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DSM-5 Substance Use Disorder: Ready for Prime Time?

Mace Beckson MD and Gregory Sokolov MD - Addictions Committee

In its “Cautionary Statement for Forensic Use,” the DSM-5 states that “there is a risk that diagnostic information will be misused or misunderstood” (p. 25). Among the major changes, DSM-5 has eliminated the DSM-IV diagnoses of Substance Abuse and Substance Dependence; these were collapsed into one diagnosis named “Substance Use Disorder” (APA, DSM-5, 2013). More specifically, three of the four Abuse criteria were added to the Dependence criteria “legal problems” was eliminated, and “craving” was added, yielding a

total of 11 criteria for the new diagnosis.

Among the rationale for these changes was that, while DSM-IV Substance Dependence has been demonstrated to have excellent reliability and validity, DSM-IV Substance Abuse has much lower reliability and validity (Hasin et al., 2013). Furthermore, the DSM-IV hierarchical relationship between Dependence and Abuse created incorrect assumptions that Abuse is a

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2014 Guttmacher Award Announced

William H. Reid, MD, MPH received 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 New York, NY, in May 2014.

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, 2012 and April 30, 2013.

The book for which Dr. Reid is being honored is: *Developing a Forensic Practice Operations and Ethics for Experts*. New York, Taylor & Francis, 2013



American Academy of Psychiatry and the Law

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COVER STORY

DSM-5 Substance Use

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milder form of Dependence, all cases of Dependence also meet criteria for Abuse, and/or Abuse is the prodrome of Dependence (Hasin et al., 2013).

Psychometric research indicated improvement of test-retest reliability of Abuse with removal of the hierarchy, latent class analysis of the combined Abuse and Dependence criteria suggested that the criteria correlated with a single factor or two closely related factors; item response theory model analysis of the combined criteria indicated “undimensionality”; and there was intermixing of the various criteria across the severity spectrum, with the exception of the “legal problems” criterion (Hasin et al., 2013). A diagnostic threshold of two (2) criteria out of the total of eleven (11) criteria was chosen specifically to achieve close approximation between the prevalence of the new single diagnosis of Substance Use Disorder and the combined prevalence of the two diagnoses of DSM-IV Abuse and Dependence, in order to “avoid a marked perturbation in prevalence without justification” (Hasin et al., 2013, p. 841). In addition, each diagnosis has a severity specifier: “As a general estimate of severity, a mild substance use disorder is suggested by the presence of two to three symptoms, moderate by four to five symptoms, and severe by six or more symptoms” (p. 484).

Critics have opposed the elimination of Substance Dependence, viewing it as a “helpful unifying heuristic for clinicians, scientists and sufferers for more than 30 years, and has strong empirical support (Drummond, 2011; p.892). Additionally, it has been argued that from a prevention perspective, there is a need for a diagnostic category that recognizes problematic and hazardous substance use, as was the intent of DSM-IV Abuse (Babor, 2011). Concern has been expressed about the diagnostic threshold being “too lenient” with resulting “false positive” diagnoses: DSM-5 Substance Use Disorder “would diagnose many whose substance involve-

ment has questionable clinical significance, leading the...diagnosis away from mainstream neurobehavioral theory regarding what constitutes a mental ‘disorder’ and ‘addiction’”; and would allow “so much heterogeneity that the clinical and research utility of the diagnostic category would be greatly compromised” (Martin et al., 2011; p. 2008).

Where in the DSM-5 is substance “addiction”? In previous editions, the Dependence diagnosis was considered to be the equivalent of addiction. The collapse of the DSM-IV Abuse and Dependence diagnoses into one diagnosis implies that the new DSM-5 Substance Use Disorder diagnosis is not equivalent to “dependence” or “addiction”. In fact, the DSM-5 states: “Some clinicians will choose to use the word *addiction* to describe more extreme presentations.” (p. 485). It appears that the reader is left to infer that the DSM-5 diagnosis closest to “addiction” is “Severe Substance Use Disorder,” which would be a “more extreme presentation.” Consistent with this, research in patients in treatment for alcohol, cocaine, or heroin addiction found that of the 11 possible DSM-5 criteria, the modal number present was ten (Hasin et al., 2012).

Is Substance Use Disorder a distinct “mental disorder”? The DSM-5 states, in its “Use of the Manual” section, that its disorders “must meet the definition of mental disorder,” which is stated to be “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation or behavior” and “are usually associated with significant distress or disability in social, occupational, or other important activities” (p. 20). The text description of DSM-5 Substance Use Disorder makes no mention of distress or impairment, while “Criterion A” refers to a “problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period” (p. 490; emphasis added). Does this wording suggest that the

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FROM THE EDITOR

Dilemmas in Private Psychiatric Practice

Charles C. Dike MD, MPH, FRCPsych



Solo psychiatric practice was always tasking. In the days of psychodynamic psychotherapy, the psychiatrist, as a receptacle

of people's angst, emotional turmoil and inner chaos, was frequently "dumped on" by their patients as the patients sought to off load their emotional baggage. Many old time psychiatrists tell stories with a mixture of dread, pride and loathing, of some of their most difficult, often borderline patients, the ones who tortured them and made their work life both exciting and miserable all at once. Complications of transference and countertransference ensnared a good number of them.

Today, the landscape has changed ...or has it? For sure, only a handful of psychiatrists have practices dedicated to psychotherapy alone; the majority have been relegated to medication management only – derisively referred to as pill-pushers. In addition to issues related to medication administration, the demands of managed care, as well as the current robust and emboldened posture of patients borne out of the recovery movement continue to place psychiatrists in a quandary. Talking to psychiatrists, one gets a sense of the frustrations they confront on a daily basis. Ethics dilemmas and pitfalls abound. I will describe a few.

A psychiatrist practicing in the Northeast USA described the case of one of her long term patients who moved to one of the Southern states. They had agreed the psychiatrist would prescribe enough medications to last 2 months with the understanding that the patient would find another psychiatrist before they ran out. Two months later, the psychiatrist gets a call from the patient asking for a refill of medications because the patient had reportedly not been able

to find another psychiatrist. What to do? Would it be safe for the psychiatrist to refill the patient's prescriptions without having seen him in 2 months? Given that the patient is on a benzodiazepam, would the psychiatrist be held liable if the patient suffered a withdrawal seizure? Has the doctor-patient relationship ended?

There are no easy answers.

Another psychiatrist reported a situation that troubled him. After seeing a patient for the first time and prescribing a low dose of psychotropic medication with the plan of gradual titration of dose to optimal level, the patient's pharmacy called to say that the insurance company would not pay for a refill of the patient's prescription if it were not a 90-day prescription. The psychiatrist objected, stating that he had only met the patient once and therefore, could not prescribe a 90 day supply of medications; he was still exploring the patient's risk of suicide. The patient was suddenly thrown into the middle of a fight between the psychiatrist and the patient's insurance company, and since the insurance company was faceless, the patient heaped all his frustration on the psychiatrist. The patient accused the psychiatrist of insensitivity and of "playing games" with the patient's life, and subsequently threatened to report the psychiatrist to the State Licensing Board. The patient had no family or friend with whom the psychiatrist could work to ensure medication safety. What to do?

A psychiatrist in solo (evening) private practice who recently began to do vital signs and weight as mandated by the current requirements of practice had a patient who's BP after three readings remained at 220/135. The psychiatrist insisted on calling the ambulance to take the patient to the hospital but the patient declined, stating that he would drive himself to the hospital. What to do? After much discussion (with the psychiatrist feeling increasingly frustrated and

stressed out by the number of patients now waiting to be seen), the psychiatrist, heart in mouth, reluctantly agreed to let the patient take himself to the hospital. When the psychiatrist later called the patient, he learned that the patient had not gone to the hospital after all! What if the patient suffered a stroke that night, or developed hypertensive encephalopathy, would the psychiatrist be liable? Needless to say, the psychiatrist had a fitful night!

Another psychiatrist who provides medication management in her private practice and shares a patient with a therapist described her dilemma. The patient calls the psychiatrist's office approximately once a week after hours, and when in crisis, more frequently, causing the psychiatrist to engage in long discussions with him. All attempts to redirect the patient to his therapist proved unsuccessful; the patient stated that he believed the psychiatrist was better able to manage his state of inner turmoil and urges to self harm. When the psychiatrist gently admonished the patient for calling her once again, the patient accused the psychiatrist of abandoning him in a time of crisis, and subsequently made veiled comments about not feeling safe, even as the patient continued to deny suicidal ideation, plans or intention to commit suicide. What to do?

These are a few examples of the struggles of psychiatrists in private practice. They are difficult, stressful, and sometimes perilous, especially for those in solo practice. The need to be alert to risks at all times and not having anyone to share the risk or even to discuss them in real time can be quite exhausting. All interactions with patients, pharmacy, and patients' family and friends should be carefully and delicately managed as the landscape of patients' involvement and demands continues to evolve and shift seemingly in the patients' favor. I have deliberately left out the exhaustive documentation requirements to spare the reader further headache. It can all seem like an uphill task! ☹

PRESIDENT'S REPORT

What is Most Ethical in Forensic Psychiatric Dilemmas?

Robert Weinstock MD



First, I want to congratulate Dr. Renee Binder on her election as president-elect of the American Psychiatric Association. It is great to have some-

body in that position who has been AAPL president and is knowledgeable about forensic matters.

In my continued effort to highlight some under recognized aspects of our field, I will address in this article not only the important role of the AAPL ethics guidelines but also the challenges that can arise in complex situations to determine the best or most ethical action, known as aspirational ethics. In most of our practice, AAPL and other organizational ethics guidelines provide clear guidance, but no guidelines can address every situation. Guidelines sometimes conflict with each other or other ethics responsibilities. In such dilemmas there can be more than one acceptable resolution with differences of opinion among good ethical forensic psychiatrists. That does not diminish the need for each of us to try to determine for ourselves the best choice in these difficult situations.

Practicing at the interface of law and psychiatry, neither the ethics of clinical practice nor that of the law suffice fully. That is a reason AAPL developed ethics guidelines for forensic psychiatric practice. Most of us want to practice ethically and promote truth and justice as delineated by Dr. Paul Appelbaum¹. The AAPL ethics guidelines and AAPL Questions and Answers assist us in our practice. They usually suffice, but in ethics dilemmas there can be no clear solutions when guidelines and other responsibilities conflict. Most of us in these circumstances still want to try to determine the best or right thing to do beyond the bare minimum needed

to avoid our getting into trouble.

When dilemmas arise in our practice, even if our duty is clear, it can be unclear how far to take that duty. Few of us are “hired guns” who distort the facts intentionally to help “our” side win. Attorneys, in contrast, are expected to make one sided cases emphasizing only that part of the truth that helps their side. They are not expected to tell the whole truth but only part of it. Unlike us, they take no oath to tell the whole truth. It is important to appreciate our differing roles. We are not the psychiatric advocate stepping into an attorney-like role to argue the psychiatric aspects to help “our” side prevail. But what does our telling the whole truth mean? The attorney who hired us will try to lead us on direct examination to present that part of the truth that helps his side. Should we endeavor to present the whole truth in court? Should we do so in our report? For attorneys it can be considered clever lawyering to leave a distorted impression to help win a case, but that is not appropriate for us. Is there an intermediate position? We are not expected to fight the attorney hiring us to present the part of the truth he wants to minimize, but we also do not want to present a distorted picture. The challenge is to find the right balance without clear parameters for doing that.

Unlike attorneys who provide representation for clients whose positions they personally may oppose, we should not take a case where we do not believe in the position we are advocating. Is it enough to support the facts even if we do not support the attorney’s goals? It is appropriate for attorneys to do what they can to represent a client’s interests and try to win so long as they do not lie. However, in our different role we should acknowledge limitations to our opinion when they exist not only to show our veracity but also because it is the

right thing to do consistent with the oath we take as a witness. The challenge is how much of the truth to volunteer. Is it acceptable to wait for good cross examination to bring the other side out or for experts’ on the other side to present it even though we know that might not occur? There are no clear answers, but it is still important to ask the questions and try to address them.

The legal system has rules limiting our role. We are supposed to answer the questions posed to us without necessarily an opportunity to fully meet the requirements of our oath to “tell the truth, the whole truth, and nothing but the truth” if the judge and attorneys cut us off and do not let the whole truth come out. We could still try not, to the degree permitted, to intentionally give a distorted portion of the truth. The goal of the legal system and part of our ethics obligation is justice, but we are limited in how far we are permitted to foster it. If we try too hard, we will upset many if not all in the courtroom who do not see that as the expert role despite our oath. Neither the judge nor the attorneys would want us to intervene if we thought the truth was not being adequately brought to the attention of a jury or we thought inequality in the skills of the attorneys would lead to an unjust outcome. However, if we think the attorney who hired us is missing crucial points even to help his side, we might want to bring in crucial information in answers to open ended questions.

The AAPL ethics guidelines are the place to begin, but in the most difficult situations there often are no guidelines or rules to help us interpret a guideline or flesh it out. In my view it is important to squarely confront the problems and analyze them. We should not distort for the purpose of “clarity” and simplicity if that can result in unjust determinations ignoring salient aspects of complex cases. Ethics should be more than appearances or simplicity to look good. We instead should face complexity and develop approaches for dealing with it. If something is complicated, we

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MEDICAL DIRECTOR'S REPORT

AAPL as Amicus Curiae

Jeffrey Janofsky MD



In 2013 AAPL had the opportunity to join two amicus briefs, *Hall v. Florida*¹ and *People of the State of New York v. David Rivera*².

In *Hall v. Florida*, a case pending in the U.S. Supreme Court, amici AAPL, APA, the American Psychological Association and others attempted to educate the Court about Intellectual Disability as a scientific and clinical topic. The underlying case revolves around how Florida defines intellectual disability under *Atkins v. Virginia*³. In *Atkins* the Supreme Court held that the Eighth Amendment prohibited the execution of offenders with intellectual disability, but left it to the states to define intellectual disability for capital defendants. Florida uses a “firm cut-off” requiring an IQ score of 70 or below to meet the first prong of the diagnostic criteria for such intellectual disability. Our amicus brief argued that accurate diagnosis of Intellectual Disability cannot rely on IQ scores alone, but requires clinical judgment based on a comprehensive assessment of general intellectual functioning, adaptive functioning, and age of onset.

In *People of the State of New York v. David Rivera*, pending in the Court of Appeals of the State of New York (New York’s highest appellate court), AAPL joined New York’s District Branch as amicus. In the course of an emergency room clinical evaluation by a psychiatric resident, Rivera admitted that he had sexually abused his niece. As required by New York law, the resident notified the appropriate State agency of the abuse. Rivera was later charged criminally with Predatory Sexual Assault against a Child. At the criminal trial, prosecutors called the psychiatric resident to testify about the defendant’s admissions about sexual abuse during his clinical evaluation. The Court

allowed the resident to testify, over the objection of the defense. The defendant was found guilty, and appealed. New York’s intermediate appellate court reversed, holding that the trial court “erred in permitting Dr. Gross to testify about Defendant’s admissions of sexual abuse and that Dr. Gross’ disclosures to ... [the State] did not operate as a waiver of Defendant’s physician-patient privilege.” The prosecution appealed. The purpose of our amicus brief in *Rivera* was to explain the clinical, legal and ethical rationale behind the physician-patient privilege. We explained how confidentiality and the privilege are particularly important in psychiatric treatment where, absent the privilege, patients may be reluctant to discuss highly personal matters.

“AAPL has joined other interested groups in fifteen amicus briefs and one petition for certiorari since signing onto our first brief with the APA in Smith v. Murray⁴ in 1986.”

Amicus briefs must be written by attorneys skilled in appellate court practice. The APA Committee on Judicial Action (CJA) has retained amicus counsel, now Aaron Panner, and previously Richard Taranto and Joel Klein. All three clerked for the U.S. Supreme Court and have been highly skilled appellate advocates. CJA keeps tabs on cases accepted for certiorari by the United States Supreme Court that are important to psychiatrists and our patients. After committee discussion and work by CJA’s counsel, CJA recommends to the APA Board of Trustees whether

APA should write its own brief, or sign on to a brief being written by another organization. The writing of such briefs can be quite complex, and may require input from many other parts of the APA, especially when the brief attempts to educate the Court regarding a clinical or scientific matter. CJA can also provide supplementary funding for District Branches who wish to hire their own amicus counsel and write amicus briefs for important state court appellate issues. *New York v. David Rivera* is an example of such a case.

Over the years, many AAPL members have served on CJA. The current chair of CJA is AAPL Past President Paul Appelbaum. Many other AAPL Past Presidents have chaired CJA including Renee Binder, Howard Zonana, Richard Ciccone and me.

APPL has never been the primary writer of an amicus brief, and has never borne the cost of writing such briefs. Instead, AAPL has joined other interested groups in fifteen amicus briefs and one petition for certiorari since signing onto our first brief with the APA in *Smith v. Murray*⁴ in 1986. In fourteen cases, APPL joined the APA, in one case AAPL joined the American Association on Mental Retardation (now the Association on Intellectual and Developmental Disabilities), and in one case AAPL joined the New York Psychiatric Association. Thirteen amicus briefs were for cases before the U.S. Supreme Court, one case was before a U.S. Court of Appeals, and one case was in New York’s highest appellate court. Along with APA, AAPL also signed onto one petition for certiorari to the U.S. Supreme Court that was denied in *Delling vs Idaho*⁵.

Thirteen of the sixteen cases we have joined involved criminal matters, with the majority about various psychiatric aspects of death penalty jurisprudence. Probably the most important appellate civil case AAPL has participated in as an amicus is *Jaffe v. Redmond*⁶, the case that established psychiatric-patient privilege in the federal courts.

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PRESIDENT'S REPORT CONTINUED

Psychiatric Dilemmas

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need to explain, and not ignore it, since doing otherwise can foster unjust outcomes with serious consequences for the participants.

An excellent example of our facing complexity honestly is found in our AAPL ethics guidelines themselves. When AAPL developed its original 'guidelines,' like many organizations we said we required forensic psychiatrists to be unbiased and objective. Although that would be wonderful in an ideal world, it is not reality. All of us are humans with biases. Judges have biases. Juries have biases. We have biases. So-called "unbiased" experts have biases. The challenge is to admit our biases but nonetheless try to be objective despite them. Claiming lack of bias is not honest. One of the founding forensic psychiatrists of AAPL, Dr. Bernard Diamond, described that in detail in his seminal paper, "The Fallacy of the Impartial Expert."² Although an old paper, his points still apply. He said all of us if we are honest with ourselves have biases. We like some people and dislike others. We may want to please our referral source. We know an attorney will hire us for a case only if we can support his position. In the criminal arena some of us may be tempted to rescue criminals with a terrible upbringing in which abuse occurred. Others may want to lock up criminals as long as possible or even have them executed to protect society. Hopefully most of us are somewhere in the middle of that continuum since striving to be objective might be especially challenging at the extremes. Similarly, in civil cases some of us may think a plaintiff who has been injured needs help regardless of legal technicalities, and wealthy insurance companies can afford to pay. Others may feel malingering is widespread and always presume it and think allowing plaintiffs to prevail results in unfair advantage to some and higher insurance rates for us all. Again hopefully most of us are somewhere in the middle of that continuum, but we differ. Dr. Dia-

mond said that in the rare situation where the expert has no initial bias, once an opinion has been reached, experts are human and want to defend their opinion rather than admit it was wrong.

Dr. Diamond thought objectivity impossible as well. He thought the only requirement should be honesty. Total objectivity might be impossible. Otherwise unless given different sets of data, experts would almost always agree. When I was chair of the AAPL ethics committee, we decided that honest experts, despite their biases, should nonetheless strive to reach an objective opinion. Otherwise, there would be no effort to find contrary data such as reading police reports after reaching a convenient opinion consistent with our biases. That would not only lack objectivity, but it would leave the expert unprepared for surprise contrary data presented on cross examination since we made no effort to discover it.

"AAPL ethics guidelines in complex situations are an important beginning but not the end of an ethics analysis"

Some have claimed the honesty of AAPL in acknowledging experts, like all people, have biases necessitating an effort to strive to be objective contrasts with experts from other organizations claiming to be impartial and objective, implying they are more objective than we. Nothing could be further from the truth. The opposite is true. It means we in AAPL honestly admit the inevitable, thereby demonstrating insight. We do not claim impossible lack of bias or objectivity. It means we are aware of our biases but strive to compensate and be objective nonetheless. By facing our biases, we are more honest and can reach more objective opinions than those who do not even admit to their human biases. It is necessary to acknowledge biases to overcome

them and reach objective opinions by facing complexity. But we must not allow distortions of our position intentionally or unintentionally. If our position is misunderstood we must clarify it.

Following ethical guidelines, an important minimum ethical requirement, is only the beginning of an ethics analysis in challenging situations. Guidelines sometimes conflict without superordinate guidelines to balance these conflicts. It is helpful to consult with senior people knowledgeable about ethics. That at least provides evidence that care has been taken to do the right thing, and they might, from experience, have good ideas, but they too have no guidelines in difficult dilemmas. The AAPL ethics guidelines help us stay out of trouble, are normative, and address areas of general consensus. Though we cannot enforce them on forensic psychiatrists not in AAPL and do not enforce them currently even on ourselves, in my opinion it is how ethical forensic psychiatry should be practiced by anybody and represents a general consensus. The APA, if they wish, can enforce our guidelines, but only insofar as they help elucidate their own ethics requirements. Nothing prevents their use for this purpose.

AAPL ethics guidelines in complex situations are an important beginning, but not the end, of an ethics analysis much like following the law is the beginning and not the last word in being a good ethical person. On rare occasions, it could even be ethical not to follow an unjust law. The challenge as an ethical forensic psychiatrist or citizen is to find the best thing to do. People should not be punished for failure to agree with what you or I think is right in complex situations. More than one solution should be acceptable. Similarly, if other psychiatrists would treat patients differently from what you and I would do, that does not necessarily make their treatment wrong or negligent even if there is a bad outcome in malpractice cases. Lack of consensus about what is right should

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ASK THE EXPERTS

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. 1. In doing an independent medical exam, it is clear that the stress of the litigation is the primary stressor. How do I address this in the report and can I let the evaluatee know that she would be better off dropping the case?

2. I was asked to evaluate an employee for a disability stress claim. The stress/disability arises from illegal activity (embezzlement) in which the employee has been engaged. There is no criminal case pending, nor is one expected. Do I reveal this in my report, and if so, how?



Sadoff: Both questions have similar issues on the stress of litigation for the plaintiff and ethical issues for the forensic psychiatrist.

The forensic experts asking these questions appear concerned about the ethics of commenting in their reports about the stress of litigation on the plaintiff and the toll it is taking on her. Does her right to sue become any less important because the process is extremely stressful and is causing her emotional pain? Should she not be involved in this litigation because the stress outweighs the rewards? Perhaps there are other emotional issues she has in suing the defendant that

far outweigh the stress or the monetary award. I strongly recommend that when faced with such a dilemma where one may not get the full picture during a single examination that the expert has several options: a full battery of psychological tests, a follow up exploratory session, refer to a treating psychiatrist for more clarification, or, ideally, all 3 options. It is not for the forensic expert to tell the plaintiff to drop the lawsuit unless the stress is so severe that in consultation with the plaintiff's attorney, the decision can be made that her mental health trumps her legal issues.

With respect to the second question, I also see the ethical issue for the expert in skirting the illegal behavior that resulted in the disability claim. What should the forensic psychiatrist put in his report that would be accurate and helpful to the decision maker that is not harmful to the examinee? Does the reporter have to go into detail about the illegal behavior or can he focus on the effects of such behavior on the examinee?

I recommend that the forensic expert needs to document the symptoms he observes and obtains by history and medical records that resulted in the person's disability.

Recall that there are 4 steps to the evaluation:

- 1) there is a stress, incident or accident
- 2) that results in an injury
- 3) that leads to impairment
- 4) that may result in a finding of disability

All four are separate and distinct but related by cause and effect. In this case, the embezzlement is the stress that causes the anxiety and depression (anticipated loss of job and/or freedom) and must be considered for all the emotional effects it has on the employee that impairs his ability to function that may result in a finding of disability. It is not unethical to mention it in the report because it is relevant and germane and is known by others. It is an essential link in the chain of events leading to the assessment. To ignore it would not be help-

ful and could reveal bias on the part of the examiner.



Kaye: These two related questions each involve the issue of the stress of litigation. In my experience, plaintiffs often underestimate the psychological

cost of litigation. It is easy to focus on the potential financial gain associated with a civil suit, and even to approximate the actual cost of the litigation itself. However, the emotional costs both in terms of time and psychological stress are often not really appreciated until the litigation is well underway and the litigants face deadlines, depositions, cross accusations, and perhaps even the shame of personal information being made public in the legal proceedings.

Regardless of my role in the litigation, I make it a point to ask the evaluatee about the effect of the litigation and how she is handling this stress. When the plaintiff's counsel hires me, I try to make certain that the person has considered the non-financial costs associated with litigation and also how she will feel if the outcome is less than what was desired. This could include a question such as "Is it worth it?" On some occasions a plaintiff has decided to drop the litigation, commenting that no one else had ever discussed this important issue.

If acting as a defense expert, it would be inappropriate for me to suggest that someone drop a lawsuit, but it is still necessary to inquire as to how the stress of the litigation affects the person's symptoms.

The second question is quite interesting and I have been involved in this type of case. The focus of a disability examination is very different from the usual criminal or civil forensic evaluation. The standards for disability are very different than those for Worker's Compensation, criminal law, or even civil tort actions and are often idiosyncratic, being derived

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CHILD COLUMN

Celeb Forensics

Stephen P. Herman MD



From time to time, forensic psychiatrists may have cases involving celebrities. This often occurs in big cities. Working in Manhattan, I have

had my share. But nothing in my practice compared to the frenzy which occurred around the Woody Allen and Mia Farrow custody dispute of the early 1990s. One sideshow of this unfortunate matter was that one of her daughters, called Dylan at the time, allegedly was molested by Allen.

This story has made the news again, because Dylan, now a young woman, has spoken out about the molestation and what it has done to her life. She insisted she remembered this happening when she was a little girl. She related very definite events surrounding the reported sexual assault. So, once again, the custody trial has made news.

I had a small part in the process twenty years ago. Dylan had been brought to the Yale Sexual Abuse Clinic for evaluation. The clinic issued a report saying the child was never molested by Allen or anyone else. What was unusual for Yale this time was that they interviewed Allen with his lawyer present. Prior to this case, I am not aware of a time when they were interested in alleged perpetrators. But this was Woody Allen, and it appeared Yale gave him special treatment.

In addition, contrary to what the media has been reporting recently, no doctor ever evaluated Dylan Farrow when she was brought to Yale. Only a nurse and a social worker saw her. The medical director of the clinic, John Leventhal, M.D., simply signed off on the report without having any direct knowledge of the evaluation and without having even a brief session with the little girl. In addition, not only did he refuse to come to

New York City to testify, he made sure all the notes connected with the Yale investigation were destroyed!

My testimony at the trial concerned the odd way the sexual abuse evaluation was conducted by Yale and how it seemed that Allen's celebrity status had a strong impact on the process. I said the court should not place any weight on the report. The judge agreed and in his decision was quite harsh on Allen.

Of course, I had no way of knowing whether the allegations were true, and I still don't. In February of 2014, Allen wrote an essay in the New York Times asserting his innocence. It was very well written. Dylan made several public statements. She was very articulate. The current story was picked up by publications from Vanity Fair to New York newspapers and, of course, the Internet. The media frenzy continued.

"The important thing for us if we have a case involving a celebrity is to remember our role and make sure we are performing our job without any influence."

Several years ago, Alec Baldwin was involved in a custody dispute and the media picked up on his having yelled at his child over the telephone. Another big circus.

The important thing for us if we have a case involving a celebrity is to remember our role and make sure we are performing our job without any influence. Celebrity status causes some forensic evaluators and therapists to act differently. There is no excuse for this.

Response from John Leventhal, MD

I appreciate the opportunity to respond to Dr. Herman's comments. I will not and have not discussed the details of the case, but make the following corrections to Dr. Herman's comments:

1. The Yale Child Sexual Abuse Clinic was a neutral evaluation service and, unlike Dr. Herman, was not hired by one side.
2. An advanced practice nurse with many years of experience evaluating children suspected of being sexually abused, not "a nurse" as noted by Dr. Herman, saw the child.
3. Dr. Leventhal did not "simply sign off on the report without having any direct knowledge of the evaluation." He regularly discussed all the findings, interviewed each parent, discussed the case with other involved clinicians, and prepared the report. The Clinic's practice was and still is to shred notes after the report has been completed.
4. The New York trial, in which Dr. Herman testified, was about custody of the children. The Clinic did not evaluate the issue of custody. Ⓢ

John M. Leventhal, MD
Professor of Pediatrics, Yale Medical School

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FELLOWS CORNER

Reflections on a Forensic Fellowship Year

Joseph Chien DO



The 2012-2013 academic year was an interesting time to be in New Haven. Coming from Los Angeles, a land without seasons, the East Coast weather was a shock. Hurricane Sandy swept through with a vengeance, washing away homes on the Long Island Sound. After I was repeatedly assured that “it doesn’t snow much here” by various locals, a blizzard deposited 32 inches of snow, paralyzing the city for days. A bigger shock: in December, some 25 miles west in Newtown, Adam Lanza shot and killed 26 people in an elementary school. The local community’s collective sense of pain and grief for the victims—mostly children—was palpable. In the aftermath of this tragedy I observed, firsthand, local debates central to forensic psychiatry on the topic of guns, violence and mental illness. While chaotic weather and the Newtown tragedy are the first things that come to mind when I think about my fellowship year, when I reflect more deeply on the experience, I conclude that this training has fundamentally changed my perspective as a psychiatrist. What follows are some of the salient things I took away from my experience.

A bigger picture of psychiatry

Prior to applying to forensic psychiatry fellowship programs, I sought the advice of many psychiatrists in the field. I was surprised to find the common sentiment that forensic training deepened their understanding of psychiatry and made them better clinicians. I think this sentiment, in large part, arises because the study of forensic psychiatry situates the practice of psychiatry into a wider social, legal, and historical context. As a clinician it becomes easy to immerse oneself in the microcosm of one’s corner of the world: an outpatient

office in a community clinic, or an inpatient ward in a hospital. Training in forensic psychiatry asks the clinician to take a step back and consider how society and the legal system view actions that a psychiatrist might take for granted as necessary or even humane, such as medicating or hospitalizing an individual against their wishes. Because these societal views change over time, the forensic psychiatry trainee is also a historian, studying the shifting attitudes towards mental health treatment, patient rights, criminal responsibility, and other topics through landmark cases that span decades of US history. The forensic psychiatrist-in-training gains the appreciation that *how* psychiatry is practiced is determined in large part by forces outside the clinical and academic realm.

“When attempting to learn something new, it behooves us to remember that we often make the biggest strides when we are out of our comfort zone.”

You don’t know what you think you know

If the process of medical residency is ideally a progression towards increasing competence in a medical field, then those entering a fellowship are usually at a high point in confidence in their clinical knowledge and ability. As I unceremoniously discovered, this confidence can be quickly shattered the first time one takes the stand against a skilled attorney. Even the process of going over one’s credentials to be an expert witness can leave one severely doubting their own

qualifications—even before the “real” questions commence! So you think you know what schizophrenia is—you’ve seen it hundreds of times in residency. Now explain the DSM criteria, point by point. Define a delusion. And, by the way, do it on the spot, in front of an audience, while wearing a stuffy suit and a tie that feels just a little too tight. Be ready to explain anything vague or contradictory that you say, in terms a layperson can understand. The same precision and thoroughness is expected in written reports as during testimony. Under this kind of pressure, one quickly comes face to face with the limits of their knowledge. For me, more often than not, I came to realize I did not know the things I thought I did well enough.

You know more than you think you know

While confidence in clinical skills may be high when entering the fellowship, one can be overwhelmed by the new legal concepts and terminology, and the sheer amount of reading required. Amidst this deluge of new information, it is easy to forget that, fundamentally, the legal system asks psychiatrists for a clinical opinion, and that is what we all spent years in residency learning how to formulate. It might take many years to master the art of writing a good forensic report, or to become a skilled expert witness on the stand, but the core knowledge of clinical psychiatry is there *a priori* in the forensic fellow. I can still hear one of my mentors encouraging me to share what I know and voice my opinion, when I often lacked the confidence to speak my mind. The message I received was: be prepared to have your opinions challenged and, at times, even distorted, but always fall back on your clinical knowledge and experience in the field of psychiatry.

You grow when out of your comfort zone

This final point that I take from my fellowship experience I will carry

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GUEST ARTICLE

Human Trafficking: What is the Role of the Forensic Psychiatrist?

Miriam Garuba, MD



Human Trafficking is a form of modern day slavery. It is defined by the U.S. Department of State as “the recruitment, har-

boring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion, for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery.” Although numbers vary in terms of estimates, according to the International Labor Organization, approximately 21 million people are affected annually¹. Virtually every country in the world is involved, either as a country of origin, transport, or destination. According to the United Nations Office on Drugs and Crime, it is the third most lucrative illegal trade in the world next to drug trafficking, with a market value of \$32 billion U.S. dollars². Different forms include forced labor, debt bondage, bonded labor, sex labor, involuntary domestic servitude, and child soldiers.

To respond to this problem, the United Nations convened in Palermo Italy, at the United Nations Convention against Transnational Organized Crime in 2000, and there created the “Protocol to Prevent, Suppress, and Punish Trafficking in Persons, especially Women and Children.” There each member state was required to create legislature to make human trafficking a criminal offense³. Consequently, President Clinton signed into law the Trafficking Victims Protection Act (TVPA) in 2000, which made any form of human trafficking illegal in the United States. Under this act, the United States Citizenship and Immigration Services (USCIS) instituted the “T” visa, to grant legal status to victims of human trafficking⁴. To qualify currently, one must:

Be a victim of trafficking as

defined by the TVPA,

Be in the U.S., American Samoa, the Commonwealth of the Northern Mariana Islands, or at a port of entry due to trafficking.

Comply with any reasonable request from a law enforcement agency for assistance in the investigation or prosecution of human trafficking (*or be under the age of 18, or be unable to cooperate due to physical or psychological trauma - the trauma exception*)

Demonstrate that they would suffer extreme hardship involving unusual and severe harm if removed from the United States.

Be admissible to the United States. If not admissible, they may apply for a waiver.

There are two different benefits available to foreign nationals, one being the granting of legal status through the “T” visa, and the other being the provision of benefits and services through the Department of Health and Human Services (DHHS) Office of Refugee Resettlement (ORR). My focus here is on assisting foreign nationals in applying for the T visa. However, to receive benefits and services, the process is as follows: if a person is identified as a victim of severe trafficking based on the requirements of the TVPA, agrees to cooperate in every reasonable way with the investigation and prosecution of severe forms of trafficking (or is unable to participate due to physical or psychological trauma), submits a bonafide T visa application that has not been denied, and has received a status of “Continued Presence” from the Department of Homeland Security (DHS, which allows the victim to remain in the United States while the case is being investigated), they can then receive a Certification letter from the U.S. Department of Health and Human Services Office of Refugee Resettlement (ORR)⁵. This letter allows victims to receive benefits and services to the same extent as

refugees and asylees.

Trafficked victims suffer from the lifetime sequelae of Post-Traumatic Stress Disorder, Major Depressive Disorder, and other forms of psychological and physical illnesses. To this end, they are in dire need of comprehensive healthcare and psychiatric services by providers who are knowledgeable about the issues. What, however, is the role of the forensic psychiatrist in regards to this population?

Since 2002, 5000 T visas have been made available annually to victims of trafficking⁶. As of 2013, only 7642 T visas had been issued⁷. This is due to different reasons, including lack of self-identification by victims, health care personnel, law enforcement, attorneys, and society in general. However, in some cases, victims are unable to participate in the investigation and prosecution of severe forms of trafficking/their application of the T visa because of the symptoms they have experienced from their trauma.

Forensic psychiatrists can assist victims by evaluating them to determine whether or not they have suffered psychological sequelae as a result of their being trafficked, which can aid them in receiving restitution from their traffickers. Albeit a bit more challenging, forensic psychiatrists can perform evaluations to determine whether or not trafficked victims fit the trauma exception, which would help some victims apply for the T visa and receive benefits. Referrals to do these evaluations can come from attorneys and non-governmental organizations. Given the limited number of visas applied for/granted, there is evidence that this is a much needed service.

Once the evaluations are completed, forensic psychiatrists can also refer these clients to much needed mental health and social services. The best practice in the field is to

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offer both comprehensive legal and social services to all victims. If you evaluate a survivor and find that they have not been connected to a social services provider, please discuss this with their attorney and/or call the National Human Trafficking Resource Center to locate the nearest social services provider. It is in the best interest of survivors and prosecution to ensure that survivors have the mental health support that they need, so that they can move on from their experience and be better victim-witnesses to aid in the prosecution of their perpetrators. Treated victims can more easily aid law enforcement in the identification and prosecution of their perpetrators.

Not enough mental health providers are aware of the challenges facing trafficked victims, and very few psychiatrists are available to provide this much needed service, due to lack of awareness around the pervasive nature of this crime. This makes it difficult for referring organizations to reach out to them. However, this can and is changing. As knowledge of this issue grows, so will the availability of psychiatrists. If provided, it is a service that can greatly address the needs of trafficked victims. ☉

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Dr. Mariam Garuba is a psychiatrist at the Manhattan Psychiatric Center.

Fellows Corner

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with me throughout my career. The Russian psychologist Lev Vygotsky theorized that children optimally learn and develop when they are given opportunities to do tasks with the help of an adult that they could not do on their own, and called this the Zone of Proximal Development. I keep returning to this concept when I think about how I learn new things. As a forensic fellow I often found myself in new and strange environments—various courtrooms and prisons throughout Connecticut—doing things that I had never done before. Fortunately, I also had the benefit of a cadre of capable “adults”—the faculty—to guide me through tasks that I could never accomplish on my own. Indeed, fellowship was a time of being challenged time after time to do unfamiliar things, and it would have been nearly impossible to manage without

the support of family, my co-fellows, and a faculty extraordinarily dedicated to education. When attempting to learn something new, it behooves us to remember that we often make the biggest strides when we are out of our comfort zone. ☉

Dr. Joseph Chien is a recent graduate of the Yale Forensic Psychiatry Program. He is Assistant Professor of Psychiatry, Oregon Health and Science University.

AAPL Awards Committee Seeks Nominations for 2014

The AAPL Awards Committee would like your help. We would be interested in receiving nominations by June 1 for the following awards:

Red AAPL – For AAPL members who have provided outstanding service to AAPL, e.g., through committee membership.

Golden AAPL – For AAPL members over the age of 60 who have made significant contributions to the field of forensic psychiatry.

Seymour Pollack Award – For APA members (who may not be AAPL members) who have made distinguished contributions to the teaching and educational functions of forensic psychiatry.

Amicus Award – For non-AAPL members who have contributed to AAPL.

Best Teacher in Forensic Fellowship Award – For outstanding faculty member in fellowship program.

Please send your nominations to Jeffrey Metzner, MD, Chair of the Award committee at jeffrey.metzner@ucdenver.edu.



PHOTO GALLERY - APA 2013 ANNUAL MEETING



APA/AAPL members taking the trolley at APA Annual Meeting held in San Francisco, CA, May 2013.



Protesters loudly objecting to the release of DSM-5 at APA May 2013.

PHOTO GALLERY - AAPL 2013 ANNUAL MEETING



At the poster presentation.



Coffee/tea break - catch up with friends time!



One of the auditoria - Grand!



AAPL President taking a break.





PHOTO GALLERY - AAPL 2013 ANNUAL MEETING CONTINUED



AAPL members returning to the hotel after a refreshing outing.



Taking a stroll behind the hotel, by the Beach. Oh, what blue skies!



Captivating presentation about the Norwegian Bomber.



Relaxing at the lobby in between presentations.



AAPL officers at 2013 APA annual meeting.



View of the hotel swimming pool/the Ocean from inside the hotel. Picturesque, isn't it?



ALL ABOUT AAPL - Committees

Inside Out: Are Publicly Accessible Sex Offender Registries a Good Idea?

Alexandria Organ, Lisa Murphy MCA, J.P. Fedoroff MD, R. Gregg Dwyer MD, EdD, Sexual Offender Committee

Beginning in the 1980s, North America witnessed the creation and implementation of laws used to govern the community-based management of sex offenders. Momentum for such policies began with the sensationalized media coverage of a small number of heinous sex offense cases, which drew attention to sex crimes against children and provided a platform for public outrage. The outcry for increased community protection from prolific sexual offenders has led to the demonization and a homogeneous categorization of all sex offenders regardless of offense type or actual risk for re-offending. Despite research indicating that the majority of sexual assaults occur in the context of a preexisting relationship, in which the offender is known to the victim, legislative decisions by policymakers have focused on the smaller number of sexual crimes perpetrated by strangers (Cole & Petrunik, 2007; Murphy, Brodsky, et al., 2009).

Several criminal justice initiatives to improve community management of sex offenders have emerged over the past three decades. The two most widely employed are sex offender registries (SORs) and public notification (PN). In the United States, what began as a single state law requiring convicted sex offenders to register their personal details with local law enforcement offices, rapidly developed into a federally mandated policy requiring detailed registration of sex offenders on state and national SORs that are publicly accessible. Similar legislation emerged in Canada, although, it developed at a much slower pace and has taken on more of a conservative approach (Murphy, Fedoroff & Martineau, 2009).

Research on the use of SORs and PN has focused on four general themes: statistical profiles of registrants, assessment of recidivism, registrant compliance and collateral consequences of registration. Studies

investigating the success of this legislation have been conflicting and have limited generalizability. To date, no research has demonstrated the efficacy of PN and publicly accessible SORs (Murphy, Fedoroff et al., 2009; Thomas, 2011). It is becoming increasingly difficult to ignore the documented collateral consequences of PN and publicly accessible SORs as research continuously fails to deliver evidence that verifies the perceived benefits offered by this system of management.

“It is becoming increasingly difficult to ignore the documented collateral consequences of PN and publicly accessible SORs as research continuously fails to deliver evidence that verifies the perceived benefits offered by this system of management.”

Rationale and Functioning of SORs and PN

Sex offender registries are searchable databases containing information about individuals residing in a specific community who have been convicted of a designated sexual offense. Upon release into the community, registrants are required to report to local law enforcement officials to provide personal information including name, date of birth, home and work addresses, car registration, aliases, and distinguishing marks. Registrants must report annually and report any changes in information, such as a

change in residence (Cole & Petrunik, 2007; McAlinden, 2007; Thomas, 2011).

The rationale behind the use of SORs is that sex offenders are believed to have an enduring predisposition to reoffend. It is believed that knowledge of where they live and work increases public safety and therefore justifies infringement of their rights to privacy and freedom of movement. It is important to note that the use of SOR legislation is not associated with individuals' criminal sentence, probation or parole. Justifications for SORs include the largely unproven hypothesis that having current and reliable information on the whereabouts of convicted sexual offenders act as a deterrent to reoffending. SORs are also intended to assist law enforcement agencies to more efficiently lead to the identification and arrest of perpetrators of new sexual crimes. This theory is based on the false premises that most sex crimes are committed by repeat offenders that are unknown to the victim and that most sex offenses are committed relatively close to where the offender resides. Neither of these theories is supported by evidence. In fact, most sex crimes are committed by first time offenders who are well known to the victim and often reside in the same house.

Public notification (PN) is the practice of notifying the community when sex offenders are released from custody back into the community. The justification for PN legislation is the belief that the public has the right to know the identity and whereabouts of people who have committed sex offenses. This raises the question of why the public does not have the right to know the identities and residences of the burglars or drunk drivers in their neighbourhood. Presumably PN laws are based on the belief

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that it will help parents to remember to warn their children to be wary of strangers. In addition, supporters insist that PN will have a deterrent effect because sex offenders will be more worried about being recognized (McAlinden, 2007; Murphy, Brodsky et al., 2009; Murphy, Fedoroff et al., 2009).

Decisions on PN requirements are typically based on a tiered system of estimated risk of recidivism and/or dangerousness. Typically the higher the estimated risk, the more extensive the range of notification. In the United States, the primary form of PN occurs through a system of publicly accessible SORs (also referred to as open SORs). Currently all state and national SORs are open to public access. Other forms of PN include media releases and flyer distribution. Some instances have been also been reported where judges will require registrants to go door-to-door distributing flyers, posting signs on their lawn and/or vehicles, wearing clothing with a large “S” clearly displayed, or having a permanent sticker placed on their drivers license reading “sex offender.” These forms of community notification have been criticized for going beyond public protection and facilitating a process of public shaming and stigmatization (McAlinden, 2007; Murphy, Brodsky, et al., 2009). Unless otherwise stated, all perceived benefits and collateral consequences discussed refer to adult registrants.

Unlike the American approach, in Canada, provincial legislation restricts the release of offender information and is separate from the SOR. Notification may occur if offenders are deemed an immediate and serious risk of violent or sexual recidivism. However, only law enforcement agencies are notified of the release of a lower risk sexual offender. If a moderate risk sexual offender is being released, police and selected community organizations (such as schools or recreational facilities) may be notified. In the case of the release of high

risk sex offenders the police may elect to do a general notification, often through public media and flyers, within a specific geographical radius. However, this legislation is rarely utilized except in the cases of the most notorious of offenders who have no other follow-up procedures, such as parole, to which they must adhere. When determining if PN is in order, it is the responsibility of the police to ensure a balance between public safety and the offender’s rights to liberty and privacy (Murphy, Fedoroff, et al., 2009).

The exact information collected and the general functioning of SORs and PN vary between jurisdictions and countries, but the intended function and rationale remains the same. Countries that currently employ SORs include: the United States, Canada, United Kingdom, Australia, Italy, France, Ireland, Germany, South Africa, South Korea and Japan. The United States and South Korea are the only places that have a linked system of registration and PN in which the registries are publicly accessible. In all the other countries listed above, SORs are private databases accessible only by authorized policing personnel (McAlinden, 2007; Thomas, 2011).

Understanding the Cost-Benefit Analysis

Laws requiring the registration and public notification of sex offenders are controversial and have been subject to considerable debate. Theoretically these mechanisms of community management have benefits for society and the offenders. However, fundamental issues have emerged with the practical implementation of these policies. While proponents of SORs argue that a private system of registration is necessary for police investigations and public safety, others have criticized the combined use of PN and SORs in a system of open registration.

Added scrutiny from which other offenders are immune: Critics of SORs and PN argue that the legislation is unjust as it imposes additional sanctions on sex offenders after completion of their sentence and they

have “paid their debt to society” (Cole & Petrunik, 2007; McAlinden, 2007). This is particularly true for sex offenders sentenced under retroactive laws in the United States who have been required to register sometimes years after their sentence has finished. Opponents question why sex offenders are burdened by additional scrutiny that is not required of other offenders who are arguably more dangerous. Emphasis may be put on murderers, whose lethal crime has not only a permanent effect on their victim, but also on the victim’s family. People who commit armed robbery or physical assault have significantly higher rates of reoffending than sex offenders but they are not placed on open SORs or receive PN (Murphy, Fedoroff, et al., 2009). Research has indicated that recidivism rates for sex offenders in the first five years of return to the community are around 12.4%, which is lower than the recidivism rate for most non-sexual offenders (Hanson & Morton-Bourgon, 2007). Furthermore, crime statistics have shown a universal and consistent decrease in sexual offenses over the past thirty years (Bartol & Bartol, 2008; McAlinden, 2007; Perrault, 2012). By these standards, sex offenders do not pose a significantly greater risk to the public in comparison to other offenders. This raises the question of why they have been selected to be placed on open SORs.

Management not for past actions but potential future actions: Concerns have been raised about placing sex offenders on SORs for future theoretical crimes, arguing that continued supervision after sentence completion constitutes unnecessary added punishment. Legislators stress that such mechanisms of community control are necessary to prevent new crimes. Assertions that the legislation is imposing further retribution have been met with little success in terms of changing dispositions. American courts have held that open SOR and PN legislation do not violate the *Eighth Amendment* (prohibition of

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“cruel and unusual punishment”) or the *Fifth Amendment* (prohibition of “double jeopardy”) as registration and notification in the United States is a civil process in which the stated intention is not to punish past behaviors but to regulate future actions. Canadian courts have made similar rulings, and have determined that being placed on the SOR is not a violation of offenders’ constitutional rights under the *Canadian Charter of Rights and Freedoms* (Murphy, Brodsky et al., 2009).

Unwanted attention to the victim:

An unintended consequence of the use of PN and publicly accessible SORs concerns the privacy of sexual abuse victims and their families. Although names of victims are not listed on SORs, instances in which the details of specific cases are publicized and the victim becomes known to the community may result in unwanted attention paid to the victim. When law enforcement officials conduct a PN involving an offender’s release and the PN highlights offense characteristics (such as descriptions of the victim and the victim’s relation to offender), the victim’s identity may be inadvertently exposed. This is especially important in smaller communities and in cases in which the child was a victim of incest. In some cases, victims may avoid reporting the index offense because of fear of being identified (Freeman-Longo, 1996; Perreault, 2012). Using PN in these instances may impede the recovery process and increase the risk of stigmatizing the victim and the victim’s family (McAlinden, 2007; Murphy, Brodsky et al., 2009).

Lack of distinction between risk

levels: Many sex offenders commit a single, situation specific sexual offense that is not part of any broader pattern of offending (Hanson & Morton-Bourgon, 2007). By adding this one time offender to an open SOR, the generic label of “sex offender” groups them in the same category as

higher risk, multi-victim offenders. This can be further aggravated by the fact that the majority of open SORs do not distinguish between risk levels on the basis of valid criteria. Not only does homogenous categorization of all sex offenders increase stigmatization for first time offenders, but it may also have the unintended consequence of impeding the efficiency of police investigations. Because reliable risk assessments are not included in the information provided in SORs, police have no logical way to prioritize investigations and time may be wasted interviewing the wrong suspects (Murphy & Fedoroff, 2013). Having SORs accessible to the public exacerbates the problem since the public has no education about the low recidivism rates of sex offenders or about how to distinguish a high-risk registrant from one who is low-risk.

“the majority of open SORs do not distinguish between risk levels on the basis of valid criteria. Not only does homogenous categorization of all sex offenders increase stigmatization for first time offenders, but it may also have the unintended consequence of impeding the efficiency of police investigations.”

Increased fear and risk of vigilante

action: Despite the fact that the intended purpose of publicly accessible SORs and PN is to empower families and engage assistance in supervision by the community, many community members become fearful of, discriminate against, and even harass

registrants. Surveys have found PN, either through media releases or open registries, without proper education about the true risk of recidivism and risk levels associated with different offender types, increases the community’s levels of distress (Zevit & Farkas, 2000).

There have been documented incidents of violent vigilante crimes by community members against sex offenders who were subject to open SORs or PN (McAlinden, 2007). The families of registrants also experience victimization as a result of the former offender’s public status on the SOR. Following the notification of the release of a sex offender in Washington State, a mob of angry community members surrounded the registrant’s family home and burned it down. Similarly, a 20-year-old man from New Brunswick, Canada accessed the Maine online SOR. He subsequently travelled to the homes of two of the registrants whose names and addresses appeared on the registry. He shot and killed them both before taking his own life. One of the individuals killed had been convicted of a statutory offense after having sexual intercourse with his girlfriend, who was only a few years younger than him but legally a minor. At the time of his murder he was living legally with the same girlfriend. A number of comparable incidents were noted in the United Kingdom after a media outlet began a “Name and Shame Campaign” in which a newly convicted sex offender was “outed” each day by newspaper that published the former offender’s picture, name and address. Examples have also been cited of innocent community members being mistaken as sex offenders and assaulted, and in one case, murdered (McAlinden, 2007; Murphy, Brodsky et al., 2009). Family members and spouses are also in danger of harm either physically or emotionally due to “guilt by association.”

These examples illustrate how open SORs and PN can have the unintended effect of interfering with successful community reintegration

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DSM-5 Substance Use

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presence of at least two of the criteria occurring within a 12-month period is, in and of itself, manifest evidence of clinically significant impairment or distress? Some guidance may be derived from the relevant statement of a Work Group member: “It is important to note that even the mild substance use disorder...can only be diagnosed in the context of significant impairment in life functioning or distress to the individual or those around them” (Schuckit, 2013; p. 662). In other words, the presence of two or more criteria, assessed to be unaccompanied by clinically significant impairment or distress, would not be sufficient to make a diagnosis of Substance Use Disorder in DSM-5. This would caution against merely adding up a criteria and comparing to the

“Additionally, given the controversy surrounding the DSM-5 among addiction specialists and researchers existing in the scientific literature, a forensic expert’s diagnosis of DSM-5 Substance Use Disorder may be met with a Daubert challenge.”

threshold or severity specifier scale.

Addiction is an issue in a variety of medico-legal contexts. Examples in the civil arena include personal injury and wrongful death actions alleging negligent prescribing practices or use of a manufactured prod-

uct; malpractice allegations of physician impairment due to substance use; Medical Board actions; denial of life-insurance benefits; termination of parental rights a; child custody; employment; and disability. Examples in the criminal arena include diversion as an alternative to incarceration; mitigation of mental state for specific intent crimes (i.e. premeditated murder); and in some jurisdictions, chronic substance use (i.e. methamphetamines) leading to psychosis may be the basis for an insanity defense under the concept of “settled insanity.” (Slovenko 1995).

In judicial and legislative contexts, the diagnostic and conceptual discontinuity between DSM-IV and DSM-5 approach to substance use disorders is likely to present problems, given that the previous DSM editions, such as DSM-IV, have been cited in court opinions over 5,500 times and in legislation over 320 times (Slovenko, 2011).

Additionally, given the controversy surrounding the DSM-5 among addiction specialists and researchers existing in the scientific literature, a forensic expert’s diagnosis of DSM-5 Substance Use Disorder may be met with a Daubert challenge. Unlike the DSM-IV diagnosis of Substance Dependence, which has been demonstrated by previous research to have excellent reliability and validity, the same is not yet true for DSM-5 Substance Use Disorder.

The DSM-5 field trials have received much criticism (Welch et al., 2013; Jones, 2012). It has been predicted that experts adopting the latest edition “will encounter criticisms related to the newness of and inexperience with DSM-5,” while experts who choose to stick with the DSM-IV “will likely experience aspersions suggesting that their practice is antiquated and outdated” (Wortzel, 2013; p. 240). Therefore, regardless of choice, the forensic expert may need a working knowledge of the issues relevant to DSM-IV and DSM-5, including the changes, rationale, research, criticisms, and the relationship of the new Substance Use Disor-

der to “dependence” and “addiction.”[®]

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Psychiatric Dilemmas

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not obviate efforts to ascertain the best thing to do. It does not mean anything goes. Most of us as professionals should try to determine what we think best. Others with slightly different values or priorities could reach opposing acceptable conclusions.

When we encounter dilemmas and guidelines do not suffice, philosophical questions can be relevant about what is good. But debates have been ongoing since ancient times about the bases for what makes something good. Oversimplifying may have some short-sighted consequentialist advantages. But convenience may violate the ethical need not to do the wrong thing if in some cases salient aspects are overlooked with unjust and thereby unethical results. Simplicity and convenience do not justify following any one rule to the exclusion of all others. Weighing conflicting duties openly can meet broader consequentialist and deontological duties.

In forensic psychiatry, challenging issues can arise in determining to what extent as doctors we owe duties to those we evaluate even if following AAPL guidelines we make clear our forensic role and that we are not the person's doctor. The AMA says we have a limited doctor-patient relationship. But what that means is unclear. The AMA says managed care doctors are supposed to put patients first, but it may be more realistic to require them just not to forget patient needs. Maybe that should be true as well for forensic psychiatrists. To have relevance for courts, we need to answer the legal question honestly and as objectively as possible even if it hurts the person we evaluate. We also may need to give some consideration to the people themselves, consistent with what Dr. Appelbaum has called "respect for persons." Some aspects of the person's welfare prohibit some roles, such as being an executioner or enabling torture. The challenge is to strike the right balance after open honest discussion.

Complexity can lead to misunderstandings and caricatures, but in my opinion we need to admit openly some issues are not simple and explain them even if potentially misunderstood. Most of our practice is not that complicated though. In most situations, our AAPL ethics guidelines are clear and address what to do and are where to begin, but they are not the last word. 

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Ask the Experts

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solely from a private insurance policy. The first thing is to make sure that you understand the definition of disability being used to decide this matter. Also, remember, you are not making the decision. That decision is the discretion of the hiring/referring entity. This is the time to try to stick

to clear descriptions of a person's capacity to perform the requisite activities/behavior of life and employment.

In this specific case, anxiety and fear associated with criminal behavior should be included, because it is an identified trigger and may well be compensable under a disability policy. There is no reporting requirement to the police because that is not part of our role as defense medical examiners. As always, prior to starting a forensic evaluation, I provide the usual and required disclaimers. When an evaluatee begins to disclose this type of material, it is reasonable to remind her of that warning.

Sadoff/Kaye: Take home point: It is often difficult to apportion the psychological stress of the litigation from the associated alleged injury or tort itself. However, it is appropriate to inquire about this issue in a neutral manner and to include this information in a forensic report. The use of quotes from the evaluatee often do a good job of conveying this information. 

Congratulations

Manuel Lopez-Leon, MD has been awarded the Psychiatry and Behavioral Science Sections "Maier I. Tuchler Award" at the American Academy of Forensic Sciences 66th Annual Scientific Meeting, held in Seattle, WA, February 17-22, 2014. Dr. Lopez Leon is Assistant Clinical Professor of Psychiatry and Assistant Professor of Child and Adolescent Psychiatry at the New York University School of Medicine

Kenneth Busch, MD received a Special Presidential Commendation from the American Psychiatric Association at the Annual Meeting of the APA in San Francisco, in May 2013. A long term chair of the International Relations Committee of AAPL, Dr. Busch brought vibrancy and energy to the Committee.

Jagannathan Srinivasaraghavan, MD was awarded the APF George Tarjan Award from the American Psychiatric Association at the Annual Meeting of the APA in San Francisco, in May 2013. This award is named after APA's first international medical graduate (IMG) president, George Tarjan, and recognizes a physician who has made significant contributions to the enhancement of the integration of IMGs into American psychiatry.

ALL ABOUT AAPL - Committees

Military Service and Canadian Incarceration: Where Are We Now?

Isabelle Coté MD, CM, FRCPC

Institutional and Correctional Psychiatry Committee

In March 2014, a small group of Canadian soldiers will haul down the Maple Leaf flag at their base in Kabul and walk onto a transport aircraft for the flight home, the last to serve in Canada's largest military deployment since the Second World War¹. Since Canada began its military contributions in Afghanistan in 2001², the media has been replete with articles on the consequences of the mental health of returning troops from combat. In 2008, the press reported that "the number of Canadian soldiers jailed in Edmonton's military prison has doubled since 2001."³ In February 2014, a Quebec soldier, Guillaume Gélinas, was accused of murdering his father and stepmother. He had been in the Canadian Armed Forces (CAF) Reserves and had served a tour in Afghanistan between 2010 and 2011⁴.

The notion that military personnel or former military personnel are involved in committing crime is not new. While much research on the subject of incarcerated veterans exists in the U.S.,⁵⁻⁸ knowledge about soldiers and veterans who are admitted to correctional institutions in Canada remains limited. Individuals convicted and sentenced for less than two years and those on remand awaiting trial are referred to custody and/or community supervision programs under the jurisdiction of provincial/territorial authorities, whereas individuals sentenced to two years or more fall under the mandate of Correctional Services Canada (CSC)⁹. There is no formal identification of ex-servicemen at any level of the criminal justice system.

This article will review the research that has been conducted on the subject in Canada since the first case report of a Canadian incarcerated veteran appeared in the September 2008 issue of the AAPL Newsletter.¹⁰ In that case, a former CAF soldier in a provincial detention centre was awaiting trial for charges of drug possession and auto

theft. Following a deployment to Afghanistan, his transition to civilian life had been very difficult, and was compounded by the separation from his wife and two children.

It was not until 2009 that the first data on former military personnel incarcerated in Canada was made available. This study, undertaken by the Addictions Research Centre of CSC, was requested by the Office of the Veterans Ombudsman Canada in order to gain a better understanding of the number of federally incarcerated offenders who had served in the Canadian military. Identifying such offenders could be important to examine the impact that military service might have on offending behavior and ensure that the offenders would receive the benefits to which they were entitled. The study found that about 3% of male offenders entering Canadian penitentiaries reported having served in the Canadian military.¹¹

In 2010, a more detailed study was published on the number of former military personnel in prison. A total of 2,054 male offenders from the Atlantic, Ontario, and Pacific regions responded to questions about military service from February 11, 2009 to May 11, 2010. Of this sample, 2.8% reported having served in the Canadian military. Of the self-reported military veterans in the study, 48% reported serving less than one year in the CAF, 36% served between one and five years, and about 14% reported serving for more than five years.¹²

In March 2011, a pilot-project on incarcerated veterans was approved by the Ministry of Community Safety and Correctional Services in three Ontario detention centres. The objectives of this study were to determine over one year the characteristics of incarcerated former military personnel, and to identify factors associated with their incarceration. In this study, nineteen male inmates reported military service. The average length of service was five

years. Thirteen (67%) served in the CAF and four (22%) had been in the U.S. Armed Forces. The average age of the inmate participants was 47 years, which is older than the average male inmate in Ontario (35 years old). Six (32%) inmates reported deployment to a war zone and/or involvement in operational missions spanning the 1970s up to the war in Iraq (but not Afghanistan). Almost all of the veterans (five out of six) who had experienced combat were diagnosed with PTSD. Previous incarcerations were reported by 84% of participating veteran inmates. All reported at least one hypothesized risk factor for incarceration (e.g. previous incarceration, mental illness, homelessness, substance and/or alcohol abuse). In all, this study showed that the population of veteran inmates detained in Ontario's detention centres was diverse in terms of the type of military service, their criminal history, the nature of their offences and the duration of time between military discharge and incarceration.¹³

The first national study about homelessness among CAF and Allied forces veterans was published in 2011.¹⁴ Alcoholism, other drug addictions and mental health problems were some of the major issues identified by the 54 participants that led ultimately to homelessness many years after their release from the military. The authors concluded that transitioning to civilian life was difficult for many veterans, and they advocated for a social covenant to care for the homeless veteran population. A secondary analysis of this study, published in 2013, looked at the psychological problems faced by veterans reintegrating into civilian life.¹⁵ After they had been released from the military, the participants felt isolated and alone in the civilian world, without a strong sense of personal identity. Unfortunately, some of them coped with this challenge by turning to crime. The authors recommended that health-care providers recognize, validate, and respond to the effects – both positive and negative – of life in the armed forces for homeless veterans.

In November 2012, an expanded

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ALL ABOUT AAPL

Forensic Scientists' Challenges and Successes in San Diego

*Manuel Lopez-Leon MD, FAAFS
Chair, Liaison with Forensic Sciences Committee*

The Forensic Psychiatry and Behavioral Science Section of the American Academy of Forensic Sciences (AAFS) is only one out of the 11 Forensic Science Sections recognized by the AAFS. For over sixty years the AAFS has served a distinguished and diverse membership. With its nearly 6,000 members it is the largest professional organization in the country dedicated to the application of science for legal purposes, and it also represents 54 other countries worldwide, spanning from the active practice of forensic science to teaching and conducting research. AAFS provides forensic psychiatrists the opportunity for professional development by expanding their professional networks, personal contacts, and even potentially, for being nominated to receive prestigious awards recognizing their scientific contributions by the forensic scientific community. As the world's most prestigious forensic science organization, the AAFS represents its membership to the public and serves as the focal reference for public information concerning the forensic science profession. Furthermore, it is the intention of our committee to bring awareness to our membership that the struggles, challenges, and successes that forensic psychiatrists experience on their day-to-day work parallel all the other forensic disciplines.

We hope that our traditional annual forensic sampler contributes to the knowledge of forensic psychiatrists through discussing interdisciplinary issues of interest and relevance to our field, while at the same time creating awareness that we are not only psychiatrists interested in legal issues, but forensic scientists that form a small part of a larger body of colleagues who face similar difficulties in establishing the validity of the scientific process to the courts and other legal bodies. A panel comprised of a group of forensic scientists from San Diego, CA, who graciously agreed to partici-

pate by discussing their experiences, challenges, and successes through their careers, formed our forensic sampler for the 2013 Annual Meeting.

One of our guest speakers was Thomas Streed, Ph.D, former Homicide Detective in the San Diego County Sheriff's Department. He is an expert in Human Behavior, who has been qualified by, and testified in, the State Superior Courts, Federal Courts, and in U.S. Military and Martial Courts. Dr. Streed has expertise in crime-scene interpretation, psychology of violent behaviors, police procedures, officer involvement in the use of force, and coercive methods of interrogation, which have in some cases been evident in criminal investigations.

Dr. Streed discussed the evaluation and analysis of police interrogation, which has, in some cases, led to coerced false confessions. A false confession is an admission of guilt in a crime in which the confessor is not responsible for the crime. False confessions can be induced through coercion or by the mental disorder or incompetency of the accused. Even though false confessions might appear to be an exceptional and unlikely event, they occur on a regular basis in case law, which is one of the reasons why jurisprudence has established a series of rules to detect, and subsequently reject, false confessions. These are called the "confession rules." Plea agreements typically require the defendant to stipulate to a set of facts establishing he/she is guilty of the offense. In the United States' federal system, before entering judgment on a guilty plea, the Court must determine that there is a factual basis for the plea. However, Dr. Streed described how jurors in some unfortunate cases accept false confessions. Dr. Streed discussed the complex issues of proof and the use of forensic experts in the recognition of confessions coerced through torture and other psychological manipula-

tions, and shared his personal experiences within national and international judicial systems.

Iain McIntyre, Ph.D., was also a guest participant in our forensic sampler panel. He has been a member of the Toxicology Section of the AAFS. He is Director and Chief Toxicologist as well as the Forensic Toxicology Laboratory Manager of the San Diego County Medical Examiner's Office. Dr. McIntyre explored some general principles of forensic toxicology and issues related to the postmortem analysis of drug distribution. He presented forensic toxicology cases that overlapped with psychiatric issues. For instance the postmortem toxicology analysis of individuals in which the presence of a wide variety of psychoactive legal and illegal drugs has helped explain erratic behaviors, mania, hostility, violence, psychosis, and even suicide and homicide. Dozens of high profile deaths have been tied to the use of such agents as well as many random senseless acts of violence. Dr. McIntyre explained the importance of the distribution and accumulation of these agents in the various tissues, and how the postmortem analysis of the bodily distribution of these agents has helped determine the actual serum concentrations at the time of death.

Finally, our third participant of the panel was Ronn Johnson, Ph.D., an expert in Police Psychology and Juvenile Fire-setters. He discussed issues and challenges commonly encountered when working with the San Diego Police Department in the identification of officers who may have mental health issues, including alcohol related disorders. Dr. Johnson discussed the process of evaluating police recruits. He pointed out the particular difficulties in the assessment of fitness for duty evaluations, and the stigma associated with such assessments among their peers. On a separate topic, Dr. Johnson also provided in-depth insight into the forensic assessment and clinical interventions for juvenile fire-setters, and the importance of differentiating this form of juvenile behaviors from arsonists. (P)



ALL ABOUT AAPL

Midwest Chapter Holds Annual Meeting

The Midwest Chapter of AAPL held its annual meeting March 21-22 in Indianapolis. The luxurious Conrad Hotel and an excellent program were arranged by Celestine DeTrana, Doug Morris, Danny Hackman, and Jim Reynolds.

Respectfully submitted,
Steve Berger



Doug Mossman playing and singing an original musical rendition to introduce his presentation on the Medical Ethics of Restoring Competence to be Punished.



Newly elected officers of the chapter: standing: Counselor Veach Jain, Treasurer Doug Morris, Counselor Megan Testa, President elect Sherif Soliman, retiring Treasurer Larry Jeckel, Past President Jim Reynolds, seated: Counselor Celestine DeTrana, President Catie Cerny, Secretary Delaney Smith.



Winners of Scholarships to attend the meeting: standing: Danny Hackman of the Selection Committee, Christopher Marett (Margolis Scholar), Annette Reynolds (Resnick Scholar), Chapter President Jim Reynolds (no relation), seated Margolis Scholars: Folabo Dare, Matt Pitcher, Brandon Moore.



The Presidential Plaque being presented to outgoing Chapter President Number 31, Jim Reynolds, by Chapter President Number 1, Phil Resnick.



ALL ABOUT AAPL

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC. FACULTY FELLOWSHIP AWARD March 2014

The directors of the American Board of Psychiatry and Neurology (ABPN) have established a faculty fellowship award. The award is intended to support the development of innovative education and/or evaluation projects that promote effective residency/fellowship training or lifelong learning of practicing psychiatrists and neurologists. Preference will be given to projects that have the potential for use in more than one site and to applicants who are at a junior or mid-faculty level.

Funding: Each year, up to two psychiatry and two neurology faculty fellows will be selected. The duration of the fellowship will normally be for two years with a maximum amount of funding of \$50,000 per year or \$100,000 total. This amount is intended to cover salary, fringe benefits, and other costs. No indirect costs will be covered. Fellows will be required to dedicate at least 25% of their professional time to the project.

Eligibility: Applicants must:

- be certified by the ABPN
- participate in the ABPN's maintenance of certification program
- hold an unrestricted license to practice medicine in a state, commonwealth, territory, or possession of the United States
- comply with the ABPN's conflict of interest policies and procedures
- hold a faculty appointment in a U.S. LCME-accredited medical school

Deadlines: Applicants must submit a completed Application Form and any related documentation by **August 18, 2014**, to the ABPN. Awards will be announced by November 3, 2014, with funding to start on January 1, 2015.

Additional Information: Additional information and the application form are posted on the ABPN web site (abpn.com).
Contact: Dorthea Juul, Ph.D., at djuul@abpn.com.



The American Board of Psychiatry and Neurology, Inc. is a not-for-profit corporation dedicated to serving the public interest and the professions of psychiatry and neurology by promoting excellence in practice through certification and maintenance of certification processes. The ABPN is a member of the American Board of Medical Specialties, an organization of 24 approved medical specialty boards.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC. 2014 FACULTY FELLOWSHIP RECIPIENTS

The American Board of Psychiatry and Neurology (ABPN) is pleased to announce the recipients of the 2014 ABPN Faculty Fellowships.

Melissa Arbuckle, MD, PhD, is an Associate Professor of Clinical Psychiatry and Associate Director of Residency Training, Department of Psychiatry, Columbia University College of Physicians and Surgeons. She will focus on creating continuing medical education courses to engage and support participants in implementing practice change.

Charles Flippen II, MD, is a Professor of Neurology and Director of Residency Training, Department of Neurology, David Geffen School of Medicine at the University of California Los Angeles. The goal of his project is to evaluate the utility of digital video recording as a method to improve neurology resident interviewing skills.

Michael Jibson, MD, PhD, is a Clinical Professor of Psychiatry and Director of Residency Education, Department of Psychiatry, University of Michigan Medical School. He will analyze the psychometric characteristics of the Clinical Skills Verification process and assess its utility for assessing specific milestones.


Robert Thompson Stone, MD, is an Assistant Professor of Neurology and Pediatrics, University of Rochester School of Medicine and Dentistry. He will develop a comprehensive system for evaluating the clinical skills of residents based on direct observation and explore the validity of this system.

The Faculty Fellowship Committee, chaired by Robert Golden, MD, includes Drs. Allison Brashear, Deborah Cowley, Steven Epstein, Laurie Gutmann, Ralph Jozefowicz, Jaffar Khan, and Kailie Shaw.

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research project on incarcerated veterans was undertaken in five Ontario detention centres with the objectives of determining, over a three-year period, the characteristics and criminogenic risk factors of incarcerated veterans. The investigators are collecting data including sociodemographic variables, military history, history of physical/mental health problems, suicidal ideation reported on admission, inmates' offence history and results of LSI-OR (an assessment tool designed to predict recidivism among offenders) if available. At press, nineteen male inmates were identified and consented to participate. While so far all have

seen their military service as a positive learning experience in their lives, over half have described adjustment to civilian life as difficult for them. Many have already been identified with substantial risks for criminal recidivism. The authors expect that the study, at completion, will not only provide information about the characteristics of incarcerated veterans in Canada, but will provide insights into their mental health care needs, both now and for when they transition back to the community. 

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by increasing registrants' fears of being identified by vigilantes. This may result in the registrant deciding they are safer by becoming non-compliant with the SOR requirements and going "underground." This is problematic since registrants who make this decision lose access to social supports and treatment, which inadvertently increases their risk for recidivism. Research by Barnoski (2007) indicated that registered sex offenders who "go underground" and are later charged with failure to comply are more than two times more likely to sexually recidivate than those who are compliant with the SOR.

Reports have indicated that compliance rates for SORs throughout the United States are disappointing with some states citing compliance rates ranging as low as 40% to 60%. In contrast, Canada's private SORs have compliance rates hovering around 95%. Presumably Canada's impressive rates of compliance are rooted in the private system of registration (Murphy & Fedoroff, 2013; Murphy, Fedoroff et al., 2009). Dismal rates of compliance, as seen in some parts of the United States, can have serious implications for overall community safety.

False sense of security: Another area of concern is the false sense of security created by SOR and PN legislation. The message set forth in the media and in legislation is the need to be hypervigilant of "stranger danger." Such legislation sensitizes women and children to the potential for abuse by unknown offenders; however, in reality the majority of sexual offenses are not committed by strangers, but by people known to the victim. In fact, incidents of stranger abduction and sexual abuse are rare. A review of research on the victim-offender relationships indicates that 80% to 98% of victims are known to the offender (McAlinden, 2007). In spite of these consistent data, legislative responses continue to be guided by a small

number of highly sensational cases and the unfounded view that "being tough on crime" requires interventions that make it harder for former sex offenders to rehabilitate and successfully reintegrate into the community.

"The inclusion of older children and adolescents in PN and publicly accessible SORs is based on the faulty assumption that young sex offenders have high rates of recidivism. In fact, recidivism rates of child and adolescent sex offenders are low."

Length or reporting period: Currently American SORs require registrants to report for designated periods of 15 years, 25 years, or life. In Canada, registrants must report for 10 years, 25 years or life. Decisions about the length of the reporting period are determined by criminal history, index offense type, number of victims and potential sentence length associated with the crime. Reporting requirements (such as, frequency and type of information) are the same regardless of the length of time served on the SOR or the estimated risk of recidivism (Murphy & Fedoroff, 2013).

Hanson, Harris, Helmus & Thornton (in press) examined the extent to which sexual offenders present an enduring risk for sexual recidivism over time. The sample included 7,740 sexual offenders with a follow-up period of 20 years. Findings indicated that the risk of sexual recidivism was highest during the first few years post release, and substantially decreased the longer individuals

remained offense-free in the community. The authors noted that this pattern was particularly strong for sexual offenders deemed high risk, as determined by the Static-99R. High-risk offenders' rate of sexual recidivism was 22% at 5 years post-release, but the rate decreased to 4.2% for the same risk group of offenders who remained offense-free in the community for 10 years. These findings illustrate that the period of highest risk for reoffending is within the first few years after being released from prison.

Based on these findings, it is believed that there is an added benefit to more intensive interventions and up-to-date offender information in the first few years post release. Since the likelihood of recidivism decreases substantially every year that the offender has been offense free, it seems reasonable to scale down the level of supervision and time between reporting periods as offense free time in the community progresses. This approach is supported by the "Risk Principle" that states that therapists of sex offenders should match level of risk with the intensity of the intervention (Bonta & Andrews, 2007). This approach will help the criminal justice system and treatment providers focus resources where they will be most effective instead of diluting resources to provide equivalent levels of surveillance on former sex offenders with all levels of risk and need.

Registration of adolescents and children: Concerns have been raised about the inclusion of older children and adolescents on publicly accessible SORs throughout the United States. Since they are accessible via the Internet they are therefore accessible around the world. The inclusion of older children and adolescents in PN and publicly accessible SORs is based on the faulty assumption that young sex offenders have high rates of recidivism. In fact, recidivism rates of child and adolescent sex offenders are low. A meta-analysis

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Digital Evidence

Andrew Nanton MD, Early Career Development Committee

Both civil and criminal forensic evaluations increasingly benefit from digital evidence. The most common examples include email and text messages, although the scope of has widened in recent years. Information from web browser logs, social media, and blogs increasingly has a place in our work. The question is how we get this information, and what it might be able to tell us. In attempting to answer these questions, it is helpful to consider several rough categories of online activity: communication, consumption, and creation.

Email and text messages, as previously mentioned, are good examples of communication. Also included in this category are the use of online chat services such as those provided by Google, Facebook, AOL, and WhatsApp (recently purchased by Facebook). Twitter can also involve the use of “direct messages” that are not publically visible. In addition to the content of the messages which may include threats or profess love, patterns of use such as contact with a potential victim, government agencies, or conspirators may prove useful. The content, if of sufficient length, may offer insight into a developing thought disorder.

Web browser logs, both from personal computers and mobile phones, can provide further collateral. These logs are an example of digital media consumption. Beyond merely looking at what a person searched for and read about, which may prove useful, these logs can also serve as a record of psychiatric decompensation. For example, an escalating number of searches for a delusional topic, or a dramatic spike in gambling and pornography, may help to illuminate a timeline of psychosis or mania.


Creation encompasses blogs, twitter microblog “tweets,” forum posts, comments to articles, and social media updates. Due to the nature of the web, many of these occupy a blurry middle ground between creation and communication. Creation, in this case, suggests transmission of information to a non-specific audi-

ence rather than a sending a message to identified recipients. This kind of information is often longer-form. Similar to email, it may be possible to identify a trend toward disorganized thought. As the audience generally assumed to be global, grandiosity could potentially be assessed.

“Beyond merely looking at what a person searched for and read about, which may prove useful, these logs can also serve as a record of psychiatric decompensation. For example, an escalating number of searches for a delusional topic, or a dramatic spike in gambling and pornography, may help to illuminate a timeline of psychosis or mania.”


In communication with forensic digital examiners and investigators, one of their primary struggles is identifying which of the thousands of files on a computer could be relevant to a forensic assessment. By understanding the potential roles of digital communication, consumption, and creation activities, forensic psychiatrists can be better equipped to assess what role they may play in forensic psychiatric assessment.

Communication between digital and psychiatric forensic experts is in its infancy, and both groups are still working to understand how to collaborate. In the event you find yourself wanting additional collateral informa-

tion that could be provided by one of the sources listed above, don't be afraid to ask for it. 

AAPL as Amicus Curiae

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The time frame for writing amicus briefs is narrow. Because AAPL relies on other organizations to write the amicus briefs that AAPL joins, it may be very close to the filing deadline before AAPL receives a copy of the brief to review. AAPL has no formal procedure for reviewing such briefs and suggesting changes, but generally there is at least an initial review by AAPL's officers, and then a subsequent review by the AAPL Council. AAPL has never considered retaining its own amicus counsel to keep us abreast of important issues and to write amicus briefs specifically affecting forensic psychiatry in the appellate courts. It might be time to do so, as AAPL becomes more involved in the public policy arena. 

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including over 11,200 youth sex offenders found a mean sexual recidivism rate of 7% over a 5-year follow-up period (compared to a meta-analysis of adult sex offenders who had a 12% sexual recidivism rate over the same follow-up period) (Hanson & Morton-Bourgon, 2007).

In 2013 the Human Rights Watch released a report on the impact of subjecting older children and adolescents to PN and open SORs. During the investigation 281 children and youths were interviewed who were required to register during late childhood or early adolescence. The study looked at the impact on children of being placed on a SOR, most of whom were accessible to the public via the Internet. Regardless of the ages of the registrants at the time of the offense, they were required to register for periods ranging from 15 years to life. The article focused on offenders' struggles with becoming productive members of society while bearing the stigma associated with the publicly accessible label of "sex offender" (Human Rights Watch, 2013).

A number of incidents of violent vigilante action taken against the youths and their families as a result of registration have been reported. "Bruce," the father of two boys placed on a SOR at ages 8 and 10 due to conviction for sexual touching of their younger sister, reported how he was helpless when a man held a gun to his 10-year-old son's head after finding out that the child was a registered sex offender. "Camilio," placed on the SOR at age 14, reported being followed home from school and harassed by men in a car. One week later he reported that bullets went through the living room window as he was watching television with his family. "Zachary" recalled constant harassment by neighbours who eventually killed his family dog. Another youth described a requirement that when he was old enough to get his driver's licence it would display the

words "sex offender" in orange capital letters directly below his photograph. Numerous examples have been described of how being on a publicly accessible SOR has negatively impacted youths' ability to form friendships or attend school. Youth interviewed in the study who are now in adulthood described difficulties obtaining employment and stable housing as a result of registration for offenses committed in their childhood (Human Rights Watch, 2013).

Fortunately, given the apparent physical and psychological harm that befalls youths who are subject to publicly accessible registration, some reconsideration of open SOR and PN laws for youth is taking place. The report calls for an exemption from subjecting children and adolescents to PN and placing them on publicly accessible SOR. It suggests that youth should only receive PN or be placed on open SORs in the most extreme and high risk of cases (Human Rights Watch, 2013).

Conclusion

Several concerns exist about the use of PN and publicly accessible SORs for both adults and youth. PN and SOR legislation was created in response to a small number of highly sensational cases that do not represent the norm for sexual offenses or sexual offenders. Registration laws aimed at protecting children and other vulnerable members of the population are falling short of their intended goals. Not only are most sex crimes committed by offenders who are known to the victim, there has been a universal decrease in sexual offenses over the past three decades. Of the individuals who do offend, sex offenders are less likely to reoffend than any other type of offender. Given the lack of evidence establishing the effectiveness of PN and open SORs and the increasing cost of maintaining a database with ever-increasing numbers of registrants, most of whom will never reoffend, continued support for publicly accessible SORs and PN needs

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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.

Christopher J. Lockey, M.D., Assistant Professor of Psychiatry/OHSU
OHSU Chief Psychiatrist, Oregon State Hospital
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to be re-examined. It is important that policies reflect current understanding of the risk of sexual reoffending and the best ways to respond. ⁽⁴⁾

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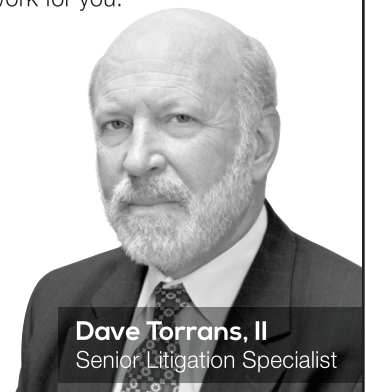
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