hanging out and, on at least one occasion, a rape. Often she heard gunfire. I visited Jenny's apartment. It was overrun by roaches, had very little furniture, and bare walls. It was a disaster area.

I interviewed Jenny several times in a safe house. She clearly was not aware of the implications of her impulsive act but cried as she stated she knew she would never see her friend again. Jenny had no idea of the charges against her nor any understanding of court procedure. Even if she had been read her Miranda rights, which she had not, she would not have understood a word. Jenny was tearful and frightened.

The judge, luckily someone who was also a psychologist, recognized the uniqueness of this case of the youngest killer in modern New York City history. She realized the child would not be served by spending about a decade in detention. The judge knew Jenny would never get the treatment she needed in a juvenile facility.

The court's plan for the child included living in a therapeutic foster home indefinitely, attending a special school for children with severe behavioral and emotional problems and receiving intensive psychotherapy. By all reports, the child is healing.

Multiple studies have determined that sentencing children as adults results in a higher incidence of recidivism than recognizing the special needs of a juvenile defendant and providing for them. While adult sentencing may satisfy the public's need for retribution, it has failed to demonstrate that it works.

Hopefully the California judge's decision will be overturned and Joseph will receive the treatment he so desperately needs. The mark of greatness of a country is not by its treatment of good children, but rather its relationship to its bad. In this country, we still have a long way to go.

Hyper-Reporting: A Survival Guide

Stephen Zerby MD

In our fellowship didactics, we just finished the Right to Treatment lecture; the embedded "treat" is viewing clips from the excellent 1980s film "Chattahoochee" in which Gary Oldman and Dennis Hopper portray inmates (it would be a stretch to refer to them as patients) at a horrendous Florida state hospital in the 1950s facing off against the evil head psychiatrist played by a glaring, nefarious Ned Beatty, and his cadre of unmanly shrinks. Oldman's character obsessively writes - using any scrap of paper available - accounts of innumerable incidents of patient abuse that he sends to patient relatives that the squinty, eyes-darting-back-and forth Beatty character attempts to cover up while puffing away at cigarettes like a true movie villain. Eventually the story reaches the highest levels of state government and the cavalry in the form of an investigative commission enters the fray to impose a multitude of "reforms" (they are not specified). I recommend the film for this lecture topic as after a long discussion of how courts and legislatures intervened to address decrepit state hospital conditions, the viewer gains in only a few minutes a truly in-depth understanding of why these reforms occurred – for example, why incidents are reported; why patients have treatment plans; and so on. Oldman and Hopper are so convincing and sympathetic that the viewer wants these abuses reported, heard, and addressed.

The world of mental health treatment is so different these days that current residents will have difficulty even recognizing the film setting as a "psychiatric hospital." So while mental health treatment has changed, we still have systems to address problems: reporting policies and practices which when properly implemented support a system of improved patient care and safety as well as the optimum safety of staff. If reporting is a good thing, logic will suggest that more reporting will be equivalent to more of a good thing; therefore, there should be no limit placed on such goodness, should there? However, it seems we sometimes find ourselves led into a territory I will refer to as "hyper-reporting."

I'm not really sure that "hyper-reporting" is a real word but it does describe certain correctional/institutional experiences quite well. When does reporting go too far, become counterproductive, and lead to environment-induced paranoia? Reporting occurs in all levels of care, but it seems that the more restrictive the setting, the higher the level of scrutiny; hence, the higher the frequency and lower the threshold for reporting.

"... if you woke up one day feeling sick or facing a major stressor of any kind, would you call in sick or go to work sick/stressed out?"

If a safety concern or a negative incident occurs, there is the need for the institution to respond in some way to enhance the contrast between the institutions of today and those of yesterday in which abuses were rampant and often covered up, leading to a stain on the history of psychiatry. Suppose that for every incident that occurs, a new protocol is instituted but none of the existing ones is ever repealed, this would mirror our federal and state legislatures that enact law after law in a similarly reactive manner until the nation becomes clogged with laws. No one really understands many of these laws, but they mandate harsh punishment should one be unfortunate enough to be found guilty of them. Assuming that a new protocol – like a new law – is difficult to repeal, an institution faces a steadily increasing ocean of protocols. The question is, at what point would these protocols reach such a critical level that the system starts drowning?

Let us look at the masters of institutional reporting - the Soviets - for a history lesson. One of Soviet dictator Josef Stalin's guiding dictums was "where there is smoke there is fire." (Lenin's was "A revolution without firing squads is meaningless." Uncle Joe really, *really* liked that one too). Therefore whenever a hapless Soviet citizen was reported for investigation, there was little chance that person would escape conviction, except his or her name was crossed out from an execution list (Stalin would, reportedly, often review the list using crayon to cross out names while at the same time playing with his young daughter). The reporter of the false charge would be heralded as a hero, at least temporarily until he or she was eventually reported to the authorities and faced the same fate of all such accused. In this way spun the cycle of the Great Terror: catching quotas of imaginary spies, counter-revolutionaries, and enemies of the state while sending thousands upon thousands of innocent persons to their demise. Sometimes it feels reassuring to read about the old Soviet Union just to remind ourselves that in whatever setting we're working, it is not as bad as those under the purvey of the sadistic NKVD (Communist Secret Police) chief Lavrenti Beria and his henchmen. Yet there are parallels to be explored as a cautionary tale for a system of self-policing run amok.

As a medical student, an attending physician in a high-risk specialty once told us a coping skill simply stated as, "just think: if you're not being sued, you're not working." Given the setting and population we serve, it sometimes feels that we should similarly tell ourselves, "if

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Richard Martinez MD, MH

Humanities and Humanity in Forensic Psychiatry

Jason Ourada MD
(To suggest members for this feature, email philip.candilis@umassmed.edu)

The unique combination of humanities and medicine that led Richard Martinez into forensic psychiatry is a lesson in versatility and work-life balance. After training in Boston in medical ethics and professional ethics at the Harvard Medical School and the Edward J. Safra Center for Ethics and the Professions at Harvard University, Dr. Martinez returned to his base in Denver and was involved in the development of the Center for Bioethics and Humanities for the University of Colorado Health Sciences Center. He spent several years teaching ethics and bolstering his interests in end of life decision-making and professional ethics in general. He taught nursing, medical, and dental students and residents before meeting the man who would be a critical mentor in his professional development.

Dr. Robert Miller led the University of Colorado, Denver (UCD) forensic psychiatry fellowship and was a nationally respected forensic psychiatrist who fueled Rick's interest in the intersection of ethics, psychiatry, and law. To Rick, forensic psychiatry seemed to be the perfect subspecialty to bring together his varied interests and the intersection of the three. Having developed an interest in public psychiatry throughout his career, Rick found that forensic psychiatry offered the unique opportunity to participate in some of the most interesting and complicated clinical work he had seen to date. He considered it the opportunity to evaluate and learn from some of the most seriously mentally ill persons. This, along with an interest in narrative and stories, meant that forensic psychiatry would offer the best opportunity to explore the many unknowns of human behavior.

As a fellowship director now himself, Rick considers the most rewarding aspect of working with fellows to be the relationships that form over the course of a year. The small number of trainees allows for more time to get to know each fellow. Even the time spent traveling to various sites for evaluations, he says, allows the gradual development of meaningful relationships that often endure beyond fellowship training. Indeed, the forensic psychiatry department at UCD is composed of several faculty who have trained there and stayed on.

Currently, Rick consults in civil and criminal forensic psychiatry, teaches forensic psychiatry and professional ethics to residents and fellows, and is the Director of Psychiatric Forensic services at Denver Health Medical Center. He is Professor of Psychiatry and Law at the University of Colorado Denver and Director of the Fellowship Program in Forensic Psychiatry. In a deeply meaningful acknowledgement of his mentor and friend, he was appointed the first Robert D. Miller Professor of Psychiatry and Law at UCD in 2009.

Dr. Martinez emphasizes that his wife and children are central to his love of life and work. "I was fortunate", he says, "to have met my wife and have three lovely children rather late in life… and they have provided a renewed interest in the world and all its wounds and traumas. I think forensic psychiatry provides poignant opportunities to share knowledge and skills that hopefully add to reasonable and balanced outcomes in the many tragic human stories one comes to participate [in] as a specialist. I like to feel useful, and believe this work provides a sense of usefulness in areas that desperately need reflection and understanding."

Influence of Race, Culture and Socio-economic Status in Forensic Psychiatry

Chinmoy Gulrajani MD, Chair, Cross Cultural Affairs Committee

In 1950, America's population was approximately 150 million. America was primarily a biracial nation and the net immigration rate was between 1-2 migrants per 1000 resident population. By 2011 the population had doubled to approximately 313 million and constituted about 4.5% of global population. During this period, the racial and ethnic composition has changed drastically. This reflects two forces. Firstly, the rate of immigration has grown many fold. The number of immigrants (people moving into the US) has increased from 250,000 in 1950 to 1.1 million in 2009, which correspond to between 3-4 migrants per resident population. Secondly, major immigrant groups grow at different rates within the nation. Immigrants bring with them a different way of life, a different language, a different cuisine, different religion and a different moral set of values; the collective attributes of their culture.

Numerous authorities have emphasized the role of culture in forensic psychiatric evaluations and the concept of cultural formulation is not alien to forensic psychiatry. The Practice Guidelines for the Forensic Psychiatric Evaluation of Competence to Stand Trial[1] enumerate the factors important to culturally competent evaluations that may come into play when evaluating individuals from non-dominant cultures. However, the guidelines acknowledge that psychiatrists will inevitably encounter novel situations, and emphasize that an increasingly multicultural America is generating new demands, challenges, and stresses for psychiatric assessments and the law. And while literature is replete with anecdotal reports describing the influence of cultural factors in forensic psychiatric evaluations, the bulk of research tackling the issue of cultural diversity in the forensic psychiatric setting is centered not on culturally, but rather racially, distinct sub groups. It has been promulgated that members of ethnic minorities are more likely to be perceived as irrational and their opinions are more likely to be discounted by mental health workers, judges and attorneys. Existing literature is testimonial to the fact that members from racial and ethnic minorities are disproportionately overrepresented in the criminal justice system.

Recent research from the social sciences has revealed another disturbing trend: that while over 90% of all Americans have violated laws that could have subjected them to a term of imprisonment at one time in their lives, an overwhelming majority of inmates hail from lower socioeconomic classes. Further, individuals from lower socioeconomic classes are more likely to be incarcerated, charged, convicted, sentenced to prison, and given longer prison terms than people from the elite class. And while race, ethnicity and culture have been a frequent consideration in forensic psychiatric discourses, there is little dialogue devoted to the socio-economic underpinnings of evaluees. At the annual conference of AAPL in Montreal in October 2012, the Committee for Cross Cultural Affairs sponsored a panel presentation to discuss the influence of race, culture and socio-economic status in the practice of forensic psychiatry.

"... while race, ethnicity and culture have been a frequent consideration in forensic psychiatric discourses, there is little dialogue devoted to the socio-economic underpinnings of evaluees."

After an introductory talk, Dr. Rosenbaum from New York discussed socioeconomic status as a determinant of health disparity within cultures. She cited Scheffert's[2] article that describes 12 social classes in the United States ranging from those who live in generational poverty to the "ruling rich." She described the concept of "health disparity," which is a type of difference in health that is closely linked with social or economic disadvantage. Dr. Rosenbaum highlighted how low socioeconomic status (SES) is a barrier to receiving health care and other resources the same way it can be for people of certain ethnicities, races, genders, or sexual orientations. She went on to cite numerous examples where socioeconomic status is a common confounding factor while studying discrimination against races and minority cultures. Notable among these was a study by Shamai et al[3] that examined the attitude of Israeli students toward new Soviet immigrants. Dr. Rosenbaum ended her talk by highlighting the need for carefully examining the socioeconomic status of examinees along with their race and culture of origin.

In her presentation titled "Race, Ethnicity, and Courts," Dr. Solange Margery Bertoglia from Philadelphia illustrated several examples of biases in the courts. In a 2004 court review from the University of Nebraska[4], there was found to be a differential in sentencing, where Hispanics, Native Americans, and African Americans commonly received harsher sentencing and there were fewer legal aid services for low income groups. She also cited studies which demonstrated that in South Carolina, Maryland, and Georgia, most victims in the cases that resulted in death penalty involved Caucasian victims, and most cases that did not result in the death penalty involved African American victims. In sexual harassment cases, a study

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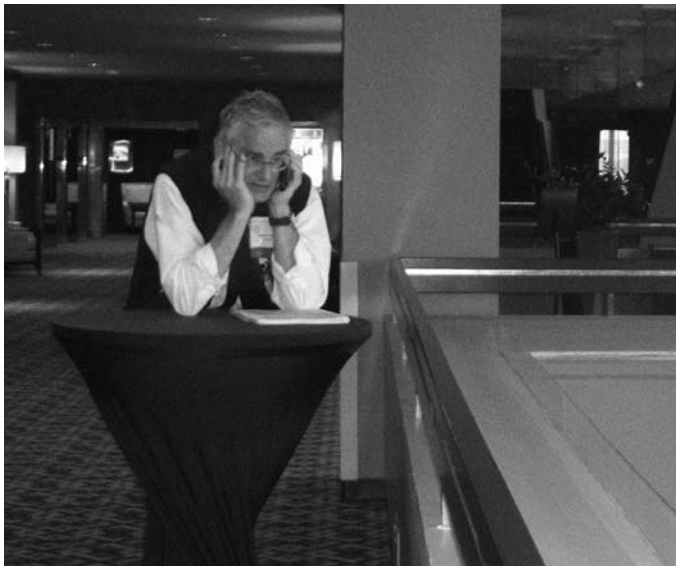
PHOTO GALLERY

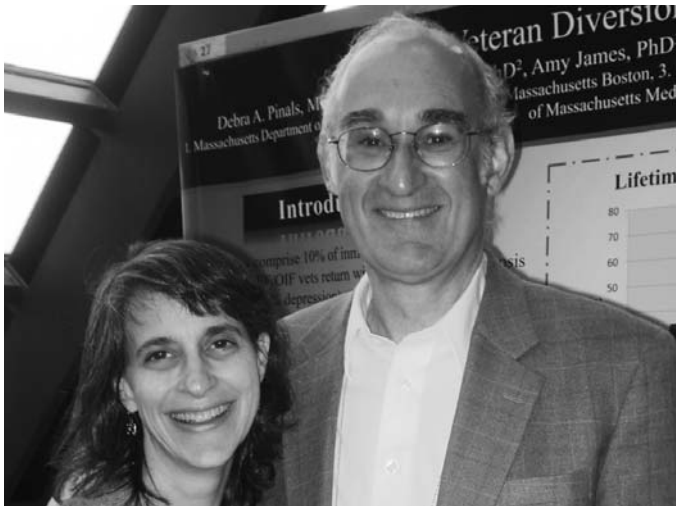
Authors/presenters pose in front of their poster.


Old Montreal was a beehive of activity!


A rare moment of solitude and reflection to take it all in.

American and British collaboration.


Chilling out at the Reception for conference attendees.



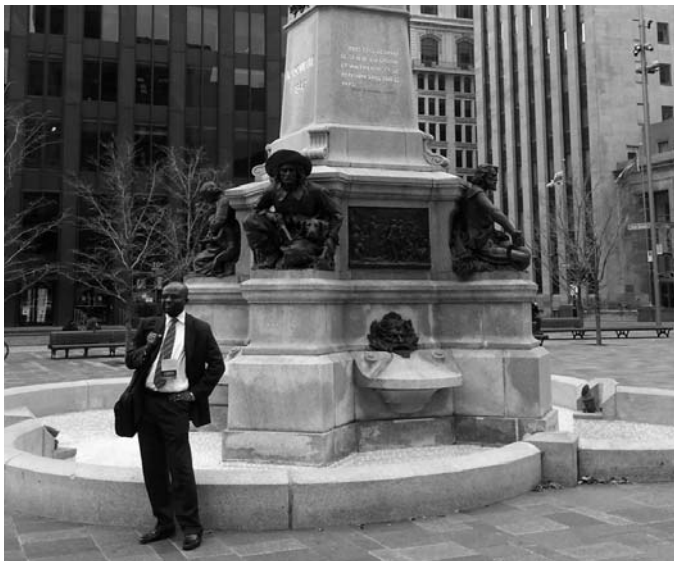
Presidents' club!

PHOTO GALLERY

At the AAPL Review Course…

Cross Atlantic connections; John Young, USA and Tony Adiele, UK.

Waiting patiently for committee members to arrive for a meeting.



Newsletter Editor on a discovery tour of Old Montreal.

Conference participants catch up for a chat.

Sheer joy at finding a book at the book stand!

Photo Credits: Steve Berger MD; Roni Seltzberg MD; James Wolfson MD

The Humanity of "Monsters"

Jason Beaman MD

When I started fellowship, I knew that I would see individuals accused of horrible acts. I knew that I would meet murderers, rapists and petty criminals. What I didn't expect is that I would see horrible acts committed by genuinely tormented souls. I was fortunate to have this eye opening experience early in the year, traveling with my fellowship director and mentor who has had a career examining people society often views as monsters and tormented souls.

The travel case allowed me to see an individual accused of two murders. It also allowed me to see that while both murders occurred at one time, one of them was insane, and the other sane. My fellowship director and I arrived on an early morning flight from Cleveland to another Midwestern city.

We were met by the Defense Attorney's assistant who drove us to the upper-class suburban jail. As we entered the jail, my fellowship director told me, "I hope you brought snacks because we won't be done for six to eight hours." I had not. After some delays, we met with the defendant. He was clean-shaven, very well spoken and polite. At first, I could not believe this was the man I read about in the police report, but as he told his story, I knew that it was.

The defendant was a married man who described his wife as his "dream girl" and "out of his league." After the honeymoon period, real life set in. His wife was a no-nonsense scientist with a substantial income; he was somewhat lost in life, having tried several different careers, never quite finding his niche. They started to live above their means and the financial pressures began to mount. These problems got worse after the birth of his daughter.

The defendant had a long history of depression and was no longer taking medications. Six months before the crime, he began having suicidal thoughts yet did not seek help. As soon as his suicidal thoughts began, he realized that he could never leave his daughter on earth without him. He had been bullied as a child and saw the world as an evil and dark place. He was convinced that this experience would be repeated for his daughter without him to guide her.

"For my fellowship director, it was another child murder, but for me it was a chance to live out what I thought fellowship would be like."

He believed his father would rape her, as soon as she was older. As his thoughts of suicide got worse, he concluded that before he took his own life, he would have to take the life of his daughter whom he loved dearly.

On the evening of the crime, the defendant and his wife got into an argument over his mismanagement of money. His wife discovered that he had overdrawn their shared account and demanded answers on how the money was used. She was persistent in her demands for answers and berated him for his poor use of money.

Over the course of that evening, the defendant drank heavily, started feeling depressed, and began contemplating suicide. He also developed intense rage and hatred towards his wife for questioning his use of their money. He felt humiliated by her comments, emasculated and worthless and decided he would kill himself. However, his rage towards his wife also grew, leading him to grab his gun, which he kept in his home for protection, walk into their living room where his wife was sitting, and shoot her twice, killing her.

The commotion caused his daughter to come into the living room. Looking over at her mother, she stated, "Daddy, what happened?" Calmly, he said "mommy's in a better place." As the defendant remained intent on killing himself, he knew that he could not leave his child behind alone, on this tormented earth to be bullied and abused. He then hugged his daughter, told her that he loved her, and shot the child once, killing her. The defendant next attempted to take his own life via multiple methods, but ultimately, was not "successful" in doing so.

At the end of the evaluation, we concluded that the murder of his wife was a sane act with the rational motive of anger. We concluded that the murder of his daughter was an insane act. He had an altruistic belief that he did what was right for his daughter. We explained our opinion to his attorney as she drove us back to the airport.

While it was a tragic situation, I was grateful for the opportunity. For my fellowship director, it was another child murder, but for me it was a chance to live out what I thought fellowship would be like. I was able to see someone who 12 hours before I thought was a monster transform into a man with a tormented soul. It was a rejuvenating experience leaving me excited for what the rest of the year would bring.

Dr. Beaman is a current fellow at the Case Western University, Cleveland forensic psychiatry fellowship program.

Royal College of Psychiatrists Forensic Faculty Conference – 2013

Graham Glancy MB, John Baird MD, FRCP

The 2013 Annual Conference of the Faculty of Forensic Psychiatry of the Royal College of Psychiatrists was held in the Scandic Hotel, Copenhagen from 6th to 8th February 2013. About 400 delegates attended and enjoyed three very full days as well as having some opportunity to explore Copenhagen itself, a safe, modern and prosperous city. The majority of the delegates and speakers were from the United Kingdom but, in addition, there were delegates not only from other countries in Europe but from the United States, Canada, Australia and New Zealand. Over the years the successive organizers have regularly reviewed the program content and the style of presentations in an endeavour to avoid any perception of staleness or repetition, to meet the expectations of delegates and to give them something new.

This year's program was a mixture of plenary sessions and one session involving short invited research papers by established academics. We were particularly impressed by the way that the senior academics were presented in rapid succession giving updates on their research in 15 minute presentations, one after the other in a session entitled "speed dating research session." This included such notable presentations as Prof. Coid's re-analysis of the MacArthur data that concluded that delusions do cause violence, welcome research on drug-induced psychosis, and an amazing study of 7000 veterans who were followed into the community with a view to assessing the high prevalence of violence and its relationship with various aspects of military duty.

There was also a session for submissions by trainees of research projects in which they have been involved with a prize for the presentation judged to be the best, and two sessions of parallel workshops allowing smaller groups to deal with specialist topics. Also, each day there was a keynote address by a distinguished expert. Of particular note was Dr. David Farrington's research, which followed three generations of a cohort with antisocial personality disorder. He demonstrated that psychopathy and antisocial personality are transmitted from generation to generation but that the link was basically related to drug abuse, family violence and discord and the resulting homelessness. On the one hand this presents a rather bleak picture, but on the other hand it suggests that attention to these factors could break the cycle. During the course of the three days there were almost a hundred presenters and there were also over sixty posters.

"... senior academics were presented in rapid succession giving updates on their research in 15 minute presentations, one after the other in a session entitled speed dating research session."

Dr. Alec Buchanan and Dr. Graham Glancy from the American Academy of Psychiatry and the Law presented a workshop on the proposed AAPL guideline for the forensic psychiatric assessment. This prompted lively discussion and highlighted the many overlaps between practice in the United Kingdom and the United States in terms of the challenges and responsibilities that must be dealt with by an expert who is undertaking an assessment. Dr. Buchanan also presented on the assessment of the risk of violence in psychiatric populations.

Also from the United States, Professor James Gilligan presented on the topic of shame, guilt, and violence.

It is not possible to list all the highlights from such a busy and varied program but a few which did catch our attention were a discussion of the challenges of the Anders Breivik case and the challenging presentation by Professor Sir Robin Murray reminding us about how much is wrong about our services for those suffering from serious mental illness, schizophrenia and other psychoses, even nowadays, and how much need there is for improvement. The forum of a debate can be a very productive setting for examining topical issues and this year there was a very successful debate on the motion "This House believes secure forensic services are out of date and unsustainable." Those supporting the debate put forward by far the most persuasive arguments and many of us were left wondering whether the huge investment of resources in secure inpatient units should not be diverted, at least in part, towards the very much greater number of mentally disordered offenders who are in prison custody and in the community. Nevertheless it was clear when considering the history of this meeting and the nature of the work undertaken by many of the participants that the secure forensic units have provided excellence in service and teaching, as well as central university departments of forensic psychiatry which have produced considerable research in the field. We suspect it would be difficult to continue these endeavors, particularly the research, within prison settings.

Despite the very full program, there was some opportunity for those with stamina to engage in some recreation and relaxation. In addition to a conference dinner there was the usual fun run round the streets of Copenhagen and a new development this year: a workshop discussing a literary novel – Engleby by Sebastian Faulks, which has a strong forensic psychiatry theme. When matters concluded on Friday and delegates either headed home or stayed on in Copenhagen for the weekend, they took with them pleasant memories of a busy, lively, educational and above all, friendly event.

Suicide by Cop

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the US than in Canada. They reviewed the files in which deadly force was used by law enforcement agents, which included 707 officer-involved shootings in North America, making it the largest study ever made. About 36% of these cases were determined to be suicide by cop cases. About 41% were killed as a result of the shootings, while 36 individuals committed suicide in front of the police by either shooting or stabbing themselves, or in some other manner. About 1% of the cases included a fatality of a law enforcement agent, while about 21% included fatalities to innocent bystanders.

Information reviewed by Dr. Collins and his research team in the SBC cases included mental health histories, duration and location of incidents, weapon possession and use by subjects, casualties, context of incidents, police service type involved, suicidal communications, behavior of the subjects, observed emotional states, intoxication with substances, threats to others, and their outcomes.

Dr. Collins pointed out that the mental health history in the cases reviewed was missing in 32% of the cases, making it likely that mental health issues are more frequent than what was found in the study. However, in those cases in which a mental history was documented, about 13% of individuals were more likely to have been psychotic at the time of the incident, 24% were being prescribed medications, and 13% were under psychological care. About 22% had a known or probable mental health diagnosis, of which 21% had a mood disorder, 15% had a thought disorder, and 17% had a substance disorder.

Males in the 4th decade of life, with unstable housing conditions, disrupted relationships and unemployed or underemployed had a higher risk. About 14% of the cases had recently lost their job. Of the 21 females, 81% were "seriously" suicidal. Although females are less likely to engage in SBC, they are more likely to act quickly in terms of their aggression, are less likely to express their ambivalence, and usually lead to quick negative resolutions of the situations; "they act quickly and it's over quickly." Of the female cases, 27% of the incidents terminated in less than an hour and 38% terminated in less then 15 minutes. Females were also more likely to have written suicide notes than males.

Dr. Collins reported that about 38% of the cases took place in public areas, 10% in businesses, and the rest in residences. SBC is lethal in more than half of the cases, and there was bodily injury in over 90% of the cases. Although 82% of the subjects were armed, some subjects had unloaded or nonoperational weapons. About 43% of the individuals had operational loaded fire guns, 18% feigned having a weapon, and 23% actually shot at the police.

The research available to date, including the findings of Dr. Collins, suggests that subjects who seek SBC have a high degree of desperation, hopelessness, impulsivity, and self-destructiveness. Dr. Collins points out that a subset of these suicidal individuals cross over into danger or threat to others, primarily police officers. There is a one in three chance of others being harmed during these incidents. These individuals pose a greater risk of homicide or at least of violence towards others.

Ask the Expert

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issue was pharmacologic in nature. The opposing expert was forced to admit that she had never prescribed the medications in question, an admission that seriously undermined her credibility.

While there is a temptation to accept all referrals (after all, we are business people) it is important to know when to say "no" and to freely refer lawyers to the appropriate colleague. Frankly, doing so actually will increase future referrals, as your honesty will be appreciated by all involved.

Certainly Dr. Sadoff has addressed the issue of time management. I have reduced my psychotherapy load to a bare minimum but find I am able to juggle a schedule of new patient evaluations and medication management with my forensic demands. However, rescheduling and rearranging will occur due to the vagrancies of the legal system.

Another potential pitfall is repeat business. While it is always nice that an attorney wants to use you as an expert repeatedly, the expert must be aware of the potential to want to always be able to help a lawyer who over the years has been a good source of business and may even have become a friend. It is critical to stick to the ethical principles of striving for impartiality and objectivity when performing every assessment.

The last issue I would raise is developing a reputation as always working for a specific side on any given issue. While no expert can control from whom the referrals come, it is unwise to always work for one side, be it plaintiff, claimant, defense, prosecutor, the State or an insurer. Throughout my career I have done my best to keep my caseload balanced in order to avoid any such claim being made. At times, this has required me rejecting a case for only that reason. I have never regretted those decisions and see it only as an investment in my reputation. I always smile when an attorney calls me and says that she wants to retain me first, because she knows if she doesn't, the other side will.

Sadoff/Kaye: Take home point: Many young forensic experts are eager to grow practices. Many early-mid career psychiatrists see forensics as a way of escaping the problems of managed care and new CPT coding headaches. Forensics requires a serious commitment, can be very time consuming and will undoubtedly affect a clinical practice. Knowing the limits of your expertise is critical to maintaining a good reputation. It is that reputation that will drive your successful career.

Sandy Hook

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as to effect gun removal from any individual who uses a gun in a threatening or inappropriate manner.[3] Gun violence among the mentally ill is more prevalent in suicide completion. The notion of blocking physician's attempts to inquire about weapon possession when treating depressed patients as in Florida's legislation (now under appellate review) and proposed legislation in 4 other states is simply misguided and violates the standard of care in treating such conditions.[4]

On the weapons side, Connecticut's Governor Malloy has now proposed additional measures:[5]

1. Comprehensive universal background checks
2. Strengthening the State's assault weapons ban
3. Banning large capacity magazines

Some interesting gun statistics were gathered by the Third Way organization. In relation to gun trafficking, they point out that there are roughly 500,000 gun crimes every year in the United States, and in nine of the ten gun crimes where the gun has been successfully traced, the person who originally bought it is not the person who used it in the crime. The typical age of someone who commits a weapons violation is 19, followed by 20, followed by 18. Yet the legal age to purchase a handgun is 21. One in three crime guns has crossed state lines.

They also present the following vignette. "It's nighttime and a van pulls into an alleyway. The driver jumps out and opens the back as a guy smoking a cigarette comes from beneath the fire escape. A dozen guns are in the back. The guy with the cigarette sizes up the guns. They talk. He peels off several hundred dollar bills, takes a Glock 9 mm from the back of the van, shoves it in his waistband, tosses his cigarette on the pavement, and heads out onto the street as another man walks up to the van to peruse the wares. What crime was committed here? Littering.[6]"

They point out that there is no federal law that makes this gun sale illegal. There is no law that says the buyer must submit to a background check. There is a law against selling a gun to a felon, a person with a restraining order or a mentally ill person, but this is difficult to enforce, since the seller does not usually have this information. This turns out to be a very high threshold. During a trial, unless the prosecutor can prove the seller knew the buyer was in one of those prohibited categories, there will be no conviction.

In terms of the mental health issues, most legislators, unlike most of the public, understand that rare events are difficult if not impossible to predict, especially where the overlap between violence and the mentally ill is very small. Most understand it is equally difficult to predict which of the mentally ill are the ones who will become dangerously violent.

The commitment statutes in Connecticut are not a significant problem and do not place impediments for physicians to hospitalize the mentally ill who represent a threat or who are gravely disabled.

It is not clear how many of these proposals by the Special Commissions and the Governor of Connecticut, the gun related or the mental health reporting and Tarasoff duty legislation, will see the light of day. The gun lobby remains powerful and gun manufacturing is an important business in Connecticut. The gun lobby is happy to write off the mentally ill in an attempt to block larger bans and monitoring.

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1. Tarasoff v. Regents of University of California, Supreme Court of California, 551 P.2d 334; July 1, 1976
2. Conn. Gen. Stat. 52-146f
3. *Conn. Gen. Stat. ß 29-38c* (2012). Seizure of firearms of person posing risk of imminent personal injury to self or others.
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5. http://www.governor.ct.gov/ malloy/lib/malloy/2013.02.21_Gun_Safety_Proposal.pdf; Accessed 3/7/2013
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Influence of Race

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(Wuensh et al) showed that mock jurors of both African American and Caucasian races tended to favor plaintiffs of their own race. They also recommended higher awards to the plaintiff when the defendant was of a different race. Dr. Bertoglia provided real examples of expert witnesses struggling at times with being impartial with a defendant in their own race.

To end, Dr. Bertoglia discussed Greenawalt's concept of the "Cultural Defense" which refers to a range of ways in which evidence about a defendant's cultural upbringing or practices could influence legal judgment about guilt or responsibility.

The next speaker, Dr. Alexander Simpson from Toronto presented his formulation of violence from a cross cultural point of view. He examined the role of the expert in assisting the courts. Dr. Simpson cited case examples to question the appropriateness of cultural exploration in non-Western born individuals whose cultural practices vary widely. To end Dr. Simpson advocated the use of culture specific techniques to facilitate elimination of bias in forensic psychiatric evaluations.

The concluding talk was delivered by Dr. Ezra Griffith from New Haven. Dr. Griffith, a longstanding proponent of the use of the cultural formulation in forensic psychiatric evaluation, introduced the concept of "voice" in forensic report writing. He promulgated that all parties involved in a particular case, for example, the defendant, the attorney, the court, and the collateral contact, have their own unique voice in the forensic psychiatric evaluation. He emphasized the need for highlighting the relevant voices in a well written forensic psychiatric report, especially the voice of the defendant in the culturally relevant context as a way of balancing the tilted scales caused by sociocultural disparity.

The panel was greeted by an over-

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Jeff Janofsky MD

Susan Hatters Friedman MD

This new column will explore career paths of some of the Rappeport Fellows, since the fellowship honoring Jonas R. Rappeport was established in 1985.

Jeff Janofsky, along with some other then-future leaders in the field of forensic psychiatry, was in the first class of Rappeport Fellows. While Dr. Janofsky is a familiar AAPL leader to many (and indeed had his presidential biography in the Journal of AAPL authored by Dr. Rappeport himself), it was enlightening to discuss with him the early parts of his career and early AAPL experiences.

The Rappeport Fellowship was especially meaningful to Dr. Janofsky as Dr. Rappeport was his mentor. He recalled that as a medical student and resident he had worked with Dr Rappeport, who had then recently been involved in the John Hinckley case. He estimated that at that time, there were 6-8 fellowships in the US, and that while forensic psychiatry has grown increasingly competitive, there are now 40-50 programs.

Dr. Janofsky described the inaugural class of 6 Rappeport Fellows becoming part of AAPL when forensic psychiatry was a much smaller field and not even a recognized subspecialty of psychiatry. One of the long-term visions of the organization, even that early on, was to professionalize forensic psychiatry and to perpetuate itself by bringing in a younger generation. This was something that the Rappeport Fellowship set out to do. While AAPL's size has grown dramatically, it has sought to retain a welcoming atmosphere toward new members, affording opportunities to meet others with similar interests and to run cases by colleagues.

Dr. Janofsky described the Rappeport Fellowship and AAPL as being of enormous help to his academic career. He explained that in addition to his experiences as Book Review Editor for JAAPL, the editors of the Journal were extraordinarily helpful to his publishing career. He also described reaping the benefits of presenting at AAPL meetings, especially early in his career as he was getting established. AAPL's atmosphere of welcoming new talent and the relatively open nature of the committees enabled him to become active in the organization, as it has for many others since. He said that he then learned from AAPL more about how to run an academic organization, which he was also able to take with him in other leadership positions.

He said that he hasn't missed an AAPL meeting since his Rappeport Fellowship year. His memorable first meeting was in Albuquerque, during the balloon festival. The Fellowship afforded him the opportunity to attend as a senior resident, and meet other "really cool" people. A highlight was being taken to dinner by forensic leaders. He also recalled that an actor playing an outlandish Russian forensic psychiatrist was a scheduled luncheon speaker, as a bit of humor, but someone forgot to alert the media relations folks, and hilarity really ensued. Finally, Dr. Janofsky talked about other long-term benefits of his many years with AAPL, including getting to know leaders from across the country, develop friendships, and hear excellent talks.

Influence of Race

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whelming response from the audience indicating a burning interest in the changing landscape of American demographics. Questions from the audience pertained to two broad categories: those related to the practical and methodological construct of an individual specific formulation that derives from the tenets described above, and those that were aimed at increasing awareness about specific minority cultures. Taking a cue from this response, and in an effort to continue this rich dialogue, the Committee for Cross Cultural Affairs has voted to sponsor another discussion for AAPL 2013 aimed at increasing awareness about cultural diversity and practices: "This is how we do it in my culture: Embracing diversity".

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MUSE & VIEWS

A pun does not commonly justify a blow in return. But if a blow were given for such cause, and death ensued, the jury would be judges both of the facts and of the pun, and might, if the latter were of an aggravated character, return a verdict of justifiable homicide.

Oliver Wendell Holmes

Submitted by Phillip Resnick MD

Shadow Program in South Jersey Prison Helps Inmates with Cognitive Impairments

Anthony Tamburello MD, Chair Institutional and Correctional Committee
Suzanne E. Blizzard MSEd, MSOT, OTR/L

The problem of the aging prison population has already been brought to the attention of the American Academy of Psychiatry and the Law[1]. According to the Bureau of Justice Statistics, between the years 2001 and 2011, the proportion of state and federal inmates over the age of 55 increased from 3.0% to 7.9% of the total inmate population[2,3]. Older incarcerated persons are more likely to suffer from one or more chronic medical or mental health conditions and require more health care services. Prisoners frequently have risk factors for dementia including substance abuse, post-traumatic stress disorder, and traumatic brain injury. Thus, cognitive impairment may be particularly prevalent in this population[4]. There is no national consensus on how to house and manage elderly inmates. Some state prisons place them in segregated units, some consolidate them into the general population, and others use hybrid models. One study suggests that consolidated housing for older inmates provided better access to mental health services[5].

Occupational therapist (OT) Suzanne Blizzard works with patients who have poor functional abilities stemming from chronic mental illnesses on the Residential Treatment Unit (RTU) at South Woods State Prison (Bridgeton, New Jersey). All patients on the RTU have access to 24-hour nursing services as well as intensive mental health services including individual and group therapies. It was apparent to Ms. Blizzard that not all the patients were able to fully benefit from this unit. Some have cognitive impairments that are manifested by poor self-care, poor cell sanitation, an inability to manage personal belongings, an inability to follow the rules of the institution, and inevitable mistreatment by a committee of psychologists worked with Ms. Blizzard to develop the "Shadow Program," which is grounded in the Canadian Model of Occupational Performance[6] and the Cognitive Disabilities Model[7]. It was proposed to local and central Department Of Corrections administration in 2009. Final approval was given in February 2011, and operations began in April 2011. Referrals for the Shadow Program may come from custody, nursing, or mental health providers. For each candidate, Ms. Blizzard completes an assessment series of the Large Allen Cognitive Level Screen[8], completes appropriate Allen's Diagnostic Modules and gathers information from real-life observations. Patients with an Allen's Cognitive Level of 4.6 (out of 6.0) or below who demonstrate deficits in self-care and cell sanitation tasks are admitted into the program.

"As correctional facilities around the nation face the inevitable challenges of meeting the complicated healthcare needs of older inmates, a responsible and cost-efficient assisted living model such as this is worth serious consideration."

Inmates participating in the Shadow Program receive assistance from trained inmate peers called Assisted Living Coordinators (ALCs). The ALC position is an institutionally assigned, paid inmate work detail. ALCs do not live on the RTU, but are conveniently housed in a nearby prison unit. Potential ALCs (usually recommended by correctional officers) must demonstrate an Allen's Cognitive Level of at least a 5.6 to be eligible. Those with a history of institutional charges for violence or theft are excluded. In fact, they must be completely free of charges for at least three years, and they may not be currently serving a sentence for a drug offense. If the candidate meets these stringent criteria, their name is forwarded to the Classification Department for final approval and job assignment.

There are presently two ALCs assisting up to 12 inmate patients with conditions ranging from Alzheimer's disease to chronic schizophrenia. Up to four ALC positions are approved, so there are opportunities to expand the program. While much of the ALC's training is "on-the-job," Ms. Blizzard meets with new workers for orientation, specifically to teach them about boundaries and the challenges associated with the detail.

The ALC's responsibilities are best described as "stand-by assistance." The ALC literally stands by the program participant to offer cues or directions to improve his task performance. The ALCs are cautioned to treat their peers as men, not children, and not to complete tasks that a patient is capable of doing by himself with support or encouragement. For example, the ALC may say, "Mr. X, it is time to get your shower," then unobtrusively observe him prepare to shower, get showered and return to the cell to manage his dirty clothes. Another inmate may require one-step directions in order to move through the same task in a timely fashion.

No matter what type of assistance is required, it must be accomplished with compassion and sensitivity. As caretakers of those with dementia know well, conflicts can arise when

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Hyper-Reporting

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you're not being reported, you're not working."

Here is a conundrum for any psychiatrist: if you woke up one day feeling sick or facing a major stressor of any kind, would you call in sick or go to work sick/stressed out? Either way, you confront risk. Calling in sick to a dysfunctional setting leads to "chatter" about whether you were really sick - comments along the line of "the doctor is a 'call-off;' I didn't know a doctor could be a 'call-off;' " the service is losing income from your call-off; and so on. When you then return to work healthy, will the staff treat you differently? You could have been reported for an inappropriate call-off. If you go to work sick (as tradition demands) you could very well be reported as possibly too sick for duty – and again investigated for operating at less than adequate capacity. Either way you are subject to investigation. Which investigation would you prefer?

The following is my take on the matter. Of the two options, it is far easier to come back to work when healthy and, later, deal with the chatter about you as well as any investigations, note-taking, or FYI emails about how much revenue you cost the service by calling off and not billing for any hours that day.

It's harder these days to be an old-school traditionalist who guts it out and works through sickness/stress because one who does so runs the risk of being reported as questionably fit to work, regardless of how well one might in reality be coping with sickness/stress. One difficult lesson for an old-schooler such as myself has been when to NOT go to work. In a formidably dense and reporting-heavy work environment you have to know when to exercise discipline and either call off from work or take a leave until your situation is over. Seriously, strongly consider this even if you are feeling fine and superbly handling whatever sickness or stressors you or your family is going through. The risks of working through such times include: 1) should any clinical mishap happen, you are a setup for blame because you "must have" been affected by being sick or stressed; 2) being investigated for something akin to "fitness for duty"; and 3) if you are able to function flawlessly while sick or stressed you still face investigation for why you are able to do so – there must be something wrong with you to not have an impairment in function, correct (This is a play on where there is smoke, there is fire)? In any of the above you face investigation that of course may turn out far more stressful than whatever cold or bug you've caught. So - just call off. That's the new way of doing things in these work settings.

Shadow Program

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patients become frustrated with a task that challenges their cognitive abilities. They may become angry or embarrassed when offered unwanted assistance. ALCs are trained to "observe and respond" rather than to react to such situations. For example, the ALC may prevent a behavioral outburst by gently drawing the participant's attention onto another task.

Challenges thus far have been few and manageable. Though housed on the same unit as nonparticipants (a "consolidated" model), participants' cells are situated closer to the officer's desk. This reduces the opportunities for higher-functioning peers to take advantage of them. Having general population inmates working this closely with special needs patients is out of the ordinary and required a period of adjustment by correctional staff. As the program has become more established and evolved over time, so has its level of acceptance by the institution. The ALCs are closely supervised and report daily to Ms. Blizzard. Cost has not been a barrier, given that the Shadow Program utilizes the pre-existing structure and staffing of an established healthcare-oriented unit, and the wages of the inmate workers are not a major expense for the institution.

If you are considering using the Shadow Program in your system, we recommend, at a minimum, having an OT on staff for consultation, development, and implementation. OTs have expertise in the field of Person-Occupation-Environment Fit, so they are well suited to adapt this program to the strengths and limitations specific to your facility. The Shadow Program is not a substitute for patients requiring a nursing home or hospice. Rather, it may preserve the maximum independence of those who may eventually require those levels of care. As correctional facilities around the nation face the inevitable challenges of meeting the complicated healthcare needs of older inmates, a responsible and cost-efficient assisted living model such as this is worth serious consideration.

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Forensic Psychiatry: Cutting Edge Issues

The Tri-State Chapter of AAPL holds its 38th Annual Meeting in New York City

Manuel Lopez-Leon MD, MACPsych

On Saturday January 26, 2013, several devoted AAPL members and committed guest speakers made their way through the bitter winter weather to the New York Academy of Medicine where the Tri-State Chapter's 38th Annual Meeting was held. The program offered five hours of Category 1 CME credits and it was held in cooperation with the New York State Office of Mental Health and the Forensic Psychiatry Clinic for the Criminal and Supreme Courts of the State of New York.

The first presenter was Christopher Kunkle, PsyD, Forensic Psychologist and Director of Institutional Sex Offender Treatment, NYS-OMH, Forensic Services. Dr. Kunkle discussed the topic of "Using Crime Scene Investigation and Criminal Profiling Methods to Inform the Assessment and Treatment of Forensic Patients." Dr. Kunkle described the process of drawing distinctions between each type of sexual homicide and the importance of understanding the many differences and nuances between the varying types of sexual homicides. Understanding the motivations and the dangerousness of sex offenders is critical not only in criminal profiling, behavioral analysis, assisting law enforcement agencies, and providing expert witness testimony, but it is also important in advising clinicians involved in the treatment of this particular type of forensic patient.

Andrew Slaby, MD, PhD, MPH, Clinical Professor of Psychiatry, NYU School of Medicine and Past President of the American Association of Suicidology, was our second guest speaker. Dr. Slaby discussed "The Evaluation, Differential Diagnosis, and Management of Suicidal Behavior." Dr. Slaby reviewed evidence-based guidelines for the evaluation of risk for self-inflicted death and institutional, professional, and community strategies for risk reduction. The level of evidence may not be on a par with some medical interventions—such as to reduce risk of lung or colon cancer—but the decision to die by one's own hand is not a simple molecular issue. Suicide results from a complex interplay of psychological, biogenetic, sociocultural, and existential variables.

"... a teenager who texts a nude picture of himself to his girlfriend could be criminally charged with distribution of child pornography and be labeled a 'sex offender' requiring to be registered as such for the rest of his life."

Because suicide is generally an impulsive act governed by complex factors, it is impossible for clinicians to predict whether or not an individual will commit suicide. However, it is the clinician's responsibility to identify significant risk factors and focus the treatment on minimizing or eliminating them.

Our third presenter was Stephen Billick, MD, Clinical Professor of Psychiatry, NYU School of Medicine and Past President of AAPL. Dr. Billick gave a captivating presentation on "Adolescents and the Internet: Normal Behavior, Sexting, and Bullying." Dr. Billick explored the social attitudes towards sex in the media and on the Internet. He pointed out that society has double standards in their attitudes related to sexual behaviors in teens in contrast to their rights. For instance a teenager who texts a nude picture of himself to his girlfriend could be criminally charged with distribution of child pornography and be labeled a "sex offender" requiring to be registered as such for the rest of his life. In contrast, teenagers are not allowed to vote or legally buy alcoholic beverages. Dr. Billick pointed out that humans are biologically programed to procreate starting during the adolescent years, and thus it is only natural for teens to engage in sexualized behaviors. Due to the technological age we currently live in, these sexualized behaviors have expanded to include sexual communications via digital devices such as in "sexting," the Internet, and social media applications. However, just as with any sexual behavior, teens need to become aware of the dangers of engaging in this type of electronic sexualized behavior. There could be legal as well as social ramifications to uploading sexual content to cyberspace; once a picture is posted on the web, it becomes a cyber footprint forever, thus it becomes indefinitely available to be found by others who could use it in negative ways such as in practicing cyber bullying.

Our final guest speakers were Jonathan Brodie, MD, PhD, Professor of Psychiatry, NYU School of Medicine and Laurence Tancredi, MD, Clinical Professor of Psychiatry, NYU School of Medicine. Drs. Brodie and Tancredi discussed the topic of "Should Neuroimaging Be Admitted as Evidence in the Courtroom?" Dr. Tancredi and Dr. Brodie described the advances in neuroimaging techniques and applicability in the courtroom, as well as their validity under the Federal rules of admissibility. Emphasis was made on how brain imaging is one of the most remarkable technological advances

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Midwest Chapter Holds 30th Annual Meeting

Steve Berger MD

The Midwest Chapter of AAPL held it's 30th Annual Meeting in Columbus, OH, on March 22-23. The Midwest chapter includes 13 1/2 states (western portion of Pennsylvania). An excellent program was planned by Caty Cerny, Delaney Smith, and Sherif Soliman. A special recognition of the 30th anniversary of this meeting was planned by the 30th President Susan Hatters-Friedman. Eighteen of the 31 presidents were in attendance. Five Resnick Scholars also attended, to encourage and support them in their interest in forensic psychiatry. Next year there will be both Resnick Scholars selected by accomplishments and Margolis Scholars selected by geography and interest.

Past Presidents of Midwest AAPL.

AAPL 2012 Research Award

Robert L. Trestman PhD, MD, AAPL Research Committee

At the 2012 AAPL Conference in Montreal, the Fourth Annual Research Poster Award competition was held. The intent of the award is to enhance the research orientation of its membership and recognize those efforts. Members of the Research Committee served as judges. Each Judge reviewed the posters displayed on Thursday, Friday, and Saturday of the conference. Clarity of Hypothesis, Methodology, Analysis, Scientific Value, and Practical Significance to the field of Forensic Psychiatry were considered in the overall evaluation.

This year, 35 posters were exhibited. Eight members of the AAPL Research Committee served as judges. The Winner of the 2012 Annual AAPL Research Poster Award is the work of Bryan Shelby, Merrill Rotter, Charles Amrhein and Kimberly Nessel for the poster entitled, "Drug Courts and Opiate Addiction: A Survey of Judges' Opinions on the Use of Medication-Assisted Therapy in Drug Court Diversion."

We look forward to continued enthusiastic participation in research efforts more broadly, and in the submission of research (both empirical and scholarly) to the Annual AAPL meeting.

Letter to the Editor

Editor:

The Child Column by Dr. Herman in the January 2013 Newsletter, entitled Forensic Aspects of Gay Conversion Therapy[1], does not make clear that the California law prohibiting "gay conversion" or "reparative therapy" applies only to patients under the age of 18[2]. Also, the law did not actually take effect on January 1st, due to an injunction issued by a three-judge panel of the Ninth Circuit Court of Appeals on December 21st, 2012, in the case of *Pickup et al. v. Brown*.

Sincerely,

Joe Simpson MD, PhD
Los Angeles

References:

1. Herman SP. Forensic Aspects of Gay Conversion Therapy. American Academy of Psychiatry and the Law Newsletter 38:11, 2013.
2. California Senate Bill 1172, September 30th, 2012.

Response:

I appreciate the comments of Dr. Simpson. Indeed the California law (SB1172) making Gay Conversion therapy illegal applies only to those younger than 18 years. As for the court challenges, a three-judge panel from the Ninth Circuit will hear the case on April 19th. I will follow through in a future column for the Newsletter.

Stephen P. Herman MD

Cutting Edge Issues

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towards understanding the relationship of behavior to brain anatomy and physiology, and how it may be used to illustrate differences in the anatomy and biological functioning when comparing different brains. For these reasons, brain images have increasingly been used in both criminal and civil trials.

After concluding the academic program, The Tri-State Chapter of The American Academy of Psychiatry and the Law held its Annual Business Meeting. The officers for 2013-2014 period were elected; Grace Lee, M.D., for President, Gregory Bunt, M.D. for Vice-President, Robert Goldstein, M.D. for Treasurer, Manuel Lopez-Leon, M.D. for Secretary, Dean De Crisce, M.D. for Councilor, and Shane Kondrad, M.D. for Councilor. The following Councilors remain in office: Tara Straka, M.D., Gloria Seo, M.D., Susan Gray, M.D., and Robert Berger, M.D.

The Tri-State Chapter of AAPL appreciates the dedicated service of Gary Collins, M.D. as immediate Past President and for his ongoing contributions.

The 38th Annual Meeting concluded with the traditional Tri-State AAPL Gourmet Dinner Party at Ai Fiori restaurant, which was superbly organized by Stuart Kleinman, M.D., under the inspiration of Richard Rosner, M.D.

DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES, TULANE UNIVERSITY SCHOOL OF MEDICINE in New Orleans, LA, is recruiting for several general and forensic psychiatrists (clinical track) for our growing department, at the Assistant/Associate Professor level, salary commensurate with experience. Candidates must have completed an approved general psychiatry residency and be board certified/eligible in general psychiatry and forensic psychiatry, respectively. Responsibilities will include direct patient care, teaching of medical students and house officers, and research (clinical and basic science) at various state hospitals, state correctional institutions, and at Tulane University Health Sciences Center. Time allocations will be based upon individual situations. Applicants must be eligible to obtain a Louisiana medical license. In addition, candidates must be eligible for clinical privileges at Tulane University Hospital and Clinic under the appropriate staff category and must agree to abide by those privileges as outlined by the current bylaws of the institution. Applications will be accepted until suitable qualified candidates are found. Email (winstead@tulane.edu) or send CV and list of references to Daniel K. Winstead, MD, Heath Professor and Chair, Department of Psychiatry and Behavioral Sciences, Tulane University School of Medicine, 1440 Canal Street TB48, New Orleans, LA 70112. For further information, you may contact Dr. Winstead, at 504-988-5246 or winstead@tulane.edu. Tulane is strongly committed to policies of nondiscrimination and affirmative action in student admission and in employment.

OREGON HEALTH & SCIENCE UNIVERSITY

Oregon Health & Science University (OHSU) has an outstanding opportunity for a BC/BE forensic psychiatrist for both clinical and forensic work in a new State forensic hospital. The position involves four days of clinical work and one day of protected time to pursue community service and academic interests. Opportunities include competency and insanity evaluations, risk assessments, court testimony, resident and fellow supervision and patient care.

Academic rank begins at the level of assistant professor and may be higher depending on credentials and experience. We provide very competitive pay and benefits, and will pay for moving expenses.

OHSU is Oregon's only academic medical center and is highly ranked nationally. Here at OHSU, we highly value a diverse and culturally competent workforce. When you join us, you join a dedicated team of caregivers, educators, researchers and administrative professionals who diligently pursue the advancement and application of knowledge to directly benefit the individuals and communities we serve.

We sincerely invite your interest in this very unique and rewarding opportunity. If you would like more information, please contact Christopher Lockey, M.D. We look forward to hearing from you.

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