American Academy of Psychiatry and the Law

37th Annual Meeting

October 26-29, 2006
Chicago, Illinois

The American Academy of Psychiatry and the Law is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians

Thirty-seventh Annual Meeting
American Academy of Psychiatry and the Law
October 26-29, 2006
Downtown Marriott, Chicago, Illinois

OFFICERS OF THE ACADEMY

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PAST PRESIDENTS

Robert T.M. Phillips, MD, PhD	2004-05	William H. Reid, MD, MPH	1988-89
Robert Wettstein, MD	2003-04	Richard Rosner, MD	1987-88
Roy J. O'Shaughnessy, MD	2002-03	J. Richard Ciccone, MD	1986-87
Larry H. Strasburger, MD	2001-02	Selwyn M. Smith, MD	1985-86
Jefrey L. Metzner, MD	2000-01	Phillip J. Resnick, MD	1984-85
Thomas G. Gutheil, MD	1999-00	Loren H. Roth, MD	1983-84
Larry R. Faulkner, M.D	1998-99	Abraham L. Halpern, MD	1982-83
Renée L. Binder, MD	1997-98	Stanley L. Portnow, MD	1981-82
Ezra E. H. Griffith, MD	1996-97	Herbert E. Thomas, MD	1980-81
Paul S. Appelbaum, MD	1995-96	Nathan T. Sidley, MD	1979-80
Park E. Dietz, MD, PhD, MPH	1994-95	Irwin N. Perr, MD	1977-79
John M. Bradford, MB	1993-94	G. Sarwer-Foner, MD	1975-77
Howard V. Zonana, MD	1992-93	Seymour Pollack, MD	1973-75
Kathleen M. Quinn, MD	1991-92	Robert L. Sadoff, MD	1971-73
Richard T. Rada, MD	1990-91	Jonas R. Rappeport, MD	1969-71
Joseph D. Bloom, MD	1989-90		

2006 ANNUAL MEETING CHAIR

Liza H. Gold, MD

EXECUTIVE OFFICES OF THE ACADEMY

One Regency Drive, P. O. Box 30, Bloomfield, CT 06002-0030
Office: 860-242-5450 Fax: 860-286-0787 Toll Free: 800-331-1389
E-mail: Office@AAPL.org Website: www.AAPL.org

Howard V. Zonana, MD
Medical Director

Jacquelyn T. Coleman, CAE
Executive Director

FUTURE ANNUAL MEETING DATES and LOCATIONS

38th Annual Meeting

October 18-21, 2007

Loews Miami Beach Hotel

Miami Beach, FL

39th Annual Meeting

October 23-26, 2008

The Westin

Seattle, Washington

40th Annual Meeting

October 29-November 1, 2009

Baltimore Marriott Waterfront

Baltimore, Maryland

GENERAL INFORMATION

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REGISTRATION DESK

(Wednesday-Sunday: Ballroom Foyer)

Hours of Operation

Wednesday	1:00 p.m. - 5:00 p.m.
Thursday	7:30 a.m. - 6:00 p.m.
Friday	7:30 a.m. - 6:00 p.m.
Saturday	6:45 a.m. - 6:00 p.m.
Sunday	7:30 a.m. - 12:00 noon

AAPL BOOKSTORE

5th Floor

DIGITAL RECORD

5th Floor

COURSE CODES

T = Thursday F = Friday S = Saturday Z = Sunday

AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW
2006 ANNUAL MEETING

GOALS:

To inform attendees about current major issues in forensic psychiatry and afford them opportunities to refresh skills in the fundamentals of the discipline, engage in discussion with peers on the standards governing the profession, and update their present knowledge.

OBJECTIVES:

Participants will improve their skills in forensic psychiatry in the following three areas: 1) service, including treatment of forensic patients, development of service delivery strategies, and enhancement of consultative abilities at the interface of psychiatry and the legal profession; 2) teaching, including new methods of training of forensic psychiatrists and classification of the tasks and functions of a forensic psychiatrists; and 3) research, gaining access to scientific data in areas that form the basis for practice of the discipline.

ACCREDITATION:

The American Academy of Psychiatry and the Law is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Academy of Psychiatry and the Law designates this educational activity for a maximum of 31.5 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

DESIGNATIONS USED IN THIS PROGRAM:

(I)	Invited
(Core)	Contains material on basic forensic practice issues
(Advanced)	Contains material that requires understanding of basic forensic practice issues

CALL FOR PAPERS
2007

The 38th Annual Meeting of the

American Academy of Psychiatry and the Law

will be held in **Miami Beach, Florida**

October 18-21, 2007

Papers may be submitted and inquiries directed to

J. Srinivasaraghavan, MD, Program Chair.

Abstract submission forms are available in the

meeting registration area during this year's meeting, by contacting the

Academy's Executive Office, or on the website: www.AAPL.org.

The deadline for abstract submission is
March 1, 2007

FINANCIAL DISCLOSURES

It is the policy of the American Academy of Psychiatry and the Law (AAPL) to insure balance, independence, objectivity, and scientific rigor in all its individually sponsored or jointly sponsored educational programs. In order to comply with the ACCME's Updated Standards for Commercial Support, the American Academy of Psychiatry and the Law requires that anyone who is in a position to control the content of an educational activity discloses all relevant financial relationships with any commercial interest pertaining to the content of the presentation. Should it be determined that a conflict of interest exists as a result of a financial relationship of a planner of the CME activity, the planner must recuse himself or herself from the planning for that activity or relevant portion of that activity. Should it be determined that a conflict of interest exists as a result of a financial relationship of a proosed presenter at a CME activity, the proposed presenter and the Education Committee must agree on a method to resolve the conflict. Refusal to disclose a conflict or the inability to resolve an identified conflict precludes participation in the CME activity.

CONTENT VALIDITY

Recommendations involving clinical medicine in a CME activity must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients. All scientific research referred to, reported or used in CME in support or justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collection and analysis.

SPEAKER FINANCIAL DISCLOSURES

The following presenters indicated that they had no relevant financial relationship pertaining to the content of their presentation:

Akhtar, S.; Adshead, G.; Africk, J.; Alizai-Cowan, S.; Allen, T.; Amble, P.; Andrade, J.; Andrade, F.; Andrew, M.; Anfang, S.; Angelari, M.; Appelbaum, K.; Appelbaum, P.; Ash, P.; Bailey, R.; Baranoski, M.; Barath, I.; Barboriak, P; Barzokis, G.; Bath, E.; Beadles, B.; Beck, J.; Beckson, M.; Berger, S.; Berlin, F.; Bernet, W.; Bhushan, P.; Bianchi, M.; Billick, S.; Binder, R.; Bogacki, D.; Bolton, M.; Boyajian, C.; Brakel, S.; Brendel, R.; Brodsky, D.; Brown, C.; Brown, P.; Buchanan, J.; Burns, T.; Buscema, C.; Busch, K.; Busse, D.; Campbell, W.; Candilis, P.; Carr-Malone, R.; Caruso, K.; Carvalho, V.; Cavanaugh, J.; Cervantes, A.; Chapman, J.; Christiansen, T.; Christopher, P.; Coffey, L.; Collins, G.; Colon, M.; Conroe, H.; Conway, T.; Coric, V.; Cunliffe, C.; Darani, S.; Davis, P.; De Crisce, D.; DeBofsky, M.; Demartinis, N.; Desai, R.; Devine, S.; Dhaliwal, G.; Dietz, P.; Dike, C.; Duncan-Brice, J.; Dutton, M.; Dwyer, R.G.; Easton, C.; Edersheim, J.; Elsamra, M.; Emiletti, L.; Etheridge, A.; Falzer, P.; Farkas, K.; Fedoroff, J. P.; Felthous, A.; Ferlauto, M.; First, M; Ford, J.; Ford, R.; Forrest, R.; Foti, M.; Frierson, R.; Galvin, M.; Gilman, H.; Glancy, G.; Glass, G.; Gold, L.; Gorbien, M.; Gould, J.; Granacher, R.; Grounds, A.; Grudzinskas, A.; Guillory, S.; Gutheil, T.; Hackett, M.; Hajian, H.; Hall, K.; Harkavy, S.; Harris, R.; Haskins, B.; Hatters-Friedman, S.; Hershberger, J.; Hoge, S.; Horton, D.; Houchin, T.; Hrouda, D.; Ibrahim, H.; Ibrahim, L.; Ishee, S.; James, D.; Janofsky, J.; Jelley, B.; Johnson, C.; Johnson, S.; Jones, T.; Jones, P.; Kammerer, M.; Kassner, R.; Kellaher, D.; Kenan, J.; Khin, E.; Kim, C.; Kis, E.; Kishi, D.; Knoll, J.; Kornberg, J.; Kralovec, J.; Kress, A.; Lange, C.; Larsen, K.; LeBlanc, V.; LeBourgeois, H.W.; Lee, J.; Leong, G.; Levin, A.; Levine, H.; Lifton, R.; Liptai, L.; Loiterstein, D.; Lourgos, P.; Luczko, G.; Maislen, A.; Malone, R.; Mankad, M.; Martinez, R.; Massafra, M.; McDermott, B.; McLaren, T.; McNiel, D.; Merideth, P.; Metzner, J.; Meyer, D.; Mills, M.; Missett, J.; Mitrevski, J.; Mohan, D.; Molden, R.; Montalbano, P.; Montgomery, S.; Morris, D.; Mossman, D.; Myers, W.; Nair, M.; Nakdarni, N.; Nanton, A.; Narayanan, P.; Neavins, T.; Newman, S.; Norko, M.; Norman, W.; Noroian, P.; Norris, D.; Novak, B.; Nowak, P.; Nuland, S.; O'Shaughnessy, R.; Onorato, A.; Pagano, K.; Park, T.; Parker, G.; Patterson, R.; Pent, M.; Phillips, R.; Piasecki, M.; Pinals, D.; Pitluck, H.; Poythress, N.; Price, M.; Quanbeck, C.; Ranseen, J.; Recupero, P.; Regehr, C.; Reich, J.; Reid, W.; Resnick, P.; Riar, K.; Rodgers, C.; Rone, L.; Rosenfeld, B.; Rosmarin, D.; Rotter, M.; Roy-Budnowski, K.; Saleh, F.; Sampl, S.; Samuel, R.; Schetky, D.; Schouten, R.; Schutte, S.; Schwartz-Watts, D.; Scott, C.; Scott, P.; Shelby, B.; Siegel, D.; Silva, J.A.; Simon, R.; Simoniello, M.; Simring, S.; Singh, B.; Slovenko, R.; Sokolov, G.; Sorrentino, R.; Sparr, L.; Spearman, B.; Stankowski, J.; Stolar, A.; Tellefsen, C.; Temporini, H.; Tidler, L.; Tomita, T.; Traverso, G.; Traverso, S.; Trestman, R.; Tucker, D.; Vincent, G.; Vnencak-Jones, C.; Voskanian, P.; Wang, E.; Weinstock, R.; Weisman, R.; Weiss, K.; West, S.; Wettstein, R.; Williams, V.; Wills, C.; Winslade, W.; Woods, L.; Zerkin, G.; Zhang, W.; Zonana, H.

The following presenters made financial disclosures:

Kaye, Neil S.	Speaker's Bureau: Pfizer, AstraZeneca, GlaxoSmithKline

SPECIAL EVENTS

THURSDAY, OCTOBER 26

Breakfast for current fellows only in Forensic Psychiatry Programs	7:00 a.m - 8:00 a.m.	Salons F-G, 5th Floor
Past Presidents' Breakfast	7:00 a.m. - 8:00 a.m.	Minnesota, 6th Floor
Opening Ceremony - President's Address (open to all attendees)	8:00 a.m. - 10:00 a.m.	Salons A-D, 5th Floor
Association of Directors of Forensic Psychiatry Fellowships Reception (for fellowship program faculty, fellows, and potential applicants)	6:00 p.m. - 7:00 p.m. .	Salon E, 5th Floor

FRIDAY, OCTOBER 27

Rappeport Fellows Breakfast (Rappeport Fellows and Committee)	7:00 a.m. - 8:00 a.m.	Minnesota, 6th Floor
Early Career Development Breakfast (Those in the first seven years after training)	7:00 a.m. - 8:00 a.m.	Miami/Scottsdale, 5th Floor
Reception (for all meeting attendees)	6:00 p.m. - 7:30 p.m.	Salons E-H, 5th Floor

SATURDAY, OCTOBER 28

AAPL Business Meeting (members only) (coffee and breafast pastries)	7:00 a.m. - 8:00 a.m.	Salon D, 5th Floor

COFFEE BREAKS WILL BE HELD IN THE SALON D FOYER

For the locations of other events scheduled subsequent to this printing, check at the registration desk.

PLEASE

BE COURTEOUS TO YOUR FELLOW ATTENDEES.

TURN CELL PHONES OFF OR SET THEM TO VIBRATE.

HOLD YOUR PHONE CONVERSATIONS OUTSIDE THE MEETING ROOM.

(SESSION MODERATORS HAVE BEEN ASKED TO ENFORCE THIS POLICY)

American Academy of Psychiatry and the Law
Thirty-seventh Annual Meeting

OPENING CEREMONY

Thursday, October 26, 2006
8:00 a.m. - 10:00 a.m.

WELCOME, INTRODUCTIONS — Robert I. Simon, MD, *President*

PRESENTATION OF RAPPEPORT FELLOWS — Philip Merideth, MD, JD, *Rappeport Fellows Chair*

2006 Rappeport Fellows
Ryan C.W. Hall, MD
John Hopkins University

Robindra K. Paul, MD, DPH
University of Pittsburgh Medical Center

AWARD PRESENTATIONS — Renée L. Binder, MD, *Chair, Awards Committee*

Golden Apple Award
Howard V. Zonana, MD

Seymour Pollack Award
Renée L. Binder, MD

Red Apple Outstanding Service Award
Michael A. Norko, MD

Award for Outstanding Teaching in a Forensic Fellowship Program
Richard L. Frierson, MD

OVERVIEW OF THE PROGRAM — Liza H. Gold, MD, *Program Chair*

INTRODUCTION OF THE PRESIDENT — Liza H. Gold, MD and Thomas G. Gutheil, MD

PRESIDENT'S ADDRESS — Robert I. Simon, MD

ADJOURNMENT — Liza H. Gold, MD

AWARD RECIPIENTS

GOLDEN AAPL AWARD

The Golden AAPL is presented for significant contributions to forensic psychiatry. AAPL members over 60 years of age are eligible.

HOWARD V. ZONANA, M.D.

Dr. Howard Zonana received his medical degree from Johns Hopkins School of Medicine and did his psychiatric residency at Massachusetts Mental Health Center. Since 1968, he has been a faculty member at Yale University and is currently a Professor of Psychiatry and an Adjunct Clinical Professor of Law. Since 1986, Dr. Zonana has been the Director of the Law and Psychiatry Division at Yale University.

Dr. Zonana has had leadership positions in the area of forensic psychiatry in the American Psychiatric Association. He has been Chair of the Council on Psychiatry and the Law and Chair of the Commission on Judicial Action. Dr. Zonana has also been active in the American Bar Association. He has served on the ABA's Commission on Mental and Physical Disability Law and has been a consultant to the Criminal Justice Mental Health Standard Subcommittee on Competence to Be Executed. Dr. Zonana was President of the American Board of Forensic Psychiatry and since 2004, has been Chair of the Committee on Subspecialty Certification and Recertification in Forensic Psychiatry of the American Board of Psychiatry and Neurology. He also has served the American Academy of Psychiatry and the Law in many capacities. He has been the President of the Association of Directors of Forensic Psychiatry Fellowships and was President of AAPL from 1992 to 1993. Since 1995, Dr. Zonana has been Medical Director of AAPL.

Dr. Zonana has had significant impact on the field of forensic psychiatry. He chaired the Task Force on Dangerous Sex Offenders of the American Psychiatric Association and the Task Force on the Videotaping of Forensic Psychiatric Evaluations for AAPL. He also has coordinated the entire AAPL Practice Guideline process for forensic psychiatrists. Under Dr. Zonana's leadership of AAPL, AAPL has signed on to Amicus Briefs concerning significant cases that have been heard by the U.S. Supreme Court. He also serves as AAPL's Alternate Delegate to the AMA. In 2003, Dr. Zonana received the American Psychiatric Association Special Presidential Commendation in recognition of outstanding leadership in forensic psychiatry for the American Psychiatric Association and for AAPL.

For his significant contributions to the field of forensic psychiatry, the American Academy of Psychiatry and the Law presents the 2006 Golden AAPL award to Dr. Howard Zonana.

SEYMOUR POLLACK DISTINGUISHED ACHIEVEMENT AWARD

To recognize distinguished contributions to the teaching and educational functions of forensic psychiatry.

RENÉE L. BINDER, M.D.

Dr. Renée L. Binder graduated from the University of California San Francisco Medical School and did her internship and residency at Mt. Zion Hospital and Medical Center in San Francisco. She is currently a Professor of Psychiatry, the Director of the Psychiatry and the Law Program, and Associate Dean in the Office of Academic Affairs at the University of California San Francisco.

Dr. Binder has been a leader in the field of forensic psychiatry. At the American Psychiatric Association, she has been Chair of the Committee on Confidentiality, the Council on Psychiatry and the Law, and the Commission/Committee on Judicial Action. She is currently a Trustee-at-Large on the Board of Trustees. She has been a co-author of many APA educational products including a videotape on confidentiality, Practice Guidelines for the Evaluation of Adults, a resource document on Mandatory Outpatient Treatment, and a resource document on Controversies in Child Custody. At AAPL, she has been a Councilor, as well as Vice-President and President. She also has been President of the Association of Directors of Forensic Psychiatry Fellowships and has been an Associate Editor of the Journal of the American Academy of Psychiatry and the Law. Dr. Binder has served on the Forensic Psychiatry Certification and Recertification Committees of the American Board of Psychiatry and Neurology and is currently a member of the forensic psychiatry steering committee. She also is Chair of the Education Committee of the AAPL Institute for Education and Research. Dr. Binder has been an invited lecturer nationally and internationally and has given presentations in England, Japan, Singapore, and Malaysia. She has published over 80 peer-reviewed articles on various forensic topics including violence risk assessment of mentally ill patients, the relationship between mental illness and violence, and the criminalization of the mentally ill. Her Presidential Address for AAPL was titled, "Are the Mentally Ill Dangerous?"

For her distinguished contributions to the field of forensic psychiatry, the American Academy of Psychiatry and the Law presents the 2006 Seymour Pollack Award to Dr. Renée L. Binder.

RED AAPL OUTSTANDING SERVICE AWARD

This award is presented for service to the American Academy of Psychiatry and the Law

MICHAEL A. NORKO, M.D.

Dr. Michael Norko did his psychiatric residency at St. Vincent's Hospital and Medical Center in New York and was a Rappeport Fellow of the American Academy of Psychiatry and the Law in 1986-1987. He then did a forensic psychiatry fellowship at Yale University and is currently an Associate Professor of Psychiatry at the Yale University School of Medicine, as well as the Chief of Forensic Services and Acting Director of the Whiting Forensic Division of Connecticut Valley Hospital. He has a Post-graduate Certificate in Mental Health Administration from the New School for Social Research and is currently a Master of Divinity Candidate at the Yale Divinity School. Dr. Norko is a member of the Forensic Psychiatry Recertification Committee, the committee that writes questions for the American Board of Psychiatry and Neurology recertification examination. He served for four years as a consultant to the American Psychiatric Association's Committee on Psychiatric Services in Jails and Prisons and is currently Chair of the American Psychiatric Association's Manfred Guttmacher Award Committee.

Dr. Norko has served AAPL in many capacities. He was Editor of the AAPL newsletter from October 1996 to October 2003 and since July 2003, he has served as Deputy Editor of the Journal of AAPL. He has been on many AAPL committees including the Institutional Forensic Psychiatry Committee, the Research Committee, the Program Committee, and the Committee on Sexual Offenders. In addition, he has been Chair of the Institutional and Correctional Forensic Psychiatry Committee and has served as a Councilor of AAPL and as its Vice-President.

For his devoted service and numerous contributions over many years to AAPL, the American Academy of Psychiatry and the Law presents the 2006 Red APPL Outstanding Service Award to Dr. Michael A. Norko.

AWARD FOR OUTSTANDING TEACHING IN A FORENSIC FELLOWSHIP PROGRAM

This award is selected by the AAPL Awards Committee from nominations submitted by individuals familiar with the nominee's qualities as a teacher.

RICHARD L. FRIERSON, M.D.

Dr. Frierson went to medical school at the University of South Carolina School of Medicine where he also did his psychiatry residency and his fellowship in forensic psychiatry. Dr. Frierson is currently an Associate Professor of Psychiatry at the University of South Carolina and since 1999, he has been the Director of the Forensic Psychiatry Fellowship. In addition, since 2000, Dr. Frierson has been a member of the Committee on Examination in the Subspecialty of Forensic Psychiatry of the American Board of Psychiatry and Neurology. In 2004, Dr. Frierson received the Teacher of the Year Award from the general psychiatry residency program at the University of South Carolina.

Dr. Frierson's outstanding teaching is described by his fellows as follows: "Dr. Frierson is an exceptional educator. He respectfully listens to his students, then carefully allows his own experience and knowledge to speak to them in a diverse manner of teaching, tailoring his approach to each individual such that the flow of information is at once paced and simple, yet challenging." "He upholds the highest ethical standards and teaches others to remain above reproach in both clinical psychiatry and also in forensic work. His unbiased approach to investigation, reporting and testimony has become a model for myself and others he has tutored." "Rick is an exceptional teacher. He is gifted in making one wanting to achieve." "Knowledgeable, compassionate, humane, highly competent, friendly, witty, and humorous are only a few of the adjectives that characterize Dr. Frierson." "Dr. Frierson knows how to provide feedback in a constructive way: not too harsh, not diminishing the fellow as an individual but at the same time conveying the important message." "Dr. Frierson proved himself to be not only a knowledgeable person and a great teacher but also a caring attending. He is concerned about his fellows' well-being. He teaches us how to keep a balance between work, study, and relaxation." "As a lecturer, Dr. Frierson has the rare ability to truly connect with his audience." "Dr. Frierson's vision has created a fellowship program that provides trainees with the rich educational environment that ultimately instills confidence and self-reliance in the graduating fellows. This personal investment in the education of his trainees and his belief in our abilities has been unique in my medical training."

In recognition of his outstanding teaching in a fellowship program, the American Academy of Psychiatry and the Law presents this award to Dr. Richard L. Frierson.

DISTINGUISHED LECTURERS

Thursday, October 26

ROBERT JAY LIFTON, MD

Beyond the Superpower Syndrome: Toward A More Humane Future

Robert Jay Lifton, MD is well known for his interest in the relationship between individual psychology and historical change, and in problems surrounding the extreme historical situations of modern times. He has published extensively on the subjects of ethics, genocide, and apocalyptic violence. He has developed a general psychological perspective around the paradigm of death and the continuity of life, with a stress upon symbolization and "formative process," as well as the malleability of the contemporary self. Since the mid 1990's, Dr. Lifton has been conducting psychological research on the problem of apocalyptic violence. Following the 9/11 attacks, he undertook a study of both Islamic violence and American responses that culminated in the 1993 publication of his book, "Superpower Syndrome: America's Apocalyptic Confrontation with the World." Dr. Lifton is also the co-editor of Crimes of War – Iraq (2006) and Hiroshima in American: Fifty Years of Denial (1995). Dr. Lifton was formerly Director of the Center on Violence and Human Survival at John Jay College of Criminal Justice. Currently, Dr. Lifton is Lecturer in Psychiatry at the Harvard Medical School and the Cambridge Health Alliance, and Distinguished Professor Emeritus of Psychiatry and Psychology at the City University of New York.

Friday, October 27

MARY ANN DUTTON, PHD

Intimate Partner Violence: Expert Testimony Over 25 Years

Mary Ann Dutton, PhD is one of the nation's most pre-eminent forensic psychologists on the issue of domestic violence. She is the Principal Investigator on several federally funded grants and has conducted multiple research studies focusing on the consequences of trauma, both domestic and otherwise, and in the treatment interventions for battered women. She has numerous publications reflecting her expertise in the research, assessment and treatment of trauma. These include a book, Empowering and Healing the Battered Woman: A Model of Assessment and Intervention (1992) and numerous articles in journals including Behavioral Science and the Law, Violence Against Women, Journal of Interpersonal Violence, UCLA Women's Law Journal, Georgetown Journal of Poverty, Law, and Policy and Journal of Traumatic Stress. Dr. Dutton is currently Professor of Psychiatry at Georgetown University Medical Center, Department of Psychiatry in Washington, DC, where she directs a course in research methods for psychiatry residents and offers lectures on issues relating to psychological trauma.

Saturday, October 28

SHERWIN NULAND, MD

Physician Assisted Suicide: How Did We Get Into This Mess? Where Do We Go From Here?

Sherwin Nuland, MD is a physician, surgeon, teacher, medical historian and best-selling author. For over twenty years, Dr. Nuland has closely followed the emerging field of biomedical ethics, undertaking a wide-ranging study of evolving principles and applying them to the rapidly changing world of medicine. In his book, How We Die, Dr. Nuland reflected on the modern ways of death, seeking to demystify the process of dying for the larger public. This book sold more than half a million copies, was a 1995 Pulitzer Prize finalist and won the National Book Award. Most recently, Dr. Nuland has published Maimonides, an intellectual biography of great philosopher and physician, which has won wide acclaim. Dr. Nuland also writes feature pieces for the New Yorker, Time, Life, National Geographic, Discover, New York Review of Books and several other periodicals. He is Chairman of the Board of Managers of the Journal of the History of Medicine and Allied Sciences. Dr. Nuland is Clinical Professor of Surgery at the Yale School of Medicine and serves on the faculty of the Institution for Social and Policy Studies.

THURSDAY, OCTOBER 26, 2006

POSTER SESSION #1 — 7:15 AM - 8:00 AM/ 9:30 AM - 10:15 AM — **CHICAGO BALLROOM FOYER**

T1 ***Re-Arrest and Re-Incarceration in the Mentally Ill in CT: 1998-2004***
Robert L. Trestman, PhD, MD, Farmington, CT
Nicholas A. Demartinis, MD (I), Farmington, CT
Karen L. Pagano, MS (I), Farmington, CT
Wanli Zhang, PhD (I), Farmington, CT
Humberto D. Temporini, MD (I), Sacramento, CA

T2 ***Prevalence of Mental Illness in Connecticut's Jails***
Robert L. Trestman, PhD, MD, Farmington, CT
Julian Ford, PhD (I), Farmington, CT
Wanli Zhang, PhD (I), Farmington, CT
Karen L. Pagano, MS (I), Farmington, CT

T3 ***DBT-Informed Treatment for Impulsive Aggression in Corrections: A Pilot Study***
Robert L. Trestman, PhD, MD, Farmington, CT
Susan Sampl, PhD (I), Farmington, CT
Wanli Zhang, PhD (I), Farmington, CT
Karen L. Pagano, MD (I), Farmington, CT

T4 ***Christmas with Katrina: A Forensic Psychiatrist in Post-Hurricane New Orleans***
Jason R. Kornberg, MD, San Diego, CA

T5 ***Consent Form Readability in Mental Health Research***
Paul P. Christopher, MD, Providence, RI
Mary Ellen Foti, MD (I), Boston, MA
Kristen Roy-Budnaus, MA (I), Worcester, MA
Paul S. Appelbaum, MD, New York, NY

T6 ***Measurement of Treatment Outcome in Paraphilic Patients***
Joel T. Andrade, MSW, LICSW (I), Bridgewater, MA
Fabian M. Saleh, MD, Worcester, MA

T7 ***Parasomnia and Violence: A Dream Defense***
Prameet J. Bhushan, MD (I), Tucker, GA

T8 ***Landmark Litigants: Where Are They Now?***
LaTricia E. Coffey, MD (I), Washington, DC
Peter Ash, MD, Atlanta, GA

T9 ***Pediatric Traumatic Brain Injury: Sports-based Litigation and Forensic Assessment***
Gagan Dhaliwal, MD, Huntsville, AL
Robert P. Granacher, MD, MBA, Lexington, KY
Ralph Slovenko, JD, PhD (I), Detroit, MI

T10 ***A Theory of Mind Model of Capgras Delusion and Violence***
J. Arturo Silva, MD, San Jose, CA
Gregory B. Leong, MD, Tacoma, WA
Douglas E. Tucker, MD, Berkeley, CA

T11 ***Physician Impairment Across Specialties***
Andrew G. Nanton, MD, Durham, NC
Mehul Mankad, MD, Durham, NC
Carrie L. Brown, MD, MPH (I), Durham, NC

T12 ***Assessing Readiness Among Dually Diagnosed Women in Jail***
Debra R. Hrouda, MSSA (I), Cleveland, OH
Kathleen J. Farkas, PhD (I), Cleveland, OH

T13 ***State Hospital Competence Restoration in Indiana***
Douglas R. Morris, MD, Indianapolis, IN
George F. Parker, MD, Indianapolis, IN

T14 ***The French Conspiracy: A Strange Case of "Temporary Insanity"***
Peter Lourgos, MD, JD, Chicago, IL
Nishad J. Nakdarni, MD (I), La Grange Park, IL

T15 ***H-10 Subscale of HCR-20 as Predictor of Inpatient Violence***
Robert P. Forrest, MD, Little Rock, AR
Raymond K. Molden, MD, Little Rock, AR

OPENING CEREMONY — 8:00 AM - 10:00 AM — **SALONS A-D**

T16 ***President's Address: Authorship in Forensic Psychiatry: A Perspective***
Robert I. Simon, MD, Potomac, MD

COFFEE BREAK

PANEL — 10:15 AM - 12:00 NOON — **SALONS A-D**
T17 ***Juvenile Murderers Grow Up: Challenges and Dispositions***
Sally C. Johnson, MD, Raleigh, NC
Roy J. O'Shaughnessy, MD, Vancouver, BC, Canada
Diane H. Schetky, MD, Rockport, ME
Park E. Dietz, MD, PhD, Newport Beach, CA

PANEL — 10:15 AM - 12:00 NOON — **LOS ANGELES/MIAMI/ SCOTTSDALE**
T18 ***Real World Challenges in Correctional Psychiatry***
James Knoll, IV, MD, Concord, NH
Fabian Saleh, MD, Worcester, MA
Lieutenant Charles Boyajian, (I), Concord, NH
Paul E. Noroian, MD, Worcester, MA

PANEL — 10:15 AM - 12:00 NOON — **INDIANA/IOWA/ MICHIGAN**
T19 ***Update from the APA Council on Psychiatry and Law***
Steven K. Hoge, MD, MBA, New York, NY
Paul S. Appelbaum, MD, New York, NY
Stuart A. Anfang, MD, Northampton, MA

WORKSHOP — 10:15 AM - 12:00 NOON — **DENVER/HOUSTON/ KANSAS CITY**
T20 ***Teaching Performance in Forensic Education***
Madelon V. Baranoski, PhD (I), New Haven, CT
Vinneth Carvalho, MD, New Haven, CT
Bobby Singh, MD, New Haven, CT
Shaheen Darani, MD, New Haven, CT
Mary Galvin, JD (I), Milford, CT

PAPER SESSION #1 — 10:15 AM - 12:00 NOON — **NW/OHIO/PURDUE**
T21 ***Contemporary Review of Capital Punishment***
Rahn K. Bailey, MD, League City, TX
James E. Lee, Jr., MD (I), Columbia, SC
Steve Schutte, JD (I), Indianapolis, IN

T22 ***Predicting Restorability of Incompetent Defendants***
Douglas Mossman, MD, Dayton, OH

T23 ***Mental Retardation and the Death Penalty***
Ari U. Etheridge, MD, San Francisco, CA

LUNCH — 12:00 NOON - 2:00 PM — **SALONS E-H**
T24 ***Beyond the Superpower Syndrome: Toward A More Humane Future***
Robert Jay Lifton, MD (I), Cambridge, MA

WORKSHOP — 2:15 PM - 4:00 PM — **SALONS A-D**

T25 Advertising or Aggrandizement? Defining the Limits on Self Promotion

Thomas G. Gutheil, MD, Brookline, MA
Donna M. Norris, MD, Wellesley, MA
Marilyn Price, MD, CM, Providence, RI
Donald M. Meyer, MD, Cambridge, MA

COURSE — 2:15 PM - 6:15 PM — **DENVER/HOUSTON/ KANSAS CITY**

T26 Insanity Defense Evaluations

Phillip J. Resnick, MD, Cleveland, OH

WORKSHOP — 2:15 PM - 4:00 PM — **LOS ANGELES/MIAMI/ SCOTTSDALE**

T27 Assessment of Alleged Workplace Stress Disability

Landy F. Sparr, MD, MA, Portland, OR
Stewart S. Newman, MD, Portland, OR

WORKSHOP — 2:15 PM - 4:00 PM — **INDIANA/IOWA/ MICHIGAN**

T28 Forensic Research: Unique Challenges

Kathleen J. Farkas, PhD (I), Cleveland, OH
Debra R. Hrouda, MSSA (I), Cleveland, OH

RESEARCH IN PROGRESS #1 — 2:15 PM - 4:00 PM — **NW/OHIO/PURDUE**

T29 Involuntary Commitment and the Probate Judge: A Survey

Michael J. Ferlauto, MD, Columbia, SC
Richard L. Frierson, MD, Columbia, SC

T30 Conditional Release Decision-Making

Barbara E. McDermott, PhD (I), Sacramento, CA
Cameron Quanbeck, MD, Sacramento, CA
David Busse, MA (I), Sacramento, CA
Felecia Andrade, BA (I), Napa, CA
Charles L. Scott, MD, Sacramento, CA

T31 Review of Commitment Statutes in the United States

Margaret A. Bolton, MD, Worcester, MA
Paul Appelbaum, MD, New York, NY
Debra A. Pinals, MD, Worcester, MA
Al Grudzinskas, JD (I), Worcester, MA

COFFEE BREAK

PAPER SESSION #2 — 4:15 PM - 5:15 PM — **SALONS A/D**

T32 Criminalization of Psychotherapist-Patient Sex

Julia P. Mitrevski, MD, San Francisco, CA

T33 Current Status of the Duty to Protect

James C. Beck, MD, PhD, Boston, MA
Andrea Maislen, JD (I), Somerville, MA

WORKSHOP — 4:15 PM - 6:15 PM — **LOS ANGELES/MIAMI/ SCOTTSDALE**

T34 The "Predator" Next Door: Management of Sexually Violent Predators and Long-Term Offenders (Advanced) - Sex Offender Committee

J. Paul Fedoroff, MD, Ottawa, ON, Canada
Samuel Jan Brakel, JD (I), Chicago, IL
Douglas Tucker, MD, Berkeley, CA
Daniel J. Brodsky, LLB (I), Toronto, ON, Canada

PANEL — 4:15 PM - 6:15 PM — **INDIANA/IOWA/ MICHIGAN**

T35 Developmental Issues and Forensic Evaluations in Children - Child and Adolescent Committe

Lillian M. Tidler, MD, Midlothian, VA
Cheryl D. Wills, MD, Laplace, LA
Stephen B. Billick, MD, New York, NY
Eraka Bath, MD, New York, NY
Fabian M. Saleh, MD, Worcester, MA

WORKSHOP — 4:15 PM - 6:15 PM — **NW/OHIO/PURDUE**

T36 Detection of Malingering in Disability Evaluations (Core)

Roger Z. Samuel, MD, Boca Raton, FL
Thomas McLaren, PhD (I), Chattanooga, TN
Henry Conroe, MD, Chicago, IL
Mark DeBofsky, JD (I), Chicago, IL

RESEARCH IN PROGRESS #2 — 5:15 PM - 6:15 PM — **SALONS A-D**

T37 Disciplinary Actions Against Psychiatrists in Maryland

Ana N. Cervantes, MD (I), Columbia, MD
Jeffrey Janofsky, MD, Timonium, MD

T38 A Difference of Opinion Regarding Risk and Negligence

H.W. LeBourgeois, III, MD, New Orleans, LA
Debra A. Pinals, MD, Worcester, MA
Valerie Williams, MA, MS (I), Worcester, MA
Paul S. Appelbaum, MD, New York, NY

MOCK TRIAL — 7:00 PM - 9:30 PM — **SALONS A-D**

T39 Medical Malpractice: Postpartum Psychosis and Suicide

Renée L. Binder, MD, San Francisco, CA
Liza H. Gold, MD, Arlington, VA
Phillip J. Resnick, MD, Cleveland, OH
Honorable Jennifer Duncan-Brice, JD (I), Chicago, IL
Tanya Park, JD (I), Chicago, IL
Beverly P. Spearman, RN, JD (I), Chicago, IL

T1 **RE-ARREST AND RE-INCARCERATION IN THE MENTALLY ILL IN CT: 1998-2004**

Robert L. Trestman, PhD, MD, Farmington, CT
Nicholas A. Demartinis, MD (I), Farmington, CT
Karen L. Pagano, MS (I), Farmington, CT
Wanli Zhang, PhD (I), Farmington, CT
Humberto D. Temporini, MD (I), Farmington, CT

EDUCATIONAL OBJECTIVE
Participants will be able to describe rearrest and reincarceration rates for mentally ill offenders, and recognize the need for quality mental health treatment during periods of incarceration as well as post-discharge.

SUMMARY
Inmates with serious mental illness are at risk of rearrest and reincarceration due to many causes. This is a retrospective review of one year reoffense and reincarceration rates for individuals released from the Connecticut Department of Correction (CDOC) and referred to the Connecticut Department of Mental Health and Addictions Services (DMHAS) for community treatment planning 6 months prior to discharge, between July 1, 1998 and January 31, 2004. Data were collected on 883 individuals and included demographic information, release dates, mental health diagnosis, presence of co-morbid substance abuse disorders, rearrest and reincarceration dates, and type of offense for original and rearrest charges (for a 12-month period after CDOC discharge). The highest frequencies of Axis I disorders were Schizophrenia, Bipolar Disorder, and Major Depression. The highest frequencies of Axis II disorders were Antisocial Personality Disorder and Borderline Personality Disorder. About 44% were rearrested within one year of discharge. 19% had two or more arrests within the first year post release. Comorbidity and diagnosis/offense relationships will also be presented. Despite case management and planning in advance of discharge to the community, inmates with serious mental illness are at high risk for rearrest and reincarceration in the first post discharge year.

REFERENCES
Hartwell S: Triple stigma: Persons with mental illness and substance abuse problems in the criminal justice system. Criminal Justice Policy Review 15(1): 84-99, 2004
Lovell D, Gagliardi G, Peterson P: Recidivism and use of services among persons with mental illness after release from prison. Psychiatr Serv 53(10):1290-96, 2002

SELF ASSESSMENT QUESTIONS
1. What is the rearrest rate after one-year post discharge in this study?
ANSWER: 44%

2. What is the ability for CDOC and DMHAS to coordinate service treatment planning for inmates upon release?
a. easy and standardized
b. moderately difficult
c. very difficult
ANSWER: c

T2 **PREVALENCE OF MENTAL ILLNESS IN CONNECTICUT'S JAILS**

Robert L. Trestman, PhD, MD, Farmington, CT
Julian Ford, PhD (I), Farmington, CT
Wanli Zhang, PhD (I), Farmington, CT
Karen L. Pagano, MS (I), Farmington, CT

EDUCATIONAL OBJECTIVE
Participants will be familiarized with the results of a pilot study assessing provision of a DBT-informed intervention in corrections, and learn some of the pragmatic and feasibility issues of providing a DBT-informed treatment in corrections.

SUMMARY
Impulsive aggression is a significant problem in correctional facilities. A DBT-informed program of skills training was implemented in this pilot study with a focus on examining the utility of such an intervention toward reducing inmate aggression. Participants (N=18) at 2 Connecticut high-security prisons for males received 16 weeks of skills training groups, followed by random assignment to 8 weeks of either skills coaching or psycho-education. Comparing baseline to post skills group follow-up, there was substantial improvement on the Buss-Perry Aggression (BPA) questionnaire dimensions of physical aggression ($F = 13.70$, $p < .01$) and anger ($F = 7.13$, $p < .05$). Inmates' disciplinary records were reviewed, and a tendency toward reduction in frequency was observed: year prior to treat-

ment: 0.39/month; during treatment: 0.14/month (F = 2.57, p = .13); and 6 months post treatment: 0.17/month. In addition to these objective improvements in function associated with a DBT-informed program, pragmatic issues of implementing a DBT-informed program of intervention in correctional settings are discussed, as well as limitations of this pilot study and recommendations for further study.

REFERENCES

Berzins LG, Trestman RL: The development and implementation of dialectical behavior therapy in forensic settings. Int J of Forensic Mental Health 3(1): 95-105, 2004

Linehan MM: Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York: Guilford Press, (1993a)

SELF ASSESSMENT QUESTIONS

1. Why is DBT-informed treatment a suitable choice for correctional populations?

a. There is a high incidence of personality disorders in the correctional population

b. It targets aggressive and impulsive behaviors, which are prevalent in the correctional population

c. Previous studies show efficacy in CBT-based interventions in forensic populations

d. All of the above

ANSWER: d

2. Name one of the key components in having a successful DBT program implemented in a correctional setting.

a. Conducting staff trainings within the facility

b. Establishing trustworthy relationships with custody staff and mental health staff

c. Maintaining communication with staff so that skills will be reinforced to the inmates

d. All of the above

ANSWER: d

T3

DBT-INFORMED TREATMENT FOR IMPULSIVE AGGRESSION IN CORRECTIONS: A PILOT STUDY

Robert L. Trestman, PhD, MD, Farmington, CT
Susan Sampl, PhD (I), Farmington, CT
Wanli Zhang, PhD (I), Farmington, CT
Karen L. Pagano, MD (I), Farmington, CT

EDUCATIONAL OBJECTIVE

Participants will be able to recognize the growing need for improved mental health screening instruments in jail settings and understand the constraints and protocols of developing and empirically validating screening instruments with offenders in correctional settings.

SUMMARY

Reliable early identification of psychiatric disorders and suicide risk factors is a critical step toward addressing the public health and safety concerns associated with the increase of mentally ill offenders in correctional facilities. Participants were recruited shortly after processing at each of the four Connecticut jails for men and one facility for women. Women (N=670) and men (N=1526) consecutively admitted to five jails completed a 55-item screen. Randomized sub-samples (100 women; 201 men) completed structured diagnostic interviews within five days. An 8-item female screen (CMHS-F) and 12-item male screen (CMHS-M) identified inmates with lifetime psychiatric disorders with 70-80+% overall accuracy and lower rates of false positives and negatives than reported for comparable screens in correctional populations. This brief screening tool may be of significant benefit for use in multiple jail settings. Unlike previous instruments, it is gender and ethnicity specific, easy to use, and with adequate sensitivity and specificity to be an effective and efficient screening tool.

REFERENCES

Diamond P, Wang E, Holzer C III, Thomas C, Cruser A: The prevalence of mental illness in prison. Admin Policy Mental Health 29:21-40, 2001

Metzner JL, Miller RD, Kleinsasser D: Mental health screening and evaluation within prisons. Bull Am Acad Psychiatry Law 22:451-57, 1994

SELF ASSESSMENT QUESTIONS

1. What percentage of male detainees has a current severe psychiatric or substance abuse disorder?
ANSWER: Over 30%

2. An effective mental health-screening tool for use in jails should:
a. Only be administered by trained mental health clinicians
b. Be sensitive and specific for both men and women
c. Be between 100 and 120 questions in length
ANSWER: b

T4 **CHRISTMAS WITH KATRINA: A FORENSIC PSYCHIATRIST IN POST-HURRICANE NEW ORLEANS**

Jason R. Kornberg, MD, San Diego, CA

EDUCATIONAL OBJECTIVE

To share my experiences as a psychiatrist deployed months following the Hurricane Katrina disaster and to evaluate the risk-management issues with regard to psychiatric delivery during this period of time.

SUMMARY

Hurricane Katrina presented many dilemmas in terms of health care delivery. Even months following this disaster, many challenges remained with regard to the delivery and utilization of mental health services. In this presentation, a forensic psychiatrist shares his experiences and reflections from his deployment to New Orleans months following this disaster.

REFERENCES

Greenough PG, Kirsch TD: Public health response -- assessing needs. N Engl J Med 353:1544-46, 2005
Voelker R: Post-Katrina mental health needs prompt group to compile disaster medicine guide. JAMA 295:259-60, 2006

SELF ASSESSMENT QUESTIONS

1. According to studies conducted by the Centers for Disease Control, what percent of individuals assessed for symptoms of post-traumatic stress disorder warranted referral for mental health services?
ANSWER: 45%

2. What is the estimated number of persons in need of mental health services in post-Katrina New Orleans, according to the Substance Abuse and Mental Health Services Administration?
ANSWER: 500,000

T5 **CONSENT FORM READABILITY IN MENTAL HEALTH RESEARCH**

Paul P. Christopher, MD, Providence, RI
Mary Ellen Foti, MD (I), Boston, MA
Kristen Roy-Budnowski, MA (I), Worcester, MA
Paul S. Appelbaum, MD, New York, NY

EDUCATIONAL OBJECTIVE

To inform attendees of the poor readability of informed consent forms used in mental health research and highlight the disparity between consent form readability and the educational level of potential study participants.

SUMMARY

Poor readability of informed consent forms is a problem in clinical research. The low educational attainments of many patients with mental illnesses might suggest a greater problem in mental health settings. We examined whether the informed consent forms used in Massachusetts Department of Mental Health (MA-DMH) research were written at a grade level higher than that achieved by potential study participants. We calculated the readability of 154 consent forms using several formulas. Readability scores were stratified by risk level of the study from which the consent form was taken. We compared these data with the maximum attained grade level of potential participants in MA-DMH approved studies. Mean readability scores for the consent forms ranged between grade level 12 and 14.5. Furthermore, mean readability scores increased with increasing study risk level. Approximately 35% of potential participants had not graduated high school, 37% had graduated high school or obtained a GED and 28% had some education beyond the 12th grade. These data demonstrate poor readability of consent forms used in MA-DMH research and highlight a mismatch between consent form readability and the educational level of potential study participants. These findings suggest that methods of reducing the complexity of forms are much needed.

REFERENCES
Sentell TL, Shumway MA: Low literacy and mental illness in a nationally representative sample. J Nervous & Mental Disease 191:549-52, 2003
Christensen RC, Grace GD: The prevalence of low literacy in an indigent psychiatric population. Psychiatric Services 50:262-3, 1999

SELF ASSESSMENT QUESTIONS

1. The findings in this poster demonstrate which of the following?

a. The average readability scores for this sample of informed consent forms were written at or above the 12th grade reading level.
b. Readability scores for informed consent forms did not vary significantly according to the risk level of the corresponding study.
c. Mean readability scores for each of the four formulas used were equal.

ANSWER: a, b, and c are incorrect. Readability scores increased with increasing study risk level (b). There was variability in the mean scores provided by each of the formulas (c).

2. Which of the following is true?

a. More than half of the adult DMH population had not completed high school.
b. More than 27% of the adult DMH population had some schooling beyond the 12th grade.
c. Nearly all of the adult DMH population had completed enough schooling to read the average informed consent form.

ANSWER: b is correct. Only 35.3% had not completed high school (a). At least 35.5% had not completed sufficient schooling to read the average informed consent form (c).

T6 MEASUREMENT OF TREATMENT OUTCOME IN PARAPHILIC PATIENTS

Joel T. Andrade, MSW, LICSW (I), Bridgewater, MA
Fabian M. Saleh, MD, Worcester, MA

EDUCATIONAL OBJECTIVE
Provide a concise overview of the DSM-IV-TR criteria for paraphilias. Discuss the role of the penile plethysmograph (PPG) in the assessment and treatment of a paraphilic patient treated with leuprolide acetate. Draw conclusions based on this review, and recommend areas for future research.

SUMMARY
Paraphilias are defined in the DSM-IV-TR as 'recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons, that occur over a period of at least 6 months." Frequently, paraphilic patients present to treatment secondary to arrest or for court-ordered treatment. The clinical assessment of paraphilias includes a thorough psychosexual history and clinical interview, and due to the forensic nature of many such assessments, should be augmented by an objective measure of deviant arousal such as the penile plethysmograph (PPG). The PPG has shown the ability to discriminate between various groups of paraphilic patients, such as those who sexually assault adults and those who target children (Looman & Marshall, 2001). This poster will review the diagnostic criteria of paraphilic disorders; provide an overview of the PPG, followed by a detailed description of its use in the treatment of a paraphilic patient. This patient was treated with the luteinizing hormone-releasing hormone (LHRH) agonist leuprolide acetate, and serial PPGs were conducted to measure treatment outcome. Conclusions will be drawn, followed by proposed areas of future research.

REFERENCES
Saleh F: A hypersexual paraphilic patient treated with leuprolide acetate: A single case report. J Sex & Marital Therapy 31:433-44, 2005
Blanchard R, Klassen P, Dickey R, Kuban ME, Blak T: Sensitivity and specificity of the phallometric test for pedophilia in nonadmitting sex offenders. Psychological Assessment 13:601-7, 2001

SELF ASSESSMENT QUESTIONS

1. To receive the diagnosis of a paraphilia which of the following is required?

a. recurrent intense sexually arousing fantasies, sexual urges, or sexual behaviors
b. sexual behaviors only
c. sexual fantasies only
d. none of the above

ANSWER: a.

1. An objective measure of deviant sexual arousal is:
a. clinical interview
b. penile plethysmograph
c. self-reported sexual history
d. sexual history questionnaire
ANSWER: b

T7 **PARASOMNIA AND VIOLENCE: A DREAM DEFENSE**

Prameet J. Bhushan, MD (I), Tucker, GA

EDUCATIONAL OBJECTIVE
This presentation will survey and discuss a sample of legal cases in this area in the context of the DSM-IV-TR recognized sleep disorders and recent research on how to evaluate these conditions.

SUMMARY
A common forensic approach to crimes committed during altered states of consciousness often focuses on those preceded by the use of substances. The issue of responsibility and states of voluntary and involuntary intoxication is clearly addressed. The law is less clear or consistent, however, in reference to altered states of consciousness created by commonly recognized sleep disorders. Furthermore, there are no clear guidelines as to how to evaluate parasomnia-induced states of altered consciousness. The literature reports that up to 2% of patients suffering from sleep disorders engage in violent behavior while asleep, raising the question: Can this be used as a legitimate defense? This presentation will survey and discuss a sample of legal cases in this area in the context of the DSM-IV-TR recognized sleep disorders and recent research on how to evaluate these conditions.

REFERENCES
Cartwright R: Sleepwalking violence: A sleep disorder, a legal dilemma, and a psychological challenge. Am J Psychiatry 161(7):1149-58, 2004
Denno D: A mind to blame: New views on involuntary acts. Behav Sci Law 21:601-18, 2003

SELF ASSESSMENT QUESTIONS
1. Which of the following is not a DSM-IV recognized Parasomnia or Sleep Disorder?
a. Parasomnia NOS
b. Alcohol Induced Sleep Disorder
c. Sleepwalking Disorder
d. Sleep Violence Disorder
e. Sleep Terror Disorder
ANSWER: d

2. Legally speaking, a defense based on Automatism implies which of the following?
a. No crime has been committed
b. A crime was committed but the accused has a full acquittal
c. The accused had voluntary control over their actions
d. The accused does not have a medically serious disease event
ANSWER: b

T8 **LANDMARK LITIGANTS: WHERE ARE THEY NOW?**

LaTricia E. Coffey, MD (I), Washington, DC
Peter Ash, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE
To illustrate the human side of forensic psychiatry cases, and to inform the reader of sequelae of legal decisions in psychiatric cases.

SUMMARY
Studying AAPL Landmark cases helps us to understand the legal context in which we practice, developing case law, patterns in lines of cases, and precedents which will guide future rulings. The litigants in these Landmark cases have become household names in our field, but there is sparse collective data on the individuals since their rulings. Their import to us persists largely as tangible examples of the principles embodied in their cases. In this study we examine the more human side: how the cases affected the named litigants directly, what their personal reactions to being named in a famous case were, and how their lives developed following the courts' decisions. We present fol-

low-up data derived from news reports and telephone interviews of those involved in a subset of recent Landmark cases in an attempt to address the influence of these historical rulings on litigants themselves.

REFERENCES

American Academy of Psychiatry and the Law, Revised Landmark Case List, (visited Feb. 2006) http://www.aapl.org/landmark_list.htm
LexisNexis, (visited Feb. 2006) http://www.lexisnexis.com/search/search1.asp

SELF ASSESSMENT QUESTIONS

1. Litigants in Landmark cases:
a. enjoy their 15 minutes of fame.
b. are unaware of the importance of their case.
c. see their case as primarily a delaying tactic because their situation had to be reheard by a lower court under the new principle established in the case.
d. evidence a heterogeneous set of responses.
ANSWER: d

2. The importance of this presentation is to:
a. squelch curiosity about the personal lives' of the litigants.
b. understand the human consequence of the legal principles disputed in the cases.
c. find out which litigants were right after all.
ANSWER: b

T9 PEDIATRIC TRAUMATIC BRAIN INJURY: SPORTS-BASED LITIGATION AND FORENSIC ASSESSMENT

Gagan Dhaliwal, MD, Huntsville, AL
Robert P. Granacher, MD, MBA, Lexington, KY
Ralph Slovenko, JD, PhD (I), Detroit, MI

EDUCATIONAL OBJECTIVE

To clarify function of a forensic psychiatrist in pediatric traumatic brain injury. To teach methods to evaluate traumatic brain injury and integrate neuropsychological, developmental and imaging data to make an opinion and prepare forensic reports and court testimony. To research case law in school and sports related litigation in context of traumatic brain injury. To discuss use of "Syndrome Evidence" in courts in context of pediatric traumatic brain injury.

SUMMARY

Some children and adolescents sustain Traumatic Brain injury (TBI) in context of sport injuries. It will illustrate available American case law where students have pursued legal action for resulting injury against coaches or schools or against companies based on product liability theory. (In Shriber v. The Care Station; and In Lister v. Bill Kelley Athletic, Inc.; Rawlings Sporting Goods Co., Inc. v. Daniels) Doctors have also been sued for medical negligence in context of sports related head injuries. (Morgan v. State of New York; Speed v. State and Welch v. Dunsmuir Joint Union High Sch. Dist). Implications of Bellman, Knight and Kahn factors that have influenced school based sport injury litigation recently will be discussed. Neuropsychiatric assessment of sports related pediatric traumatic brain injury along with concepts of causation, damages and impairment determination, functional intellectual capacity, current and preinjury academic ability estimates, adaptation, developmental indices and neuropsychological evaluation (Use of NEPSY and Continuous performance test(CPT) will be addressed. Finally, the presentation will describe the admissibility of "Syndrome Evidence" in children to establish whether a traumatic event happened and how it can apply to traumatic brain injury in children.

REFERENCES

Robert P. Granacher: Traumatic Brain Injury: Methods for Clinical and Forensic Neuropsychiatric Assessment, CRC PRESS, 2003
Shriber v. The Care Station, (Los Angeles Cty. Super. Ct. Cal. Nov. 10, 1998)

SELF ASSESSMENT QUESTIONS

1. What are two legal principles guiding school based sport injury litigation?
ANSWER: ordinary negligence and recklessness

2. What are some of neuropsychological tools used to assess traumatic brain injury?
ANSWER: NEPSY and Continuous Performance Test (CPT)

T10 A THEORY OF MIND MODEL OF CAPGRAS DELUSION AND VIOLENCE

J. Arturo Silva, MD, San Jose, CA
Gregory B. Leong, MD, Tacoma, WA

EDUCATIONAL OBJECTIVE

To describe a theory of mind neuropsychiatric model of Capgras delusional misidentification associated with violent behavior. The participant will also learn about the basic types of delusional misidentification of others and of the self.

SUMMARY

In delusional misidentification, the affected individual often misidentifies other persons and/or his or herself. The Capgras delusion (syndrome), or syndrome of doubles, has been the most well known form of delusional misidentification. In this delusion, the affected individual misidentifies the psychological identity of another with the other person's appearance remaining unchanged. The individual with the Capgras delusion often perceives the delusionally misidentified object as a malicious impostor or double of the original person. Violence directed toward the delusionally misidentified object by the person with a Capgras delusion has been increasingly recognized as a significant forensic psychiatric problem. However, a comprehensive explanation for the Capgras delusion associated with violence has yet to emerge. The Theory of Mind paradigm has been to explain socialization deficits in both autism and schizophrenia. Utilizing recent advances in psychiatric knowledge, we propose a Theory of Mind neuropsychiatric model in order to better explicate the association between the Capgras delusion and violence.

REFERENCES

Silva JA, Leong GB, Weinstock R, Klein RL: Psychiatric factors associated with dangerous misidentification syndromes. Bull Am Acad Psychiatry Law 23:53-61, 1995
Silva JA, Leong GB, Weinstock R, Sharma KK, Klein RL: Delusional misidentification syndrome and dangerousness. Psychopathology 27:215-19, 1994

SELF ASSESSMENT QUESTIONS

1. Which of the following is the basic definition of the Theory of Mind?
a. a philosophical system
b. the estimation of mental states of others and the self
c. a psychosomatic explanation of consciousness
d. none of the above
ANSWER: b

2. Which two areas of the brain are thought to be most prominent in explicating the relationship between the Capgras delusion and violence?
a. temporal lobe and parietal lobe
b. temporal lobe and limbic system
c. prefrontal cortex and limbic system
d. prefrontal cortex and occipital lobe
ANSWER: c

T11 PHYSICIAN IMPAIRMENT ACROSS SPECIALTIES

Andrew G. Nanton, MD, Durham, NC
Mehul Mankad, MD, Durham, NC
Carrie L. Brown, MD, MPH (I), Durham, NC

EDUCATIONAL OBJECTIVE

To explore the relationship between specialty and professional infraction among impaired physicians.

SUMMARY

The scientific literature referencing the specialty of an impaired physician against the type of infraction involved in loss of licensure is limited. This study provides a descriptive analysis of disciplinary actions reported by the North Carolina Medical Board (NCMB) with attention to infraction type, self-reported specialty, and gender. The bimonthly reports of the NCMB from 2000 through 2005 were reviewed for specialty and infraction among all licensees, including both physicians and physician extenders. The NCMB provided information regarding infractions by 469 providers. 400 of 469 offenders were physicians; 69 were physician extenders. Among practitioners, the most common infraction was substance abuse (123/469 (26%)). The next most frequent types of infractions were administra-

tive (113/469 (24%)) and improper prescribing practices (101/469 (22%)) respectively. Practitioners averaged 1.4 offenses each across specialties, indicating that many individuals committed more than one type of offense prior to action by the NCMB. Anesthesiologists were the most frequently impaired by substance abuse (7/16 (43%)), followed by psychiatrists (10/27 (37%)). The most frequent infractions listed were substance abuse, administrative violations, and improper prescribing practices. These trends suggested that some specialties were more likely to have committed certain kinds of infractions.

REFERENCES

Khaliq AA, Dimassi H, Huang CY, Narine L, Smego RA: Disciplinary action against physicians: Who is likely to get disciplined? Am J Medicine. 118(7):773-7, 2005
Clay SW, Conatser RR: Characteristics of physicians disciplined by the State Medical Board of Ohio. J Am Osteopathic Association. 103(2):81-8, 2003

SELF ASSESSMENT QUESTIONS

1. What is the most common infraction endangering the license of physicians and extenders?
ANSWER: Substance Abuse

2. Which specialty had the highest percentage of offenders implicated in boundary violations?
ANSWER: Obstetrics and Gynecology

T12 **ASSESSING READINESS AMONG DUALLY DIAGNOSED WOMEN IN JAIL**

Debra R. Hrouda, MSSA (I), Cleveland, OH
Kathleen J. Farkas, PhD (I), Cleveland, OH

EDUCATIONAL OBJECTIVE

To explore the levels of readiness for treatment among dually diagnosed women detained in a county jail.

SUMMARY

Women in the criminal justice system are frequently court-ordered to receive some form of treatment for their use of alcohol and other drugs. The growing awareness and support for the assessment of clients' readiness for change with the corresponding call for stage-appropriate intervention brings forth the need to assess clients and develop appropriate interventions. A total of 198 dually diagnosed female jail detainees completed the study. Women endorsed high levels of readiness for change on the SOCRATES 8 – only 10 (5%) endorsed responses consistent with ambivalence, 123 (65%) recognition, and 57 (30%) taking steps. While on the surface, these rates appear high, they can best be understood when considered in context. The location and situation of the person has a significant impact on her/his motivation for treatment and choice of intervention. While best practices indicate individuals court-ordered to treatment upon release be assumed to be in early persuasion, women who were incarcerated endorsed responses indicating a higher level of readiness for change. This, in combination with the length of stay in the jail setting of this subject pool provides support for starting stage-appropriate interventions while women are in jail.

REFERENCES

Prochaska J, DiClemente C, Norcross J: In search of how people change: Applications to addictive behaviors. American Psychologist 47(9):1102-14, 1992
Miller WR, Tonigan JS: Assessing drinkers' motivations for change: The Stages of Change Readiness and Eagerness Scale (SOCRATES). Psychology of Addictive Behaviors 10: 81-89, 1996

SELF ASSESSMENT QUESTIONS

1. How does the context of the research influence the measure of readiness to change?
ANSWER: This study indicates that women detained in jail score primarily in the recognition and taking steps stages of change. This may be influenced by the fact that the sample had been incarcerated for an average of 5 weeks at interview.

2. What are the implications of these findings for treatment planning in corrections settings?
ANSWER: Implications include the development of additional services to capitalize on the perceive readiness to change among female jail detainees.

T13 **STATE HOSPITAL COMPETENCE RESTORATION IN INDIANA**

Douglas R. Morris, MD, Indianapolis, IN
George F. Parker, MD, Indianapolis, IN

EDUCATIONAL OBJECTIVE

To review trends in admissions, restoration rates, and length of stay, by hospital and by diagnostic category, of defendants admitted to Indiana state hospitals for restoration of competence to stand trial from 1988 through 2005, by analyzing a database of 1,475 admissions.

SUMMARY

Introduction: Restoration to competence (RTC) has become increasingly important for Indiana state hospitals over the past 15 years. Most RTC admissions are sent to one primarily, but not exclusively, forensic state hospital, but many are admitted to other state hospitals.
Methods: A Department of Mental Health and Addiction database of defendants admitted for RTC between 1988 and 2005 was analyzed for trends in annual admissions, length of stay (LOS) and success of restoration by hospital and by diagnostic category.
Results: Preliminary analysis of 1,475 RTC admissions showed an increase in annual admissions over the study period, but the percentage success of restoration gradually decreased. LOS declined steadily after 1997. Admission of defendants with psychosis increased steadily over the study period; mood disorders and mental retardation (MR) admits were steady. MR defendants had a longer LOS and a lower rate of restoration than defendants with psychotic or mood disorders. The forensic hospital had a lower LOS for RTC than the other hospitals, but the difference decreased over time.
Discussion: The forensic state hospital had better RTC outcomes than general state hospitals. ICST defendants with MR had poor outcomes.

REFERENCES

Miller RD: Hospitalization of criminal defendants for evaluation of competence to stand trial or for restoration of competence: clinical and legal issues. Behav Sci Law 21:369-91, 2003
Mumley DL, Tilllbrook CE, Grisso T: Five year research update (1996-2000): Evaluations for competence to stand trial (adjudicative competence). Behav Sci Law 21:329-50, 2003

SELF ASSESSMENT QUESTIONS

1. State statutes permit which of the following maximum length of stay for inpatient restoration of competence to stand trail?

a. 1 year
b. 1-5 years
c. depends on the potential maximum sentence
d. no statutory limit
e. all of the above

ANSWER: e

1. Criminal charges against Indiana NCST defendants not restored within statutory time limits:

a. are automatically dropped
b. persist for a maximum of 1 year if the defendant continues to meet civil commitment criteria
c. are dropped for misdemeanors but may persist for up to 5 years for felony charges
d. may persist indefinitely, at the discretion of the prosecutor
e. undergo judicial review to determine the merits of the charges

ANSWER: d

T14 THE FRENCH CONSPIRACY: A STRANGE CASE OF "TEMPORARY INSANITY"

Peter Lourgos, MD, JD, Chicago, IL
Nishad J. Nakdarni, MD (I), La Grange Park, IL

EDUCATIONAL OBJECTIVE
To present attendees with a complex and atypical case of an individual with transient psychosis who was adjudicated Not Guilty by Reason of Insanity (NGRI).

SUMMARY
Mr. P.M. is a Dutch national with no significant history of mental illness who came to Chicago on a work visa and gained employment as a restaurant supervisor. In early 2005, he began developing a complex delusional (persecutory and somatic) system related to his co-workers and the French government. In an agitated and psychotic state, he attacked a police officer and was charged with aggravated battery. His psychotic symptoms had resolved by the time of his forensic evaluations. He was eventually adjudicated NGRI by the trial court, even though he denied suffering from any mental illness. This case presents interesting issues of co-morbid substance abuse, paranoid personality characteristics, atypical psychosis, potential malingering, and the appropriate use of the NGRI defense in an individual who continues to assert that he was never truly mentally ill.

REFERENCES
Murphy D: Brief psychoses in forensic psychiatry. J Forensic Psychiatry 11(2):328, 2000
Broughton et al: Malingered psychosis. J Forensic Psychiatry 12(2):407-22, 2001

SELF ASSESSMENT QUESTIONS
1. What is the most common cause of transient psychosis?
a. bipolar disorder
b. stroke
c. substance abuse
d. heavy metal intoxication
ANSWER: c

2. What must be ruled out when a forensic evaluee presents with a claim of temporary insanity?
a. intoxication
b. malingering
c. schizophrenia
d. major depressive disorder
ANSWER: b

T15 H-10 SUBSCALE OF HCR-20 AS PREDICTOR OF INPATIENT VIOLENCE

Robert P. Forrest, MD, Little Rock, AR
Raymond K. Molden, MD, Little Rock, AR

EDUCATIONAL OBJECTIVE
The educational objective is to present new scientific data obtained through a retrospective chart review concerning the use of the H-10 subscale of the HCR-20 as a potential predictor of inpatient violence.

SUMMARY
To evaluate whether the H-10 subscale of the HCR-20 can predict inpatient violence among forensic psychiatric patients, the investigators conducted a retrospective chart review study of 188 consecutive forensic discharges from the Arkansas State Hospital between 08/01/03 and 10/31/04. Data collected included demographic and clinical characteristics, H-10 scores completed with admission data, and number and circumstances of violent incidents. Subject characteristics included: mean age of 36.6, 75% male, 56% non-whites, mean age at first hospitalization 26.7, mean number of hospitalizations 2.0 and median H-10 score of 9.0. Sixty-three (33.5%) of the subjects had 1 or more violent incidents (total 312) during the hospitalization. Logistic regression analyses demonstrated that subjects who had a H-10 score greater than 9 were three times (Odds Ratio 3.2, p value .003) more likely to commit one or more incidents of violence compared to those with a score of 9 or less, controlling for admission GAF, race, age of first hospitalization, number of hospitalizations, and admission symptoms of psychosis, mania, or aggression. The H-10 subscale may be a useful admission tool to predict violent behavior in a forensic setting. High risk subjects could be targeted for special interventions to minimize the risk of violence during hospitalization.

REFERENCES
Apperson L, Mulvey E, Lidz C: Short-term clinical prediction of assaultive behavior: Artifacts of research methods. Am J of Psychiatry 150: 1374-9, 1993
Arango C, Calcedo Barba A, Gonzalez-Salvador T: Violence in inpatients with schizophrenia: A prospective study. Schizophrenia Bull 25:493-503, 1999

SELF ASSESSMENT QUESTIONS
1. Which of these factors had any statistically significant ability to predict the potential for violence of forensic psychiatric patients while hospitalized on a forensic unit?
a. H-10
b. sex
c. history of aggression
d. personality disorder
ANSWER: a

2. What was the most statistically significant predictor of inpatient violence among hospitalized forensic psychiatric patients?
ANSWER: Presence of psychosis, mania or aggression on admission with a four-fold increase in violence.

T16 PRESIDENT'S ADDRESS: AUTHORSHIP IN FORENSIC PSYCHIATRY: A PERSPECTIVE

Robert I. Simon, MD, Potomac, MD

EDUCATIONAL OBJECTIVE
To learn about the many opportunities that writing in forensic psychiatry provides for personal growth, learning, creativity, gratifying collaboration with colleagues and the potential for practice development.

SUMMARY
Every forensic psychiatrist must write. Writing is a skill that must be learned and honed. Forensic writing often begins with reports of forensic psychiatric reports. Some forensic psychiatrists progress beyond reports to write book reviews, case reports, columns, research proposals, articles, chapters and finally books. Forensic psychiatry provides many fascinating cases and topics that provide copious material for writing. Editorials, articles and books are posted on the internet to a vast audience. More referrals are coming via the internet from lawyers and other professionals. It is very difficult, however, to write if the sole motivation is money or to obtain referrals. Good writing is demanding, requiring time, skill, commitment and a quiet mind. To enjoy writing requires a passionate desire to learn and to communicate with others. Some forensic psychiatrists loathe writing. They will try to avoid writing, whenever possible. If that fails, they resort to procrastination. Some forensic psychiatrists write constantly, making writing an essential aspect of their forensic psychiatric practice. Writing encourages creativity and learning, especially in areas of special interest. Collaboration with other authors can be stimulating and gratifying. Some forensic psychiatrists believe that they should only write an article, chapter or book if they are established experts. A good way to learn about a topic of special interest, however, is to write about it.

REFERENCES
Strunk W, White EB: The Elements of Style, 4th Edition, New York: MacMillan, 2000
Johnson SR: Becoming a Productive Academic Writer. Academic Physician and Scientist, November/December 2004, pp 1-3

SELF ASSESSMENT QUESTIONS
1. A major purpose of forensic psychiatric writing is:
a. recognition
b. referrals
c. learning
d. collegiality
ANSWER: c

2. A basic impediment to writing an article, chapter or book is:
a. getting started
b. self doubt
c. fear of criticism
d. perfectionism
ANSWER: a

T17 JUVENILE MURDERERS GROW UP: CHALLENGES AND DISPOSITIONS

Sally C. Johnson, MD, Raleigh, NC
Roy J. O'Shaughnessy, MD, Vancouver, BC, Canada
Diane H. Schetky, MD, Rockport, ME
Park E. Dietz, MD, PhD, Newport Beach, CA

EDUCATIONAL OBJECTIVE
Through review of an unusual case history and the issues it raises, the panel hopes to provide a forum for an academic discussion of the challenges presented in determining the disposition and long term management of juvenile murderers.

SUMMARY
This panel arises from review of a tragic and unusual case of multiple murder and suicide, brought to the attention of the discussants by the family of the murder victims, who are interested in staging an academic discussion about the issues raised by the case. None of the discussants have any therapeutic or evaluative relationship to the case and there are no criminal legal proceedings pending. The panel will review the case and the unusual history that unfolded-matricide and attempted patricide as a juvenile, double murder and suicide during the instant event and a possible history of serial murder. The case will be used as a springboard to discuss the difficult and challenging problems presented in the disposition of a juvenile murderer and the conflict that arises in trying to balance the needs and rights of juveniles against the needs and concerns of society. It will also touch on the way families cope with such an event. Discussion will focus on four areas 1) prediction of future risk of violence in juveniles; 2) determining disposition in cases of juvenile murder; 3) the development of multiple/serial murderers; and 4) whether changes are warranted in the management of these cases.

REFERENCES
O'Shaughnessy, R: Violent adolescents: psychiatry, philosophy, and politics. J Am Acad Psychiatry Law 32:12-20, 2004
Schetky, D: Risk assessment of violence in youths, in Principles and Practice of Child and Adolescent Forensic Psychiatry. Edited by Schetky D, Benedek E. Washington, DC: American Psychiatric Publishing, Inc., 2002

SELF ASSESSMENT QUESTIONS
1. Approximately what percent of adolescents affirm at least one violent act in the previous year?
a. 10%
b. 30%
c. 50%
d. 75%
ANSWER: b

2. In Benedek and Cornell (1989) typologies of youth who commit homicide, which setting describes where the majority of homicides were completed?
a. in the context of conflict
b. during commission of a crime
c. in the midst of a psychotic episode
ANSWER: b

T18 REAL WORLD CHALLENGES IN CORRECTIONAL PSYCHIATRY

James Knoll, IV, MD, Concord, NH
Fabian Saleh, MD, Worcester, MA
Lieutenant Charles Boyajian, (I), Concord, NH
Paul E. Noroian, MD, Worcester, MA

EDUCATIONAL OBJECTIVE
Participants will be familiar with the complex and realistic challenges facing forensic psychiatrists who work in a correctional setting. Participants will identify and discuss forensic and treatment challenges, and be familiar with current solutions and practices.

SUMMARY
Corrections is a complex and challenging environment in which to practice psychiatry. The long-term effects of deinstitutionalization have plunged a beleaguered mental health system into a correctional system, which has

become increasingly punitive and unhealthy. The panelists will discuss some of the "real world" problems commonly faced by correctional psychiatrists such as the treatment/management of highly antisocial individuals, the tendency to over diagnose malingering, and the importance of intermediate levels of care. A veteran correctional officer will discuss how psychiatrists can develop successful working relationships with prison staff. The unique challenges of working with female inmates and with inmates transferred to psychiatric hospitals for acute evaluation and treatment will be reviewed. Finally, the challenges of providing adequate, psychiatrically informed sex offender treatment in a prison setting will be discussed.

REFERENCES

Applebaum K: The role of correctional officers in multidisciplinary mental health care in prisons. Psychiatric Services. 52:27-28, 2001
Peters RH, LeVasseur ME, Chandler RK: Correctional treatment for co-occurring disorders: results of a national survey. Behav Sci Law. 22(4):563-84, 2004

SELF ASSESSMENT QUESTIONS

1. The majority of research indicates that psychopathic offenders:
a. get worse with treatment
b. get better with treatment
c. respond to therapeutic communities
d. there is not enough data
ANSWER: d

2. How many inmates in correctional facilities have major mental health disorders?
a. 10 %
b. 16 %
c. 24%
d. 45%
ANSWER: b

T19 **UPDATE FROM THE APA COUNCIL ON PSYCHIATRY AND LAW**

Steven K. Hoge, MD, MBA, New York, NY
Paul S. Appelbaum, MD, New York, NY
Stuart A. Anfang, MD, Northampton, MA

EDUCATIONAL OBJECTIVE

To provide an update on recent developments in psychiatry and law at the APA.

SUMMARY

The presenters will summarize developments in the APA Council. It is anticipated that the topics to be covered will be psychiatrists' participation in interrogation, psychiatrists' responses to security investigations, and the release of patient information to state medical boards. Dr. Appelbaum will summarize the development of APA policy with respect to interrogation, a topic brought to national attention by events at Guantanamo Bay. The APA developing a position that reconciles the legitimate interests in interrogation with ethics. Dr. Hoge will summarize the development of a resource document that addresses psychiatrists' response to security investigations. Tens of thousands of investigations are conducted annually, many of which call for the release of information by psychiatrists. The structure of the security investigation process, methods for proceeding, and standards are not familiar to the average psychiatrist. These topics and the appropriate manner for responding will be addressed. Dr. Anfang will address the release of confidential treatment information to medical boards. The Council has been working on a resource document that addresses the problems raised when the board request follows from the complaint of a third party, not in the treatment relationship.

REFERENCES

Okie S: Glimpses of Guantanamo: Medical ethics and the war on terror. New Eng J of Med 353:2529-34, 2005
Intelligence Interrogation. Field Manual 34-52. Washington, DC: Department of the Army. September 1992, pp3-18

SELF ASSESSMENT QUESTIONS

1. In the conduct of security investigations for job applicants, federal investigators may access confidential patient information:

a. based on their need to know
b. only with the permission of the applicant
c. only by court order
d. following a case by case review by the Attorney General

ANSWER: b

2. Which of the following represents the official policy of the APA?

a. resource document
b. position statement
c. task force report
d. all of the above

ANSWER: b

T20 **TEACHING PERFORMANCE IN FORENSIC EDUCATION**

Madelon V. Baranoski, PhD (I), New Haven, CT
Vinneth Carvalho, MD, New Haven, CT
Bobby Singh, MD, New Haven, CT
Shaheen Darani, MD, New Haven, CT
Mary Galvin, JD (I), Milford, CT

EDUCATIONAL OBJECTIVE

Participants will become familiar with a particular "performance" technique – the mock trial format – that is used to hone the skills of forensic fellows in presenting their oral ideas effectively and persuasively, in a manner that stands up to cross-examination and critical analysis.

SUMMARY

The education and socialization of forensic psychiatrists are complex undertakings that require trainees to master technical knowledge and learn how to present written and oral opinions effectively. The latter functions we call "performance" and we consider them critical components of forensic practice that can be taught in fellowship programs. This workshop will demonstrate a mock trial format that is used in one training program to inculcate in the trainees special techniques relevant to oral performance. The format will demonstrate use of experienced jurists in a criminal mock trial exercise with forensic fellows. We will review aspects of the fellows' performances and the effect of "trial practice" on developing their skills, honing their strengths and individual styles and correcting their ineffective communication patterns. This teaching mechanism will also be employed to demonstrate how, with performance principles in mind, inexperienced forensic psychiatrists can be helped to cope with the difficulties of oral exposition of their ideas, which includes the expectation that their oral performance must withstand cross-examination and other critical analysis.

REFERENCES

Gutheil TG: The Psychiatrist as Expert Witness. Washington, DC: American Psychiatric Press, 1998
Gutheil TG, Hauser M, White MS, et al: "The whole truth" versus "the admissible truth": An ethics dilemma for expert witnesses. J Am Acad Psychiatry Law 31:422-27, 2003

SELF ASSESSMENT QUESTIONS

1. Effective expert testimony by a forensic psychiatrist requires:

a. mastery of psychiatric knowledge
b. use of the accepted style of oral testimony
c. careful preparation
d. effective communication skills

ANSWER: a, c, and d

2. Effective oral exposition in testimony:

a. is an art form and talent that cannot be taught
b. incorporates a set of skills that can be taught and practice of those skills
c. is practiced by "hired guns" who lack true expertise
d. is an elusive concept, the importance of which is greatly exaggerated in forensic psychiatry

ANSWER: b

T21 CONTEMPORARY REVIEW OF CAPITAL PUNISHMENT

Rahn K. Bailey, MD, League City, TX
James E. Lee, Jr., MD (I), Columbia, SC
Steve Schutte, JD (I), Indianapolis, IN

EDUCATIONAL OBJECTIVE
To educate individuals on the history and current events of capital punishment.

SUMMARY
The utilization of the death penalty remains a highly contested argument in today's society. A milestone was reached in 2005 when the 1000th person was executed in this country. Since 1972, states have wrestled with conforming their laws to those provided by the federal government. The state of Indiana reinstituted the death penalty in 1977. Since then, the state has established a noteworthy history concerning capital punishment. It is one of the only states that have overturned a death penalty case at the level of the Indiana Supreme Court. Over the last 29 years, there have been 92 death sentences imposed. Forty-nine individuals have had their sentences vacated while on appeal. Furthermore, there have been 21 executions successfully completed in Indiana, and 17 are currently sentenced to die. There are many misconceptions when dealing with capital punishment and race; however, there are three main constructs that have been maintained through research. Capital punishment disproportionately affects three main groups: individuals who are disenfranchised, those who fail to utilize private representation, and those who commit crimes against wealthy victims. The investigators of this paper are interested in providing a contemporary review of the demographics of capital punishment in Indiana and abroad.

REFERENCES
Appelbaum PS, Gutheil TG: Clinical Handbook of Psychiatry and the Law, 2nd Edition. Baltimore, MD: Williams & Wilkins, 1991
Rosner, R: Principles and Practice of Forensic Psychiatry, 2nd Edition. London: Arnold, 2003

SELF ASSESSMENT QUESTIONS
1. When was capital punishment "reinstated"?
a. 1945
b. 1967
c. 1972
d. 1979
ANSWER: c

2. What is unique about the history of capital punishment in the state of Indiana?
a. It was one of the only states to overturn a case on the level of the Indiana Supreme Court.
b. It was the first state to reinstate the death penalty.
c. It was the last state to reinstate the death penalty.
d. Indiana currently has more individuals than any other state on death row.
ANSWER: a

T22 PREDICTING RESTORABILITY OF INCOMPETENT DEFENDANTS

Douglas Mossman, MD, Dayton, OH

EDUCATIONAL OBJECTIVE
At the conclusion of this presentation, participants will be able to identify clinical factors that will improve judgments about whether treatment can restore a criminal defendants' competence to stand trial.

SUMMARY
U.S. courts frequently require forensic examiners to offer opinions about restorability when criminal defendants are found incompetent to stand trial. Several authors have suggested, however, that mental health professionals cannot predict whether treatment for competence restoration will succeed. This study asked whether reliable information available when examinations occur might permit more accurate testimony about restoration.
A review of records from 351 consecutive patients sent to a state psychiatric hospital for competence restoration showed that lower probability of restoration was associated with: a misdemeanor charge; longer cumulative length of stay; older age; and diagnoses of mental retardation, schizophrenia, and schizoaffective disorder. Logistic regression equations allowed selection of subgroups with high probabilities (>90 percent) and low probabilities (<30 percent) of restoration. In cross-validation simulations, predictive equations had receiver operating characteristic areas

of 0.728 for all defendants and 0.746 for felony defendants. These findings provide empirical support for testimony that two types of incompetent evaluees have well-below-average probabilities of being restored: chronically psychotic defendants with histories of lengthy inpatient hospitalizations, and defendants whose incompetence stems from irremediable cognitive disorders (such as mental retardation). However, courts may still deem low probabilities of success to be "substantial" enough to warrant attempts at restoration.

REFERENCES

Miller RD: Hospitalization of criminal defendants for evaluation of competence to stand trial or for restoration of competence: Clinical and legal issues. Behav Sci Law 21:369-391, 2003
Pinals DA: Where two roads meet: restoration of competence to stand trial from a clinical perspective. New Eng J on Crim & Civ Confinement 31:81-108, 2005

SELF ASSESSMENT QUESTIONS

1. Concerning restoration of competence to stand trial, previous studies have suggested that:
a. clinical factors consistently allow examiners to identify defendants who are not restorable
b. clinicians' predictions about restoration were highly accurate
c. most defendants sent for competence restoration are not restored
d. predictions about restorability are highly accurate
e. all the above
f. none of the above
ANSWER: f

2. This study suggests that a well-below-average likelihood of successful restoration is associated with:
a. a longstanding psychotic disorder that has resulted in lengthy periods of psychiatric hospitalization
b. an irremediable cognitive disorder (e.g., mental retardation)
c. both a and b
d. none of the above
ANSWER: c

T23 MENTAL RETARDATION AND THE DEATH PENALTY

Ari U. Etheridge, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

To review state legislative actions in response to Atkins v. Virginia.

SUMMARY

In 2002, the United States Supreme Court prohibited the execution of the mentally retarded in Atkins v. Virginia. However, the Court deferred implementation of the ban to the states. Currently, 26 of the 38 states which allow capital punishment have statutes with a specific prohibition of the execution of the mentally retarded. The American Psychiatric Association's Council on Psychiatry and the Law issued a Resource Document following the decision to assist the development of statutory language in light of Atkins. This article will examine the state statutes with regard to areas of interest for forensic psychiatrists as delineated in the resource document: the definition of mental retardation; assessment procedures for mental retardation; and qualification of experts. This article will also focus on how the California state statute has been interpreted in the courts, illustrating areas of controversy, in particular the use of IQ tests and other psychological exams.

REFERENCES

Atkins v. Virginia, 536 U.S. 304 (2002)
Bonnie RJ: The American Psychiatric Association's resource document on mental retardation and capital sentencing: Implementing Atkins v. Virginia. J Am Acad Psychiatry Law 32:304-8, 2004

SELF ASSESSMENT QUESTIONS

1. How do states define "intellectual functioning" in the assessment of mental retardation in capital cases?
ANSWER: Depends on the state: thirteen states use a numeric IQ score, others do not specify or use a two standard deviations below the mean cutoff.

2. What is the Flynn Effect?
ANSWER: The Flynn Effect is a phenomenon in which there is a systematic and pervasive rise in IQ scores over time, rendering test norms obsolete.

T24 BEYOND THE SUPERPOWER SYNDROME—TOWARD A MORE HUMANE FUTURE

Robert Jay Lifton, MD, Cambridge, MA

EDUCATIONAL OBJECTIVE
To identify psychological and historical characteristics of American behavior associated with the "superpower syndrome."

SUMMARY
I will discuss the relevance of several earlier studies—on Chinese thought reform, Hiroshima survivors, Vietnam veterans, and Nazi doctors—to contemporary psychological and historical dilemmas. I will examine the dangers of the "superpower syndrome." And I will suggest ways in which the meanings we give to events such as the Vietnam war, 9/11, and the Iraq war can lead to more humane policies and approaches.

REFERENCES
Lifton, RJ: Superpower Syndrome: America's Apocalyptic Confrontation with the World. New York: Nation Books, 2003
Lifton, RJ (with Richard Falk and Irene Gendzier): Crimes of War—Iraq. New York: Nation Books, 2006

SELF ASSESSMENT QUESTIONS
1. How does "superpower syndrome" manifest itself in American policy?
ANSWER: It leads to aggressive actions such as the "war on terrorism" that have no limits in time or place.

2. What is the importance of the collective need for meaning in response to such disasters as the Vietnam war, 9/11, and the Iraq war?
ANSWER: The meanings embraced enter into national consciousness and greatly influence political and military decisions.

T25 ADVERTISING OR AGGRANDIZEMENT? DEFINING THE LIMITS ON SELF PROMOTION

Thomas G. Gutheil, MD, Brookline, MA
Donna M. Norris, MD, Wellesley, MD
Marilyn Price, MD, CM, Providence RI
Donald J. Meyer, MD, Cambridge, MA

EDUCATIONAL OBJECTIVE
To review the topic of advertising and self promotion in marketing forensic services.

SUMMARY
Marketing one's services is a useful and necessary part of the business aspect of forensic work. There are no clear guidelines, however, as to what are the limits of one's self-promotion in the service of such marketing. It is even possible for experts to get themselves in trouble by their efforts to publicize their skills. In this workshop Dr. Gutheil will review the narcissistic dynamic aspects of forensic work; Drs. Norris, Price and Meyer will review an informal study of experts' websites and their descriptions of their services and will present reality cases of expert witnesses whose self-promotions have led them into difficulty. All four workshop leaders will organize and lead an audience discussion of the limits of the issue of self promotion within forensic marketing.

REFERENCES
Gutheil TG: The Psychiatrist as Expert Witness (Chapter on Marketing). Washington DC: American Psychiatric Press, 1998
Gutheil TG, Simon RI: Narcissistic dimensions of expert witness practice. J Am Acad Psychiatry Law 33:55-8, 2005

SELF ASSESSMENT QUESTIONS
1. Discovery of false or exaggerated claims on one's resumé may lead to all the following EXCEPT:
a. painful cross examination
b. a malpractice claim
c. an ethics complaint
d. a board of registration complaint
e. peer censure
ANSWER: b

2. What element(s) of the AAPL code of ethics is/are violated by a false or exaggerated claim on one's resumé?
ANSWER: V, qualifications (and perhaps IV, honesty)

T26 INSANITY DEFENSE EVALUATIONS

Phillip J. Resnick, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

To systematically evaluate criminal defendants and formulate well reasoned opinions about criminal responsibility.

SUMMARY

The distinctions between the defenses of not guilty by reason of insanity, guilty but mentally ill, and diminished capacity will be explained. Tests for criminal responsibility will be placed in their historical perspective, including the wild beast test, McNaughtan standard, irresistible impulse, Durham rule, Model Penal Code, and the 1984 Federal rule. Participants will receive practical suggestions on conducting sanity interviews. Clues to knowledge of wrongfulness (legal and moral) and ability to refrain will be delineated. The limitations of the "policeman at the elbow" test will be examined. The faculty will discuss which diseases may qualify for an insanity defense, such as psychoses, mental retardation, paraphilias, PTSD, amnesia, and pathological gambling. Intoxication and battered woman syndrome will also be covered. Common errors in writing insanity reports will be identified. Participants will practice writing insanity opinions after watching a videotaped case vignette. Handouts will include 11 landmark insanity case summaries, 55 suggestions for cross-examiners of psychiatrists, 12 clues to malingered psychoses, principles of writing insanity reports, and two sample reports.

REFERENCES

Resnick PJ: Malingered Psychosis, in Clinical Assessment of Malingering and Deception. Edited by Rogers R. New York: Guilford Press, 1997, pp47-67

Resnick PJ, Noffsinger SG: Competency to Stand Trial and the Insanity Defense, in Textbook of Forensic Psychiatry. Edited by Simon RI, Gold LH. Washington, DC: American Psychiatric Publishing, Inc., 2004, pp329

SELF ASSESSMENT QUESTIONS

1. Components of the McNaughtan test do not include:
a. mental disease or defect
b. lack of understanding of the nature and quality of the act
c. lack of knowledge of the wrongfulness of the act
d. inability to refrain
e. a causal nexus between the disease and other arms of the test
ANSWER: d

2. Which of the following does not qualify for an insanity defense?
a. Schizophrenia
b. Multiple personality Disorder
c. PTSD
d. Voluntary intoxication
e. Mental retardation
ANSWER: d

T27 ASSESSMENT OF ALLEGED WORKPLACE STRESS DISABILITY

Landy F. Sparr, MD, MA, Portland, OR
Stewart S. Newman, MD, Portland, OR

EDUCATIONAL OBJECTIVE

At the conclusion of this session, participants should be able to recognize that workplace stress claims vary state-by-state, may include "fault" determination, and often have complex antecedents that require collateral investigation.

SUMMARY

Mental stress is subjective, and therefore, can only be measured by others (including psychiatrists and judges) by observing behavior. When behavior departs from the norm it may be defined as constituting a mental illness manifesting itself in an inability to function in the workplace and become the basis for a mental stress claim. When, how, and for how long such disability should be compensated remains a difficult legal policy question. Acceptance of stress claims under workers' compensation varies considerably by state. Private insurers often hire so-called independent medical examiners (IME) to render an opinion as to whether or not treatment is reasonable or necessary. In the process of performing IMEs we evaluated 20 employees who filed stress claims against their employers. Many of the claims involved conflict with supervisors. In this workshop we will review the psychiatric assessment of these workplace stress claims including a discussion of common pitfalls. We found that the majority of claimants

had obsessive-compulsive personality traits and were significantly resistant to change. There is little discussion of the IME process in the medical or psychiatric literature. The purpose of this workshop is to provide a forum for such discussion with ample opportunity for audience participation.

REFERENCES

deCarteret JC: Occupational stress claims: Effects on workers compensation. Am Assoc Occupational Health Nurses J. 42(10):494-8, 1994
Greenwood v Pontiac Board of Education, 186 Mich App 389, 465 NW 2d 362 (1990)

SELF ASSESSMENT QUESTIONS

1. Workers compensation systems recognize mental disabilities in one form or another in:
a. less than 25% of the states
b. more than 50% of the states
c. more than 75% of the states
d. all the states
ANSWER: b

2. The stated purpose of so-called independent medical examinations (IME's) is to:
a. deny claims
b. review the appropriateness of a claimant's specific treatment
c. find alternative less serious claimant diagnoses
ANSWER: b

T28 FORENSIC RESEARCH: UNIQUE CHALLENGES

Kathleen J. Farkas, PhD (I), Cleveland, OH
Debra R. Hrouda, MSSA (I), Cleveland, OH

EDUCATIONAL OBJECTIVE

To build skills around and raise awareness of critical issues in conducting scientifically sound forensic research.

SUMMARY

The criminal justice system has become a de facto component of the mental health system. Studies of prison and jail populations show problems of mental illness, victimization and substance abuse are common among inmates and detainees. In addition, inpatient, residential, and outpatient settings receive referrals of patients involved in the criminal justice system at many levels of adjudication. Researchers interested in forensic populations need to understand the challenges inherent in conducting research in this realm. This presentation will focus on key factors that are unique to research in criminal justice populations (e.g. informed consent, safety and security, confidentiality, ownership and use of forensic information, retention and attrition of subjects, and validity and/or interpretation of results). In addition, the special training and skill sets that are necessary to conducting research will be discussed. The presentation will provide concrete, practical information crucial for the novice and advanced researcher alike.

REFERENCES

Camp S: The rewards and challenges of pursuing research in a correctional agency. J Criminal Justice Education 16(1):110-24, 2005
Welsh W, et al: Building an effective research partnership between a university and a state correctional agency. Prison Journal 84(2):143-70, 2004

SELF ASSESSMENT QUESTIONS

1. What are some of the obstacles to conducting scientifically sound research in a corrections setting?
ANSWER: Unless sampling plan takes the booking process into account, the sample may not be representative of the population of interest.

2. What are the special concerns regarding obtaining informed consent in a correctional setting?
ANSWER: Prisoners are considered a special population and require additional safeguards and protections according the federal guidelines for protection of human subjects.

T29 INVOLUNTARY COMMITMENT AND THE PROBATE JUDGE: A SURVEY

Michael J. Ferlauto, MD, Columbia, SC
Richard L. Frierson, MD, Columbia, SC

EDUCATIONAL OBJECTIVE

Briefly review the requirements for serving as a South Carolina probate judge. Assess probate judges' general knowledge of mental health issues germane to the involuntary commitment process. Discuss current and potential mental health training options for probate judges.

SUMMARY

By way of legislation and court proceedings, each state has developed specific mechanisms for emergency mental health commitment which attempt to balance the liberty rights of the individual with the parens patria and police powers of the state. Previous authors have scrutinized the decision making process of physicians and judges involved in the commitment process, but few have looked at the earlier screening stage that can occur when family or friends petition the court to detain a person they consider dangerous. This study consisted of a written survey sent to probate court judges in South Carolina who are charged with reviewing these petitions. They represent the first point in a decision tree that can potentially lead to unnecessary detention while a person awaits initial psychiatric assessment. This presentation also attempts to analyze existing training standards for South Carolina probate judges in mental health and mental health law and explore possible areas for improvement so fewer individuals are needlessly detained and overcrowded emergency centers are less burdened.

REFERENCES

Husted JR, Nehemkis A: Civil Commitment viewed from three perspectives: Professional, family and police. Bull Am Acad Psychiatry Law 23:533-46, 1995
Bursztajn HJ, Hamm RM, Gutheil TG: Beyond the black letter of the law: an empirical study of an individual judge's decision process for civil commitment hearings. J Am Acad Psychiatry Law 25:79-94, 1997

SELF ASSESSMENT QUESTIONS

1. The minimum educational background required in order to be elected a probate judge in South Carolina is:
a. J.D.
b. Bachelor's degree
c. High school degree and four years experience
d. No minimum
ANSWER: c

2. South Carolina probate judges are required to obtain at least how many hours of continuing legal education each year?
a. 5 hrs
b. 15 hrs
c. 30 hrs
ANSWER: b

T30 CONDITIONAL RELEASE DECISION-MAKING

Barbara E. McDermott, PhD (I), Sacramento, CA
Cameron Quanbeck, MD, Sacramento, CA
David Busse, MA (I), Sacramento, CA
Felecia Andrade, BA (I), Napa, CA
Charles L. Scott, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

To educate the audience in those factors traditionally used in making release decisions and provide recommendations for alternative methods.

SUMMARY

In Foucha v. Louisiana, the Supreme Court ruled that dangerousness alone was not sufficient for the continued commitment of insanity acquittees, requiring that states demonstrate both mental illness and dangerousness. Unfortunately, research indicated that psychiatrists were wrong two out of three times in the prediction of violent behavior. Recently, second-generation risk assessments have provided users with specific methods for estimating future risk of violence. These assessments are based on research evaluating the statistical relationships between both static and dynamic factors and violent offending. Despite their ability to predict violence more accurately

than clinical judgment alone, very few forensic facilities use these actuarial risk assessments in making release decisions. It is hypothesized that the reasons for such non-use are related to the labor intensity of such risk assessments, most of which require the administration of the Hare Psychopathy Checklist-Revised (PCL-R). This study examined the release decisions made by clinicians at a forensic facility. The records of 100 patients released into the community were examined to determine those factors clinicians most associated with readiness for release. Data will be presented regarding how decisions were made, including any use of structured risk assessments or assessments of mental illness. Implications regarding recommendations for release decision-making will be discussed.

REFERENCES

McDermott BE, Thompson J: The review panel process: An algorithm for the conditional release of insanity acquittees. Int J Law Psychiatry, In Press

Monahan J, Steadman HJ, Appelbaum PS, Robbins PC, Mulvey EP, Silver E, Roth LH, Grisso T: Developing a clinically useful actuarial tool for assessing violence risk. British J Psychiatry 176: 312-19

SELF ASSESSMENT QUESTIONS

1. Traditionally, clinicians rely on which factor in determining if a patient is ready for release?
a. offense seriousness
b. length of commitment
c. psychotic symptoms
d. gender
ANSWER: a

2. Which method is most often used as a measure of dangerousness in release decisions?
a. structured risk assessments
b. clinical judgment
c. offense seriousness
d. number of past offenses
ANSWER: c

T31 **REVIEW OF COMMITMENT STATUTES IN THE UNITED STATES**

Margaret A. Bolton, MD, Worcester, MA
Paul Appelbaum, MD, New York, NY
Debra A. Pinals, MD, Worcester, MA
Al Grudzinskas, JD (I), Worcester, MA

EDUCATIONAL OBJECTIVE

To review similarities and differences regarding dangerousness and need-for-treatment criteria in current civil commitment statutes in the United States.

SUMMARY

This presentation will provide an overview of existing commitment statutes and identify trends in language looking at the need for treatment and dangerousness criteria. Involuntary hospitalization of persons with mental illness is at odds with personal liberty. The laws governing civil commitment criteria reached a high water mark in the protection of civil liberties in the 1972 Lessard v. Schmidt decision. Not all states adopted Lessard's protections, but across the country "dangerousness" became essential to commitment criteria and procedural safeguards were strengthened. Since the time of the Lessard case, events in many states have driven changes in commitment statutes. A recent example of such an event was the death of Kendra Webdale in NY, pushed under a subway train by a person with mental illness. As a result, many state laws changed in hopes of providing more oversight, treatment and ability to confine those thought to be mentally ill and dangerous. Competing forces, including calls for timely treatment of mental illness, reactions to high-profile disastrous incidents, desires to protect civil liberties, and shrinking resources for treatment, have emerged as critical factors in shaping mental health care delivery systems and laws, as revealed in this survey of current statutes.

REFERENCES

Appelbaum PS: Almost a Revolution: Mental Health Law and the Limits of Change. New York: Oxford University Press, 1994

Brennan KJ: Recent developments under Kendra's Law. New York State Bar Association Journal 7(2):24-34

SELF ASSESSMENT QUESTIONS

1. In regard to a "gravely disabled" category for commitment:
a. most states' statutes contain a provision for this status
b. this category only applies to people who qualify for guardianship/conservator
c. decompensation is almost always required
d. hospitalization of people meeting this criterion is always required
ANSWER: a

2. The need for treatment:
a. is clearly stated and defined in most commitment statutes.
b. is included in the definition of mental illness in most statutes.
c. is often not a part of emergency detention statutes.
d. is usually outweighs dangerousness in commitment statutes.
ANSWER: c

T32 CRIMINALIZATION OF PSYCHOTHERAPIST-PATIENT SEX

Julia P. Mitrevski, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

To discuss the current statutes criminalizing psychotherapist-patient sexual contact. In addition to reviewing the twenty-six statutes, controversial issues pertaining to the arguments for and against enacting such statutes will be addressed in hopes to stimulate further interest and discussion in this area.

SUMMARY

The first state statute criminalizing psychotherapist-patient sexual contact was enacted in Wisconsin in 1983. While the criminalization of psychotherapist-patient sexual contact remains controversial, state legislatures in more than half of the United States have enacted such statutes. Critics have argued that there are unanswered questions, including ethical and legal questions, about criminalizing psychotherapist-patient sex, and warn against adopting legislation before the issue has been fully studied and understood. This article reviews the current twenty-six statutes and discusses the relevant trends and differences. The criminal statutes are not uniform and vary from state to state with respect to what circumstances, professionals, and behaviors are covered. The majority of statutes only apply to current patients. Generally, the statutes indicate that consent by the patient is not a defense. The most narrow statutes apply to sexual contact only during a session or by means of therapeutic deception.

REFERENCES

Strasburger LH: There Oughta Be A Law— criminalization of psychotherapist-patient sex as a social policy dilemma, in Physician Sexual Misconduct. Edited by Bloom JD, Nadelson CC, Notman MT. Washington DC: American Psychiatric Press, Inc., 1999, pp 19-36

Jorgenson L, Randles R, Strasburger L: The furor over psychotherapist-patient sexual contact: New solutions to an old problem. Wm and Mary L Rev 32:645-732, 1991

SELF ASSESSMENT QUESTIONS

1. What are some arguments for and against criminalization of psychotherapist-patient sexual contact that have been discussed in the literature?

ANSWER: Proponents have argued that criminalization would deter future violations, that offenders deserve criminal punishment, and that current remedies do not apply to unlicensed therapists. Critics of criminalization argue that remedies already exist, that criminalization might discourage reporting, and that deterrence has been unproven.

2. What are some general trends among the enacted statutes criminalizing psychotherapist-patient sexual contact?

ANSWER: Most statutes criminalize sexual contact broadly (and not just penetration), indicate that consent is not a defense, and include only current patients (and not former patients).

T33 **CURRENT STATUS OF THE DUTY TO PROTECT**

James C. Beck, MD, PhD, Boston, MA
Andrea Maislen, JD (I), Somerville, MA

EDUCATIONAL OBJECTIVE
To provide the listener with knowledge of current case and statute law relating to the duty to protect, and with understanding of the clinical relevance of that law.

SUMMARY
Since the original Tarasoff decision in 1974, the duty to warn or protect has been a substantial source of concern to practicing clinicians. The purpose of this presentation is to assess whether recent court decisions appear to better reflect the realities of clinical practice than did early cases. A Lexis/Nexis based search was made for Tarasoff related cases and review articles for the years 1998-2005. Results: 34 cases were found. Only four defendants were found to be negligent. Courts consistently limit the duty, almost always finding no duty to control outpatients; no duty to protect the public at large; and no duty to protect persons who have independent knowledge of the threat to their safety. Statutes limiting the duty in 27 states have clearly had an effect on the outcome of these cases. This review illustrates that the courts have gradually come to a better understanding of the realities of clinical practice. Clinicians have less to fear from the courts in these cases than formerly. Psychiatrists in states with no statute should consider working toward passage of a statute that defines the duty and spells out what is required to fulfill it.

REFERENCES
Tarasoff v. Regents of the University of California, 17 Cal 3d. 425, 551 P2d. 334 (1976)
Williamson v. Liptzin, 141 N.C.App 1, 539 SE 2d 313 (2000)

SELF ASSESSMENT QUESTIONS
1. Recent cases on the duty to protect:
a. have held therapists to an increasingly onerous standard.
b. have been applied to voluntarily but not involuntarily hospitalized patients.
c. have typically led to plaintiff's verdicts.
d. have infrequently led to plaintiff verdicts.
ANSWER: d

2. All of the following are true, except:
a. Recent case law has significantly expanded the duty to protect.
b. Insurance company statistics illustrate the low frequency of payouts for breach of the duty to protect.
c. Courts only rarely find that a duty to the general public exists.
d. Statutes apply to medical but not to financial decisions.
ANSWER: a

T34 **THE "PREDATOR" NEXT DOOR: MANAGEMENT OF SEXUALLY VIOLENT PREDATORS AND LONG-TERM OFFENDERS (ADVANCED) – SEX OFFENDERS COMMITTEE**

J. Paul Fedoroff, MD, Ottawa, ON, Canada
Samuel Jan Brakel, JD (I), Chicago, IL
Douglas Tucker, MD, Berkeley, CA
Daniel J. Brodsky, LLB (I), Toronto, ON, Canada

EDUCATIONAL OBJECTIVE
Participants in this workshop will become familiar with a variety of approaches to the management of high-risk offenders in the community. Topics will include civil commitment legislation, sex offender registration and "circle of support" offender management. Legal, psychiatric, American and Canadian perspectives will be presented.

SUMMARY
This workshop is a continuation of the workshop on Sexually Violent Predators and Dangerous Offenders presented at the AAPL 2005 Montreal conference. It will present questions and answers to the problem of what happens when high-risk offenders are released from custody. Jan Brakel, J.D., will outline sex offender registration/notification laws in the U.S.—such laws are part of the Sexually Violent Predator (VP) laws in all 16 states that have these laws. In addition every state in the U.S. has an independent set of sex offender registration/notification laws. They have been constitutionally approved but remain controversial for a number of reasons that will be discussed. Douglas Tucker, M.D. will present on current psychiatric assessment and treatment methods used in the community

management of conditionally-released Sexually Violent Predators, based on his experience in California. Daniel Brodsky, LL.B. will present on the national registry and community notification laws for convicted sex offenders that became law throughout Canada on December 15, 2004 and the distinctively Canadian theoretical approach to the management of dangerous and long-term offenders. Paul Fedoroff, M.D. will report on the success of the Canadian approach to high risk sex offenders with particular emphasis on a novel management approach arising out of the need to reintegrate a highly marginalized and stigmatized population into the community termed "Circles of Support and Accountability."

REFERENCES

Petrunik M: Managing unacceptable risk: Sex offenders, community response, and social policy in the United States and Canada. Int J Offender Therapy and Compar Criminol 46(4):483-511, 2002
Prentky R, Janus E, Setko M, (eds): Sexually Coercive Behavior: Understanding and Management. New York: New York Academy of Sciences, 2004

SELF ASSESSMENT QUESTIONS

1. Which of the following procedures aimed at convicted sex offenders in the U.S. does not require an independent finding of dangerousness?

a. Commitment as a Sexually Dangerous Predator
b. Commitment as a Sexually Dangerous Person
c. Registration as a Sex Offender
d. "Regular" Civil Commitment

ANSWER: c [as per Connecticut Department of Public Safety v. Doe, 538 U.S. 1 (2003)]

2. Which of the following strategies is/are not a part of the clinical management of conditionally released Sexually Violent Predators?

a. GPS satellite monitoring, urine toxicology monitoring, computer usage monitoring
b. Depot antiandrogen medications, individual and group relapse-prevention psychotherapy
c. Goal of long-term maintenance of clinical and legal monitoring
d. Goal of eventual discontinuation of clinical and legal monitoring

ANSWER: c

T35 DEVELOPMENTAL ISSUES AND FORENSIC EVALUATIONS IN CHILDREN – CHILD AND ADOLESCENT COMMITTEE

Lillian M. Tidler, MD, Midlothian, VA
Cheryl D. Wills, MD, Laplace, LA
Stephen B. Billick, MD, New York, NY
Eraka Bath, MD, New York, NY
Fabian M. Saleh, MD, Worcester, MA

EDUCATIONAL OBJECTIVE

To increase the awareness for general psychiatrists as well as child and adolescent psychiatrists of the role of developmental factors when conducting assessments of child abuse, child and adolescent sexual behaviors and adolescent criminal behaviors.

SUMMARY

Understanding and addressing developmental factors in the assessments of children and adolescents who have been victims of child abuse, have had sexual behavior problems, have been involved in juvenile delinquency proceedings and who have committed serious criminal offenses, is of paramount importance. Topics covered in this presentation will include how child abuse affects developmental trajectories, the role of child drawings in conducting assessments, evaluation of children's sexual play, understanding various developmental factors involved in child and adolescent sexual behavior problems and in adolescents who commit serious adolescent criminal offenses. Case examples will be presented. In addition, developmental factors which contribute to juvenile delinquency and the role of school based interventions will be covered.

REFERENCES

Smyke AT, Dumitrescu A, Zeanah CH: Attachment disturbances in young children I: The continuum of caretaking casualty. J Am Acad Child & Adolescent Psychiatry 41(8):972-89, 2002
Sarnoff C: Latency. New York: Jason Aronson Inc, 1981

SELF ASSESSMENT QUESTIONS

1. Which are effects of disrupted early childhood attachments?
a. sterotypies
b. language delays
c. aggressive behavior
d. all of the above
ANSWER: d

2. The latency period of child development represents:
a. absence of sexual drives and fantasies
b. a period of sexual drive intensity contained by complex ego defenses
ANSWER: b

T36 **DETECTION OF MALINGERING IN DISABILITY EVALUATIONS (CORE)**

Roger Z. Samuel, MD, Boca Raton, FL
Thomas McLaren, PhD (I), Chattanooga, TN
Henry Conroe, MD, Chicago, IL
Mark DeBofsky, JD (I), Chicago, IL

EDUCATIONAL OBJECTIVE

To improve the skills of clinicians in detecting malingering in disability claimants.

SUMMARY

While malingering has been estimated to occur in 7.5% to 33% of disability claimants, the assessment of malingering in disability claims can be very demanding. This workshop will utilize a disability case to illustrate the factors that are helpful in determining the presence or absence of malingering. The workshop will take the form of 2 sides arguing for and against the presence of malingering in that case. A psychiatrist, Dr. Samuel, will present the case and provide determinants of malingering. A neuropsychologist, Dr. McClaren, will buttress these arguments with psychological test results. A second psychiatrist, Dr. Conroe, and a disability attorney, Mr. DeBofsky, will provide a rebuttal by arguing for the claimant, and against the finding of malingering. Mr. DeBofsky will also discuss a lawyer's perspective of disability issues in general. Handouts with information on the case, as well as on factors that suggest the presence of malingering and factors arguing against malingering, will be provided.

REFERENCES

Samuel RZ, Mittenberg W: Determination of malingering in disability evaluations. Primary Psychiatry 12(12):60-68, 2005
Mittenberg W, Patton C, Canyock EM, Condit DC: Base rates of malingering and symptom exaggeration. J Clin Exp Neuropsychol 24(8):1094-1102, 2002

SELF ASSESSMENT QUESTIONS

1. What proportion of disability cases involves probable malingering and symptom exaggeration?
ANSWER: 30%

2. What is the main difference between malingering and factitious disorder?
ANSWER: Malingering is done for an external incentive while factitious disorder is done for intrapsychic needs.

T37 **DISCIPLINARY ACTIONS AGAINST PSYCHIATRISTS IN MARYLAND**

Ana N. Cervantes, MD (I), Columbia, MD
Jeffrey Janofsky, MD, Timonium, MD

EDUCATIONAL OBJECTIVE

Participants will learn the nature of disciplinary actions taken against psychiatrists in Maryland by the State Medical Board.

SUMMARY

Maryland has consistently ranked among the states with the lowest rates of disciplinary actions against physicians. While most state boards use the standard of "preponderance of the evidence," Maryland is one of only 15 states where the standard of proof required for a physician to be found guilty of unprofessional conduct is "clear and convincing." The Maryland Board of Physician Quality Assurance investigates complaints against physicians

accused of unprofessional conduct. Disciplinary actions taken against physicians are reported on a quarterly basis, but complaints against physicians that do not result in disciplinary action are not public information. We reviewed data from the past 10 years to determine the frequency and type of complaints received by the board, and disciplinary actions taken by the board against psychiatrists in Maryland. We analyzed data from the past 10 years involving disciplinary actions by the Maryland Board of Physician Quality Assurance against psychiatrists.

REFERENCES

Morrison J, Morrison T: Psychiatrists disciplined by a state medical board. Am J Psychiatry 158 (3):474-78, 2001
Kohatsu N, Gould D, Ross L, Fox P: Characteristics associated with physician discipline. Arch Intern Med 164:653-58, 2004

SELF ASSESSMENT QUESTIONS

1. In the majority of states, the standard of proof required for a physician to be found guilty of professional misconduct is:
a. beyond a reasonable doubt
b. preponderance of the evidence
c. clear and convincing
ANSWER: b

2. The Maryland Board of Physicians disciplines physicians who:
a. violate the Maryland Medical Practice Act
b. breach the standard of care for physicians
c. violate the Maryland criminal law
ANSWER: c

T38 A DIFFERENCE OF OPINION REGARDING RISK AND NEGLIGENCE

H.W. LeBourgeois, III, MD, New Orleans, LA
Debra A. Pinals, MD, Worcester, MA
Valerie Williams, MA, MS (I), Worcester, MA
Paul S. Appelbaum, MD, New York, NY

EDUCATIONAL OBJECTIVE

To explore differences in the opinions of forensic and general psychiatrists regarding risk and the standard of care in potential malpractice cases.

SUMMARY

It is not uncommon for psychiatrists to reach different opinions regarding the risk of suicide or violence posed by a patient or to reach different conclusions as to whether clinical interventions equate with the accepted standard of care. Such differences of opinion may lead to dispute over patient management in clinical and medicolegal contexts, such as malpractice evaluations, where disagreements regarding aspects of care are highlighted during adversarial proceedings with opposing experts. However, there are limited data examining whether practice as a forensic psychiatrist affects opinions about risk and standards of care when reviewing the same clinical information. In the current study, 235 psychiatrists reviewed hypothetical case scenarios involving potentially suicidal or violent patients and offered opinions regarding suicide/violence risk and whether the standard of care was met. Variables examined included forensic experience, gender, training, and years of clinical experience. Results demonstrate that general and forensic psychiatrists manifest significantly different opinions regarding suicide risk, violence risk, and the standard of care in violence cases. We also found significant gender differences regarding standard of care opinions in suicide cases. Potential implications of the findings on both clinical treatment and forensic evaluations are discussed.

REFERENCES

Commons ML, Miller PM, Gutheil TG: Expert witness perceptions of bias in experts. J Am Acad Psychiatry Law 32:70-5, 2004
Sattar SP, Pinals DA, Din AU, et al: To commit or not to commit: the psychiatry resident as a variable in involuntary commitment decisions (in press; accepted for publication in Academic Psychiatry)

SELF ASSESSMENT QUESTIONS

1. All of the following are true of results of the above study, except:

a. forensic psychiatrists rated violence risk significantly higher than clinical psychiatrists in cases involving potential violence

b. forensic psychiatrists rated suicide risk significantly higher than clinical psychiatrists in cases involving potential suicide

c. psychiatrists with greater than 20 years in clinical practice rated suicide risk significantly lower than less experienced psychiatrists in cases involving potential suicide

ANSWER: c

2. In the current study, in what type of cases were female psychiatrists significantly more likely to rate care as negligent, when compared to male psychiatrists?

a. violence cases

b. suicide cases

c. sex-offender cases

ANSWER: b

T39 **MEDICAL MALPRACTICE: POSTPARTUM PSYCHOSIS AND SUICIDE**

Renée L. Binder, MD, San Francisco, CA
Liza H. Gold, MD, Arlington, VA
Phillip J. Resnick, MD, Cleveland, OH
Honorable Jennifer Duncan-Brice, JD (I), Chicago, IL
Tanya Park, JD (I), Chicago, IL
Beverly P. Spearman, RN, JD (I), Chicago, IL

EDUCATIONAL OBJECTIVE

To provide instruction to forensic psychiatrists at all levels of experience through a mock trial presentation. Attorneys will examine and cross examine defense and plaintiff experts, presided over by a judge, to demonstrate legal strategies and expert witness skills in a case based on actual events and litigation.

SUMMARY

A young woman with no prior psychiatric history suffered a postpartum psychosis shortly after the successful delivery of her first child. Six days after discharge from a psychiatric inpatient facility, she disappeared from her home. Four days after her disappearance, she committed suicide by jumping from a hotel window. The family sued the inpatient physician and the hospital for malpractice. This case was evaluated by Renee Binder, MD, retained by the defense and Liza H. Gold, MD, retained by the plaintiff. Tanya Park, JD, one of the defense attorneys in the case, and Beverly Spearman, RN, JD, one of the plaintiff's attorneys will examine and cross examine Drs. Binder and Gold in a mock trial format, presided over by the Honorable Judge Jennifer Duncan-Brice. Dr. Phillip Resnick, one of the most experienced teachers in the mock trial educational format, will moderate the presentation. The mock trial will provide an opportunity for forensic psychiatrists at all levels of experience to learn about legal strategies in psychiatric malpractice cases and to learn courtroom skills from watching the examination and cross examination of the two experts retained by the opposing sides.

REFERENCES

Meyer DJ, Simon RI: Psychiatric malpractice and the standard of care, in The American Psychiatric Textbook of Forensic Psychiatry. Edited by Simon RI, Gold LH. Washington DC: American Psychiatric Publishing Inc, pp 185-204, 2004

Simon RI: Assessing and Managing Suicide Risk: guidelines for clinically based risk management. Washington DC: American Psychiatric Publishing, 2004

SELF ASSESSMENT QUESTIONS

1. Malpractice cannot occur absent an individual doctor's departure from the relevant standard of care. As applied to professionals, the legal doctrine of the standard of care is defined as:

a. That degree of care, knowledge, and skill that results in an acceptable treatment outcome.
b. That degree of care, knowledge, and skill that results in correct diagnoses and therapeutic assumptions.
c. That degree of care, knowledge, and skill ordinarily possessed and exercised in similar situations by a member of the profession in the same field.
d. That degree of care, knowledge, and skill that results in the most improvement as fast as possible.

ANSWER: c

2. The following statements are all true regarding the standard of care doctrine except:

a. The standard of care is both a medical and a legal concept.
b. A national standard of care exists for most jurisdictions in the United States.
c. In some jurisdictions, the applicable standard of care is that of the local patterns of practice.
d. Jurisdictions may vary in how they define the concept of "the skill and care ordinarily employed" by an average member of the profession.

ANSWER: a

FRIDAY, OCTOBER 27, 2006

POSTER SESSION #2 — 7:15 AM - 8:00 AM/ 9:30 AM - 10:15 AM — **CHICAGO BALLROOM FOYER**

F1 ***Clinical and Ethical Consideration in People with GID***
Fabian M. Saleh, MD, Worcester, MA
Joel T. Andrade, MSW, LICSW (I), Bridgewater, MA

F2 ***Termination of Parental Rights: Expert Testimony***
Kenneth J. Weiss, MD, Bala Cynwyd, PA
David F. Bogacki, PhD (I), Camden, NJ

F3 ***Mentally Ill Sex Offenders: Mentally Ill or Merely Deviant***
Priya Narayanan, MD (I), Bronx, NY
Merrill Rotter, MD, Bronx, NY

F4 ***Female Sexual Offending: The Impact of Substance Abuse***
R. Gregg Dwyer, MD, EdD, Columbia, SC
Fabian M. Saleh, MD, Worcester, MA
Albert Grudzinskas, Jr., JD (I), Worcester, MA

F5 ***Development of a Brief Mental Health Screening Instrument for Newly Incarcerated Adults***
Robert L. Trestman, PhD, MD, Farmington, CT
Julian Ford, PhD (I), Farmington, CT
Wanli Zhang, PhD (I), Farmington, CT

F6 ***Impact of Provider Feedback and Utilization Review in Corrections***
Robert L. Trestman, PhD, MD, Farmington, CT
Nicholas A. Demartinis, MD (I), Farmington, CT
Mohammed Elsamra, MD (I), Farmington, CT
Wanli Zhang, PhD (I), Farmington, CT

F7 ***The Relationship Between BPD and Violent Offenses***
Lobna Ibrahim, MD (I), Farmington, CT
Robert I. Trestman, PhD, MD, Farmingon, CT
Wanli Zhang, PhD (I), Farmington, CT
Karen L. Pagano, MS (I), Farmington, CT

F8 ***A Female Patient with Multiple Paraphilias: A Case Study***
Crystal S. Kim, BA (I), Washington, DC
Fabian M. Saleh, MD, Worcester, MA
R Gregg Dwyer, MD, EdD, Columbia, SC
Fred S. Berlin, MD, PhD, Baltimore, MD

F9 ***Treatment Options for Sexual Offenders in Prison***
Sara G. West, MD , Cleveland Heights, OH

F10 ***SPECT Scan Use in Mild Traumatic Brain Injury***
Timothy M. Houchin, MD, Lexington, KY
Jonh D. Ranseen, PhD (I), Lexington, KY
Timothy S. Allen, MD, Lexington, KY

F11 ***Forensic Overview of Serial Homicidal Poisoners***
Barbara G. Haskins, MD, Charlottesville, VA
Eindra K. Khin, MS (I), Charlottesville, VA
J. Artura Silva, MD, San Jose, CA

F12 ***Committing Sex Offenders Under General Commitment Statutes: A Progress Report from New York***
Roger M. Harris, MD, White Plains, NY
Howard E. Gilman, MD, Ridgewood, NJ
Stephen Harkavy, JD (I), New York, NY
Sadie Z. Ishee, JD (I), New York, NY
William J. Winslade, PhD, JD (I), Galveston, TX

F13 ***MMPI: Psychological Screening at the Workplace***

Gagan Dhaliwal, MD, Huntsville, AL

F14 ***Parricide and Juvenile Psychopathy: Use of PCL-YV***

Gagan Dhaliwal, MD, Huntsville, AL
Wade C. Myers, MD, Tampa, FL
Gina Vincent, PhD (I), Worcester, MA
Norman Poythress, PhD (I), Tampa, FL

WORKSHOP — 8:00 AM - 10:00 AM — **SALON D**

F15 ***Curbside Consultations in Forensic Psychiatry***

Debra A. Pinals, MD, Worcester, MA,
Paul S. Appelbaum, MD, New York, NY
Thomas Gutheil, MD, Brookline, MA
Howard V. Zonana, MD, New Haven, CT

PANEL — 8:00 AM - 10:00 AM — **SALONS ABC**

F16 ***The CATIE Study: Use, Misuse, and Abuse***

Graham D. Glancy, MB, ChB, FRCPsych, Etobicoke, ON, Canada
Neil S. Kaye, MD, FRCPc, Wilmington, DE
Philip J. Candilis, MD, Worcester, MA
Henry S. Levine, MD, Bellingham, WA

PANEL — 8:00 AM - 10:00 AM — **INDIANA/IOWA/ MICHIGAN**

F17 ***Perspectives on Malingering***

Ricky D. Malone, MD, MPH, Kensington, MD
Rosemary Carr-Malone, MD, Bethesda, MD
Christopher L. Lange, MD, Olney, MD
Adrian T. Kress, MD (I), Bethesda, MD

PANEL — 8:00 AM - 10:00 AM — **NW/OHIO/PURDUE**

F18 ***POWs v. Torturers: A New Cause of Action?***

Andrew P. Levin, MD, Hartsdale, NY
Liza H. Gold, MD, Arlington, VA
Anthony Onorato, JD (I), Washington, DC

RESEARCH IN PROGRESS #3 — 8:00 AM - 10:00 AM — **DENVER/HOUSTON KANSAS CITY**

F19 ***Crime, Culture, and Psychiatry in Pacific Islanders***

Jeff Gould, MD , San Francisco, CA
Erika V. Kis, BA (I), San Mateo, CA

F20 ***Drugs and Crime: The Interface Between Drug Diversion and the Criminal Justice System***

Caroline J. Easton, PhD (I), New Haven, CT
Susan Devine, MSN (I), New Haven, CT
Mark Simoniello, LCSW (I), New Haven, CT

F21 ***Role of Substance Abuse in Intimate Partner Violence: the Addiction - Domestic Violence Equation***

Caroline J. Easton, PhD (I), New Haven, CT
Susan Devine, MSN (I), New Haven, CT
Paul T. Amble, MD, Middletown, CT

F22 ***Juvenile Court Jurisdiction Outcome in Maryland***

Todd Christiansen, MD, Silver Spring, MD
Jeffrey S. Janofsky, MD, Timonium, MD

COFFEE BREAK

PANEL — 10:15 AM - 12:00 NOON — **SALON D**

F23 ***Sharia Law and Psychiatry***

Charles C. Dike, MD, MRCPsy, MPH, New Haven, CT
Syed N. Akhtar, MD, FRCPC, Dartmouth, NS, Canada
Saadia Alizai-Cowan, MD, Jessup, MD
Hauwa Ibrahim, JD (I), New Haven, CT

WORKSHOP — 10:15 AM - 12:00 NOON — **SALONS ABC**

F24 ***Road Trip: Tips and Pitfalls for the Traveling Expert***

Thomas G. Gutheil, MD, Brookline, MA
Robert I. Simon, MD, Potomac, MD
William H. Reid, MD, Horseshoe Bay, TX

PANEL — 10:15 AM - 12:00 NOON — **INDIANA/IOWA/ MICHIGAN**

F25 ***Law Enforcement Interviews of Hospital Patients***

Paul S. Appelbaum, MD, New York, NY
Paul M. Jones, MD (I), New York, NY
David M. Siegel, JD (I), Boston, MA
Debra A. Pinals, MD, Worcester, MA

PANEL — 10:15 AM - 12:00 NOON — **NW/OHIO/PURDUE**

F26 ***Forensic Options in False Allegations of Parental Sexual Abuse in Child Custody Disputes - Child and Adolescent Committee***

Dean M. De Crisce, MD, Brooklyn, NY
Stephen B. Billick, MD, New York, NY
Joe Kenan, MD, Beverly Hills, CA
Fabian M. Saleh, MD, Worcester, MA

PANEL — 10:15 AM - 12:00 NOON — **DENVER/HOUSTON KANSAS CITY**

F27 ***Public Protection: UK and Irish Perspectives - International Relations Committee***

Kenneth G. Busch, MD, Chicago, IL
David V. James, MD, Oxford, United Kingdom
Gwen Adshead, MBBS, MA, FRCPsych, Berkshire, United Kingdom
Adrian T. Grounds, FRCP, Cambridge, United Kingdom
Damian Mohan, MD (I), Dublin, Ireland

LUNCH — 12:00 NOON - 2:00 PM — **SALONS E-H**

F28 ***Intimate Partner Violence: Expert Testimony Over 25 Years***

Mary Ann Dutton, PhD (I), Washington, DC

PANEL — 2:15 PM - 4:00 PM — **SALON D**

F29 ***Creating a Balance: Forensic Career and Personal Life***

Tara M. Neavins, PhD (I), Middletown, CT
Donna M. Norris, MD, Wellesley, MA
Debra A. Pinals, MD, Worcester, MA
Madelon V. Baranoski, PhD (I), New Haven, CT
Thomas G. Gutheil, MD, Brookline, MA

COURSE — 2:15 PM - 6:15 PM — **DENVER/HOUSTON/ KANSAS CITY**

F30 ***Establishing a Forensic Practice - Private Practice Committee***

Pogos H. Voskanian, MD, Huntington Valley, PA
Steven H. Berger, MD, Franfort, IN
Robert P. Granacher, MD, MBA, Lexington, KY
Henry S. Levine, MD, Bellingham, WA
Carla Rodgers, MD, Bala Cynwyd, PA
Diane H. Schetky, MD, Rockport, ME
Christine Tellefsen, MD, Baltimore, MD

PANEL — 2:15 PM - 4:00 PM — **SALONS ABC**

F31 ***Bad Nature, Bad Nurture, and Testimony at Murder Trials (Advanced)***

Stephen A. Montgomery, MD, Nashville, TN
William Bernet, MD, Nashville, TN
Cindy L. Vnencak-Jones, PhD (I), Nashville, TN
Paul S. Appelbaum, MD, New York, NY

PANEL — 2:15 PM - 4:00 PM — **INDIANA/IOWA/ MICHIGAN**

F32 ***Proposed AAPL Guidelines: Trial Competence, Disability Assessments***

Douglas Mossman, MD, Dayton, OH
Liza H. Gold, MD, Arlington, VA

PANEL 2:15 PM - 4:00 PM **NW/OHIO/PURDUE**

F33 Serial Killers: From Cradle to Grave

Charles L. Scott, MD, Sacramento, CA
Barbara Beadles, MD, Sacramento, CA
Hagop Hajian, MD, Sacramento, CA
Richard "Chad" Ford, MD, Sacramento, CA

COFFEE BREAK

PANEL 4:15 PM - 6:15 PM **SALON D**

F34 Addiction and Criminal Responsibility - Addiction Psychiatry Committee

Mace Beckson, MD, Los Angeles, CA
George Barzokis, MD (I), Los Angeles, CA
Samuel Jan Brakel, JD (I), Chicago, IL
Robert Weinstock, MD (I), Los Angeles, CA

PANEL 4:15 PM - 6:15 PM **SALONS ABC**

F35 Mental Health Courts: Forensic Challenges and Outcomes

Gregory G. Sokolov, MD, Davis, CA
Honorable Talmadge R. Jones, JD (I), Sacramento, CA
Mark E. Kammerer, MS (I), Chicago, IL

PAPER SESSION #3 4:15 PM - 6:15 PM **INDIANA/IOWA/ MICHIGAN**

F36 He Said--She Said: Evaluating Credibility and Damages

Renée L. Binder, MD, San Francisco, CA
Dale E. McNiel, PhD (I), San Francisco, CA

F37 Forensic Consultation in a Class Action Lawsuit

Richard J. Kassner, MD, New York, NY
Barry Rosenfeld, PhD (I), Bronx, NY

F38 Establishing Liability for Fear of Future Illness

Mohan Nair, MD, Beverly Hills, CA
Chris Johnson, JD (I), San Francisco, CA

F39 Empirical Findings on Legal Difficulties Common to Practicing Psychiatrists: A Review

James H. Reich, MD, MPH, San Francisco, CA

RESEARCH IN PROGRESS #4 4:15 PM - 6:15 PM **NW/OHIO/PURDUE**

F40 Hello Again, Mrs. Robinson: Sexual Abuse of Male Teens

Vinneth Carvalho, MD, New Haven, CT
Howard V. Zonana, MD, New Haven, CT
Lakeesha Woods, PhD (I), New Haven, CT
Josephine Buchanan, BA (I), New Haven, CT
Madelon V. Baranoski, PhD (I), New Haven, CT

F41 Women, Substance Abuse, and Violence

Paul T. Amble, MD, Middletown, CT
Susan Devine, APRN (I), New Haven, CT
Caroline Easton, PhD (I), New Haven, CT

F42 Filicide in the Italian Press From 1992 to 2004

Giovanni B. Traverso, MD, Siena, Italy
Simona Traverso, MD (I), Siena, Italy
Laura Emiletti, Psychologist (I), Siena, Italy
Monica Bianchi, Psychologist (I), Siena, Italy
Maria I. Massafra, Criminologist (I), Siena, Italy

F43 Mothers Thinking of Murder: Psychiatric Inquiry

Susan J. Hatters-Friedman, MD, Cleveland Heights, OH
Renee M. Sorrentino, MD, Boston, MA
Joy E. Stankowski, MD, Strongsville, OH
Phillip J. Resnick, MD, Cleveland, OH

F1 CLINICAL AND ETHICAL CONSIDERATION IN PEOPLE WITH GID

Fabian M. Saleh, MD, Worcester, MA
Joel T. Andrade, MSW, LICSW (I), Bridgewater, MA

EDUCATIONAL OBJECTIVE

To provide an overview of the clinical criteria of Gender Identity Disorder (GID), including an historical overview of changes in this diagnostic category. Discuss ethical and legal considerations in the assessment of GID. Draw conclusions based on available research and propose areas of future research.

SUMMARY

Gender Identity Disorder (GID) is a disorder characterized by a clinically distressing and persistent identification as the opposite gender in conjunction with persistent discomfort with one's assigned gender. Although epidemiological data are scarce, it is estimated that GID occurs in approximately 1 in 10,000 males and 1 in 30,000 females. Because of its infrequent occurrence, many clinicians are unfamiliar with the clinical manifestations of this disorder. The proposed treatments, for GID include hormone therapy and possible gender reassignment surgery. Because of the implications of these treatments, thorough assessment over a prolonged period is necessary. This poster will provide an overview of the clinical criteria of this disorder including the historical evolution of this diagnosis. We will review relevant research pertaining to issues that impact clinical assessment including comorbidity and differential diagnosis. Ethical and legal considerations related to GID assessment and treatment will also be discussed. Based on this review, conclusions will be drawn as well as proposed areas of future research.

REFERENCES

Hepp U, Kraemer B, Schnyder U, Miller N, Delsignore A: Psychiatric comorbidity in gender identity disorder. J Psychosomatic Research 58:259-61, 2005
Money J: The concept of gender identity disorder in childhood and adolescence after 39 years. J Sex & Marital Therapy 20-l63-77, 1994

SELF ASSESSMENT QUESTIONS

1. Gender Identity Disorder more frequently affects
a. females
b. males
c. equal prevalence
ANSWER: b

2. The diagnosis of Gender Identity Disorder requires:
a. cross-gender identification
b. the desire for gender reassignment surgery
c. persistent discomfort with one's own gender
d. both a and c
e. None of the above
ANSWER: e

F2 TERMINATION OF PARENTAL RIGHTS: EXPERT TESTIMONY

Kenneth J. Weiss, MD, Bala Cynwyd, PA
David F. Bogacki, PhD (I), Camden, NJ

EDUCATIONAL OBJECTIVE

The participant will learn about ways to enhance expert testimony in TPR cases; the effects of case law on the nature and scope of testimony will be illustrated by New Jersey opinions.

SUMMARY

The authors have previously described the clinical characteristics of a sampling of defendants facing termination of parental rights (TPR). This poster describes some of the issues faced by the expert witness, as well as examples of New Jersey case law that shape the content of the testimony. Examples of these issues include: approaching the ultimate issue; bringing functional significance to Axis-I and Axis-II disorders; defending attacks on methodology; and when to abandon reunification efforts.

REFERENCES

Azar ST, Lauretti AE, Loding BV: The evaluation of parental fitness in termination of parental rights cases: a functional-contextual perspective. Clin Child Fam Psychol Rev 1:77-100, 1998
Schetky DH, Angell R, Morrison CV, Sack WH: Parents who fail: a study of 51 cases of termination of parental rights. J Am Acad Child Psychiatry 18:366-83, 1979

SELF ASSESSMENT QUESTIONS

1. Parental lack of fitness must be proved by:
a. psychiatric testimony
b. a preponderance of the evidence
c. clear and convincing evidence
d. beyond a reasonable doubt
ANSWER: c

2. A diagnosis of mild mental retardation in a parent:
a. can be sufficient proof of lack of fitness to parent
b. is never dispositive of parenting capacity
c. must be coupled with an Axis-I disorder to be useful in court
ANSWER: b

F3 MENTALLY ILL SEX OFFENDERS: MENTALLY ILL OR MERELY DEVIANT

Priya Narayanan, MD (I), Bronx, NY
Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE

Participants will gain an understanding of the unique characteristics of sexual offenders who also suffer from major mental illness with particular emphasis on risk-related factors.

SUMMARY

The management by the mental health system of individuals convicted of sexual offenses continues to receive support and attention in many jurisdictions. The controversy surrounding this practice is usually associated with concern about redefining sexual offending behavior as a mental illness, with ramifications for treatment, risk management and resource allocation. Even without the contentious decisions about responsibility for management, practitioners often find themselves having to work with individuals who have a history of inappropriate and/or illegal sexual incidents, but who also suffer from a "traditional" major mental illnesses, such as schizophrenia or major affective disorder. In this study, we review the characteristics of this subpopulation of sexual offenders. A chart review was conducted of 53 individuals, hospitalized at a state psychiatric center, who carry at least one Axis I diagnosis other than a sexual disorder. Data collected includes demographic characteristics, psychosocial features (including histories of abuse and arrest), diagnosis, and in-hospital incidents. The STATIC 99 and HCR-20 were utilized to determine risk level for each patient. These data provide a description of the mentally ill sexual offending population, and a basis for comparing this unique group with demographic, diagnostic and risk findings described in the literature about sexual offenders generally.

REFERENCES

Murrey GJ, Briggs D, Davis C: Psychopathic disordered, mentally ill and mentally handicapped sex offenders: a comparative study. Medical Science Law 32 (4): 331-6, 1992
American Psychiatric Association: Dangerous Sex Offenders: A Task Force Report. Washington, DC: American Psychiatric Association, 1999

SELF ASSESSMENT QUESTIONS

1. Potential confounds in addressing sexual offending behavior in the mentally ill include:
a. psychosis
b. impulsivity
c. social skill deficits
d. all of the above
ANSWER: d

2. Mentally ill sexual offenders may share which of the following characteristics with non-mentally ill offenders:
a. psychopathy
b. pedophilic interest
c. cognitive distortions
d. all of the above
ANSWER: d

F4 FEMALE SEXUAL OFFENDING: THE IMPACT OF SUBSTANCE ABUSE

R. Gregg Dwyer, MD, EdD, Columbia, SC
Fabian M. Saleh, MD, Worcester, MA
Albert Grudzinskas, Jr., JD (I), Worcester, MA

EDUCATIONAL OBJECTIVE
This poster will inform the audience of the relationship between use of substances (alcohol and drugs) and sexual offending by females. Emphasis is on using the research and legal literature to enhance clinicians' knowledge and ability in the areas of female sex offender initial evaluations, risk assessment and associated testimony.

SUMMARY
Females accounted for 1.3% of 18,446 arrests for forcible rape and 8.5% of 63,759 sex offenses, not including forcible rape and prostitution, reported in the 2003 Uniform Crime Reports. They have also been credited with 6% of juvenile sex offense victims overall and 12% of victims under six years old. To what extent has research identified substance abuse among female sex offenders? When present how does it impact on volition, risk assessment and treatment considerations? A review of research and legal literature is presented to enhance clinicians' understanding of the relationship between female sexual offending and substance abuse. A brief overview of female sexual offending is presented to serve as the foundation for considering the impact. Crime statistics, data from published quantitative examinations of actual offenders and relevant case law examples are provided to frame the clinical issues. Recommendations relevant to both treatment and testimony are provided.

REFERENCES
Federal Bureau of Investigation (US). Crime in the United States 2003 uniform crime reports. Washington, DC: FBI; 2004 Oct
Snyder HN. Sexual assault of young children as reported to law enforcement: victim, incident, and offender characteristics. Washington, DC: U.S. Department of Justice Office of Justice Programs; 2000 Jul. Report No.: NCJ 182990

SELF ASSESSMENT QUESTIONS
1. Female sex offenders are credited with offending what percentage of victims under six years of age?
a. 12%
b. 23%
c. 42%
d. 63%
ANSWER: a

2. According to U.S. Department of Justice data from victim reporting, offenders have been identified as using alcohol during what percentage of rapes/sexual assaults?
a. 10%
b. 30%
c. 50%
d. 80%
ANSWER: b

F5 DEVELOPMENT OF A BRIEF MENTAL HEALTH SCREENING ADULTS INSTRUMENT FOR NEWLY INCARCERATED ADULTS

Robert L. Trestman, PhD, MD, Farmington, CT
Julian Ford, PhD (I), Farmington, CT
Wanli Zhang, PhD (I), Farmington, CT

EDUCATIONAL OBJECTIVE
Participants will be able to identify the prevalence of psychiatric illness in Connecticut's jails, and understand the necessity for improved treatment among mentally ill inmates and psychiatric illness as it relates to the risk of recidivism.

SUMMARY
Mentally ill individuals are increasingly coming within the purview of correctional programs as a result of societal changes such as deinstitutionalization, the shifting emphasis on return-to-work rather than welfare for disadvantaged adults, and the managed care approach to reducing funding for healthcare services and facilities. This presentation reports the prevalence of psychiatric illness in five of Connecticut's adult jails. Axis I and Axis II diagnoses

are reported for men and women. Data was used from a previous study that collected information on participants from four male Connecticut jails and one female Connecticut jail with the objective of developing a brief screening tool. Results: 64.9 % men and 77.0% women have one or more diagnoses. Greatest prevalence's were: Affective disorders--Caucasian men 32.5%, Caucasian women 64.8%; PTSD--African-American men 23.8%, Hispanic women 45.0 %; Borderline PD--Caucasian men 16.0%, Caucasian women 26.4%; and ASPD--Hispanic men 53.7%, Hispanic women 33.3%. Comorbidity of mental illness and offense type was also explored. The highest frequencies of offenses were drug-related crimes and technical violations. There is a growing need for adequate treatment of mentally ill inmates and continuing investigation of how the presence of a psychological disorder relates to criminal behavior.

REFERENCES

Fisher W, Packer I, Simon L, Smith D: Community mental health services and the prevalence of severe mental illness in local jails: Are they related? Administration and Policy in Mental Health 27(6): 371-82, 2000
Teplin LA: Psychiatric and substance abuse disorders among male urban jail detainees. Am J Public Health 84(2): 290-3, 1994

SELF ASSESSMENT QUESTIONS

1. Which group of individuals had the highest incidence of affective disorders (64.8%) in this study?
ANSWER: white females

2. According to the US Department of Justice statistics from 1998, approximately how many mentally ill offenders are incarcerated on any given day?
ANSWER: Over a quarter of a million (283,800)

F6 IMPACT OF PROVIDER FEEDBACK AND UTILIZATION REVIEW IN CORRECTIONS

Robert L. Trestman, PhD, MD, Farmington, CT
Nicholas A. Demartinis, MD (I), Farmington, CT
Mohammed Elsamra, MD (I), Farmington, CT
Wanli Zhang, PhD (I), Farmington, CT

EDUCATIONAL OBJECTIVE

At the conclusion of this presentation, the participant should be able to recognize the potential benefit of direct prescriber feedback and utilization review in modifying prescribing practices in correctional institutional settings to optimize antipsychotic management.

SUMMARY

Atypical antipsychotics have become first-line therapy for psychosis in the community and increasingly in correctional systems. A systematic intervention including individual provider feedback, educational sessions, and preferred medication procedures was instituted in the Connecticut Department of Correction to address quality of care and cost of antipsychotic treatment. This study is a retrospective analysis of the effect of these interventions on antipsychotic prescribing patterns from January to December 2002. System interventions included: 1) written individual feedback including prescribing rates; 2) quarterly educational group meetings; and 3) a required form to clinically justify non-preferred medication requests, reviewed by the Mental Health Director. Outcome measures were the percentage of prescriptions and monthly cost for each of the four studied antipsychotics pre and post-intervention. Overall utilization of preferred antipsychotic medication increased significantly over the study period ($p < 0.004$). There was a significant overall decrease in the utilization of non-preferred medication over the study period; Olanzapine decreased from 45.7% to 27.2% of atypical antipsychotic prescribing ($p < 0.001$). The combination of written individual feedback, educational pharmacotherapy sessions, and preferred medication procedures were effective in changing prescribing patterns and limiting the cost of atypical antipsychotics in the correctional setting.

REFERENCES

Trestman RL: Commentary: problems in correctional psychiatry. J Am Acad Psychiatry Law 30:30-2, 2002
Nilsson G, Hjemdahl P, Hassler A, Vitols S, Wallen NH, Krakau I: Feedback on prescribing rate combined with problem-oriented pharmacotherapy education as a model to improve prescribing behavior. Eur J Clin Pharmacol 56(11):843-8, 2001

SELF ASSESSMENT QUESTIONS

1. Why was olanzapine considered a non-preferred medication in this study?
ANSWER: It was primarily used as a sleeping medication and high cost.

2. What component of this program made it unique, as compared to previous studies?
ANSWER: The requirement of providers to medically justify non-preferred prescribing.

F7 **THE RELATIONSHIP BETWEEN BPD AND VIOLENT OFFENSES**

Lobna Ibrahim, MD (I), Farmington, CT
Robert I. Trestman, PhD, MD, Farmingon, CT
Wanli Zhang, PhD (I), Farmington, CT
Karen L. Pagano, MS (I), Farmington, CT

EDUCATIONAL OBJECTIVE

Participants will be able to recognize the prevalence rate of Borderline Personality Disorder in Connecticut's jails and prisons, and understand the relationship between BPD and violent offenses.

SUMMARY

Borderline Personality Disorder (BDP) is a diagnosis with criteria including impulsivity, aggressive behaviors and emotional instability; measures of BPD are significantly correlated with physical aggression and individuals with BPD may be more likely to commit violent crimes. Does BPD diagnosis correlate with violent offense in newly incarcerated inmates in all 5 of Connecticut's adult jails? About 84 inmates with a SCID II diagnosis of BPD were compared to 413 inmates without a diagnosis of BPD by gender, age, education, and non violent (drug related, prostitution, technical violation, motor vehicle related, burglary) vs. violent crimes (weapons, robbery, assault, manslaughter, murder, sexual assault). The study was IRB approved. Overall, 18% of BPD inmates and 15% of non-BPD inmates were charged with violent offenses (N.S.) When examined by gender, men were more likely to be charged with a violent crime than non-BPD men at the trend level ($p<0.1$). No difference was found in women. The hypothesis was partially supported in that men with BPD who were incarcerated were more likely to have been charged with violent offenses.

REFERENCES

Dutton DG, Starzomski AJ: Borderline personality in perpetrators of psychological and physical abuse. Violence Vict 8(4):326-37, 1993
Putkonen H, Komulainen EJ, Virkkunen M, Eronen M, Lonnqvist J: Risk of repeat offending among violent female offenders with psychotic and personality disorders. Am J of Psychiatry 160: 947-51, 2003

SELF ASSESSMENT QUESTIONS

1. What is the percentage of Borderline Personality Disordered individuals in this study?
ANSWER: 17% (84)

2. Are men or women with BPD more likely to be charged with violent offenses in this study?
ANSWER: Men

F8 **A FEMALE PATIENT WITH MULTIPLE PARAPHILIAS: A CASE STUDY**

Crystal S. Kim, BA (I), Washington, DC
Fabian M. Saleh, MD, Worcester, MA
R. Gregg Dwyer, MD, EdD, Columbia, SC
Fred S. Berlin, MD, PhD, Baltimore, MD

EDUCATIONAL OBJECTIVE

To provide basic and intermediate level background regarding the correctional environment as it pertains to segregation inmates, dually-committed inmates and other special status detainees.

SUMMARY

Inmates who require segregation in correctional settings differ from general population inmates in many dimensions. It is known that there is an increased prevalence of psychiatric disorders among inmates confined in segregated housing. However the origin of these disorders has not been determined. This presentation discusses the theoretical effects of segregated housing and its correlation with mental disorders. Insanity acquittees are another distinct subgroup of prisoners who may be under the joint supervision of a correctional facility and a department of mental health. The care of these prisoners requires coordination between agencies to ensure compliance and continuity of supervision. This presentation will discuss strategies for management of dually-committed offenders.

REFERENCES

Cote, et. al: Co-ocurring mental disorders among criminal offenders. Bull Am Acad Psychiatry Law 18:271-81, 1990
Silver SB, Cohen MI, Spodak MK: Follow-up after release of insanity acquittees, mentally disordered offenders, and convicted felons. Bull Am Acad Psychiatry Law 17(4): 387-400, 1989

SELF ASSESSMENT QUESTIONS

1. Approximately how many inmates in segregated housing are found to have severe mental disorders?

a. 75%
b. 50%
c. 30%
d. 10%

ANSWER: c

2. Which of the following groups have the highest criminal recidivism rate in the five years following de-institutionalization?

a. insanity acquittees
b. non-mentally ill prisoners
c. mentally disordered prisoners

ANSWER: c

F9 TREATMENT OPTIONS FOR SEXUAL OFFENDERS IN PRISON

Sara G. West, MD, Cleveland Heights, OH

EDUCATIONAL OBJECTIVE

To highlight the different treatment options available for sexual offenders and inventory how they are being used within the penal system in the United States.

SUMMARY

Crimes committed by sexual offenders are a significant and rapidly increasingly problem in today's society. Most often, the first time that those committing sexual crimes access psychiatric care is in the penal system. The various departments of correction throughout the country have a number of options for treatment at their disposal, including pharmaceuticals, therapy and castration. This poster will briefly discuss those options and focus on how select states use different approaches to treat sexual offenders during and following their incarceration.

REFERENCES

Saleh FM, Guidry LL: Psychosocial and biological treatment considerations for the paraphilic and nonparaphilic sex offender. J Am Acad Psychiatry Law 31:486-93, 2003
Meyer WJ, Collier CM: Physical and chemical castration of sex offenders: a review. J Offender Rehabilitation 1:1-18, 1997

SELF ASSESSMENT QUESTIONS

1. List three treatment options available for sexual offenders.

ANSWER: SSRI's, psychotherapy, castration (chemical and surgical)

2. How many states' departments of correction allow castration?

ANSWER: None

F10 SPECT SCAN USE IN MILD TRAUMATIC BRAIN INJURY

Timothy M. Houchin, MD, Lexington, KY
Jonh D. Ranseen, PhD (I), Lexington, KY
Timothy S. Allen, MD, Lexington, KY

EDUCATIONAL OBJECTIVE

The purpose of this poster presentation is to educate the forensic evaluator on varying issues that arise from the usage of SPECT scans in the evaluation of traumatically brain injured individuals.

SUMMARY

Single Photon Emission Computed Tomography (SPECT) is a highly sensitive method for evaluating traumatically brain-injured individuals. Although in the forensic setting it is used with some frequency, there are a number of areas of contention amongst experts in the field. SPECT scans may unveil evidence of traumatic brain injury that would otherwise go undetected by routine CT, MRI scanning or neuropsychological testing. However, there may be instances when employing

such a technique actually undermines the litigant's argument. For example, individuals with a variety of psychiatric disorders will frequently manifest abnormalities on SPECT scan imaging that may be indistinguishable from mild traumatic brain injury. In this poster session, we will describe how current medical literature impacts the admissibility and usefulness of SPECT scan in forensic evaluation of mild traumatic brain injury with respect to Daubert Standards.

REFERENCES

Davalos D, Bennett T: A review of the use of single-photon emission computerized tomography as a diagnostic tool in mild traumatic brain injury. Applied Neuropsychol 9(2):92-105, 2002
Hofman P, Stapert S, Kroonenburgh J, Jolles J, de Kruijk J, Wilmink J: MR imaging, single-photon emission CT, and neurocognitive performance after mild traumatic brain injury. Am J Neuroradiol 22(3):441-9, 2001

SELF ASSESSMENT QUESTIONS

1. Identify a psychiatric disorder that may objectively worsen the SPECT scan of mild traumatically brain injured individuals.

ANSWER: Depression

2. Of CT, MRI, or SPECT scanning, which is most sensitive in the detection of mild traumatic brain injury?

ANSWER: SPECT

F11 **FORENSIC OVERVIEW OF SERIAL HOMICIDAL POISONERS**

Barbara G. Haskins, MD, Charlottesville, VA
Eindra K. Khin, MS (I), Charlottesville, VA
J. Artura Silva, MD, San Jose, CA

EDUCATIONAL OBJECTIVE

The learner will be able to: 1) describe demographic characteristics of victims and perpetrators of homicidal poisoning, including gender, race, age ranges, method (acute, subacute, chronic); and 2) discuss proposed motives of poisoners; and 3) characterize medical and non-medical serial poisoners.

SUMMARY

Despite its sensationalistic appeal, there remains a dearth of information on homicidal poisoning. A few studies have attempted to redress this. This workshop reviews forensic features of poisoning cases. The rate of poisoning of non-family members has risen, so that currently 64% of cases occur outside of the family (FBI Uniform Crime Reporting (UCR) supplementary homicide reports (SHR) (1990-1999)). Male and female victims are equal. Victims range from infants to the elderly. For female victims, males tend to be the perpetrators. For male victims, sex ratios of the perpetrators are approximately equal. Generally, racial lines are not crossed between victim and perpetrator. Despite the popular image, fewer than 1% of FBI reported cases involved a lover triangle.* There is a dearth of data on poisoner motives. Our study combs through the literature to conduct an in-depth analysis of a significant number of serial poisoning cases in the last two centuries in an attempt to develop a more comprehensive profile of the serial poisoner, focusing on the much unexplored area of motive. One interesting finding of our study is that the most common occupational background for these serial homicidal poisoners turns out to be the medical profession, at a proportion much higher than what's been previously reported.

REFERENCES

Trestrail III JH: Criminal Poisoning: An Investigational Guide for Law Enforcement, Toxicologists, Forensic Scientists, and Attorneys. Totowa, NJ: Humana Press, 2000
Westveer AR, Jarvis JP, Jensen III CJ: Homicidal poisoning: the silent offense. FBI Law Enforcement Bull 73:1-8, 2004

SELF ASSESSMENT QUESTIONS

1. Over the last decade, the majority of homicidal poisoners apprehended were:

a. male
b. female

ANSWER: a

2. The most common professional background for serial poisoners in the last century appears to be:

a. housewives
b. politicians
c. medical professionals (physicians, nurses, etc.)
d. lawyers
e. businessmen

ANSWER: c

F12 **COMMITTING SEX OFFENDERS UNDER GENERAL COMMITMENT STATUTES: A PROGRESS REPORT FROM NEW YORK**

Roger M. Harris, MD, White Plains, NY
Howard E. Gilman, MD, Ridgewood, NJ
Stephen Harkavy, JD (I), New York, NY
Sadie Z. Ishee, JD (I), New York, NY
William J. Winslade, PhD, JD (I), Galveston, TX

EDUCATIONAL OBJECTIVE

The attendees will learn the history of general commitment and compare the criteria of these laws to the sexual violent predator laws. Pertinent court decisions will be reviewed. Treatment outcomes will be discussed, historically as well as currently in relation to the paraphilias and ASPD. Application of general commitment laws to sex offenders will be examined.

SUMMARY

As of March 2006, New York State had not passed a Sex Offender Commitment Statute and was using the general commitment statutes to commit men who have been convicted of sex offenses. This panel will discuss the history of general civil commitment reviewing decisions by the USSC and within New York State. We will also review the clinical standards that have evolved under the general commitment laws and review if these standards can be applied to sex offenders. Does this application of the statutes represent a further evolution away from parens patriae towards police power? We will discuss if it is necessary to have a sex offender commitment statute or can these men be committed under the existing commitment laws. We will also discuss the current legal challenges to the use of the laws for sex offenders, funding issues, the impact on limited inpatient resources and how this can lead to the re-stigmatization of the mentally ill. It appears that the prosecutors are selecting men who have histories of mental illness. These do not necessarily appear to be the most dangerous individuals who are released. Does the application of these laws to these men put other groups at risk, such as those not traditionally viewed as mentally ill?

REFERENCES

American Psychiatric Association: Dangerous sex offenders: A task force report of the American Psychiatric Association Washington, DC: Author, 1999, pp 1-167
Winick BJ, LaFond JQ: Protecting society from sexually dangerous offenders: Law, justice and therapy. Washington, DC: Am Psychological Assoc, 2003, pp 25-333

SELF ASSESSMENT QUESTIONS

1. The use of commitment laws has always had elements of social control and safety. In what ways are the use of general civil commitment laws as applied to sex offenders different from the historical role of civil commitment as a social safety tool?

ANSWER: Using these statutes for individuals who have committed sex offenses appears to broaden 1) the clinical criteria usually used (severe mental illness v. paraphilias, APD), 2) the time frame of the most recent dangerous behavior (recent acts versus offenses committed years ago), and 3) the time frame used for anticipating dangerous behavior days versus years).

2. An objection to the civil commitment of sex offenders is that there is no proven effective treatment for this group. How is this similar and different from the civil commitment of psychotic individuals in the pre-psychopharmacology era? Does this apply to using antisocial personality disorder as the sole criterion for mental abnormality in the SVP laws?

ANSWER: Within the context of civil commitment, it is only recent that we have “proven” treatments of these conditions, which implies that civil commitment has been based on public safety and attempts at humane care. There are significant questions about the effectiveness of sex offender treatment and currently commitment is primarily based on public safety.

F13 **MMPI: PSYCHOLOGICAL SCREENING AT THE WORKPLACE**

Gagan Dhaliwal, MD, Huntsville, AL

EDUCATIONAL OBJECTIVE

To enhance consulting skills of forensic psychiatrists within the occupational community. To clarify the role of psychological testing, especially MMPI, used by employers in the hiring process. To access case law in workplace litigation, role of federal and legislation, and future implications of use of psychological testing in hiring process.

SUMMARY

About forty-six percent of employers use some form of psychological testing to screen work applicants or potential employees at their workplaces.
Minnesota Multiphasic Personality Inventory (MMPI) is one of the most commonly use psychological tests, which inquires into an applicant's social and personal attitudes and beliefs. Some employers rely heavily on psychological and personality tests in selecting work force, because the tests are simple and convenient to use and can select a worker with specific skills and characteristics well suited for a certain profession. However, psychological testing in the workplace has been criticized on the basis that it is ineffective in predicting future employee performance, and that the tests were developed to diagnose psychological disorders, not to identify the best or worst employees. Additionally, these tests can violate the privacy rights of job applicants since they reveal personal attitudes toward religion, politics, family and marital values, and sex, therefore raising concerns that these tests can promote workplace discrimination. The poster will describe the use of psychological testing, especially MMPI, in the workplace and the case law that has generated from its use, including the cases of Bennett v. County of Suffolk; Thompson v. Borg-Warner Protective Services, Corp; and Reynolds v. Arizona. It will address how work applicants have rarely succeeded in challenging these practices, and how employers have prevailed in this type of litigation and have found ways to continue the practice of subjecting applicants to psychological testing during the hiring process.

REFERENCES

Menjoge SS: Testing the limits of anti-discrimination law: How employers' use of pre-employment psychological and personality tests can circumvent Title VII and the ADA. NC L Rev 82-326, Dec 2003
Varnagis v. City of Chicago, No. 96 C 6304, 1997 U.S. Dist.

SELF ASSESSMENT QUESTIONS

1. What are the concerns about using psychological testing during the hiring process in the workplace?
ANSWER: Concerns about its ability to predict a worker's skills and risk of increasing workplace discrimination

2. What is one of the commonly used psychological tools in workplace?
ANSWER: MMPI

F14 **PARRICIDE AND JUVENILE PSYCHOPATHY: USE OF PCL-YV**

Gagan Dhaliwal, MD, Huntsville, AL
Wade C. Myers, MD, Tampa, FL
Gina Vincent, PhD (I), Worcester, MA
Norman Poythress, PhD (I), Tampa, FL

EDUCATIONAL OBJECTIVE

To teach methods of evaluating psychopathic traits in adolescents in juvenile and criminal court settings. To gain access to new research data in juvenile psychopathy. To enhance consulting skills in the area of parricide and juveniles charged with violent crimes. To discuss the use of PCL-YV in a 14-year-old boy accused of parricide in New Mexico. To discuss how courts handle testimony regarding psychopathy and to review case law in PCL-R and PCL-YV.

SUMMARY

Parricide constitutes a phenomenon where one kills his or her parent. Adolescents accused of parricide often raise concerns about either their past exposure to abuse or demonstrating psychopathic traits. The presentation will define the concept of juvenile psychopathy and explain how to use PCL-YV and share data regarding its reliability and validity, in addition to additional tools and modalities to assess psychopathic traits in adolescents. Aspects of clinical and forensic evaluation of adolescents accused of parricide will be described using a recent case of a 14-year-old boy who shot his father, stepmother and a stepsister in New Mexico. Juvenile psychopathic traits were introduced into evidence during testimony based on Psychopathic Checklist- Youth Version (PCL-YV) and additional sources of evaluation. Finally case law on PCL-R and the PCL-YV and evidentiary standards that regulate testimony regarding juvenile psychopathy will be discussed along with how courts apply the relevance, probative and prejudicial aspects of evidence to psychopathy. Judge Kennedy's reference to "psychopathy" in a recent Supreme Court landmark case (Roper v. Simmons), involving juvenile death penalty indicates that courts will probably continue to deal with juvenile psychopathy in the future.

REFERENCES
Vincent G M, Hart S D: Psychopathy in childhood and adolescence, in Psychopaths: Current International Perspectives. Edited by Blauuw E, Sheridan L. Amsterdam, The Netherlands: Elsevier, 2002, pp 113-26
Forth AE, Hare RD, Cooke DJ: Psychopathy: Theory, research, and implications for society. New York: Springer-Verlag , 1998, pp 205-30

SELF ASSESSMENT QUESTIONS
1. What is a common risk factor for parricide?
ANSWER: Exposure to abuse

2. What tool is used to assess psychopathic traits in adolescents?
ANSWER: PCL-YV

F15 CURBSIDE CONSULTATIONS IN FORENSIC PSYCHIATRY

Debra A. Pinals, MD, Worcester, MA,
Paul S. Appelbaum, MD, New York, NY
Thomas Gutheil, MD, Brookline, MA
Howard V. Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE
At the end of this presentation, participants will be able to discuss case examples of actual forensic curbside consultations on topics including boundary violations, confidentiality, risk management and ethics; and describe suggested mechanics of managing and documenting informal curbside consultations.

SUMMARY
Informal medical consultations, commonly referred to as "curbside consults" occur daily in routine practice. The mechanics of participating in informal clinical consultations have received little attention in the literature. Although these types of consults generally involve telephone contact and more recently have included email communications about an unknown patient, potential liability for the consultant exists. Forensic psychiatrists are often among practitioners identified for their off-the-cuff opinions about complex medicolegal, regulatory and risk management clinical conundrums. Common areas of inquiry include advice related to violence risk assessment, questions of confidentiality and Tarasoff-type analyses, boundary violations, conduct of forensic psychiatric practice, and ethical matters. Often such consultation requests afford little time and limited information, yet the availability of collegial guidance can be extremely helpful in difficult clinical situations. In this workshop, presenters will describe actual curbside consultation case questions they have received over years of practice. Each scenario will be followed by an opportunity for attendees to comment and participate in discussions aimed at unraveling the consultation question presented. Presenters will also share with participants their approach to managing and documenting such informal consultations.

REFERENCES
Cohn SL: The role of the medical consultant. Med Clin North Am 87:1-6, 2003
Hendel T: Informal consultations: Do new risks exist with this age-old tradition? J Med Pract Manage 17(6):308-11, 2002

SELF ASSESSMENT QUESTIONS
1. A central issue in the determination of liability for a consultant rests on the establishment that:
a. there was a physician-patient relationship and a duty to the patient
b. the consultant falls under the doctrine of respondeat superior
c. none of the above
ANSWER: a

2. Informal consultations always should involve:
a. a very definitive order for action
b. guidance to the extent possible and education
c. critique of the current clinical treatment
ANSWER: b

F16 THE CATIE STUDY: USE, MISUSE, AND ABUSE

Graham D. Glancy, MB, ChB, FRCPsych, Etobicoke, ON, Canada
Neil S. Kaye, MD, FRCPc, Wilmington, DE
Philip J. Candilis, MD, Worcester, MA
Henry S. Levine, MD, Bellingham, WA

EDUCATIONAL OBJECTIVE

To educate members about the recent literature on antipsychotics and raise forensic implications of this study.

SUMMARY

A recent study suggested that perphenazine, a first generation antipsychotic, demonstrated similar efficacy to three atypical antipsychotics. One atypical was the most effective but was associated with lower safety. In this presentation, sponsored by the Psychopharmacology Committee, we will review this study, including its strengths and limitations. We will address some psycholegal issues, placing the study in a context of "standard of care." Finally, we will include a discussion on reinformed consent when treating patients with antipsychotics.

REFERENCES

Lieberman JA, et al: Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. N Engl J Med 353:1209-23, 2005
Chaimowitz G, Glancy GD, Blackburn J: The need for reinformed consent with continued traditional neuroleptic treatment. Bull Canadian Psychiatric Association 35(3):17-20

SELF ASSESSMENT QUESTIONS

1. Which of the following was not proven in the CATIE study?
a. that first generation antipsychotics had a better effect on positive symptoms
b. that olanzapine recipients were less likely to discontinue medication
c. that atypicals have equal extra-pyramidal effects.
d. that discontinuation rates are generally equal across all the medications except olanzepine
ANSWER: a

2. Which of the following applies to the CATIE study?
a. very high discontinuation rates
b. did not include data on case management
c. did not include data on substance abuse
d. suggested a range of medications should be available
e. all of the above
ANSWER: e

F17 PERSPECTIVES ON MALINGERING

Ricky D. Malone, MD, MPH, Kensington, MD
Rosemary Carr-Malone, MD, Bethesda, MD
Christopher L. Lange, MD, Olney, MD
Adrian T. Kress, MD (I), Bethesda, MD

EDUCATIONAL OBJECTIVE

Development of a clinical approach to the diagnosis and treatment of malingering, offering a practical example of its importance.

SUMMARY

The word malingering generally connotes a patient whose secondary gain far surpasses any help they are seeking. Many providers believe the most appropriate disposition of such patients is to terminate their treatment. However, malingering happens in psychiatric offices every day, and is sometimes done by participants who most need treatment. This panel will describe a clinical approach to diagnosing malingering by allowing the clinician to focus on the core psychological issues driving the need to embellish or falsify symptoms, rather than focusing on the pure content of the malingered symptoms. The panel will also discuss the treatment of malingering, with the goal of reducing the behavior. At the core of this topic is identifying the major countertransference issues that contribute to a clinician's pejorative views of malingering. Finally, the panel will discuss how the treatment of malingering is a practical issue, especially in the military, where the diagnosis of malingering can lead to criminal prosecution under the Uniformed Code of Military Justice (with a prison sentence of up to ten years). The panel will address the statistics of such prosecutions over the past seventeen years.

REFERENCES

Lipian M, Mills M: Malingering, in Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 7th Edition. Edited by Sadock B. Baltimore: Lippincott, Williams, and Wilkins, 2000

Malone R, Lange C: A clinical approach to malingering. J Am Acad Psychoanalysis and Dynamic Psychiatry 35:1, 2007 (in press)

SELF ASSESSMENT QUESTIONS

1. The most common core issue leading clinicians to perceive a malingering patient as one not needing or wanting psychiatric help is a sense of:

ANSWER: betrayal

2. In time of war, a solider who deliberately self-injures himself faces ____ years of confinement, and ___ if done to avoid service.

ANSWER: five; ten

F18 POWS V. TORTURERS: A NEW CAUSE OF ACTION?

Andrew P. Levin, MD, Hartsdale, NY
Liza H. Gold, MD, Arlington, VA
Anthony Onorato, JD (I), Washington, DC

EDUCATIONAL OBJECTIVE

The participant will learn the legal basis for actions related to torture and violations of the Geneva Conventions and the complexities of evaluating torture victims.

SUMMARY

During Operation Desert Storm, American pilots and infantry captured by Iraqi forces were tortured by Iraqi intelligence and held under inhumane conditions until their release in March 2001. In 2003, seventeen American POWs and their families brought action in DC District Court against the Republic of Iraqi under the "terrorism exception" of the Foreign Sovereign Immunities Act seeking compensatory and punitive damages for the horrific acts of torture they suffered during their captivity. Plaintiffs' counsel retained Drs. Levin and Gold to document the psychological effects of torture and its long-term effects on the men and their families. Dr. Levin will describe the general pattern of post-traumatic responses among the POWS and their families, placing these in the context of research on torture and prisoners of war. Dr. Gold will then focus on the specific challenges in developing evaluations of military men scattered across the country and on active duty overseas. Mr. Onorato, a member of the plaintiffs' team, will review the legal basis for this claim, discuss the issues that led to its reversal by the DC Court of Appeals, and prospects for similar actions in the future.

REFERENCES

Gerrity E, Keane TM, Tuma F: The Mental Health Consequences of Torture. New York: Kluwer Academic/Plenum Publishers, 2001

Acree v. Republic of Iraq, 361 U.S. App. D.C. 410

SELF ASSESSMENT QUESTIONS

1. Which of the following is not a protective factor for victims of torture?

a. a strong belief system
b. prior treatment for a mental illness
c. prior knowledge of and expectations concerning torture
d. specialized immunization training

ANSWER: b

2. What is the central provision of the Foreign Sovereignty Immunities Act?

a. foreign governments are sovereign in American courts.
b. american courts have no jurisdiction in suits involving foreign courts.
c. torture can be the basis for a suit against a foreign government.
d. foreign states generally enjoy immunity from suit in American courts.

ANSWER: d

F19 CRIME, CULTURE, AND PSYCHIATRY IN PACIFIC ISLANDERS

Jeff Gould, MD , San Francisco, CA
Erika V. Kis, BA (I), San Mateo, CA

EDUCATIONAL OBJECTIVE
The presentation will provide an in-depth examination of cultural variables that serve as risk factors for criminal activity. The role of ethnic identification and acculturation will be discussed as it relates to crime, substance abuse, access to mental health and substance abuse treatment.

SUMMARY
The largest population of Pacific Islanders (PIs) in the continental United States resides in the San Francisco Bay Area (SFBA). Preliminary evidence demonstrates that PIs are strikingly over represented in the criminal justice system and are the largest under-utilizers of all health services, including medical, psychiatric, and substance abuse treatment. Most counties within the SFBA are very large and PIs only make up 1% of the total population. In one SFBA county, PIs represented 75% of all defendants charged with capital murder over a two-year period with 89% of those defendants having substance use disorders. It was also discovered that PIs are approximately 5% to 11% of the county jail populations and probation referrals. Compared to their population percentage of 1%, these statistics are alarming. In order to formulate culturally appropriate preventive strategies, a close examination of the unique factors contributing to this phenomenon is required. Currently, very little research is available regarding these issues in the PI community. The study examines 200 PIs who are on adult probation in order to identify specific demographic, social, and cultural variables that contribute to and protect against mental disorders, substance abuse, health disparities, and criminal offending among PIs.

REFERENCES
Le T, Arifuku ID, Louie C, Krisberg M: Not Invisible: Asian Pacific Islander Juvenile Arrests in San Francisco County. Oakland: National Council on Crime and Delinquency, 2001, pp 10-44
Morris MW, Arifuku ID, Tillson RW, Garcia V, Dhanoa S, Juneja P, Krisberg B: An Assessment of Disproportionate Minority Confinement in San Mateo County. Oakland: National Council on Crime and Delinquency, 2003, pp 1-67

SELF ASSESSMENT QUESTIONS
1. The role of disaggregating Asian and Pacific Islander (API) data by the U.S Census in the year 2000 served to:
a. reveal that Pacific Islanders ranked lower than Asians on every measure of health, education and standard of living used to determine assistance needs.
b. provide further evidence that this is a homogenous cultural group.
c. establish a standard of disaggregating API data within the scientific community.
ANSWER: a

2. With respect to substance abuse, this study found that:
a. Pacific Islanders (PIs) were proportionally represented compared to other cultural groups.
b. even though PIs were overrepresented in terms of substance abuse problems, there were very few in substance recovery treatment.
c. even though PIs were overrepresented in terms of substance abuse problems, none were referred to substance recovery treatment over a two-year period.
d. even though PIs were underrepresented in terms of substance abuse problems, they were overrepresented in substance recovery treatment referrals.
ANSWER: b

F20 DRUGS AND CRIME: THE INTERFACE BETWEEN DRUG DIVERSION AND THE CRIMINAL JUSTICE SYSTEM

Caroline J. Easton, PhD (I), New Haven, CT
Susan Devine, MSN (I), New Haven, CT
Mark Simoniello, LCSW (I), New Haven, CT

EDUCATIONAL OBJECTIVE
Participants will learn about the Connecticut Statute designed to divert drug offenders from the Department of Corrections into substance abuse treatment. Participants will also learn about the characteristics of drug offenders who successfully complete treatment and have lower rates of re-offending.

SUMMARY
Alcohol and illicit drug use contribute to crime and violence in a number of ways. Despite early preventive education and intervention strategies for first-time offenders, state prisons are becoming increasingly crowded with drug offenders. In a recent study, 22% of federal and 33% of state prisoners reported committing their current offense while under the influence of drugs. Convicted drug offenders had the highest incidence of drug use at the time of their offense. The purpose of the present study was to assess treatment outcome among substance-using offenders who were court ordered to receive a forensic substance dependency evaluation. A total of 100 defendants were evaluated. Seventy-seven percent of the defendants were male offenders and had a prior history of arrests. More than 74% of the clients were found to be substance dependent at the time of the alleged offense, and more than three-quarters were recommended to receive substance abuse treatment. The findings suggest that of the defendants who were recommended to treatment (70%), only 43% were granted treatment. Of those who were granted treatment, 91% of the drug diversion clients successfully completed treatment. Furthermore, the results suggest that there were differences between the drug diversion clients who completed treatment and those who did not receive treatment. The clients who successfully completed treatment had a lower number of rearrests compared with the clients who did not receive treatment.

REFERENCES
Hubbard RL, Craddock SG, Anderson J: Overview of 5-year follow-up outcomes in the drug abuse treatment studies (DATOS). J Subst Abuse Treat 25(3):125-34, 2003
French MT, Zarkin GA, Hubbard RL, Rachal JV: The effects of time in drug abuse treatment and employment post-treatment drug use and criminal activity. Am J Drug Alcohol Abuse 19(1):19-33, 1993

SELF ASSESSMENT QUESTIONS
1. Some studies suggest that substance abusers with criminal involvement have significantly less substance use and criminal re-offending after how many months/years of follow-up?

a. 3 months
b. 6 months
c. 12 months
c. All of the above
ANSWER: d

2. Other studies suggest that which diagnosis is linked to poorer substance abuse and legal outcomes among drug diversion clients?

a. Generalized Anxiety Disorder
b. Borderline Personality Disorder
c. Antisocial Personality Disorder
d. Major Depressive Disorder
ANSWER: c

F21 **ROLE OF SUBSTANCE ABUSE IN INTIMATE PARTNER VIOLENCE: THE ADDICTION - DOMESTIC VIOLENCE EQUATION**

Caroline J. Easton, PhD (I), New Haven, CT
Susan Devine, MSN (I), New Haven, CT
Paul T. Amble, MD, Middletown, CT

EDUCATIONAL OBJECTIVE
Participants will learn about the relationships among substance use, intimate partner violence, and response to treatment.

SUMMARY
A large percentage of domestic violence episodes involve alcohol or drug use. A large proportion of victims reported that the offender had been drinking or using illicit drugs before the violent incident. Furthermore, although alcohol use has frequently been implicated in interpersonal violence, research indicates that males who batter typically use both alcohol and drugs. The purpose of this study was to assess substance use, legal, and violence characteristics among 85 men with co-occurring alcohol dependence and domestic violence who were stipulated to treatment. Additionally, we assessed prevalence of illicit drug use and treatment response among this population of offenders. Male offenders participated in 3 months of substance abuse treatment. The findings showed that 37% of the alcohol dependent offenders tested positive for marijuana and/or cocaine use during 12 weeks of treatment. The results of the study illustrated that 80% of substance-using domestic violence offenders successfully completed treatment with significant reductions in substance use and frequency of violent episodes. However, upon further exploration, results illustrated that offenders who tested

positive for any illicit drug use during treatment had significantly poorer treatment outcomes (e.g., increased anger expression and violence and an increase in alcohol and drug use) at the end of treatment and at the 6-month follow-up point as compared to domestic violence offenders who did not have active drug use during treatment.

REFERENCES

Moore TM, Stuart GL: Illicit substance use and intimate partner violence among men in batterers' intervention. Psychology of Addictive Behaviors 18(4):385-9, 2004
Easton C, Swan S, Sinha R: Prevalence of family violence in clients entering substance abuse treatment. J Subst Abuse Treat 18:23-8, 2000

SELF ASSESSMENT QUESTIONS

1. A large percentage of domestic violence episodes involve:
a. only cocaine use
b. only marijuana use
c. either alcohol or drug use
d. none of the above
ANSWER: c

2. The most commonly used illicit drugs among alcohol dependent domestic violence offenders are:
a. only cocaine use
b. only marijuana use
c. cocaine and/or marijuana use
d. phencyclidine (PCP Dust)
ANSWER: c

F22 **JUVENILE COURT JURISDICTION OUTCOME IN MARYLAND**

Todd Christiansen, MD, Silver Spring, MD
Jeffrey S. Janofsky, MD, Timonium, MD

EDUCATIONAL OBJECTIVE

The participant will learn which juvenile transfer criteria are most closely associated with juvenile's being transferred from adult to juvenile court in Baltimore City, Maryland.

SUMMARY

Maryland criminal law excludes several serious offenses from juvenile court jurisdiction when the alleged offender is 14-years old or older. The law also provides a process for youthful defendants charged with such crimes to be transferred from the adult to the juvenile criminal justice system.
Maryland law sets forth five transfer criteria from adult to juvenile court, which includes a juvenile's age, mental and physical maturity, amenability to treatment, nature of the alleged crime, and public safety. In Baltimore City, psychiatrists and psychologists working for the Circuit Court Medical Office are frequently ordered by the Court to evaluate defendants for such transfers. This study attempts to evaluate which factors correlate most with juvenile's being retained in the adult court system or transferred to the juvenile justice system. The study consists of a chart review of all transfer of jurisdiction evaluations that were done by psychiatrists and psychologists in the Medical Office of the Circuit Court for Baltimore City in the year 2004. These evaluations were compared to the public record of the Circuit Court for Baltimore City to determine whether a youth had been retained in the criminal system or had been transferred to the juvenile system.

REFERENCES

Sellin T, Wolfgang ME: The Measure of Delinquency. Montclair, New Jersey: Patterson Smith, 1978
Feld BC: Race, youth, violence, and the changing jurisprudence of waiver. Behav Sci Law 19:3-22, 2001

SELF ASSESSMENT QUESTIONS

1. Maryland law sets forth which criteria allowing a youthful offender's case to be transferred from adult court to juvenile court:

a. age
b. mental and physical maturity
c. amenability to treatment
d. nature of the alleged crime
e. all of the above

ANSWER: e

2. Defendants 14 years old or older are originally adjudicated in adult criminal court in Maryland for which of the following crimes:

a. murder
b. robbery
c. larceny
d. status offenses

ANSWER: a

F23 SHARIA LAW AND PSYCHIATRY

Charles C. Dike, MD, MRCPsy, MPH, New Haven, CT
Syed N. Akhtar, MD, FRCPC, Dartmouth, NS, Canada
Saadia Alizai-Cowan, MD, Jessup, MD
Hauwa Ibrahim, JD (I), New Haven, CT

EDUCATIONAL OBJECTIVE

To understand how psychiatric expertise can be applied to legal issues under the Sharia law.

SUMMARY

Although Muslims, followers of the Islamic religion, represent approximately one fifth of the world's population, not much is known by non-Muslims about the legal system that is derived from Islam. Sharia, the Islamic law, covers not only religious rituals, but political, social, domestic and private life. Sharia is primarily meant for all Muslims, but applies to a certain extent also for people living inside a Muslim society. In some Muslim countries such as Saudi Arabia and Pakistan, mental illness is still seen as punishment of Allah or inflicted by the spirits. Suicide and suicide attempts are crimes under Islamic law, and the mere use of alcohol and drugs attracts severe punishments. With regard to forensic psychiatry, is there a role for expert witnesses? If so, can a non-Muslim be an expert witness in a Sharia court? Is there fairness and equity in the application of Sharia? Is there a notion of competency to stand trial? What is the qualification of the Sharia judges and attorneys? Is Sharia the same in all countries where it is practiced? The panel discussion will give an overview on Islamic law and practice, the role of psychiatry and psychiatrists, and gender and politico-social issues.

REFERENCES

Pridmore S, Pasha MI: Psychiatry and Islam. Australas Psychiatry 12(4):380-5, 2004
Maqsood RW: Sharia: A Practical Guide. Available at www.bbc.co.uk/religion/religions/islam (accessed January 6, 2006)

SELF ASSESSMENT QUESTIONS

1. Sharia:

a. is the predominant legal system in Muslim countries
b. may apply to non- Muslims
c. applies only to practicing Muslims
d. is conducted in English
e. all of the above

ANSWER: b

2. Sharia is derived from:

a. the Koran
b. all known sayings of Prophet Muhammad
c. analogy, when direct instruction is not in the Koran
d. consensus among Islamic scholars
e. all of the above

ANSWER: e

F24 ROAD TRIP: TIPS AND PITFALLS FOR THE TRAVELING EXPERT

Thomas G. Gutheil, MD, Brookline, MA
Robert I. Simon, MD, Potomac, MD
William H. Reid, MD, Horseshoe Bay, TX

EDUCATIONAL OBJECTIVE
To present and discuss the special problems associated with being an expert who travels to testify.

SUMMARY
The expert who must travel to a remote location to testify for trial or deposition, or to perform an IME, is off his/her home turf in more ways than one. There are legal, licensure, and jurisdictional issues to confront; special problems of travel itself; and numerous aids to successful accomplishment of the travel-and-testify paradigm. Dr. Simon will present issues of board of registration concerns about testifying outside a state in which one is licensed and other hazards on the way. Dr. Gutheil will describe useful gadgets and other items that make travel easier. Dr. Reid will describe particular travel experiences that illustrate the problems and their solutions. Audience discussion and examples will be solicited and discussed.

REFERENCES
Gutheil TG: The Psychiatrist as Expert Witness. Washington, DC: American Psychiatric Press, 1998
Simon RI, Gutheil TG: The forensic expert practicing on the road: new hazards along the way. Psychiatric Annals 33:202-6, 2003

SELF ASSESSMENT QUESTIONS
1. Out-of-state experts are vulnerable to licensure and ethics complaints because:
a. they usually cannot be liable in a classic malpractice model
b. the AMA has defined forensic testimony as the practice of medicine
c. they may be accused of practicing medicine without a license
d. all of the above
ANSWER: d

2. The traveling expert is well advised to:
a. assume the travel will take longer than the retaining attorney asserts
b. prepare for adverse weather conditions
c. bring more money than you think you will need
d. when in doubt, clear your function with the local board of registration if possible
e. all of the above
ANSWER: e

F25 LAW ENFORCEMENT INTERVIEWS OF HOSPITAL PATIENTS

Paul S. Appelbaum, MD, New York, NY
Paul M. Jones, MD (I), New York, NY
David M. Siegel, JD (I), Boston, MA
Debra A. Pinals, MD, Worcester, MA

EDUCATIONAL OBJECTIVE
Participants will understand the significance of police access to hospital patients; medical, psychiatric, legal, and ethical issues posed by police interviews in the hospital; the need for pertinent professional guidelines; proposed principles for dealing with these situations.

SUMMARY
Law enforcement requests to interview patients in the hospital are everyday occurrences in busy medical centers. In hospital emergency and trauma departments, and sporadically on other services, police question patients who are victims, witnesses, or suspects in crimes ranging from traffic violations to homicides. Most interviews are time sensitive, and how they are conducted can have significant medical, legal, and societal consequences. However, no laws explicitly govern police access to patients, nor are there relevant professional guidelines, either for physicians or police. Decision-making is consequently unstructured, ad hoc, and highly variable. This panel discussion will present an illustrative case, review the paucity of relevant literature, and summarize recent interview data. The panelists will explore the relevant responsibilities and rights of patients, hospital staff, and law enforcement, and review the risks inherent in existing ad hoc, unstructured decision making. The panel will conclude by proposing principles and recommendations to guide decision-making when law enforcement officials seek direct access to hospital patients.

REFERENCES
Jones PM, Appelbaum PS, Siegal DM, and The Massachusetts Working Group on Law Enforcement Access to Hospital Patients: Law enforcement interviews of hospital patients: a conundrum for clinicians. JAMA 295:822-25, 2006
Mincey v. Arizona, 437 U.S. 385 (1978)

SELF ASSESSMENT QUESTIONS

1. Which of the following is not included in the HIPAA privacy regulations?
a. specific protected health information about hospital patients that may be disclosed to law enforcement
b. circumstances under which protected health information may be released to law enforcement without the patient's permission
c. a definition of what constitutes "protected health information"
d. requirement for a written release from the patient before hospital staff may allow law enforcement to interview or photograph the patient

ANSWER: d

2. On which of the following two hospital services are police officers most likely to ask to interview patients who are victims, witnesses and or suspects in a crime?
a. emergency medicine and medical intensive care
b. emergency medicine and trauma surgery
c. trauma surgery and psychiatry
d. trauma surgery and medical intensive care

ANSWER: b

F26 FORENSIC OPTIONS IN FALSE ALLEGATIONS OF PARENTAL SEXUAL ABUSE IN CHILD CUSTODY DISPUTES – CHILD AND ADOLESCENT COMMITTEE

Dean M. De Crisce, MD, Brooklyn, NY
Stephen B. Billick, MD, New York, NY
Joe Kenan, MD, Beverly Hills, CA
Fabian M. Saleh, MD, Worcester, MA

EDUCATIONAL OBJECTIVE
At the conclusion of this panel the participant will be able to understand the literature on the false allegations of sexual abuse; parental alienation syndrome; characteristics and evaluation of sexual offenders; evaluation of claims in custody disputes; and reintegration of the child with both parents.

SUMMARY
Divorce and custody proceedings appear to increase the likelihood of allegations of sexual abuse. The number of false allegations has increased. Often the child is restricted from the accused parent for protection during the evaluation, which may lead to alienation of the accused parent, influencing the reporting and later outcome of the dispute. Evaluators need to be aware of the need for objective assessment of these allegations in consideration of custody recommendations. In this panel we wish to engage forensic evaluators in a discussion, through a moderated panel, participation, and literature review on the issues surrounding sexual abuse allegations in custody disputes. Dr. De Crisce will present the literature on false allegations of sexual abuse in child custody disputes and will review the evaluation of sexual offenders. Dr. Saleh will present data on the characteristics of both juvenile and adult sexual offenders and the use of those characteristics in the evaluation of allegations. Dr. Kenan will discuss parental alienation and the biasing of the child by one parent against the other through allegations of sexual abuse in custody disputes. Finally, Dr. Billick will discuss forensic options in disputes with an emphasis on working towards reintegrating the children with both parents.

REFERENCES
Billick S, Ciric C: Role of psychiatric evaluator in child custody disputes, in Principles and Practice of Forensic Psychiatry, 2nd Edition. Edited by Rosner R. New York: Oxford University Press, 2003, pp 331-47
Thoennes N, Tjaden P: The extent, nature, and validity of sexual abuse allegations in custody and visitation disputes. Child Sexual Abuse & Neglect 14(2):151-63, 1990

SELF ASSESSMENT QUESTIONS
1. How common are allegations of sexual abuse made within the context of divorce and custody proceedings?
ANSWER: In a large study by Thoennes N, Tjaden P (1990), a small proportion of custody disputes involved sexual abuse allegations, less than 2%. Other studies conclude percentages that range from 1-30%.

2. How often are these allegations determined to be without substantiation?
ANSWER: In larger studies, allegations without substantiation were found in 5-20%.

F27 **PUBLIC PROTECTION: UK AND IRISH PERSPECTIVES - INTERNATIONAL RELATIONS COMMITTEE**

Kenneth G. Busch, MD, Chicago, IL
David V. James, MD, Oxford, United Kingdom
Gwen Adshead, MBBS, MA, FRCPsych, Berkshire, United Kingdom
Adrian T. Grounds, FRCP, Cambridge, United Kingdom
Damian Mohan, MD (I), Dublin, Ireland

EDUCATIONAL OBJECTIVE
To provide the audience with examples of the ways in which psychiatrists are required to play a role in public protection in contemporary society in the United Kingdom and Ireland and to discuss some of the professional and ethical issues that arise from this.

SUMMARY
Modern society nowadays, particularly in the Western world, feels at risk of attack and of civil disturbance of various kinds arising both from individuals and groups. In the United Kingdom and Ireland politicians are increasingly expecting psychiatrists to play a role in public protection through the use of psychiatric skills to assess threatened risk in the community and the use of detention under the Mental Health Act and confinement in secure hospitals. These political expectations lead to ethical and professional challenges for the psychiatrists involved, and the four presenters will each give their own perspective on the way these trends have influenced their work and the dilemmas which arise for them. Dr. David James will talk about his contribution as a psychiatrist to the protection of prominent public figures; Dr. Gwen Adshead will talk about the psychiatric implications of current antiterrorism legislation which includes indefinite imprisonment without trial; Dr. Adrian Grounds will talk about psychiatric aspects of the early release scheme for paramilitary prisoners in Northern Ireland and Dr. Damian Mohan will talk about his contact with law enforcement and criminal justice agencies in the Republic of Ireland.

REFERENCES
Scalora M, Baumgartner JV, Zimmerman W, Callaway D, Maillette M, Covell C, Palarea R, Krebs J, Washington D: Risk factors for approach behavior towards the U.S. Congress. J Threat Assessment 2:35-55, 2002
Green SA, Bloch S: Working in a flawed mental health care system: An ethical challenge. Am J Psychiatry 158:1378-83, 2001

SELF ASSESSMENT QUESTIONS
1. When psychiatrists become involved in public protection issues through working with criminal justice, law enforcement, and government agencies, what important principles should they keep in mind?
ANSWER: They should remain aware of the limitations of their expertise and in contact with colleagues to avoid isolation, and always be alert for ethical issues.

2. Which of the following statements is correct of those people engaging in inappropriate communications or approaches to public figures?
a. 40% are women.
b. Mental illness is uncommon.
c. It is a minority that threaten.
d. The majority have a history of criminal convictions.
ANSWER: c

F28 INTIMATE PARTNER VIOLENCE: EXPERT TESTIMONY OVER 25 YEARS

Mary Ann Dutton, PhD (I), Washington, DC

EDUCATIONAL OBJECTIVE

The objective of this keynote presentation is to increase knowledge of the historical context and current status of expert testimony concerning intimate partner violence. Attendees will be able to articulate a model of expert testimony for intimate partner violence that incorporates the current state of scientific knowledge in this field.

SUMMARY

Testimony about intimate partner violence was introduced in the 1970s in a landmark case involving a defendant who was eventually acquitted of killing her husband. Since that time, there has been an evolution in the approach to evaluation and testimony in this area. The scientific evidence guiding an evaluation in cases involving intimate partner violence continues to develop, as has the approach to expert testimony that rests upon it. This presentation will address changes and current status in this area of forensic psychiatry and psychology, including a critique and discussion of battered woman syndrome, which is neither a legal defense nor a psychiatric diagnosis. A number of factors limit its utility as a model for forensic evaluation and testimony in cases involving partner violence. The explosion of empirically-based knowledge and information about the nature of partner violence and its acute and chronic effects, both in adult victims and their children, provides the scientific foundation for the work of forensic experts in this area. A clinical hypothesis-testing model to guide the evaluation and testimony will be offered.

REFERENCES

Dutton MA, Goodman L A: Coercion in intimate partner violence: Toward a new conceptualization. Sex Roles 52:743-56, 2005

Dutton MA: Battered women's strategic response to violence: The role of context, in Future Interventions with Battered Women and Their Families. Edited by Edleson JL, Eisikovits ZC. Thousand Oaks, CA: Sage Publications Inc, 1996, pp 105-24

SELF ASSESSMENT QUESTIONS

1. Describe why battered woman syndrome is limited in its utility as a framework for expert evaluation and testimony in cases involving intimate partner violence.

ANSWER: 1) no single profile of battered victim; 2) term battered woman syndrome is vague; 3) PTSD not the major or sole explanation of the legal issue in case; 4) relevant factors for explaining legal issue in case goes beyond psychiatric symptoms; 5) the term, “battered woman syndrome” creates an image of pathology when none may exist.

2. What factors in addition to facts of the alleged incident should be examined in evaluating a battered victims’ behavior allegedly involved self-defense?

ANSWER: 1) economic and tangible resources; 2) societal and cultural factors; 3) institutional system factors; 4) social networks, including the family and the perpetrator; 5) individual characteristics, including personal history, medical and psychiatric history, and prior coping efforts to deal with violence and abuse.

F29 CREATING A BALANCE: FORENSIC CAREER AND PERSONAL LIFE

Tara M. Neavins, PhD (I), Middletown, CT
Donna M. Norris, MD, Wellesley, MA
Debra A. Pinals, MD, Worcester, MA
Madelon V. Baranoski, PhD (I), New Haven, CT
Thomas G. Gutheil, MD, Brookline, MA

EDUCATIONAL OBJECTIVE

This panel discussion will address the inherent challenges in negotiating a balance between devoting ample time to a forensic career and personal life, including family, friends, social activities, and relaxation. The panel will address the nature of this conflict and consider possible solutions from panelists’ personal experience and empirical investigation.

SUMMARY

For many forensic practitioners, it is a challenge to reconcile and maintain the vital balance among the competing demands of forensic work -- with its unpredictable, hurry-up-and-wait, rhythms -- and family, recreation, and a social/personal life. Forensic practitioners must negotiate the challenging and tenuous balance between taking on exciting but time-consuming projects while considering how these choices impact other areas. This panel, chaired by Dr. Neavins, will hear from individuals who have been relatively successful with such multi-tasking. Dr. Norris will share her insight and humor regarding her experiences with motherhood while developing a forensic

career. Dr. Pinals will address how to set priorities to maintain one's professional-personal balance. Dr. Baranoski will explore the challenges of setting priorities for the future while immersed in present demands and the seductive myths of academic and professional life. Dr. Gutheil will discuss the foregoing presentations, describe his own experiences, and report on empirical work conducted by his program on this issue. Following these presentations, Dr. Neavins will invite audience members to ask questions to help hone skills for creating balance between a forensic career and personal life. Practical suggestions, stories of success, and tales of triumphs and disasters will be offered and solicited.

REFERENCES

Kearney AJ, Gutheil TG, Commons ML: Trading forensic and family commitments. Bull Am Acad Psychiatry Law 24:533-46, 1996

Levinson W, Kaufman K, Tolle SW: Women in academic medicine: Strategies for balancing career and personal life. J Am Med Wom Assoc 47:25-33, 1992

SELF ASSESSMENT QUESTIONS

1. The instrument created by Kearney, Gutheil, and Commons (1996) to address choices between family and professional responsibilities is based, in part, on which of the following theories?

a. social learning
b. behavioral economics
c. psychoanalysis
d. none of the above

ANSWER: b

2. Forensic practitioners agree that the most challenging aspect of balancing career and personal life is:

a. the high level of abstraction of forensic work
b. having to work with attorneys
c. desperate housewives/homehubbies/partners
d. matters of timing

ANSWER: d

FRIDAY

F30 **ESTABLISHING A FORENSIC PRACTICE- PRIVATE PRACTICE COMMITTEE**

Pogos H. Voskanian, MD, Huntington Valley, PA
Steven H. Berger, MD, Franfort, IN
Robert P. Granacher, MD, MBA, Lexington, KY
Henry S. Levine, MD, Bellingham, WA
Carla Rodgers, MD, Bala Cynwyd, PA
Diane H. Schetky, MD, Rockport, ME
Christine Tellefsen, MD, Baltimore, MD

EDUCATIONAL OBJECTIVE

At the completion of this course, the participant should be able to conduct a competent forensic evaluation; write a forensic report and formulate clinical findings in legal context; understand principles of effective and ethically permissible marketing and advertisement; learn principles of business management of practice; and establish and develop forensic practice.

SUMMARY

Forensic psychiatry is a subspecialty of psychiatry where clinical and scientific findings must be formulated in legal context. Therefore, a psychiatrist in the practice of forensic psychiatry should be comfortable in formulating his or her clinical findings in a legal language and providing answers to legal questions. The practice of forensic psychiatry, unlike clinical practice, involves presentation of clinical findings to lay audience, jurors, and legal professionals. Marketing and development of forensic practice is also different from that of clinical practice. Residency programs usually do not provide adequate training and background to residents to enable them to venture into starting an independent forensic practice. This course is structured to provide a conceptual framework and some pearls to clinicians with little or no experience in operating a forensic practice. The course can also be helpful to graduating forensic psychiatry fellows in helping them to start up and promote their practice. The purpose of the course is to familiarize clinical psychiatrist with the legal system, legal requirements and expectations of forensic evaluations, forensic reports, and expert testimony. The course will address issues related to establishing contractual agreements with attorneys, nuances of marketing process, and business management of the practice.

REFERENCES

Berger SH: Establishing a Forensic Psychiatry Practice: A Practical Guide. New York: WW Norton, 1997, pp 15-116
Simon RI, Gold LH: Textbook of Forensic Psychiatry. Washington, DC, London, England: The American Psychiatric Publishing, 2004, pp 3-556

SELF ASSESSMENT QUESTIONS

1. a thorough forensic report can be useful for:
a. educating jurors regarding clinical findings
b. establishing the basis for medicolegal opinion
c. marketing forensic practice
d. nhancing credibility of opinion
e. personal satisfaction with work product
f. all of the above
ANSWER: f

2. Forensic reports:
a. should heavily utilize clinical and scientific terminology
b. should be double spaced and opinions typed in bold font
c. draft reports are encouraged to obtain approval of referring attorney prior to finalizing the report
d. should be preferably written using simple expressions that can be easily understood by a layperson
e. must be helpful for referring attorney to win the case
ANSWER: d

F31 BAD NATURE, BAD NURTURE, AND TESTIMONY AT MURDER TRIALS (ADVANCED)

Stephen A. Montgomery, MD, Nashville, TN
William Bernet, MD, Nashville, TN
Cindy L. Vnencak-Jones, PhD (I), Nashville, TN
Paul S. Appelbaum, MD, New York, NY

EDUCATIONAL OBJECTIVE

To familiarize attendees with recent research linking specific genotypes and childhood maltreatment as risk factors for violent behavior, explain how this genotyping is performed, discuss how this type of information has been used in testimony in criminal trials, and consider the ethical ramifications of this type of evaluation and testimony.

SUMMARY

Recent research in which subjects were studied longitudinally from childhood until adulthood has started to clarify how a child's environment and genetic makeup interact to create a violent adolescent or adult. Caspi et al. found that when male subjects had a low activity of MAOA and also were maltreated as children, there was a much greater likelihood the person would manifest violent antisocial behavior in the future. Caspi et al. have also found that individuals with one or two copies of the short allele of the 5-HTT gene, "exhibited more depressive symptoms, diagnosable depression, and suicidality in relation to stressful life events" than individuals with two long alleles. Information regarding a defendant's genotype, exposure to child maltreatment, and experience of unusual stress may be appropriate to present during the mitigation phase of criminal trials.
Dr. Bernet will provide an overview of this recent research. Dr. Vnencak-Jones will explain the specific laboratory procedures used to assess for these genotypes. Dr. Montgomery will review the authors' experiences in presenting genetic information at criminal trials and how this use of genotyping has fared in light of Daubert criteria. Dr. Appelbaum will comment on the ethical ramifications of this type of analysis and testimony.

REFERENCES

Caspi A, et al: Role of genotype in the cycle of violence in maltreated children. Science 297:851, 2002
Caspi A, et al: Influence of life stress on depression: Moderation by a polymorphism in the 5-HTT gene. Science 301:386-89, 2003

SELF ASSESSMENT QUESTIONS

1. Research has shown that the most important finding as related to increased risk of violence and the serotonin system is:

a. that overall serotonin activity is lower
b. that overall serotonin activity is higher
c. that there has been some disruption in serotonin function
d. that the serotonin system is unrelated to violent behavior

ANSWER: c

2. Generally, courts have ruled that:

a. testimony about genotyping and risk of violence is admissible
b. genotyping of criminal defendants is a violation of their constitutional rights
c. testimony about a history of childhood maltreatment is irrelevant for sentencing hearings
d. current genotyping techniques lack sufficient reliability for court admissibility

ANSWER: a

F32 **PROPOSED AAPL GUIDELINES: TRIAL COMPETENCE, DISABILITY ASSESSMENTS**

Douglas Mossman, MD, Dayton, OH
Liza H. Gold, MD, Arlington, VA

EDUCATIONAL OBJECTIVE

During this workshop, participants will become familiar with current drafts of the proposed AAPL guidelines for evaluating competence to stand trial and conducting disability assessments, and have opportunities to discuss the guidelines and provide input that will be incorporated into the final versions.

SUMMARY

AAPL Task Forces have prepared drafts of practice guidelines on two of the most common types of forensic evaluations: competence to stand trial (CST) and assessment of disability. The CST guideline summarizes relevant American legal standards and offers recommendations for forensic psychiatrists who conduct evaluations of competence to stand trial in the United States. The authors hope the CST guideline will provide individual forensic psychiatrists with a comprehensive overview of the legal context in which evaluations of adjudicative competence occur, descriptions of examination methods and reporting techniques, and the scientific bases for these evaluations. The guideline on disability assessments reviews general principles of assessment, including ethical considerations, and offers more specific recommendations for specific types of assessments, such as Social Security disability, workers' compensation, private insurance, ADA, and fitness for duty. Neither guideline proposes to prescribe or define "standards of care" for performing CST or disability evaluations. This panel will devote one hour to discussions of each draft guideline. The guidelines' lead authors will give short presentations about key features of the drafts; audience members will then be invited to ask questions and offer comments. Audience feedback will be used in preparing final drafts of the guidelines.

REFERENCES

Melton GB, Petrilla J, Poythress NG, Slobogin C: Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers, 2nd Edition. New York: Guilford Press, 1997, pp 3-613
Drukteinis A: Disability, in American Psychiatric Publishing Textbook of Forensic Psychiatry. Edited by Simon RI, Gold LH. Washington DC: American Psychiatric Publishing Inc, 2004, pp 287-302

SELF ASSESSMENT QUESTIONS

1. Concerning evaluations of competence to stand trial, which of the following statements is NOT correct?

a. Fewer than 10,000 evaluations take place in the U.S. each year.
b. Dusky v. U.S. (1960) is still a relevant legal standard.
c. Examiners may now avail themselves of several structured evaluation formats.
d. For incompetent defendants, examiners usually must state whether treatment would "restore" competence to stand trial.
e. Although they do not function as treating physicians when they assess adjudicative competence, forensic examiners still should act responsibly concerning evaluees' health needs.

ANSWER: a

2. When conducting evaluations for disability benefits, what should psychiatrists know?
a. The standard for disability set by the Social Security Administration (SSA) has for the most part been adopted by private disability insurers.
b. Both the SSA and private disability insurers require that the disability be due to one of eight recognized categories of mental disorders.
c. Standards for disability may vary depending upon the policy and/or the insurer, and evaluators should understand the relevant standard in each case.
d. Standards for disability are set by statutory law.
ANSWER: c

F33 SERIAL KILLERS: FROM CRADLE TO GRAVE

Charles L. Scott, MD, Sacramento, CA
Barbara Beadles, MD, Sacramento, CA
Hagop Hajian, MD, Sacramento, CA
Richard "Chad" Ford, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
The panelists will enhance consulting skills of the forensic psychiatrist by providing education on key features distinguishing serial killers from spree and mass killers, provide a review of the criminology and psychiatric literature regarding serial killers, and review unique subpopulations of serial killers to include juveniles and females.

SUMMARY
Dr. Scott will review key definitions that distinguish various types of individuals who commit multiple murders to include spree killers, mass killers, serial killers, and serial sexual homicide. The FBI Behavioral Science Unit (BSU) homicide classification scheme will be presented as well as key features that distinguish single from serial murders. Dr. Hajian will review the literature addressing issues of juvenile serial killers, known childhood antecedents to adult serial killing, neuropsychiatric developmental (DNM) factors, and the importance of identifying emerging sexually sadistic killing fantasies in youth as an opportunity to intervene prior to homicidal actions being taken. Dr. Ford will describe key features to evaluate in adult male serial killers to include severe personality disorders, psychopathy, sexual sadism, other paraphilias, "signatures," and disposal site location choice. A presentation of the BTK killer will highlight common features of adult male serial murderers. Dr. Beadles will present a summary of the literature on female serial killers and highlight those factors that distinguish female from male serial murderers. Kelleher's study of 100 female serial killers will be reviewed. The role and limitations of forensic psychiatrists in writing evaluation reports and in providing expert witness testimony will also be emphasized.

REFERENCES
Kraemer GW, Lord WD, Heilbrun K: Comparing single and serial homicide offenses. Behav Sci Law 22:325-43, 2004
Myers WC: Serial murder by children and adolescents. Behav Sci Law 22:357-74, 2004

SELF ASSESSMENT QUESTIONS
1. The most common motivation for serial murderers to kill compared to single murderers is:
a. anger
b. sexual
c. revenge
d. financial
ANSWER: b

2. According to the FBI terminology, homicides characterized as a single event with two or more locations and no emotional cooling off period is best defined as a:
a. serial murder
b. mass murder
c. spree murder
d. rage murder
ANSWER: c

F34 **ADDICTION AND CRIMINAL RESPONSIBILITY - ADDICTION PSYCHIATRY COMMITTEE**

Mace Beckson, MD, Los Angeles, CA
George Barzokis, MD (I), Los Angeles, CA
Samuel Jan Brakel, JD (I), Chicago, IL
Robert Weinstock, MD (I), Los Angeles, CA

EDUCATIONAL OBJECTIVE
To understand relevant biological, legal, and societal issues regarding addiction, criminal responsibility, and diminished capacity.

SUMMARY
Criminal offenders commonly are under the influence of alcohol and/or drugs at the time of the offense and may be substance-dependent, or "addicted." Substance dependence is a brain-based behavioral disorder. Substances cause neurotoxic damage that affects impulse control. Also, individuals who develop addiction may have developmental dysregulation of myelination, which may cause deficits in inhibitory control functions. George Bartzokis, MD will discuss a novel "myelin model'" of human brain evolution in relation to responsibility. Samuel Jan Brakel, Esq. will discuss three landmark cases: Robinson v. California (can't punish for status of being addicted); Powell v. Texas (may punish for behavior even if resulting from addiction); and Montana v. Egelhoff (State may prohibit use of voluntary intoxication evidence to challenge criminal intent). Robert Weinstock, MD will discuss societal and ethical facets related to addiction and personal responsibility. He will address the concept that addicted individuals have some capacity to make choices even though making the choice not to use substances may be more difficult than for nonaddicted individuals. Society also is more reluctant to forgive addicts for their choices as compared to psychotic individuals despite some similarities between the behavioral issues for each of these two groups.

REFERENCES
Beckson M, Bartzokis G, Weinstock R: Substance abuse and addiction in forensic psychiatry, in Principles and Practice of Forensic Psychiatry, 2nd Edition. Edited by Rosner R. London: Arnold, 2003, pp 672-84
Baratzokis G: Brain myelination in prevalent neuropsychiatric developmental disorders: primary and comorbid addiction. Ann Am Soc Adolescent Psychiatry 29:55-96, 2005

SELF ASSESSMENT QUESTIONS
1. In DSM-IV Substance Dependence, the individual continue use of the substance?
a. because it is pleasurable
b. despite significant substance-related problems
c. because the individual wants to
ANSWER: b

2. Myelination affects
a. synapses
b. conduction velocity
c. arborization
ANSWER: b

F35 **MENTAL HEALTH COURTS: FORENSIC CHALLENGES AND OUTCOMES**

Gregory G. Sokolov, MD, Davis, CA
Honorable Talmadge R. Jones, JD (I), Sacramento, CA
Mark E. Kammerer, MS (I), Chicago, IL

EDUCATIONAL OBJECTIVE
To present an overview of mental health courts in the United States, including: history of their development, challenges for treating and forensic psychiatrists, potential barriers in developing a court, and outcome measures of existing programs.

SUMMARY
The presence of mental health courts across jurisdictions in the United States has been growing. Since the late 1990s, over 100 mental health courts have been established or are in the planning stages. Mental health courts have been defined as adult criminal courts that have a separate docket dedicated to persons with mental illnesses; their objective is to divert criminal defendants from jail into mental health treatment programs and to monitor

the progress of defendants during the treatment, with the ability to impose criminal sanctions (i.e., jail time) for treatment noncompliance. Dr. Sokolov will present an overview of the history of mental health courts, including a review of the literature, and will present challenges and possible roles for jail psychiatric services and forensic psychiatrists, including a discussion of the issues of dual agency and confidentiality. Judge Jones of Sacramento County Superior Court will discuss the challenges jurisdictions may face when planning to implement a mental health court program. Mr. Kammerer will present outcome data of the Cook County Mental Health Court Program, including presenting some specific cases to illustrate treatment outcomes. Time will be allowed for audience members to present issues or cases of their mental health courts.

REFERENCES

Cosden M, et al: Efficacy of a mental health treatment court with assertive community treatment. Behav. Sci Law 23:199-21, 2005
Boothroyd RA, et al: Clinical outcomes of defendants in mental health court. Psychiatric Serv. 56: 829-34, 2005

SELF ASSESSMENT QUESTIONS

1. All the following regarding mental health courts are true EXCEPT?
a. They are adult criminal courts.
b. There are separate dockets for mentally ill defendants.
c. They divert defendants from jail into mental health treatment programs.
d. They monitor defendants found NGRI (not guilty by reason of insanity).
e. All of the above are true.
ANSWER: d

2. The idea of mental health courts came out of the success of what other court model?
a. family court
b. juvenile court
c. drug court
d. domestic violence court
e. none of the above
ANSWER: c

F36 HE SAID--SHE SAID: EVALUATING CREDIBILITY AND DAMAGES

Renée L. Binder, MD, San Francisco, CA
Dale E. McNiel, PhD (I), San Francisco, CA

EDUCATIONAL OBJECTIVE

To understand the role of the forensic evaluator in determining credibility and damages when there are allegations of inappropriate sexual behavior and there is no corroborating evidence.

SUMMARY

In this paper, we present civil cases that involved allegations of boundary violations or sexual assault where there was no corroborating evidence (e.g., no medical reports or eyewitness statements). In these cases, the alleged perpetrator denied any wrongdoing. Both plaintiff and defense attorneys wanted to know about the credibility of their clients. We point out that forensic experts do not determine the truth of what happened. It is always the fact finder (the judge or jury) who determines who is telling the truth. Nevertheless, forensic experts can give information to attorneys and to the fact finder that will help with this determination. We discuss the role of the evaluator and psychological testing in terms of ruling in or out alternative explanations for the plaintiff's account of events. In addition, we discuss how, from a clinical perspective, perceptions of being harmed can lead to psychological signs and symptoms, but that this should not be used for determinations of whether an event actually met the legal definitions of rape or boundary violations.

REFERENCES

Dvoskin JA: Commentary: two sides to everything—the need for objectivity and evidence. J Am Acad Psychiatry Law 33:482-3, 2005
Binder RL: Sexual harassment: issues for forensic psychiatrists. Bull Am Acad Psychiatry Law 20:409-18, 1992

SELF ASSESSMENT QUESTIONS

1. Who of the following determines the ultimate credibility of a plaintiff or defendant?
a. the plaintiff's expert
b. the defendant's expert
c. the fact finder
d. the plaintiff's mother
e. the defendant's mother
ANSWER: c

2. Which of the following is relevant information in determinations about the credibility of the plaintiff?
a. presence or absence of psychosis
b. consistencies or inconsistencies in reporting
c. presence or absence of confusion
d. evidence or absence of evidence of exaggeration of symptoms in other contexts
e. all of the above
ANSWER: e

F37 **FORENSIC CONSULTATION IN A CLASS ACTION LAWSUIT**

Richard J. Kassner, MD, New York, NY
Barry Rosenfeld, PhD (I), Bronx, NY

EDUCATIONAL OBJECTIVE

At the end of this presentation, participants should be familiar with a model for the forensic psychiatric/psychological evaluation of personal injury claims in a large-scale class action lawsuit.

SUMMARY

In May and June 2005, a six-member investigating team, representing the Physicians for Human Rights and the Bellevue/NYU School of Medicine Program for Survivors of Torture, conducted a study in a case of illegal mass cremations in Punjab, India, which is pending before India's National Human Rights Commission. The lawsuit includes 756 named litigants, all of whom had family members killed and illegally cremated by Indian security forces from 1992 to 1993. Because not all litigants could be individually evaluated, the subjects of the study were 131 of these family members. However, in addition to the death of a family member, many subjects also endured torture and threats to their own lives. Significant levels of morbidity were diagnosed in both the family members of torture victims and survivors of personal torture. Scant studies profile a defined approach in this nascent area of forensic psychiatric involvement. The methods and results of this study will be presented as a generally applicable model for forensic psychiatric/psychological consultation in class action lawsuits. This includes issues relevant to representational sampling, the choice of investigational instruments, the structured interview, and the possibility to work in an investigational team.

REFERENCES

Kumar R, Singh A: Reduced to Ashes: The Insurgency and Human Rights in Punjab. Kathmandu Nepal: South Asia Forum for Human Rights, 2003
Rosenfeld B, Keller A: Evaluation of Litigants Pertaining to Writ Petition (Crl.) No. 447/95 Committee for Information and Initiative on Punjab v. State of Punjab

SELF ASSESSMENT QUESTIONS

1. In a class action lawsuit,
a. it is critical to individually evaluate every possible member of the class.
b. there are well-established methods for how to conduct such evaluations.
c. psychological testing is not appropriate.
d. none of the above
ANSWER: d

2. "Losses" in a class action lawsuit may include which of the following?
a. direct psychological impairments
b. doctors bills
c. loss of income from work
d. all of the above
ANSWER: d

F38 ESTABLISHING LIABILITY FOR FEAR OF FUTURE ILLNESS

Mohan Nair, MD, Beverly Hills, CA
Chris Johnson, JD (I), San Francisco, CA

EDUCATIONAL OBJECTIVE
To help understand the scope and complexity cases involving of fear based liability.

SUMMARY
An action to recover damages for fear of future disease is based on theories of intentional infliction of emotional distress, negligent infliction of emotional distress, or as an element of damages based on some independent underlying liability. "Like the sword of Damocles, he knows it is there, but not whether or when it will fall." Justice Ruth Bader Ginsburg wrote for the majority. In 2000, a closely divided Supreme Court ruled 5-4 in Norfolk & Western Railway v. Ayers, that the fear of developing asbestos-related cancer is enough to collect monetary damages, even if plaintiffs are showing no signs of cancer and may never develop the disease. The scope of such litigation is explosive and may include: Environmental/occupational toxic exposures (perchlorate/heavy metals/solvents), radiation, mold, medications/vaccines (Thimerosal/Gulf War Syndrome/Hormone Therapy), HIV AIDS exposure/needle stick, breast injury, future risk of developing depression from using medications used to treat ADHD, future risk of developing tardive dyskinesia/diabetes/infertility from using antipsychotic/mood stabilizers, noise exposure and hearing loss. Important elements of proof in such cases include reasonableness of the plaintiff's fear, the degree of certainty that the plaintiff was actually exposed to a disease-causing agent, and the probability that the plaintiff will actually contract the feared disease. Some jurisdictions have used the "more likely than not" standard but case law continues to evolve in this important area. Illustrative cases, the use of behavioral science expert testimony and evidentiary standards are discussed.

REFERENCES
Potter v Firestone Tire & Rubber Co, 6 Cal4th 965, 25 Cal Rptr2d 550, 863 P2d 795, 1993
Norfolk & Western Railway v Ayers et al, 538 US 135, 2003

SELF ASSESSMENT QUESTIONS
1. Norfolk & Western Railway v. Ayers, involves what causative agent
a. Asbestos
b. per chlorate
c. DDT
d. Chromium
e. DES Diethylstilboestrol
ANSWER: a

2. What are "stand alone" claims of Fear Liability cases?
ANSWER: Cases where the claim is entirely mental without evidence of current physical injury.

F39 EMPIRICAL FINDINGS ON LEGAL DIFFICULTIES COMMON TO PRACTICING PSYCHIATRISTS: A REVIEW

James H. Reich, MD, MPH, San Francisco, CA

EDUCATIONAL OBJECTIVE
This presentation reviews the sparse amount of empirical literature on psychiatrists who get into legal difficulties with their practice of psychiatry. Participants will learn the major areas of concern in malpractice as well as some possible approaches to the problem.

SUMMARY
The goal was to examine published empirical reports of psychiatrists' difficulty with the law. A literature review was performed which revealed three empirical studies since 1990. Major areas of legal difficulty include: incorrect treatment (including medication), suicide, failure to diagnose a medical condition and inappropriate sexual advances/contact. Although the tendency to get into legal difficulty seems to be proportional to the severity of the patient's illness, there are exceptions such as ECT. In general it appears that practices with higher risk, more severely ill, patients are the most likely to experience legal difficulty. However, there is the possibility the key factor may be adjusting the level of legal precautions to the level of risk of the practice to maximize protection without practicing an undue amount of defensive medicine. Another area that the study highlights is to pay attention to who discusses the issue of a bad outcome with a patient, as frequently it is not the treating physician. Certain potential difficulties appear to have easy remedy (such as routinely having all patients screened for physical illness) while others will remain difficult clinical problems (e.g., suicide) or social problems (inappropriate sexual contact between clinician and patient).

REFERENCES
Slawson PF: Psychiatric malpractice: recent clinical loss experience in the United States. Medicine and Law 10:129-38, 1991
Morrison J, Morrison M: Psychiatrists disciplined by a state medical board. Am J Psychiatry 158:474-8, 2001

SELF ASSESSMENT QUESTIONS
1. Which of the following is not found to be a major area of malpractice difficulty?
a. doctor-patient sexual contact
b. misdiagnosis
c. suicide
d. ECT
ANSWER: d

2. Statistically lower levels of malpractice difficulties have been found in which of the following groups?
a. child psychiatrists
b. board certified psychiatrists
c. university-based psychiatrists
d. women psychiatrists
ANSWER: d

F40 HELLO AGAIN, MRS. ROBINSON: SEXUAL ABUSE OF MALE TEENS

Vinneth Carvalho, MD, New Haven, CT
Howard V. Zonana, MD, New Haven, CT
Lakeesha Woods, PhD (I), New Haven, CT
Josephine Buchanan, BA (I), New Haven, CT
Madelon V. Baranoski, PhD (I), New Haven, CT

EDUCATIONAL OBJECTIVE
To present demographic, psychiatric, social and situational profiles of women who were charged as sexual offenders after sexual relationships with adolescent males and to examine relevant psychiatric, legal, and social factors related to assessment, diagnosis, recidivism, punishment, and treatment.

SUMMARY
Beyond the media-sensational cases of women who develop sexual relationships with adolescent boys, there is an increase in forensic cases in which women are charged with sexual assault of teenage boys. These cases provide an opportunity to examine the circumstances surrounding abuse as well as offender and victim characteristics. Our preliminary data on offender characteristics (e.g., psychiatric diagnoses, demographic, history of sexual abuse, MMPI results), victim characteristics (e.g., age, physical development, family characteristics, school performance and adjustment) and the circumstances of the relationship (e.g., initial contact, length of relationship, identifier of abuse, and legal outcome) indicate several different profiles relevant to social norms, victim response, and legal consequences such as convictions and sentencing patterns. Factors that vary across different profiles include the psychiatric diagnoses and history of sexual abuse of the offender and psychosocial adjustment of the victim. The characteristics of these women will be contrasted with those of women who abuse pre-adolescents. The results suggest directions for further research, prevention and treatment and highlight the effect of the ambiguity of social norms.

REFERENCES
Shakeshaft C: Educator sexual misconduct: a synthesis of existing literature. US Dept Educ Policy and Program Studies Service 2004 Doc# 2004-09
Nelson A, Oliver P: Gender and the construction of consent in child-adult sexual contact: beyond gender neutrality and male monopoly. Gender and Society. 12:554-77, 1998

SELF ASSESSMENT QUESTIONS
1. Women who are charged with sexual assault of adolescent males
a. always view their behavior as helpful to the boy
b. all have a history of being sexually abused
c. are never predatory in their behavior
d. have no one particular psychiatric profile
e. lack the capacity for intimacy
ANSWER: d

2. Cultural and societal norms around sexual activity between adults and adolescents:
a. lack clarity and consistency
b. deter inappropriate behavior except in antisocials
c. vary in relationship to educational norms
d. protect against incest and child abuse
ANSWER: a

F41 **WOMEN, SUBSTANCE ABUSE, AND VIOLENCE**

Paul T. Amble, MD, Middletown, CT
Susan Devine, APRN (I), New Haven, CT
Caroline Easton, PhD (I), New Haven, CT

EDUCATIONAL OBJECTIVE
To enhance the participants' knowledge of the pervasive pattern of violence perpetrated by women in homes where substance abuse exists.

SUMMARY
Men (n=85) who were alcohol dependent, arrested for domestic violence, and taking part in court-ordered treatment for substance abuse were questioned about abuse perpetrated by their partners (in this study all were female). Their responses indicated that up to 59% of the female partners used drugs or alcohol during the men's treatment. In a follow-up study, the female partners (n=41) of these men were interviewed specifically about their violent behaviors. Of the women interviewed: 21% reported beating/punching their partner; 46% reported pushing or shoving their partner; 15% reported kicking their partner; 30% caused their partner to have a bruise, cut or sprain; 33% reported slapping their partner; and 3% reported using a knife or threatening their partner with a gun. The above are only a small sample of the fields of inquiry regarding violence that will be presented. The results will be presented in detail along with a discussion of these findings. Ramifications include the need to assess and integrate treatment services for women in households where only the men have been identified to have treatment needs. Also, clinicians must be aware of the high rate of violence in these homes and the effects it will have on the children who are raised there.

REFERENCES
Moore TM, Stuart GL: Illicit substance use and intimate partner violence among men in batterers' intervention. Psych Addict Behav 18(4):385-9, 2004
O'Farrell TJ, Fals-Stewart W: Behavioral couples therapy for alcoholism and drug abuse. J Subst Abuse Treat 18:51-4, 2000

SELF ASSESSMENT QUESTIONS
1. In this study, what percent of women who had suffered abuse by their partners self-reported that they inflicted physical pain on their partner as well?
ANSWER: 21%

2. In incidents of male-to-female physical aggression, within this study, how much more likely is it that the male was consuming alcohol that day?
ANSWER: 11 times

F42 **FILICIDE IN THE ITALIAN PRESS FROM 1992 TO 2004**

Giovanni B. Traverso, MD, Siena, Italy
Simona Traverso, MD (I), Siena, Italy
Laura Emiletti, Psychologist (I), Siena, Italy
Monica Bianchi, Psychologist (I), Siena, Italy
Maria I. Massafra, Criminologist (I), Siena, Italy

EDUCATIONAL OBJECTIVE
This study will hopefully provide advances in the scientific knowledge of profiles of parents who commit filicide, also attempting to extract relevant factors for building up a meaningful classification of this not well understood phenomenon, for identification of risk and for enabling effective intervention strategies.

SUMMARY
In a twelve-year review (1992-2004) of all filicide cases reported by the Italian press 233 incidents were identified involving 243 authors (46.7% fathers, 53.3% mothers) and 267 victims (51.6% males, 48.4% females). Age of the victims ranged from the newborns to 49 years, with more than 50% of victims being younger than 6 years of age.

Most offenses occurred in the family home (more than 70%), and the most common methods were strangulation and other violent mechanical asphyxia (26.2%), the use of a firearm (25.1%), stabbing (13.9%), abandonment or neglect (13.5%).

Filicide was frequently followed by suicide or attempted suicide of the perpetrator (34.9%); out of these 80 people, 50 (62.5%) were males and 30 (37.5%) were females. Given the source of our data, the prevalence of a psychiatric disorder in the perpetrators was very difficult to measure. However, at the time of the offense, more than 60% of perpetrators were suffering from psychiatric illness, usually a depressive disorder. Only in a few cases (2.7%) the perpetrator suffered from a psychotic state. The abuse of alcohol or drugs was rare. Comparison with recent studies (Bourget D, Gagnè P, 2002, 2005) reveals overlapping results.

REFERENCES

Bourget D, Gagnè P: Maternal filicide in Québec. J Am Acad Psychiatry Law 30:345-51, 2002
Bourget D, Gagnè P: Paternal filicide in Québec. J Am Acad Psychiatry Law 33:354-60, 2005

SELF ASSESSMENT QUESTIONS

1. From which psychiatric disorder were parents who committed filicide found more likely to be affected at the time of the offense?

a. anxiety disorder
b. depressive disorder
c. schizophrenia
ANSWER: b

2. Which is the most common method of perpetrating filicide found in our study?

a. carbon monoxide poisoning
b. violent mechanical asphyxia
c. beating
ANSWER: b

F43 **MOTHERS THINKING OF MURDER: PSYCHIATRIC INQUIRY**

Susan J. Hatters-Friedman, MD, Cleveland Heights, OH
Renée M. Sorrentino, MD, Boston, MA
Joy E. Stankowski, MD, Strongsville, OH
Phillip J. Resnick, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

At the end of this presentation, the participant should be able to recognize rates of filicidal thoughts among depressed mothers with young children, and be more comfortable routinely inquiring about filicidal thoughts among psychotic, depressed, or suicidal mothers.

SUMMARY

Child murder by mothers, or maternal filicide, is a public health concern. While many cases of maternal filicide are related to neglect or abuse, other cases are related to maternal mental illness. However, based on clinical and forensic experience, it appeared that psychiatrists did not routinely inquire of their female patients whether they had thoughts of harming their children. In this study (currently N=194) of psychiatrists affiliated with academic departments, respondents were asked whether they routinely query women about motherhood and about filicidal thoughts. Results indicated that the majority of psychiatrists believe that they inquire about motherhood in their female patients a great majority (90-100%) of the time. While some psychiatrists reported that they inquire about filicidal thoughts among both psychotic mothers and suicidal mothers, others only ask more generally about homicidal thoughts. Often psychiatrists would be willing to discuss filicide cases that have had media coverage with patients, which could introduce the inquiry. The majority of psychiatrists underestimated the percentage of depressed mothers of young children with filicidal thoughts. Suggestions for further education of psychiatrists, and for increased comfort in inquiring about filicidal thoughts will be made.

REFERENCES

Friedman SH, Horwitz SM, Resnick PJ: Child murder by mothers: A critical analysis of the current state of knowledge and a research agenda. Am J of Psychiatry 162(9):1578-87, 2005
Friedman SH, Hrouda DR, Holden CE, Noffsinger SG, Resnick PJ: Child murder committed by severely mentally ill mothers: An examination of mothers found not guilty by reason of insanity. J Forensic Sciences 50(6):1466-71, 2005

SELF ASSESSMENT QUESTIONS

1. What percentage of depressed mothers with children under age 3 experienced filicidal thoughts?
a. 5%
b. 10%
c. 26%
d. 41%
e. 51%
ANSWER: d

2. Which of the following is the most frequent "motive" for maternal filicide?
a. altruistic filicide
b. acutely psychotic filicide
c. fatal maltreatment filicide
d. spouse revenge filicide
e. unwanted child filicide
ANSWER: c

SATURDAY, OCTOBER 28, 2006

AAPL BUSINESS MEETING — 7:00 AM – 8:00 AM — **SALON D**

PANEL — 8:15 AM - 10:00 AM — **SALON D**
S1 ***Terrorism and the Death Penalty: Expert Testimony and Legal Strategy in the Moussaoui Trial***
Jeffrey L. Metzner, MD, Denver, CO
Raymond F. Patterson, MD, Washington, DC
Michael B. First, MD (I), New York, NY
Gerald T. Zerkin, JD (I), Richmond, VA
Paul Montalbano, PhD (I), Washington, DC

COFFEE BREAK

A/V SESSION — 10:15 AM - 12:00 NOON — **SALON D**
S2 ***Two Views of Insanity: The Ohio Interstate Shooter Case Peer Review Committee (AAPL Members Only)***
David Rosmarin, MD, Harvard, MA
Phillip Resnick, MD, Cleveland, OH
Mark J. Mills, JD, MD (I), Washington, DC
Robert Wettstein, MD, Pittsburgh, PA
William H. Reid, MD, MPH, Horseshoe Bay, TX

PANEL — 10:15 AM - 12:00 NOON — **SALONS ABC**
S3 ***Forensic Sampler: Motor Vehicle Accidents - Liason with Forensic Sciences Committee***
Alan R. Felthous, MD, Chester, IL
Robert Weinstock, MD, Los Angeles, CA
Karl A. Larsen, Jr., PhD (I), Chicago, IL
Clare Cunliffe, MD (I), Chicago, IL
Laura L. Liptai, PhD (I), Moraga, CA
Haskell M. Pitluck, JD (I), Cyrstal Lake, IL

PANEL — 10:15 AM - 12:00 NOON — **INDIANA/IOWA/ MICHIGAN**
S4 ***Correctional Patients: Transition and Management***
Steven K. Hoge, MD, MBA, New York, NY
Gary R. Collins, MD, New York, NY
Kenneth L. Appelbaum, MD, Westborough, MA
Merrill Rotter, MD, Bronx, NY

WORKSHOP — 10:15 AM - 12:00 NOON — **NW/OHIO/PURDU**E
S5 ***Performing Fitness for Duty Evaluations on Residents and Fellows***
William H. Campbell, MD, MBA, San Antonio, TX
Andrea G. Stolar, MD, Cleveland, OH

WORKSHOP — 10:15 AM - 12:00 NOON — **DENVER/HOUSTON/ KANSAS CITY**
S6 ***Limits on Confidentiality in Employment Evaluations***
Ronald Schouten, MD, JD, Boston, MA
Rebecca Brendel, MD, JD, Boston, MA
Judith Edersheim, MD, JD, Boston, MA
James Beck, MD, PhD, Boston, MA

LUNCH — 12:00 NOON - 2:00 PM — **SALONS E-H**
S7 ***Physician Assisted Suicide: How Did We Get Into This Mess? Where Do We Go From Here?***
Sherwin Nuland, MD (I), Newton, MA

A/V SESSION — 2:15 PM - 4:00 PM — **SALON D**
S8 ***The Trial of Hamlet***
Thomas G. Gutheil, MD, Brookline, MA

WORKSHOP — 2:15 PM - 4:00 PM — **SALONS ABC**

S9 ***Expert Consensus Guideline Series for the Treatment of Bipolar Disorder in the Correctional Setting***

Charles A. Buscema, MD, Fayetteville, NY
Peter N. Barboriak, MD, Raleigh, NC
Jeffrey L. Metzner, MD, Denver, CO
Robert L. Weisman, DO (I), Rochester, NY

COURSE — 2:15 PM - 6:15 PM — **DENVER/HOUSTON/ KANSAS CITY**

S10 ***Understanding Risk Assessment***

Michael A. Norko, MD, New Haven, CT
Madelon V. Baranoski, PhD (I), New Haven, CT

WORKSHOP — 2:15 PM - 4:00 PM — **INDIANA/IOWA/ MICHIGAN**

S11 ***Independent Psychiatric Evaluations and Private Disability Insurance***

Peter Brown, MD, FRCPC, Chattanooga, TN
Keith A. Caruso, MD, Brentwood, TN
Stuart A. Anfang, MD, Northampton, MA

WORKSHOP — 2:15 PM - 4:00 PM — **NW/OHIO/PURDUE**

S12 ***Secret Service Assessments of Presidential Threats***

Robert T.M. Phillips, MD, PhD, Annapolis, MD
George Luczko, BS (I), Washington, DC
Tara Conway (I), Washington, DC
James R. Missett, MD, PhD, Menlo Park, CA
James L. Cavannaugh, Jr., MD, Chicago, IL

COFFEE BREAK

PANEL — 4:15 PM - 6:15 PM — **SALON D**

S13 ***Forensic Issues Pertaining to Older Adults***

Daniel Loiterstein, MD (I), Chicago, IL
James L. Cavanaugh, MD, Chicago, IL
Martin Gorbien, MD (I), Chicago, IL
Marguerite Angelari, LLM (I), Chicago, IL

PANEL — 4:15 PM - 6:15 PM — **SALONS ABC**

S14 ***Sexual Harrassment: Who Is Believed?***

Marilyn Price, MD, Providence, RI
Patricia R. Recupero, JD, MD, Providence, RI
Liza H. Gold, MD, Arlington, VA
Thomas G. Gutheil, MD, Brookline, MA

PAPER SESSION #4 — 4:15 PM - 6:15 PM — **INDIANA/IOWA/ MICHIGAN**

S15 ***Differentiating Field Sobriety Test Results***

George S. Glass, MD, Houston, TX

S16 ***Mental Illness, Violence Risk, and Race in Juvenile Detention: Disproportionate Minority Contact (DMC)***

Rani A. Desai, PhD, MPH (I), West Haven, CT
Paul R. Falzer, PhD (I), West Haven, CT
John F. Chapman, PsyD (I), Wethersfield, CT

S17 ***Sex Offenders and Insanity: An Examination of 42 Individuals Found Not Guilty by Reason of Insanity***

Brad Novak, MD, Belmont, CA
Barbara McDermott, PhD (I), Sacramento, CA
Charles L. Scott, MD, Sacramento, CA
Stacey Guillory, MA (I), Sacramento, CA

S18 ***A Pilot Study: Obsessive Compulsive Traits v. Impulsivity Among Sex Offenders***

Denise C. Kellaher, DO, Honolulu, HI

RESEARCH IN PROGRESS #5 4:15 PM - 6:15 PM **NW/OHIO/PURDUE**

Delusions on Death Row

Donna M. Schwartz-Watts, MD, Columbia, SC

The Influence of Prior Trauma and Situational Stress on Use of Force Decisions in Police Officers

Cheryl Regehr, PhD (I), Toronto, ON, Canada
Vicki LeBlanc, PhD (I), Toronto, ON, Canada
Blake Jelley, PhD (I), Aylmer, ON, Canada
Irene Barath, BA (I), Aylmer, ON, Canada

The Efficacy of Suicide Risk Screening Instruments

Jason Hershberger, MD, New York, NY
Ricardo Martinez, MA (I), New York, NY
David Horton, BA (I), New York, NY

Survey Says! Judges' Opinions on Neuroimaging Evidence

Marc A. Colon, MD, Shreveport, LA
Bryan C. Shelby, MD, JD (I), Shreveport, LA

S1 TERRORISM AND THE DEATH PENALTY: EXPERT TESTIMONY AND LEGAL STRATEGY IN THE MOUSSAOUI TRIAL

Jeffrey L. Metzner, MD, Denver, CO
Raymond F. Patterson, MD, Washington, DC
Michael B. First, MD (I), New York, NY
Gerald T. Zerkin, JD (I), Richmond, VA
Paul Montalbano, PhD (I), Washington, DC

EDUCATIONAL OBJECTIVE
To describe the psychiatric and legal challenges of providing mental health testimony in regard to mitigation in the sentencing phase of the only person to stand trial and face the death penalty for the September 11 terrorist attacks on the World Trade Center and the Pentagon.

SUMMARY
Zacarias Moussaoui was the only defendant to stand trial for the September 11, 2001 terrorist attacks on the United States. His four-year trial presented multiple legal and psychiatric challenges. Questions arose concerning his competency to stand trial and to represent himself. After Mr. Moussaoui pled guilty, his court-appointed attorneys were faced with the task of trying to prevent an uncooperative, unsympathetic and ungrateful client from receiving the death penalty. Mr. Moussaoui refused to allow Michael First, MD, the expert retained by his attorneys, to examine him. In contrast, he did allow prosecution experts Raymond Patterson, MD, and Paul Montalbano, PhD, to examine him, raising unusual problems for defense strategy. Defense attorneys Gerald Zerkin and Edward MacMahon, Jr. will discuss the difficulties in defending this client and the role of mental health testimony in his defense. Dr. Michael First, who testified for the defense despite the lack of a personal evaluation of the defendant, will describe the bases of his opinions. The prosecution experts, Drs. Patterson and Montalbano will discuss their examinations of and opinions regarding Mr. Moussaoui, and Dr. Patterson will discuss his testimony in this singular case.

REFERENCES
Godinez v. Moran (92-725), 509 U.S. 389 (1993)
American Academy of Psychiatry and the Law: Ethics guidelines for the practice of forensic psychiatry, www.aapl.org, revised 2005

SELF ASSESSMENT QUESTIONS
1. The competency standard for pleading guilty or waiving the right to counsel is:
a. the same as the competency standard for standing trial.
b. a "higher" standard because the decision to waive constitutional rights requires a higher level of mental functioning than that required to stand trial.
c. dependent on the defendant's ability to adequately represent himself/herself.
ANSWER: a

2. The position of the American Academy of Psychiatry and the Law on offering an expert opinion in regard to an individual who has not been personally examined is as follows:
a. It is unethical to do so.
b. An opinion may be rendered on the basis of other information if, after earnest effort, it is not possible to conduct a personal examination.
c. It is not necessary to clearly indicate that opinions and any reports or testimony based on those opinions were not based personal examination, thus limiting opinions expressed.
ANSWER: b

S2 TWO VIEWS OF INSANITY: THE OHIO INTERSTATE SHOOTER CASE-PEER REVIEW COMMITTEE

David Rosmarin, MD, Harvard, MA
Phillip Resnick, MD, Cleveland, OH
Mark J. Mills, JD, MD (I), Washington, DC
Robert Wettstein, MD, Pittsburgh, PA
William H. Reid, MD, MPH, Horseshoe Bay, TX

EDUCATIONAL OBJECTIVE
Attendees will have the opportunity to view video trial testimony and reasoning of two national experts in insanity evaluations, Drs. Resnick and Mills. Three other experts in insanity will critique the expert witnesses.

SUMMARY
This presentation is formal, confidential peer review and open to current AAPL members only. Between October

2003 and February 2004, Charles McCoy shot mostly at vehicles on I-270 in the Columbus area some 200 times, striking many and killing one woman. Among his charges were 9 counts of felonious assault, 8 counts of attempted murder, 1count of murder with specification, and 1 count of aggravated murder. Both experts diagnosed him with paranoid schizophrenia. The final verdict was a hung jury with a vote of 8 for NGRI and 4 for guilty. After that a plea bargain was agreed to, resulting in a 27-year prison sentence. This presentation will contrast the style and reasoning of Dr. Resnick's testimony and report for the prosecution and Dr. Mills' testimony and report for the defense.

REFERENCES

Shuman DW, Rogers R: Conducting Insanity Evaluations, 2nd Edition. New York: Guilford Press, 2000, pp 1-61
Gutheil TG: The Psychiatrist as Expert Witness, Washington, DC: American Psychiatric Press, 1998, pp 1-16

SELF ASSESSMENT QUESTIONS

1. What is the insanity standard in Ohio?

ANSWER: A person is not guilty by reason of insanity relative to a charge of an offense only if the person proves, in the manner specified in Section 2901.05 of the Revised Code, that at the time of the commission of the offense, the person did not know, as a result of a severe mental disease or defect, the wrongfulness of the person's acts.

2. What is the burden of proof in Ohio?

ANSWER: The burden of going forward with the evidence of an affirmative defense, and the burden of proof, by a preponderance of the evidence, for an affirmative defense, is upon the accused.

S3 FORENSIC SAMPLER: MOTOR VEHICLE ACCIDENTS - LIAISON WITH FORENSIC SCIENCES COMMITTEE

Alan R. Felthous, MD, Chester, IL
Robert Weinstock, MD, Los Angeles, CA
Karl A. Larsen, Jr., PhD (I), Chicago, IL
Clare Cunliffe, MD (I), Chicago, IL
Laura L. Liptai, PhD (I), Moraga, CA
Haskell M. Pitluck, JD (I), Cyrstal Lake, IL

EDUCATIONAL OBJECTIVE

To foster awareness among forensic psychiatrists of their role in relationship to other forensic scientists. To enhance interdisciplinary collaboration and knowledge sharing. To discuss the roles of toxicology, pathology, engineering, and jurisprudence in investigating and litigation motor vehicle accidents.

SUMMARY

Vehicle accidents are a major cause of death, injury, disability, and impairment. Several disciplines, beyond psychiatry and psychology, make major contributions to the investigation of motor vehicle accidents and to litigating issues arising from them in court. To be maximally effective, it behooves forensic experts to acquire familiarity with the contributions made by other disciplines. The disciplines of toxicology, pathology, engineering, and the law address the investigation and litigation of motor vehicle accidents. Dr. Larsen will explain the functions performed by forensic toxicologists including utilization of antimortem drug tests and postmortem toxicological analysis. Dr. Cunliffe will describe the forensic pathologist's approach to motor vehicle deaths, the purposes of autopsy, and the types of injuries that are incurred from accidents caused by motor vehicles as well as bicycles. Dr. Liptai will describe the contribution made by biomedical and mechanical engineering in the investigation of motor vehicle accidents, with special emphasis on the causation of pedestrian trauma. Judge Pitluck will address driving under the influence of alcohol and drugs with some examples of different kinds of accidents that occur, including some that may not be "accidents."

REFERENCES

Cleiman SB, Egan SB: Trauma induced psychiatric disorders and civil law, in Principles and Practice of Forensic Psychiatry, 2nd Edition. Edited by Rosner R. London: Arnold, 2003, pp 290-300
DiMaio DJ, DiMaio VJM: Deaths Due to motor vehicle accidents, in Forensic Pathology. Edited by DiMaio DJ, DiMaio VJM, Boca Raton: CRC Press, 1993, pp 253-83

SELF ASSESSMENT QUESTIONS

1. Forensic urine drug testing is typically done using:

a. preliminary screening and confirmation utilizing the same analytical technique
b. just one analytical method is sufficient to report all positive results
c. at least three analytical methods
d. preliminary screening using typically some kind of immunochemical method and confirmation using a different and conclusive method such as gas chromatography-mass spectrometry

ANSWER: d

2. In automobile accidents, so-called "dicing injuries" of the skin are caused by:
a. impact with the windshield
b. ejection from the vehicle followed by secondary impact with the ground
c. fragments of glass from the side or rear windows
d. deployment of the front or side airbags
ANSWER: c

S4 **CORRECTIONAL PATIENTS: TRANSITION AND MANAGEMENT**

Steven K. Hoge, MD, MBA, New York, NY
Gary R. Collins, MD, New York, NY
Kenneth L. Appelbaum, MD, Westborough, MA
Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE
To describe the scope and nature of the problems related to the transition of mentally ill inmates to the community. Presentations will define the impediments to successful transition to the community and will describe innovative approaches designed to improve compliance and to reduce recidivism.

SUMMARY
Dr. Hoge will describe the scope and nature of problems faced in successful transition, including the interruption of entitlements, inadequate access to housing, poor social supports, and difficulties accessing treatment. He will summarize the work of the APA's Task Force on Outpatient Forensic Services, which will identify approaches to transition and management of this population. Dr. Appelbaum will describe his experience as Director, Correctional Mental Health Program, at the University of Massachusetts and how that system has attempted to provide services and interventions to overcome obstacles in successful transition. Dr. Collins, the Director of the Assisted Outpatient Treatment Program for Manhattan, will describe how outpatient commitment has been applied to correctional populations: inmates leaving Riker's Island and state facilities. The results of an empirical examination, underway, will be presented. Data will be presented on the rate of commitment, characteristics of committed inmates, and outcomes. Dr. Rotter will describe his work with the New York Department of Corrections and address whether the creation of specialized services is preferable to "mainstreaming." He will discuss the problems of stigmatizing correctional patients, and whether this population is sufficiently different from the ordinary population of chronic mentally ill to warrant specialized programs and approaches.

REFERENCES
Travis J: But They All Come Back: Facing the Challenges of Prisoner Reentry. Washington, DC: Urban Institute Press, 2005
Haimowitz S: Slowing the revolving door: community reentry of offenders with mental illness. Psychiatric Services 55:373-75, 2004

SELF ASSESSMENT QUESTIONS
1. The US Department of Justice estimates indicate what percentage of the population in jails and prisons have a serious mental illness?
a. 4%
b. 8%
c. 16%
d. 24%
ANSWER: c

2. According to the Bureau of Justice Statistics, state prison inmates with a mental condition, compared to other inmates were:
a. more likely to be incarcerated for a violent offense
b. less likely to be incarcerated for a violent offense
c. as likely to be incarcerated for a violent offense
ANSWER: a

S5 **PERFORMING FITNESS FOR DUTY EVALUATIONS ON RESIDENTS AND FELLOWS**

William H. Campbell, MD, MBA, San Antonio, TX
Andrea G. Stolar, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE
Participants will learn federal mandates relevant to psychiatric practice.

SUMMARY
Practicing psychiatrists often consult forensic psychiatrists about the legal aspects of psychiatric practice. Psychiatrists are now practicing in an era in which compliance with government imposed duties is expected in a number of areas. In recent years, psychiatrists have faced increased exposure to civil and criminal penalties for noncompliance with federal laws regulating psychiatric practice. This workshop will provide a general overview of several of these laws as they apply to general psychiatric practice, including the Health Insurance Portability and Accountability Act (HIPAA), the "False Claims" Provisions of the Social Security Act, the Federal False Claims Act, the Federal Health Care Program Anti-Kickback Statute, the Stark laws and regulations, the Emergency Medical Treatment and Active Labor Act (EMTALA), and the Americans With Disabilities Act (ADA). Case studies will be used to highlight issues relevant to psychiatric practice. Participants will be engaged in an interactive discussion of common problems encountered by practicing psychiatrists.

REFERENCES
American Psychiatric Association: HIPAA Education Packet. Available at http://www.psych.org/members/hipaa/hipaa_packet.cfm
Wheeler, AM: Top ten legal and risk management areas of concern for psychiatrists, in Entering Private Practice. Edited by Lazarus JA: Washington, DC: American Psychiatric Publishing, 2005, pp 139-59

SELF ASSESSMENT QUESTIONS
1. All of the following statements regarding the HIPAA Privacy Rule are true except:
a. Psychotherapy notes are given special protection under HIPAA.
b. The drafters of HIPAA envisioned it as providing a "ceiling" for privacy interests, so even if a state law provides greater protection of a patient's rights, the state law will not apply.
c. If a covered psychiatrist enters into any agreements with outside vendors or consultants with whom he or she shares protected health information (PHI), the psychiatrist should have a "business associate contract" that describes how each contractor will protect the health care information.
d. The HIPAA Privacy Rule permits a psychiatrist to disclose information in response to a subpoena if he or she receives "satisfactory assurance" from the party who sent the subpoena that reasonable efforts have been made to ensure that the patient has been given notice of the request.
ANSWER: b

2. All of the following statements regarding federal mandates are true except:
a. The "false claims" provisions of the Social Security Act set forth criminal penalties, many of which are felonies, for a variety of actions, including knowingly and willfully making false statements in any application for payment under a federal health care program.
b. Under the Federal False Claims Act, substantial civil monetary penalties may be imposed on physicians who knowingly submit false claims.
c. The Federal Health Care Program Anti-Kickback Statute makes it a felony for anyone to knowingly and willfully offer, pay, solicit or receive any remuneration for referring a patient for services covered by Medicare or Medicaid.
d. The Stark laws and regulations were enacted to prevent "dumping" of indigent noninsured patients.
ANSWER: d

S6 LIMITS ON CONFIDENTIALITY IN EMPLOYMENT EVALUATIONS

Ronald Schouten, MD, JD, Boston, MA
Rebecca Brendel, MD, JD, Boston, MA
Judith Edersheim, MD, JD, Boston, MA
James Beck, MD, PhD, Boston, MA

EDUCATIONAL OBJECTIVE
Participants will appreciate the protections of confidentiality and the limits on protected information imposed by Tarasoff obligations, statutory law, and other reporting obligations in the setting of employment evaluations. Attendees will gain an understanding of the practical implications of confidentiality law through the use of case examples.

SUMMARY
Although forensic evaluators are familiar, in general, with the presence of limitations on confidentiality in evaluations, the specific nature of information protections and limitations on confidentiality in employment evaluations is often not clearly understood. This workshop will begin with an historical overview of the development of exceptions to the duty of confidentiality. A discussion of the current status of the common law duty to warn doctrine will follow. Next, an exploration of statutorily-imposed duties to disclose information will follow. The impact of HIPAA on confidentiality and information sharing will be addressed. Finally, case examples from our practice will be used to highlight the principles introduced and to demonstrate their application in employment-related evaluations of individuals in several different lines of work .

REFERENCES
Eddy S, Schouten R: Workplace forensic psychiatry: the Americans with Disabilities Act and the Family and Medical Leave Act, in Mental Health and Productivity in the Workplace. Edited by Kahn JP, Langlieb AM. San Francisco: Josey-Bass, 2003, pp 369-86
Schouten R: Impaired physicians: is there a duty to report to state licensing boards? Harvard Rev Psychiatry 8:36-9, 2000

SELF ASSESSMENT QUESTIONS
1. Mandated reporting statutes include all of the following subtypes except:
a. child protection
b. domestic violence
c. elder abuse
d. infectious disease
e. past felonies
ANSWER: e

2. HIPAA regulations apply to:
a. fitness for duty evaluations
b. pre-employment examinations
c. ADA evaluations
d. FMLA evaluations
e. all of the above
ANSWER: e

S7 PHYSICIAN ASSISTED SUICIDE: HOW DID WE GET INTO THIS MESS? WHERE DO WE GO FROM HERE?

Sherwin Nuland, MD (I), Newton, MA

EDUCATIONAL OBJECTIVE
To understand the origins and history of the assisted-suicide movement, the positions at present taken by exponents and opponents, and to explore possible solutions.

SUMMARY
The notion of suicide as a way of solving problems of a nonpsychiatric nature has been with us since the classical period. But in the 19th century, matters took a new turn, as the medical profession increasingly was asked to become involved. Since that time, medical organizations have in general resisted, but individual physicians and groups have made strong arguments in favor, as have outspoken members of the general public. After long experience in Holland, the practice was legalized. The U.S. Supreme Court has decided against advocates of a right to be helped to die, while the State of Oregon has approved a measure. If the Dutch and Oregon experiences have been as salutary as claimed, why have their practices not become more widespread? There are problems with each of the systems, which may be lessened by a somewhat different way of approaching the objections of major stakeholders.

REFERENCES
Quill T: Death and Dignity. New York: W. W. Norton, 1993
Humphry DL, Clement M: Freedom to Die. New York: St. Martin's Press, 1998

SELF ASSESSMENT QUESTIONS
1. Why were physicians not involved in assisted suicide until the 19th century?
ANSWER: Because they had no special abilities to be of help, but then morphine became available and syringes were invented.

2. What is the real meaning of the word "euthanasia"?
ANSWER: A good or easy death

S8 THE TRIAL OF HAMLET

Thomas G. Gutheil, MD, Brookline, MA

EDUCATIONAL OBJECTIVE
To show a mock trial of a literary figure.

SUMMARY
Supreme Court Justice Kennedy presides over the trial of Hamlet (pleading insanity) for the murder of Polonius. Experts Alan Stone, MD and Thomas G. Gutheil, MD give testimony in this unusual videotape.

REFERENCES

Shakespeare W: Hamlet
Gutheil TG: The Psychiatrist as expert witness. Arlington, VA: Am Psychiatric Publishing, 1998

SELF ASSESSMENT QUESTIONS

1. Shakespeare apparently intended Hamlet to be:
a. bipolar
b. schizophrenic
c. malingering
d. borderline
e. none of the above
ANSWER: c

2. Hamlet simulated madness to?
ANSWER: save his life

S9 EXPERT CONSENSUS GUIDELINE SERIES FOR THE TREATMENT OF BIPOLAR DISORDER IN THE CORRECTIONAL SETTING

Charles A. Buscema, MD, Fayetteville, NY
Peter N. Barboriak, MD, Raleigh, NC
Jeffrey L. Metzner, MD, Denver, CO
Robert L. Weisman, DO (I), Rochester, NY

EDUCATIONAL OBJECTIVE

This pocket guide for treating bipolar disorder in jails and prisons is the first concerted effort to organize the experts' consensus of best practice guidelines from both civil and correctional settings, for therapeutic interventions with this heterogeneous spectrum disorder. Correctional clinicians should find this guideline useful for the treatment of challenging bipolar patients.

SUMMARY

Dr. Buscema discusses the creation of this expert consensus panel, the necessity for practice guidelines in corrections, and the objectives of a guideline survey. The introduction consists of the components of the survey, the measurement techniques employed, and the presentation of results, translated from data to survey guidelines. The guideline analysis will focus on recommendations for treatment of bipolar spectrum disorder in the correctional setting. Dr. Barboriak compares the results of the Expert Consensus Guidelines for the Treatment of Bipolar in the Correctional Setting with those of the Expert Consensus Guideline Series of 2000 and the Texas Implementation of Medication Algorithms update of 2004. The comparison demonstrates the impact of the correctional setting on the development of therapeutic strategies. Dr. Metzner discusses the idiosyncratic nature of prison environments, as illustrated by the initial twenty questions of the survey instrument that focused on a variety of systems' issues germane to correctional mental health. These responses will be evaluated with respect to uniformity with nationally recognized standards. Dr. Weisman reviews the Expert Consensus Guidelines and their relation to treatment in county jails. Complicating factors include environmental stressors secondary to incarceration, inadequate resources for psychiatric evaluation, and avoidance of treatment due to stigma and fear of victimization.

REFERENCES

Keck PE, Perlis RH, Otto MW, et al: Treatment of bipolar disorder 2004. Postgrad Med Special Report. 2004 [Dec]:1-120
Suppes T, Dennehy EB, Hirschfeld RM, et al: The Texas implementation of medication algorithms: update to the algorithms for treatment of bipolar disorder. J Clin Psychiatry, 66(7):870-6, 2005

SELF ASSESSMENT QUESTIONS

1. Which of the following medications is indicated for maintenance treatment of bipolar disorder?
a. olanzapine
b. lithium
c. aripiprazole
d. all of the above
e. none of the above
ANSWER: d

2. What are some of the specific variables that the correctional environment imposes on all guideline development?
a. medication costs
b. facility security
c. co-occurring disorders
d. all of the above
e. none of the above
ANSWER: d

S10 **UNDERSTANDING RISK ASSESSMENT**

Michael A. Norko, MD, New Haven, CT
Madelon V. Baranoski, PhD (I), New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will understand research data underlying risk assessment; statistical/analytical limits of such research; distinctions between actuarial and clinical assessments of risk and the use of the appropriate techniques for specific purposes; several critiques of risk assessment approaches; and a proposed risk management model.

SUMMARY

The assessment of risk for violence in psychiatric patients is a significant factor in clinical, policy, legislative, and forensic decisions. The advancement of population-based and community-controlled studies of mental illness and violence, and the emergence of risk assessment measures that have found favor with the courts in quantifying future dangerousness have defined the practice, policies, and standards for risk assessment. Familiarity with the relevant research, legal and clinical issues that shape practice and the relative merits of the different assessment tools is essential to this area of forensic practice. This course will present a framework for understanding the role of psychiatry in risk assessment. We will explore the strengths and limitations of various approaches to determining risk through a critical review of seminal research on the correlates of violence and the accuracy of risk assessments. An analysis of the appropriate use of actuarial versus clinical assessment will be presented, as well as a review of recent critiques (including ethical concerns) regarding risk assessment. Models of risk assessment and management that accommodate a synthesis of available research will be presented. Finally, we will describe an alternative approach to risk management, based on the assessment and enhancement of the individual's functional capacities.

REFERENCES

Norko MA, Baranoski MV: The state of contemporary risk assessment research. Canadian J Psychiatry 50: 18-26, 2005
Mullen PE: Forensic mental health. Br J Psychiatry 176: 307-11, 2000

SELF ASSESSMENT QUESTIONS

1. Actuarial measures of risk assessment:
a. are the most accurate in assessing imminent risk of violence to self or others
b. quantify life-long risk for violence
c. can not inform policy development and management of services
d. are not useful in sentencing evaluations
ANSWER: b

2. Barriers to measuring the correlation between violence and mental illness include all of the following except:
a. varying definitions of violence
b. the length of follow-up
c. effect of clinical interventions
d. inability to perform prospective studies
ANSWER: d

S11 **INDEPENDENT PSYCHIATRIC EVALUATIONS AND PRIVATE DISABILITY INSURANCE**

Peter Brown, MD, FRCPC, Chattanooga, TN
Keith A. Caruso, MD, Brentwood, TN
Stuart A. Anfang, MD, Northampton, MA

EDUCATIONAL OBJECTIVE

The objective of the presentation is to provide an overview of both the similarities and the unique differences of independent evaluations requested by private disability insurers.

SUMMARY

Independent psychiatric evaluations of claimants for private disability insurance carriers are among the most challenging and complex of tasks performed by forensic psychiatrists. This workshop will include three presentations. Participants

will be given an introduction to: the specialized issues and terminology; the application of professional standards to this area; and practical considerations (e.g. confidentiality, length and nature of the evaluation, integrating psychometric, neuropsychological or other ancillary testing measures, preparing the report and billing issues). An example of a typical report will be provided with a discussion of relative strengths and potential pitfalls. Thirdly, the formal portion of the presentation will conclude with a discussion of what happens after a report is submitted, the possible course of subsequent litigation and a review of relevant case law. Finally, participants will be encouraged share their own experiences of disability determinations and to discuss common problems and possible solutions.

REFERENCES

Drukteinis, AM: Disability, in The American Psychiatric Publishing Textbook of Forensic Psychiatry, Chapter 13. Edited by Simon RI, Gold LH. Washington DC: American Psychiatric Publishing, Inc, 2004, pp 287-301
Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. AM J Psychiatry 154:448-56, 1997

SELF ASSESSMENT QUESTIONS

1. Useful disability evaluations include:
a. careful consideration of relevant clinical and nonclinical factors
b. clear understanding of both the nature of the occupation and of the proposed restrictions and limitations
c. explicit probing of functional capacity across different domains
d. all of the above
ANSWER: d

2. Less than useful disability evaluations include failure to consider:
a. appropriate sources of information
b. potential sources of bias
c. both strengths and weaknesses of expert conclusions
d. the continued failure of Microsoft to provide "think check" and the consequent need for evaluators to carefully read their own reports
e. all of the above
ANSWER: e

S12 SECRET SERVICE ASSESSMENTS OF PRESIDENTIAL THREATS

Robert T.M. Phillips, MD, PhD, Annapolis, MD
George Luczko, BS (I), Washington, DC
Tara Conway (I), Washington, DC
James R. Missett, MD, PhD, Menlo Park, CA
James L. Cavannaugh, Jr., MD, Chicago, IL

EDUCATIONAL OBJECTIVE

To aid in the understanding of the Secret Service's protective mission, underscore the importance of relationships with the mental health community and to expand the understanding of threat assessment in the prevention of harm to the President or other protectees.

SUMMARY

The goal of the Secret Service protective intelligence and threat assessment programs is to identify assess and manage persons who have the interest and ability to mount attacks against protectees. Through the use of video this workshop will examine actual USSS protective intelligence cases; describe how the forensic psychiatric consultant in the Mental Health Liaison Program assisted agents with their protective intelligence investigations; review and assess the attack related behavior indices; and explore relevant duty to protect and legal issues that give rise to specific exclusions to privileged communication when a potential harm to the President or other protectee of the Secret Service exists.

REFERENCES

Phillips, RTM: Assessing presidential stalkers and assassins. J Am Academy Psychiatry Law 34(2):154-64, 2006
Phillips, RTM: Celebrity and presidential targets, in Stalking: a Psychiatric Perspective. Edited by Pinals D. Submitted for publication Oxford University Press 2006

SELF ASSESSMENT QUESTIONS

1. When evaluating a potential subject's risk of dangerousness to a USSS protectee the goal of the Secret Service protective intelligence and threat assessment programs is to:

a. identify
b. assess
c. manage
d. all of the above

ANSWER: d

2. The USSS Mental Health Liaison Program utilizes the expertise of forensic psychiatric consultants for:

a. case consultation
b. field based training
c. professional liaison
d. all of the above

ANSWER: d

S13 FORENSIC ISSUES PERTAINING TO OLDER ADULTS

Daniel Loiterstein, MD (I), Chicago, IL
James L. Cavanaugh, MD, Chicago, IL
Martin Gorbien, MD (I), Chicago, IL
Marguerite Angelari, LLM (I), Chicago, IL

EDUCATIONAL OBJECTIVE

Attendees will be able to recognize the expanding importance of geriatric psychiatry and elder law in forensic practice. Specific issues explored will include: the effects of aging on cognition; assessment of decisional capacity in older adults; how competency and guardianship are adjudicated; and the complexities of elder abuse and neglect.

SUMMARY

By the year 2030, 70 million people will be over the age of 65. This represents twice the number of older adults living in the United States as in 2000. The growth of this age group compels scholars to examine applicable scenarios pertaining to psychiatry as applied to legal issues. Dr. Loiterstein, a geriatric psychiatrist and internist, will review specific syndromes resulting in cognitive impairment which may impair an older adult's decisional capacity. Professor Angelari of the Loyola University School of Law Elder Law Initiative will review the ethical and legal constructs guiding physicians and lawyers when differing opinions lead to conflict and require adjudication of incompetence. Impaired cognition and decisional capacity place older adults at risk for self neglect or elder abuse. Dr. Gorbien, a geriatric internist and authority regarding elder abuse, will review risk factors and types of abuse, including physical, verbal or emotional abuse, financial exploitation, or physical, medical and emotional neglect. Presentations will be followed by panel discussion and summary by Dr. Cavanaugh, emphasizing forensic paradigms for assessing decisional competencies, elder abuse and neglect.

REFERENCES

Gorbien MJ, Eisenstein AR: Elder abuse and neglect. Clin Geriatr Med 21:315-32, 2005
Angelari M: Adult guardianship: protecting the elderly or shielding abusers? Public Interest Law Reporter 8(3):6-10, 2003

SELF ASSESSMENT QUESTIONS

1. What is competency?

ANSWER: Competency is a legal term concerning an individual's legal capacity to make certain decisions and perform certain acts.

2. What are some risk factors for elder abuse?

ANSWER: Older age, lack of access to resources, low income, social isolation, minority status, low level of education, functional impairment, substance abuse by elder or caregiver, previous history of family violence, history of psychological problems, caregiver stress, and cognitive impairment.

S14 SEXUAL HARRASSMENT: WHO IS BELIEVED?

Marilyn Price, MD, Providence, RI
Patricia R. Recupero, JD, MD, Providence, RI
Liza H. Gold, MD, Arlington, VA
Thomas G. Gutheil, MD, Brookline, MA

EDUCATIONAL OBJECTIVE

To provide an understanding of the evaluator's role in assessment of credibility and malingering in sexual harassment litigation and to highlight concerns about reporting sexual harassment that can lead to delays in filing a complaint.

SUMMARY
The resolution of a sexual harassment claim is often times determined by the credibility of the plaintiff versus that of the defendant. Attorneys may retain experts to offer testimony that directly or indirectly reflects on the credibility of the litigants. Dr. Patricia Recupero will review the legal development of sexual harassment law particularly with respect to the admissibility of expert testimony regarding credibility. She will present an update of recent case law. While forensic evaluators are not qualified to make credibility assessments as to whether or not sexual harassment has occurred, they are qualified to provide an assessment of the likelihood of malingering. Dr. Liza Gold will discuss the proper role of the forensic expert and offer a framework to be used when considering the malingering of symptoms by litigants. She will use case examples to highlight pitfalls. Dr. Marilyn Price will review the literature concerning responses to sexual harassment. A victim's failure to promptly take action or file a complaint can be used undermine credibility even though research would indicate that victims often delay in making a report. Dr. Thomas Gutheil, who has considerable experience in the evaluation of plaintiffs in sexual harassment cases, will act as a discussant.

REFERENCES
Gold LH: Sexual Harassment: Psychiatric Assessment in Employment Litigation. Arlington, VA: American Psychiatric Press, 2004
Cortina LM, Wasti SA: Profiles in coping responses to sexual harassment across persons, organizations and cultures. J Appl Psychol 90:182-92, 2005

SELF ASSESSMENT QUESTIONS
1. Common responses to sexual harassment include:
a. avoidance
b. appeasement
c. pretending the situation is not happening
d. all of the above
e. none of the above
ANSWER: d

2. In assessment of malingering one might consider the:
a. medicolegal context of the presentation
b. marked discrepancy between the person's claimed stress or disability and the objective findings
c. lack of cooperation in the evaluation and in complying with prescribed treatment regime
d. presence of antisocial personality disorder
e. all of the above
ANSWER: e

S15 DIFFERENTIATING FIELD SOBRIETY TEST RESULTS

George S. Glass, MD, Houston, TX

EDUCATIONAL OBJECTIVE
Learn to distinguish Standardized Field Sobriety Test (SFST) results when individuals may also have the odor of alcohol on their breath.

SUMMARY
Drowsiness can and does affect an individual's performance when driving and has been noted to be a significant cause of motor vehicle accidents. Specific types of individuals are most likely to have sleep-related accidents, and these accidents have specific characteristics. The fact that the accident was due to drowsiness is usually missed by the police officer at the scene, and often a mild concussion will be caused by the accident. Both drowsiness and a mild concussion can cause the driver to then fail the SFSTs. Many of the same symptoms that appear with an elevated Blood Alcohol Concentration (BAC) may be present with either drowsiness, or an automobile accident-related concussion, even when the driver has a BAC much lower than the 0.08% required for a DWI conviction. A sober driver with the odor of alcohol on his breath who is sleepy, or has suffered a concussion may then be mistaken for an intoxicated driver and wrongfully arrested for DWI. Without a thorough neurological examination by a trained medical professional or a CT scan at or very near the time of the accident, accurate assessment of the cause for failure of a Standardized Field Sobriety Test battery may not be possible. The similarities among the symptoms of alcohol intoxication, minimal brain injury, and fatigue may at least partially explain why the Standardized Field Sobriety Tests are less accurate and useful than they are presented as being by law enforcement agencies and may also account for the disclaimer the government prints on all the studies of these tests it has funded.

REFERENCES
Adekoya D, Thurman DJ, White DD, Webb KW: Surveillance for traumatic brain injury deaths—United States, 1989-1998. MMWR Surveill Summ 51(10):1-14, 2002
Bruns J, Hausser WA: The epidemiology of traumatic brain injury: a review. Epilepsia 44(10):2-10, 2003

SELF ASSESSMENT QUESTIONS
1. Approximately what percentage of healthy, nonintoxicated volunteers would fail each of the three NHTSA-funded Standardized Field Sobriety Tests for DWI?
a. 0%
b. 10%
c. 20%
d. 30%
e. 50%
ANSWER: c (slightly more than 20%)

2. What are the signs that distinguish a drowsiness-related automobile accident?
a. often a single car accident, when driver is alone
b. nighttime for young adults, late afternoon for geriatrics
c. more likely on high speed road when driver does not take corrective action
d. none of the above
ANSWER: a and c

S16 MENTAL ILLNESS, VIOLENCE RISK, AND RACE IN JUVENILE DETENTION: DISPROPORTIONATE MINORITY CONTACT (DMC)

Rani A. Desai, PhD, MPH (I), West Haven, CT
Paul R. Falzer, PhD (I), West Haven, CT
John F. Chapman, PsyD (I), Wethersfield, CT

EDUCATIONAL OBJECTIVE
To understand the role of mental illness in disproportionate minority contact. To understand the implications of results for reducing DMC and improving system decision-making.

SUMMARY
This paper explores the association among race, mental illness, and violence risk among juvenile detainees. The presentation will define and review the literature on disproportionate minority contact (DMC); present analyses that examine mental illness as a potential explanation for DMC; and discuss the implications of results for reducing DMC and improving system decision-making. Data were taken from intake interviews on 482 detained youth in CT in 2004-2005. Results indicate that racial minorities in detention have significantly lower violence risk than Caucasians, but are disproportionately represented among detention populations relative to their proportions in the general population (i.e. DMC). Our results conclude that DMC is not explained by mental illness, seriousness of charges, violence risk, or sociodemographics such as age and gender. Implications are two-fold. First, mandated efforts to reduce DMC will not be successful if they are aimed at improving behavior or reducing symptoms of mental illness among detained minority youth. Instead, efforts should be focused on reducing racial disparity in decisions made within the juvenile justice system. Second, research is needed to explore the ways in which decisions are made, and ways to appropriately incorporate mental illness information into detention decisions without violating the rights of youths in custody.

REFERENCES
Leiber MJ, Fox KC: Race and the impact of detention: Race and the impact of detention on juvenile justice decision making. Crime Delinquency 51(4):470-97, 2005
Hartstone EC, Richetelli DM: A reassessment of minority overrepresentation in Connecticut's juvenile justice system. 2001 June 5; http://www.opm.state.ct.us/pdpd1/grants/jjac/reassess_final_report-final_version2.pdf

SELF ASSESSMENT QUESTIONS
1. What is the definition of DMC?
ANSWER: A phenomenon where racial minority groups are present in the justice system at proportions that exceed their representation in the general population.

2. What causes DMC?
ANSWER: We don't know. However, it is not violence, seriousness of charges, mental illness, age, or gender.

S17 SEX OFFENDERS AND INSANITY: AN EXAMINATION OF 42 INDIVIDUALS FOUND NOT GUILTY BY REASON OF INSANITY

Brad Novak, MD, Belmont, CA
Barbara McDermott, PhD (I), Sacramento, CA
Charles L. Scott, MD, Sacramento, CA
Stacey Guillory, MA (I), Sacramento, CA

EDUCATIONAL OBJECTIVE
The objective of this scientific paper is to familiarize participants with the defense of not guilty by reason of insanity as it relates to sex offenders.

SUMMARY
Although there currently exists a large amount of research on the characteristics and treatment of sex offenders, little research has investigated the characteristics of sex offenders who have been adjudicated insane. The study included 42 patients at Napa State Hospital who were adjudicated insane. The sample was further divided into offenders whose victims were children and whose victims were adults. Data were collected using a structured chart review instrument. A large percentage of the sex offenders received a primary diagnosis of schizophrenia or schizoaffective disorder and many had a comorbid substance use disorder. The high percentage of sex offenders in the current study diagnosed as schizophrenia or schizoaffective disorder may represent a previously unstudied subgroup of sex offenders. An alternative explanation is that the experts did not adequately evaluate substance use and intoxication, assess for malingering, and appropriately apply the proper legal standard for insanity.

REFERENCES
Warren J, et al: Opinion formation in evaluating sanity at the time of the offense: An examination of 5175 pre-trial evaluations. Behav Sci Law 22:171-86. DOI: 10.1002/bsl.559, 2004
Fulero B: Empirical research on the insanity defense and attempted reforms: Evidence toward informed police. Law and Human Behavior 23(3):375-94, 1999

SELF ASSESSMENT QUESTIONS
1. When evaluating a sex offender who is pleading NGRI it is important to consider:
a. intoxication at the time of the offense
b. the proper legal standard for insanity
c. the possibility of malingering
d. all the above
ANSWER: d

2. Previous research suggests sex offenders have a significant rate of:
a. schizophrenia
b. successful NGRI defenses
c. substance use disorders
d. all the above
ANSWER: c

S18 A PILOT STUDY: OBSESSIVE COMPULSIVE TRAITS V. IMPULSIVITY AMONG SEX OFFENDERS

Denise C. Kellaher, DO, Honolulu, HI

EDUCATIONAL OBJECTIVE
A pilot study on the compulsive and impulsive trait levels among paraphilic and non-paraphilic sex offenders will be discussed along with a review of relevant studies. Future directions in treatments are proffered on the basis of existing research.

SUMMARY
Sex offenders have been categorized clinically as "paraphilic" and "non-paraphilic" and may be further described as either "impulsive" or "compulsive." An algorithmic delineation between these groups based on presence of a paraphilia and based on impulsivity versus compulsivity may provide a more focused approach in the administration of treatment to sex offenders. Currently, treatment tends to be more governed by legal history than by clinical variables. In this pilot study, 21 male adjudicated sex offenders participating in outpatient group therapy were evaluated by the Millon Clinical Inventory-III, the Yale-Brown Obsessive-Compulsive Scale (YBOCS), and the Barratt Impulsive Scale, Version 11 (BIS-11) to determine if significant differences in obsessive-compulsive and impulsive traits existed between paraphilic and non-paraphilic sex offenders. Approximately 44% of the paraphiles showed measurable obsessive-compulsive traits versus 25% of the non-paraphiles on the YBOCS. Only 44% of the paraphiles demonstrated significant impulsive traits versus

84% of the non-paraphiles as measured by the Barratt Impulsiveness Scale, Version 11. Based on these findings, paraphilic offenders demonstrated more obsessive-compulsiveness and non-paraphilic offenders demonstrated more impulsivity. Clinical assessment of these traits could direct future treatment efforts, potentially incorporating modalities used to treat obsessive-compulsive disorder and impulsivity.

REFERENCES

Saleh FM, Guidry LL: Psychosocial and biological treatment considerations for the paraphilic and nonparaphilic sex offender. J Am Acad Psychiatry Law 31(4):486-93, 2003
Bradford JM: The neurobiology, neuropharmacology, and pharmacological treatment of the paraphilias and compulsive sex behavior. Canadian J Psychiatry 46(1):26-34, 2001

SELF ASSESSMENT QUESTIONS

1. In general, paraphilic and obsessive-compulsive disordered patients have the following in common:
a. obsessions
b. compulsions
c. age of onset of clinical impairment
d. research has shown clinical response to serotonergic agents
e. all of the above
ANSWER: e

2. The following treatment is FDA approved for the treatment of sex offenders:
a. leuprolide acetate
b. medroxyprogesterone acetate
c. fluoxetine
d. all of the above
e. none of the above
ANSWER: e

S19 DELUSIONS ON DEATH ROW

Donna M. Schwartz-Watts, MD, Columbia, SC

EDUCATIONAL OBJECTIVE

Attendee will become familiar with effects of schizophrenia on death row inmates' ability to make knowing and intelligent decisions about their methods of execution.

SUMMARY

The execution of mentally disordered inmates remains a much-debated topic legally and professionally. In 2005, 3383 inmates were on death rows across the United States. As of 1/19/2006, 1005 inmates had been executed nationwide since 1976. Little is known about the prevalence of schizophrenia among death row inmates. Inmates with mental illness are disproportionately represented in correctional institutions. Presently, 36 states have the death penalty. Methods of execution still available in the United States include: lethal injection, electrocution, gas chamber, hanging and firing squad. Many states have statutory provisions that allow inmates to choose their methods of death. To date, no studies have been published that explore the reasoning behind an inmate's method of choice for execution. Even less is known about mentally ill defendants' choices of execution. The purpose of this research is to study a subset of schizophrenics on death row who actually chose their method of execution based on a delusional belief. Their choices for execution are compared to nonpsychotic inmate choices. This study should stimulate further research in this area to better delineate epidemiological data and perhaps to assist examiners who are evaluating inmates to determine their competency to be executed.

REFERENCES

http://deathpenaltyinfo.org/FactSheet.pdf, accessed August 2006
Metzner JL, et al: Treatment in jails and prisons, in Treatment of Offenders with Mental Disorders. Edited by Wettstein RM. New York: The Guilford Press, pp 211-64, 1998

SELF ASSESSMENT QUESTIONS

1. Why do schizophrenics on death row choose less popular methods for execution?
ANSWER: Their choices are based on delusional beliefs about death and afterlife.

2. What is the Supreme Court case that discusses parameters required for competency to be executed?
ANSWER: Ford v. Wainwright, 477 U.S.399 (1986)

S20 THE INFLUENCE OF PRIOR TRAUMA AND SITUATIONAL STRESS ON USE OF FORCE DECISIONS IN POLICE OFFICERS

Cheryl Regehr, PhD (I), Toronto, ON, Canada
Vicki LeBlanc, PhD (I), Toronto, ON, Canada
Blake Jelley, PhD (I), Aylmer, ON, Canada
Irene Barath, BA (I), Aylmer, ON, Canada

EDUCATIONAL OBJECTIVE
To understand stress and trauma factors affecting professional decision-making and professional competency.

SUMMARY
An important body of literature explores work related stress and PTSD in police officers that can result in substance use, decreased performance, increased health risks and disruption of social support networks. What is not clear, however, is the degree to which stress and trauma symptoms affect decision-making in high demand, particularly use-of-force, situations. This research is a controlled investigation of performance in an acutely stressful condition aimed at exploring the contributions of previous traumatic exposure, physiological arousal and coping strategies on use-of-force decisions in police officers. In this study police recruits are placed in a high-fidelity simulation scenario. Measures include pre-scenario administration of standardized measures addressing prior trauma exposure, current PTSD symptoms and coping styles; physiological stress responses (heart rate, cortisol) before, during and after the stress scenario exposure; and expert evaluations of the quality of performance. Post-scenario interviews address subjective stress and rationale for decision-making. A final follow-up phase is planned for 6 months, 1 year and 2 years post-training to determine if there are early predictors of stress and trauma in those working in high stress jobs. This presentation will focus on initial data analysis and the implications for forensic evaluations of individuals accused of excessive use-of-force.

REFERENCES
LeBlanc VR, MacDonald RD, McArthur B, King K, Lepine T: Paramedic performance in calculating drug dosages following stressful scenarios in a human patent simulator. Prehospital Emergency Care, in press
Neylan T, Brunet A, Pole N, Best S, Metzler T, Yehuda R & Marmar C: PTSD symptoms predict waking salivary cortisol levels in police officers. Psychneuroendocrinology 30:373-81, 2004

SELF ASSESSMENT QUESTIONS
1. Is there a relationship between heart rate, subjective stress and use of force decisions?
ANSWER: Yes

2. Does previous traumatic exposure influence use of force decision-making?
ANSWER: Yes

S21 THE EFFICACY OF SUICIDE RISK SCREENING INSTRUMENTS

Jason Hershberger, MD, New York, NY
Ricardo Martinez, MA (I), New York, NY
David Horton, BA (I), New York, NY

EDUCATIONAL OBJECTIVE
The presentation details the history and construction of correctional suicide risk screening instruments with an emphasis on their clinical utility. The presenters will feature their research in progress, emphasizing the need for improved validation and psychometric testing pertaining to risk screening in order to enhance clinical utility and administrative efficiency.

SUMMARY
Despite improvement in jail suicide prevention efforts across the past 20 years, responding to inmates at increased risk of suicide remains a central function of psychiatrists in correctional settings. Current response methods rely on intake screening instruments for the accurate assessment of suicide potential in offender populations, but there is a dearth of research evaluating their effectiveness in identifying inmates in need of further psychiatric attention. In New York City jails, the Suicide Prevention Screening Guidelines (SPSG), an 18-item structured interview completed by correction officers, is used to this end. Presently, the NYC DOHMH is undertaking a programmatic series of research studies that are designed to submit the SPSG to contemporary psychometric analyses (reliability, validity, factor analysis, ROC), evaluate its capacity to identify inmates with elevated suicide risk, and suggest possibilities for further development that will make the SPSG more sensitive to suicide potential and enhance its predictive accuracy.

REFERENCES
Hayes LM: Prison suicide: An overview and guide to prevention. Prison J 75: 431-56, 1995
Dahle KP, Lohner JC, Konrad N: Suicide prevention in penal institutions: Validation and optimization of a screening tool for early identification of high-risk inmates in pretrial detention. Int J Forensic Ment Health 4:53-62, 2005

SELF ASSESSMENT QUESTIONS

1. What advantages do current statistical techniques such as ROC-Curve analysis and logistic regression possess that the content analysis techniques of the 1980s cannot provide?

ANSWER: The content analysis techniques employed in the construction of the SPSG, and other screening instruments of its time, selected risk factors from the literature pertaining to general suicide risk in order to construct a scale that assesses suicide potential in correctional facilities. Statistical methods not available in the 1980s, such as logistic regression and ROC analysis, provide researchers with the ability to assess the content chosen to construct instruments such as the SPSG, specifically to refine their performance in inmate populations.

2. How do these statistical techniques, when applied to the validation and further development of suicide risk assessment instruments, help to make them as functional as possible in terms of clinical utility?

ANSWER: Modern statistical methods present researchers with the ability to optimize risk assessment instruments via identification of high yield risk factors so that fewer false positives and false negatives are identified in the screening classification process. This will route inmates with "true" elevated suicide potential directly toward the appropriate clinical care while decreasing the burden of elevated case loads that result from inefficiently designed screening instruments.

S22 SURVEY SAYS! JUDGES' OPINIONS ON NEUROIMAGING EVIDENCE

Marc A. Colon, MD, Shreveport, LA
Bryan C. Shelby, MD, JD (I), Shreveport, LA

EDUCATIONAL OBJECTIVE

The attendee will review the latest findings of an original survey designed to assess trial court judges' answers to questions about admissibility of expert testimony in both civil and criminal proceedings where neuroimaging was offered into evidence; the survey will encompass selected states and jurisdictions.

SUMMARY

A review of case law and selected briefs related to the admissibility of neuroimaging evidence under the Frye and Daubert standards has revealed patterns in the way judges choose to admit neuroimaging evidence. In order to elucidate and further refine our understanding of how judges use and handle neuroimaging evidence, a survey with a regional sample of state and federal trial court judges was used to determine their approach to such evidence. The information was collected using a standardized survey form mailed to trial court judges in Arkansas, Louisiana, Texas with the addition of Mississippi. The survey was narrowed to questions concerning neuroimaging and its use as psychiatric evidence in trial proceedings. Potential questions to be answered included the following. First, what are the surveyed judges' general opinions of the reliability of neuroimaging evidence in cases involving forensic psychiatric issues? Second, what can be learned from trial court judges' use of the Daubert standard to rule on neuroimaging evidence? Third, how do trial court judges see the evolving role of neuroimaging in forensic psychiatric cases? Finally, challenges and pitfalls in surveying the judiciary will be discussed, as well as intentions to duplicate the survey in other jurisdictions.

REFERENCES

Dobbin SA, et al: Surveying difficult populations: Lessons learned from a national survey of state trial court judges, Justice System J 22:3, 2001

Krafka C, et al: Judge and attorney experiences, practices, and concerns regarding expert testimony in federal civil trials. Available at the Federal Judicial Center, http://www.fjc.gov/library/fjc_catalog.nsf

SELF ASSESSMENT QUESTIONS

1. As far as applying the Daubert test, the MOST important person in evaluating expert testimony or evidence is the:

a. Court of Appeals Judge
b. State or Federal Supreme Court Justice
c. County or District Clerk of Court
d. Judge in the Court of Original Jurisdiction (Trial Court Judge)
e. Bailiff

ANSWER: d

2. When applying the Daubert test, a judge

a. may hold a hearing
b. may act as a "gatekeeper" and evaluate the substance and methods of expert testimony
c. may give different weights to the "Daubert" factors when evaluating expert evidence
d. may also use a similar "Frye" test as a factor
e. all of the above

ANSWER: e

SUNDAY, OCTOBER 29, 2006

WORKSHOP — 8:00 AM - 10:00 AM — **SALON D**

Z1 ***Systemic and Teaching Failures from Liability Risk with Trainees***

Thomas G. Gutheil, MD, Brookline, MA
Kathryn C. Hall, MD, Seattle, WA
Michelle Pent, MD, Albuquerque, NM

PANEL — 8:00 AM - 10:00 AM — **DENVER/HOUSTON/ KANSAS CITY**

Z2 ***Tobacco Tales: Legislation, Litigation, and Civil Rights***

Maureen Hackett, MD, Minneapolis, MN
Paul S. Appelbaum, MD, New York, NY
Samuel Jan Brakel, JD (I), Chicago, IL
Steven S. Simring, MD, Tenafly, NJ
Joel J. Africk, JD (I), Chicago, IL

PANEL — 8:00 AM - 10:00 AM — **SALONS ABC**

Z3 ***The AAPL Ethics Revision: Description and Analysis - Ethics Committee***

Philip J. Candilis, MD, Arlington, MA
Philip T. Merideth, MD, JD, Jackson, MS
Howard V. Zonana, MD, New Haven, CT
Debra A. Pinals, MD, Worcester, MA
Kenneth L. Appelbaum, MD, Westborough, MA
Jeffrey S. Janofsky, MD, Timonium, MD

PANEL — 8:00 AM - 10:00 AM — **SALONS F/G**

Z4 ***The History, Ethics, and Future of Research Involving Prisoners - Research Committee***

Cameron D. Quanbeck, MD, Davis, CA
Barbara McDermott, PhD (I), Sacramento, CA
Robert L. Trestman, PhD, MD, Farmington, CT

PANEL — 8:00 AM - 10:00 AM — **MIAMI/SCOTTSDALE**

Z5 ***The Ultimate Taboo: When An NGRI Acquittee Reoffends***

Madeline Andrew, MD, Napa, CA
Phillip Resnick, MD, Cleveland, OH
Charles L. Scott, MD, Sacramento, CA
Gregory G. Sokolov, MD, Davis, CA
Humberto Temporini, MD (I), Sacramento, CA

COFFEE BREAK

WORKSHOP — 10:15 AM - 12:00 NOON — **SALON D**

Z6 ***Developing and Using Case-Based Materials: Teaching Forensic Psychiatry Across the Spectrum***

Melissa Piasecki, MD, Reno, NV
Debra A. Pinals, MD, Worcester, MA
Margaret Bolton, MD, Worcester, MA
Jeffrey S. Janofsky, MD, Timonium, MD

PANEL — 10:15 AM - 12:00 NOON — **SALONS ABC**

Z7 ***Voluntary Community-Based Sex Offender Treatment: Defining Roles for Forensic Clinicians - Research Committee***

Todd Tomita, MD, FRCPC, Vancouver, BC, Canada
Eugene Wang, MD, Port Coquitlam, BC, Canada
Kulwant Riar, MBBS, FRCPC, Burnaby, BC, Canada
Dawn L. Kishi, JD (I), Honolulu, HI

WORKSHOP — 10:15 AM - 12:00 NOON — **DENVER/HOUSTON/ KANSAS CITY**

Z8 ***Conducting Evaluations in Custody Litigation***

Philip Scott, DO, Whitefield, MS
W.M. Norman, PhD (I), Fort Worth, TX
Philip J. Davis, PhD (I), Lubbock, TX

PANEL 10:15 AM - 12:00 NOON **SALONS F/G**

Z9 ***Internet and Child Pornography: The Impact on Forensic Assessments***

Humberto D. Temporini, MD (I), Sacramento, CA
Vladimir Coric, MD, New Haven, CT
Charles L. Scott, MD, Sacramento, CA

PANEL 10:15 AM - 12:00 NOON **NW/OHIO**

Z10 ***Suicide Assessment: Does Diagnosis Matter?***

Lisa A. Rone, MD, Chicago, IL
James L. Cavanaugh, Jr., MD, Chicago, IL
Patricia C. Nowak, JD (I), Chicago, IL
Terrence M. Burns, JD (I), Chicago, IL
John B. Kralovec, JD (I), Chicago, IL

Z1 SYSTEMIC AND TEACHING FAILURES FROM LIABILITY RISK WITH TRAINEES

Thomas G. Gutheil, MD, Brookline, MA
Kathryn C. Hall, MD, Seattle, WA
Michelle Pent, MD, Albuquerque, NM

EDUCATIONAL OBJECTIVE
To explore institutional responses to bad clinical outcomes with potential liability on situations that abandon or fail to support trainees; to identify systemic shortcomings and to suggest remedies.

SUMMARY
Bad clinical outcomes, such as suicide or other violence, occur in training as elsewhere in clinical practice. We will explore institutional responses to such outcomes from the trainee's perspective, with particular focus given to cases that involve liability risk. The teaching component of managing a bad clinical outcome, such as a thorough case review in supervision or a morbidity/mortality conference, is at times lost in the institutional drive to minimize liability risk at best or to scapegoat at worst. Risk management practices that tend to curtail critical review of cases may leave the trainee in significant distress without resources to process a bad outcome or in a marginalized position within the treatment team. Using case examples, the panel will explore the dynamics of institutional response to bad outcomes and highlight the pitfalls of emphasizing risk management at the expense of clinical teaching. In a workshop format, the panel will suggest and discuss practical remedies for the problems and solicit audience participation, examples, and discussion.

REFERENCES
Lefevre FV: A survey of physician training programs in risk management and communication skills for malpractice prevention. J Law Med & Ethics 28:258-66, 2000
Simon RI: Defensive psychiatry and the disruption of treatment boundaries. Int J Psychiatry Related Sciences 37:124-31, 2000

SELF ASSESSMENT QUESTIONS
1. Which of the following is discoverable?
a. attending-resident discussions that occur during formal supervision
b. an institution-sponsored morbidity and mortality conference
c. both of the above
d. neither of the above
ANSWER: c

2. Which of the following statements about hospital risk management systems is FALSE?
a. Overzealous attention to liability risk can obscure the teaching of trainees.
b. Comprehensive study and planning around risk control decreases liability potential.
c. Failures in risk management are a determinant in malpractice lawsuits.
d. None are false; all are true.
ANSWER: d

Z2 TOBACCO TALES: LEGISLATION, LITIGATION, AND CIVIL RIGHTS

Maureen Hackett, MD, Minneapolis, MN
Paul S. Appelbaum, MD, New York, NY
Samuel Jan Brakel, JD (I), Chicago, IL
Steven S. Simring, MD, Tenafly, NJ
Joel J. Africk, JD (I), Chicago, IL

EDUCATIONAL OBJECTIVE
Presenting medical, legal and ethical issues involving tobacco addiction, patient rights and tobacco's presence within psychiatric treatment. An examination of legislation including removing tobacco from state treatment facilities and of the tobacco litigation process will launch deliberation on the role of forensic psychiatrists in medicine's struggle with tobacco.

SUMMARY
Medical facilities became smoke-free in 1988 when JCAHO made accreditation contingent upon such policy. Most psychiatric facilities avoided this conversion as it was thought to create an undue burden for mentally ill patients.

Currently, the ever-increasing number of smoke-free public places draws a stark contrast to smoking accessible psychiatric treatment facilities. The panel will discuss this issue starting with Maureen Hackett who developed and testified in support of a new law removing tobacco from MN's State facility grounds and eliminating a previous exemption for indoor smoking in psychiatric treatment facilities. Information regarding smoking and mental illness and its treatment will be incorporated into the description of this legislative process. Steven Simring will discuss tobacco litigation especially as the debate centered on addiction and individuals' compromised decision-making. A discussion of the tension between patient's rights and the desire to protect them and others from the consequences of smoking will be led by Paul Appelbaum. Attorney Jan Brakel will outline the state of the law with particular focus on patients in institutions where residual privacy, due process and equal protection rights may be invoked. Attorney Joel Africk will describe how institutions have been converted to smoke-free despite attempts to invoke these rights.

REFERENCES

Quinn J, et al: Results of the conversion to a tobacco-free environment in a state psychiatric hospital. Admin Policy Mental Health 27(6):451-3, 2000

Klesges RC, et al: Efficacy of forced smoking cessation and an adjunctive behavioral treatment on long-term smoking rates. J Consulting Clin Psychology 67(6):952-8, 1999

SELF ASSESSMENT QUESTIONS

1. Frequency of aggression as measured by the Overt Aggression scale found that physical rates of aggression dropped by what percent within two months of converting a Texas State Hospital grounds to smoke-free?

ANSWER: 50% (from 266 incidents to 133)

2. How much higher is the metabolic clearance of olanzapine in smokers compared to non-smokers?

ANSWER: 40%

Z3 THE AAPL ETHICS REVISION: DESCRIPTION AND ANALYSIS – ETHICS COMMITTEE

Philip J. Candilis, MD, Arlington, MA
Philip T. Merideth, MD, JD, Jackson, MS
Howard V. Zonana, MD, New Haven, CT
Debra A. Pinals, MD, Worcester, MA
Kenneth L. Appelbaum, MD, Westborough, MA
Jeffrey S. Janofsky, MD, Timonium, MD

EDUCATIONAL OBJECTIVE

To review the background, process, and content of the recent organizational ethics guidelines revision.

SUMMARY

In 2005, AAPL completed a revision of its organizational ethics guidelines. Against the backdrop of guidelines changes at the AMA and APA, this 5-year effort of the Ethics Committee, Executive Council, and AAPL members resulted in a clarification of the organization's ethics statement.

Dr. Philip Merideth will describe the impetus behind the call for the revision, including elements of AAPL guidelines history. Dr. Philip Candilis will describe the make-up of the revision committee, its process, and overall goals, including a review of changes. Dr. Debra Pinals will describe the Executive Council's process and contributions to the final document, with Dr. Howard Zonana describing the anticipated effects of the revision. As discussants, Drs. Kenneth Appelbaum and Jeffrey Janofsky will join the panelists and the audience in a discussion of the meaning of the revision, including political, legal, and practical consequences.

REFERENCES

American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry, Bloomfield, CT: AAPL, 2005

American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry, Bloomfield, CT: AAPL, 1995

SELF ASSESSMENT QUESTIONS

1. Which of the following organizations have begun or completed ethics guidelines revisions in the past 5 years?
a. APA
b. AMA
c. American Psychological Association
d. AAPL
e. all of the above
ANSWER: e

2. The role of the AAPL Ethics Committee includes all of the following EXCEPT:
a. education
b. consultation
c. enforcement
d. referral
ANSWER: c

Z4 **THE HISTORY, ETHICS, AND FUTURE OF RESEARCH INVOLVING PRISONERS – RESEARCH COMMITTEE**

Cameron D. Quanbeck, MD, Davis, CA
Barbara McDermott, PhD (I), Sacramento, CA
Robert L. Trestman, PhD, MD, Farmington, CT

EDUCATIONAL OBJECTIVE

In this presentation, participants will learn historical events that have led to current prisoner research protections; ethical considerations in the use of prisoners as research subjects; and possible changes in federal regulations governing prisoner research and how this may impact psychiatric research in this area.

SUMMARY

In the United States, research involving prisoners as subjects has had a long and complex history. Prior to the 1970s biomedical and behavioral research in prisons was extremely common. After several reports of the exploitation and coercion of prisoner subjects, stringent federal guidelines were implemented that served to protect prisoners. The primary ethical concern driving these protections was the idea that prisoners are unable to provide voluntary consent due to the inherently coercive environment of a penal institution. These regulations have had a chilling effect, and there is currently little research performed in prison populations. Many have argued that prisoners are overprotected and have a right to participate in research they may benefit from. In response, officials at the Department of Health and Human Services have considered loosening protections in order to allow more inmates to volunteer for research. In this panel, we will review the history of prisoner research and the ethical concerns that lead to current protections; research on the perceived coercion and capacity of forensic inpatients to consent to research; and current challenges faced in conducting research on prisoners, possible changes on the horizon, and the potential of prison research to advance forensic psychiatry.

REFERENCES

McDermott BE, Gerbasi JA, Quanbeck CD, Scott CE: Capacity of forensic patients to consent for research: The use of the MCAT-CR. J Am Acad Psychiatry Law33(3):299-307, 2005
Waltz, E: US ponders unlocking the gates to prisoner research news@nature 29 December 2005 doi: 10.1038/nm0106-3

SELF ASSESSMENT QUESTIONS

1. Which of the following subjects are considered to be prisoners for the purpose of conducting research?
a. insanity acquittees being treated in a forensic state hospital
b. pretrial jail inmates
c. individuals serving a life sentence in a prison setting
d. a patient civilly committed to a community hospital
e. all of the above
ANSWER: e

2. Which of the following is the correct definition of "minimal risk" in prisoner research guidelines?
a. no more psychological or physical discomfort or harm than is encountered in a routine medical exam
b. the potential benefits to the patient outweigh the risks
c. a non-prisoner considers the research to be minimal risk
d. the risk of death is less than 0.1%
ANSWER: a

Z5 THE ULTIMATE TABOO: WHEN AN NGRI ACQUITTEE REOFFENDS

Madeline Andrew, MD, Napa, CA
Phillip Resnick, MD, Cleveland, OH
Charles L. Scott, MD, Sacramento, CA
Gregory G. Sokolov, MD, Davis, CA
Humberto Temporini, MD (I), Farmington, CT

EDUCATIONAL OBJECTIVE
To provide an overview of NGRI acquitees who reoffend examining mental defenses and the challenges faced by the forensic psychiatrist during the evaluation process and at trial.

SUMMARY
This panel will focus on evaluating new offenses committed by insanity acquittees and the challenges faced by the forensic psychiatrist. The panel will present an overview including the prevalence of reoffending, both in the hospital and after conditional release. Difficulties unique to performing these evaluations will be discussed. These include the presence of dual diagnoses, personality disorders, and illicit drug trade within a forensic setting. Potential for evaluator bias and jury bias will be examined. Difficulties with inpatient documentation will be reviewed. A brief video for training hospital staff to properly document violent assaults will be shown. The faculty will present a case of an insanity acquittee who murdered his sleeping roommate while he was a patient in a forensic hospital. The case will illustrate how these issues were addressed at trial. The case will also highlight the practical differences in evaluating diminished responsibility and insanity and their respective burdens and standards of proof.

REFERENCES
Quanbeck C: Inpatient hospital aggression, Psychiatric Clinics of North America, (accepted for publication October, 2006)
Miller R: Criminal responsibility, in Principals and Practices of Forensic Psychiatry. Edited by Rosner, R. New York: Chapman and Hall, 1994, pp 198-213

SELF ASSESSMENT QUESTIONS
1. The presence or absence of bifurcation in a trial will:
a. affect an evaluator's analysis of a case
b. will not affect whether an experts opinion will be introduced as evidence bearing on sanity or mens rea
c. may affect whether the evaluator will ultimately be called to testify
d. none of the above
ANSWER: c

2. All of the following are true EXCEPT:
a. the insanity defense is raised in about 1% of felony cases
b. women are overrepresented
c. whites are overrepresented
d. recidivism is lower than for matched felons
ANSWER: d

Z6 DEVELOPING AND USING CASE-BASED MATERIALS: TEACHING FORENSIC PSYCHIATRY ACROSS THE SPECTRUM

Melissa Piasecki, MD, Reno, NV
Debra A. Pinals, MD, Worcester, MA
Margaret Bolton, MD, Worcester, MA
Jeffrey S. Janofsky, MD, Timonium, MD

EDUCATIONAL OBJECTIVE
At the end of this workshop, participants will understand the development and applications of a case-based curriculum in forensic psychiatry to meet the learning needs of medical students, residents and fellows.

SUMMARY
Medical education has long used teaching cases to demonstrate findings and to provide contexts for diagnostic and clinical reasoning. Educators in forensic psychiatry can use teaching cases to introduce medical-legal concepts, demonstrate assessment techniques and encourage analytic skills in trainees. This workshop will explore the possibilities for using cased-based learning with medical students, psychiatry residents, forensic fellows and continuing

medical education. We will demonstrate how digital video technology and written case materials can be used in seminars and independent study, applying concepts behind evidence-based teaching. Specific attention will be given to appropriate case selection, confidentiality concerns and formatting discussion questions. Workshop attendees will develop lists of forensic topics suitable to learners at different levels and explore the use of technology to bring forensic didactics "to life" with multimedia learning modules.

REFERENCES

McParland M, Noble LM, Livingston G: The effectiveness of problem-based learning compared to traditional teaching in undergraduate psychiatry. Medical Education 38:859-67, 2004
Huang C: Designing high-quality interactive multimedia learning modules. Comput Med Imaging Graph 29(2-3):223-33, 2005

SELF ASSESSMENT QUESTIONS

1. Higher student examination performance in psychiatry with PBL curricula appeared to be related to
a. improved attitudes towards psychiatry
b. improved learning in small groups
c. male gender
ANSWER: b

2. Educational media complement traditional textbook learning in what way(s)?
a. Media are more dynamic and able to reflect current state of knowledge.
b. Media are customizable to populations of learners
c. Media allow for visualization of non-verbal information.
d. All of the above.
ANSWER: d

Z7

VOLUNTARY COMMUNITY-BASED SEX OFFENDER TREATMENT: DEFINING ROLES FOR FORENSIC CLINICIANS – RESEARCH COMMITTEE

Todd Tomita, MD, FRCPC, Vancouver, BC, Canada
Eugene Wang, MD, Port Coquitlam, BC, Canada
Kulwant Riar, MBBS, FRCPC, Burnaby, BC, Canada
Dawn L. Kishi, JD (I), Honolulu, HI

EDUCATIONAL OBJECTIVE

To review challenges, limitations, and benefits of voluntary community-based sex offender treatment programs across jurisdictions; to discuss how forensic clinicians can act more effectively as consultants and clinicians in this setting.

SUMMARY

Efficacious treatment of sex offenders poses daunting challenges in the mental health, correctional, and legal arenas. Although programs for sex offenders vary across jurisdictions, community-based treatment of sex offenders is increasingly utilized in the United States and abroad. The need for further attention in this area is emphasized by the scarcity of literature surrounding treatment for sex offenders within the community when compared to literature in correctional settings. Understanding the legal and clinical issues surrounding community-based sex offender treatment is necessary to appreciate the potential challenges, limitations, and benefits. Drs. Tomita and Wang discuss early findings in high-risk adult offenders referred for voluntary treatment under a new Canadian mandate, elements of the treatment program, and logistical challenges of ensuring that the mandate is applied toward under serviced rural areas. Dr. Riar discusses similar issues in a Youth Sexual Offenders Program and post-treatment recidivism data. Ms. Kishi, a former sex crimes prosecutor, compares how differing statutes across the U.S., Canada, and other international jurisdictions affect practice issues for forensic clinicians. Clinicians will gain an understanding of how to act more effectively as consultants within the legal system and as clinicians in providing treatment-targeting recidivism in this particularly challenging population.

REFERENCES

Petrunik M: The hare and the tortoise: Dangerousness and sex offender policy in the United States and Canada. Canadian J Criminology Crim Justice 45(1):43-72, 2003
Abracen J, Mailloux DL, Serin RC, Cousineau C, Malcolm PB, Looman J: A model for the assessment of static and dynamic risk factors in sexual offenders. J Sex Res 41(4):321-8, 2004

SELF ASSESSMENT QUESTIONS

1. Which of the following ideas is most consistent with the early forensic-clinical model of dangerousness?

a. Due process of law and offender accountability are of highest priority.
b. Determinate time of sentence should be proportionate to severity of the crime.
c. Indeterminate time of confinement for individuals whose personality disorder predisposes them to crime.
d. Where reoffense risk is minimal, confinement should continue indefinitely for public protection.

ANSWER: c

2. In a community protection approach, which of the following predictions about violence risk would be seen as the greatest mistake?

a. false negative
b. false positive
c. overestimating risk based on clinical rather than actuarial methods

ANSWER: a

Z8 CONDUCTING EVALUATIONS IN CUSTODY LITIGATION

Philip Scott, DO, Whitefield, MS
W.M. Norman, PhD (I), Fort Worth, TX
Philip J. Davis, PhD (I), Lubbock, TX

EDUCATIONAL OBJECTIVE

This workshop is intended to present a model for the conduct of custody evaluations. Attendees will receive information about specific methods and procedures for collecting information when completing court-ordered, child-custody evaluations. The presenters will discuss examples of techniques for collecting parent, child and collateral information.

SUMMARY

An increasing number of mental health professionals are asked to provide evaluations in custody disputes. These disputes affect large numbers of cases in family courts and impact increasing numbers of children. This workshop is designed to present topics for the custody evaluator from the initial contact regarding a custody evaluation to the completion of a concise and informative report. The model presented includes informed consent, clarification of financial responsibilities, clinical interviews, psychological testing (if done) and other data collection procedures and techniques. Data collection, report writing and trial testimony information will be discussed. We will discuss evaluations as distinct from evaluations of a number of different persons and specific to family evaluation which includes collecting information from, for example, collaterals and other mental health professionals and integrating the information collected into a concise document to assist the court with child-custody decisions.

REFERENCES

Benjamin GA, Gollan JK: Family Evaluation in Custody Litigation: Reducing Risks of Ethical Infractions and Malpractice. Washington, DC: American Psychological Association, 2003
American Psychological Association: Guidelines for the Conduct of Custody Evaluations. Washington, DC, 1993

SELF ASSESSMENT QUESTIONS

1. During the past twenty years approximately how many children have entered family courts as a result of custody disputes?

a. 500,000
b. 750,000
c. 1,000,000
d. 2,000,000

ANSWER: d

2. What percentage of families do experts estimate are able to design and settle disputes resulting in custody litigation going before the Courts?

a. 10%
b. 20%
c. 30%
d. 40%

ANSWER: a

Z9 INTERNET AND CHILD PORNOGRAPHY: THE IMPACT ON FORENSIC ASSESSMENTS

Humberto D. Temporini, MD (I), Farmington, CT
Vladimir Coric, MD, New Haven, CT
Charles L. Scott, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
To develop a standardized forensic assessment of individuals accused of possession of internet-obtained child pornography.

SUMMARY
Prior to the development of the internet, the production and trafficking of child pornography was difficult and expensive. With the development of digital imaging technology and online communication (email, file transfer protocols (FTP), internet relay chat (IRC) and peer-to-peer data transmission), that is no longer the case. The Child Online Protection Act (COPA) of 1998 penalized the display and exchange of child pornography on the internet. As both state and federal authorities have aggressively prosecuted these crimes, forensic psychiatrists are often asked to assess the suspects at different stages of the legal process. In state courts, defense attorneys may request evaluations to assess diminished capacity while prosecutors may request risk assessments of future behavior. In federal courts, psychiatric examinations are often requested to aid in sentencing. This panel will provide a background on the psychiatric aspects of pornography use as a predictor of future behavior (Dr Scott), discuss the forensic assessment of the suspects and review data from evaluations performed by the presenters (Dr. Coric and Dr. Temporini). Finally, the panel will present a framework for the type of report that is useful to legal authorities in these cases.

REFERENCES
Seto M, Eke A: The criminal histories and later offending of child pornography offenders. Sex Abuse. 17(2):201-10, Apr 2005
McGrath M, Casey E: Forensic psychiatry and the Internet: Practical perspectives on sexual predators and obsessional harassers in cyberspace. J Am Acad Psychiatry Law. 30(1):81-94, 2002

SELF ASSESSMENT QUESTIONS
1. What type of psychiatric evaluations are often requested in individuals accused of possessing child pornography?
ANSWER: Risk assessments, diminished capacity, evaluations to aid the court during sentencing

2. "Online" crimes involving child pornography are usually prosecuted by:
a. Federal authorities
b. State authorities
c. Internet service providers (ISPs)
d. a and b
ANSWER: d

Z10 SUICIDE ASSESSMENT: DOES DIAGNOSIS MATTER?

Lisa A. Rone, MD, Chicago, IL
James L. Cavanaugh, Jr., MD, Chicago, IL
Patricia C. Nowak, JD (I), Chicago, IL
Terrence M. Burns, JD (I), Chicago, IL
John B. Kralovec, JD (I), Chicago, IL

EDUCATIONAL OBJECTIVE
We will present a case involving medical malpractice litigation and discuss standard of care issues when psychiatry is consulting to another medical service. Suicide assessment in postpartum psychiatric illness will be reviewed. Psychiatric experts and attorneys for both the defense and plaintiff will allow attendees to observe a model for expert-attorney collaboration.

SUMMARY
The panel will present a case of a woman with perinatal psychiatric illness, which allegedly culminated in her death by suicide four days after delivering quadruplets by Caesarian section. She was obstetrically hospitalized over two months on a university high-risk obstetrical unit prior to the delivery and discharged three days post-operatively. She was followed and treated while hospitalized by the university psychiatric consultation liaison service. We will address the elements necessary for an adequate suicide assessment prior to discharge in this context with a focus on the question of whether the perinatal psychiatric diagnosis was predictive of potential suicide risk postpartum.

We will discuss issues of standard of care when psychiatry is consulting to another service and will demonstrate the importance of psychiatric expert and attorney collaboration for both defense and plaintiff in malpractice litigation. Our presentation will be enhanced by the in vivo discussion between experts and attorneys from both perspectives.

REFERENCES

Jacobs DG (ed): Harvard Medical School Guide to Suicide Assessment and Intervention. San Francisco, CA: Jossey-Bass Publishers, 1999

Stoudemire A, Fogel BS, Greenberg, DB (eds): Psychiatric Care of the Medical Patient, 2nd edition. UK: Oxford University Press, 2000

SELF ASSESSMENT QUESTIONS

1. Which of the following are known risk factors for post-partum suicide?

a. lack of family or community support
b. postpartum psychosis
c. assisted fertilization
d. perinatal/ postpartum depression
e. a,b,c
f. a,b,d
g. all of the above

ANSWER: f

2. Standards of care when psychiatry is consulting to another medical service are predicated on:

a. The other medical service's standards of care.
b. Standards established by the American Psychiatric Association and established local practice for psychiatric care.
c. The requirement that an expert in the area of psychiatry for which patient is being treated see the patient in consultation.

ANSWER: b

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