American Academy of Psychiatry and the Law

39th Annual Meeting

October 23-26, 2008
Seattle, Washington

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.

The American Academy of Psychiatry and the Law designates this educational activity for a maximum of 33.25 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Thirty-ninth Annual Meeting
American Academy of Psychiatry and the Law
October 23-26, 2008
Seattle, Washington

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PAST PRESIDENTS

Alan R. Felthous, MD	2006-07	Joseph D. Bloom, MD	1989-90
Robert I. Simon, MD	2005-06	William H. Reid, MD, MPH	1988-89
Robert T.M. Phillips, MD, PhD	2004-05	Richard Rosner, MD	1987-88
Robert Wettstein, MD	2003-04	J. Richard Ciccone, MD	1986-87
Roy J. O'Shaughnessy, MD	2002-03	Selwyn M. Smith, MD	1985-86
Larry H. Strasburger, MD	2001-02	Phillip J. Resnick, MD	1984-85
Jefrey L. Metzner, MD	2000-01	Loren H. Roth, MD	1983-84
Thomas G. Gutheil, MD	1999-00	Abraham L. Halpern, MD	1982-83
Larry R. Faulkner, M.D	1998-99	Stanley L. Portnow, MD	1981-82
Renée L. Binder, MD	1997-98	Herbert E. Thomas, MD	1980-81
Ezra E. H. Griffith, MD	1996-97	Nathan T. Sidley, MD	1979-80
Paul S. Appelbaum, MD	1995-96	Irwin N. Perr, MD	1977-79
Park E. Dietz, MD, PhD, MPH	1994-95	G. Sarwer-Foner, MD	1975-77
John M. Bradford, MB	1993-94	Seymour Pollack, MD	1973-75
Howard V. Zonana, MD	1992-93	Robert L. Sadoff, MD	1971-73
Kathleen M. Quinn, MD	1991-92	Jonas R. Rappeport, MD	1969-71
Richard T. Rada, MD	1990-91		

2008 ANNUAL MEETING CHAIR

Debra A. Pinals, MD

EXECUTIVE OFFICES OF THE ACADEMY

One Regency Drive, P. O. Box 30, Bloomfield, CT 06002-0030
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E-mail: Office@AAPL.org Website: www.AAPL.org

Howard V. Zonana, MD
Medical Director

Jacquelyn T. Coleman, CAE
Executive Director

CALL FOR PAPERS 2009

The 40th Annual Meeting of the American Academy of Psychiatry and the Law will be held in **Baltimore, Maryland**

October 29-November 1, 2009

Papers may be submitted and inquiries directed to Marilyn Price, MD, CM, Program Chair.

Abstract submission forms will be posted online at www.AAPL.org.

The deadline for abstract submission is March 1, 2009

FUTURE ANNUAL MEETING DATES and LOCATIONS

40th Annual Meeting

October 29-November 1, 2009

Baltimore Marriott Waterfront, Baltimore, Maryland

41st Annual Meeting

October 21-24, 2010

JW Marriott Starr Pass Resort, Tucson, Arizona

42nd Annual Meeting

October 27-30, 2011

Park Plaza Hotel and Towers, Boston, Massachusetts

GENERAL INFORMATION

Table of Contents

REGISTRATION DESK

(Grand Foyer, Grand Level)

Hours of Operation

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

AAPL BOOKSTORE

Grand Foyer, Grand Level

MONDO DIGITAL SOLUTIONS, INC.

Grand Foyer, Grand Level

COURSE CODES

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

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

American Academy of Psychiatry and the Law
Institute for Education and Research
AIER

The AIER was developed to stimulate educational and research activities, provide educational resources and activities, and to aid education and research by encouraging tax-exempt donations to forensic education and research programs.

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The American Academy of Psychiatry and the Law's Institute for Education and Research, Inc., is exempt from federal income taxes as a public charity under IRS Section 501 (c) (3).

A MESSAGE TO PHYSICIAN ATTENDEES
CONTINUING MEDICAL EDUCATION CHANGES

I. Gaps: In compliance with the Updated Accreditation Criteria of the Accreditation Council for Continuing Medical Education (ACCME), the Education Committee of AAPL has identified "professional practice gaps."

Definition: A "professional practice gap" is the difference between what a health professional is doing or accomplishing compared to what is achievable on the basis of current professional knowledge.

For this Annual Meeting the following gaps have been identified based on the AAPL Educational Mission Statement printed on the next page:

1. Not practicing forensic psychiatry at the highest level attainable based on current knowledge of the fundamentals of the field

2. Lacking the knowledge of content or technique to teach psychiatrists the fundamentals of forensic psychiatry in the most effective ways

3. Lacking the ability to conduct or assess research in forensic psychiatry

II. Changes in behavior/objectives: It is intended that, as a result of attending this meeting, psychiatrists will be able to identify changes in *competence or performance* that are desirable.

Definitions: Competence" is knowing how to do something. "Performance" is what a psychiatrist would do in practice if given the opportunity.

III. Evaluation: The Updated Accreditation criteria are designed to integrate with the new requirements for maintenance of certification. (For more information see www.ABPN.org.) Physicians are expected to perform self assessments of their practice, but AAPL, as an organization accredited by the ACCME, is expected to measure how its educational activities assist physicians in this activity. Thus, there are new questions in the evaluation form at the end of this Program Book. Those questions address your intended changes in competence or performance. In a few months, we will contact all physician meeting attendees to ask you if you actually HAVE experienced changes in competence or performance. Your responses, now and in the future, will assist us and ultimately you in determining educational activities that are most useful to you.

Thank you in advance.

Debra Pinals, MD and Marilyn Price, MD
Co-chairs, Education Committee

AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW
Continuing Medical Education Mission Statement

The Bylaws of the American Academy of Psychiatry and the Law place education first among the purposes for which the Academy exists.

Purpose: Through the education process, the Academy desires to: promote the exchange of ideas and experiences that enrich the field of psychiatry and the law, provide practical knowledge for members and others with an interest in this area, foster the development of future psychiatrists in this field, and encourage research.

Target Audience: Our target audience includes members and other psychiatrists interested in forensic psychiatry.

Content areas: Each educational offering of the Academy shall have as content areas subjects that improve skills in at least one of the following: 1) practice, including treatment of forensic patients and forensic examinations in the criminal and civil context, development of service delivery and risk management strategies, and enhancement of consultative abilities at the interface of psychiatry and the law; 2) teaching, including developing new and improving existing methods of forensic training of psychiatrists; and 3) research, including the development and application of scientific data in areas that form the basis for practice of the discipline. The scope of the Academy's educational activities includes forensic psychiatric aspects of civil, criminal, and correctional issues, and other related topics.

Types of activities: The Academy carries out its educational mission through the Annual Meeting, the Semiannual Meeting, the Forensic Review Course, the *Journal of the American Academy of Psychiatry and the Law*, the AAPL Newsletter, the Learning Resource Center, the website, committees and ethics and practice guidelines.

Results: The Academy expects the results of its CME program to be improvement in competence or performance.

Adopted: September 5, 2008

FINANCIAL DISCLOSURE/CONFLICT OF INTEREST

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 disclose 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 proposed 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.

The ACCME definition of a commercial interest is "…any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients." The ACCME does not consider providers of clinical services or publishers to be commercial interests.

All speakers have been advised of the following:

- Slides, posters, and handouts may not contain any advertising, trade names or product group messages of any commercial entity.
- If a presentation describes the use of a device, product, or drug that is not FDA approved or the off-label use of an approved device, product, or drug, it is the speaker's responsibility to disclose this information during the presentation.
- Presentations must give a balanced view of therapeutic options. Use of generic names contributes to this impartiality. If the content of a presentation includes trade names, where possible, trade names from several companies should be used.
- 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.

Instances of bias or failure to conform to any of the above instructions should be reported to the Education Committee by means of the evaluation form. Please be as specific as possible in reporting.

SPEAKER FINANCIAL DISCLOSURES

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

Adams, K.; Adiele, T.; Adler, L.; Anderson, A.; Anfang, S.; Appelbaum, K.; Arboleda-Florez, J.; Ash, P.; Baranoski, M.; Barboriak, P.; Baskin, J.; Baxter, P.; Beckson, M.; Beimish, B.; Benitez, C.; Bethel, W.; Bickle, A.; Billick, S.; Binswanger, I.; Black, D.; Blair, W.; Boehnlein, J.; Bogo, M.; Boland, R.; Bondar, J.; Bonnie, R.; Boyar, E.; Bradford, J.; Bresler, S.; Browning, J.; Buchanan, J.; Buchi, H.; Buckland, J.; Burke, W.; Burlington, B.; Busch, K.; Busse, D.; Butler, J.; Campbell, W.; Campbell, J.; Campbell, A.; Candilis, P.; Carr, W.; Cerny, C.; Chaffin, J.; Chaimowitz, G.; Chakunta, U.; Chapman, A.; Chard, K.; Chism, L.; Christopher, P.; Ciccone, R.; Clayfield, J.; Colley, J.; Conroe, H.; Crisp, W.; Cumming, I.; Daniel, A.; Davidson, C.; de Crisce, D.; DeBofsky, M.; Deem, A.; del Busto, E.; Derrick, B.; Dev, D.; Dhaliwal, G.; DiGiovanna, B.; Drizin, S.; Dwyer, G.; Eist, H.; Elbogen, E.; Eliason, S.; Esposito-Smythers, C.; Fedoroff, P.; Felthous, A.; Ferranti, J.; Ferrari, M.; Finkle, M.; Fisher, W.; Fozdar, M.; Freeman, B.; Frierson, R.; Frischer, K.; Fujii, D.; Garuba, M.; Garvey, K.; Glancy, G.; Goldwaser, A.; Goni, M.; Gould, J.; Granacher, R.; Greenspan, M.; Griffith, E.; Grisso, T.; Grounds, A.; Grudzinskas Jr., A.; Guise, J.; Gunn, J.; Gunter, T.; Gutheil, T.; Guyer, M.; Halavonich, R.; Haller, L.; Harlow, M.; Hatters Friedman, S.; Hauser, M.; Hayos, C.; Hayward, J.; Hazelwood, R.; Helfand, S.; Henderson, C.; Hinton, J.; Hoge, S.; Holden, C.; Ibarra, P.; Janke, P.; Janofsky, J.; Jerrell, J.; Johnson, S.; Joseph, E.; Justice, B.; Kaempf, A.; Kambam, P.; Kan, D.; Kapoor, R.; Kaufman, A.; Kazim, A.; Keram, E.; Kim, C.; Kissin, M.; Kleinman, S.; Knight, S.; Knoll, J.; Kuroski-Mazzei, A.; Lam, J.; Lamberti, S.; Larkin, F.; LeBlanc, V.; LeBourgeois III, HW.; Lee, B.; Lemmen, C.; Leo, R.; Leonard, C.; Leong, G.; Lewis, C.; Lidz, C.; Mack, A.; MacKinnon, T.; Maden, A.; Manguno-Mire, G.; Marlowe, W.; Martell, D.; Martone, C.; Mayman, D.; McDermott, B.; McKee, G.; McMillan, J.; Metzner, J.; Miller, M.; Mizer, B.; Mohandessi, S.; Morris, D.; Mossman, D.; Mulbry, L.; Mullen, P.; Myers, W.; Nair, M.; Nanton, A.; Nelken, M.; Nemoianu, A.; Newman, S.; Newman, A.; Norko, M.; Noroian, P.; Norris, D.; North, C.; O'Shaughnessy, R.; Osher, F.; Palumbo, T.; Parker, G.; Parker, I.; Peele, R.; Penn, J.; Perdue, J.; Philips, K.; Phillips, R.; Pinals, D.; Pozios, V.; Punwani, M.; Purcell, R.; Quanbeck, C.; Qui, F.; Rasco, S.; Recupero, P.; Regehr, C.; Resnick, P.; Riar, K.; Richards, L.; Rogge, S.; Roof, J.; Rosenfeld, B.; Rosmarin, D.; Rosner, R.; Rosner, R.; Ross, C.; Ross, E.; Rotter, M.; Roy-Bujnowski, K.; Ryan, C.; Sadoff, R.; Saleh, F.; Salem, A.; Samuel, R.; Sattar, P.; Schneider Jr., H.; Schwartz-Watts, D.; Scott, C.; Shefchick, T.; Shelby, B.; Sheth, M.; Shlonsky, A.; Shugarman, R.; Sieleni, B.; Silva, JA.; Simon, A.; Simon, L.; Simpson, J.; Sokolov, G.; Soliman, S.; Soliman, L.; Sorrentino, R.; Spirito, A.; Srinivasaraghavan, J.; Stanislaus, A.; Stankard, P.; Stroud, Z.; Swartz, M.; Talley, J.; Taylor, R.; Temporini, H.; Thomas, M.; Thrush, C.; Trestman, R.; Tucker, D.; Turpin, S.; Vanderpool, D.; Varshney, N.; Vlach, D.; Volin, J.; Warburton, K.; Watters, D.; Way, B.; Wegelin, J.; Weinstock, R.; Weisman, R.; Weiss, K.; Welch, R.; Westmoreland, P.; Wettstein, R.; Wills, C.; Windle, M.; Winick, B.; Wolfson, J.; Woodbury-Smith, M.; Wortzel, H.; Yang, S.; Yastro, K.; Young, J.; Zapf, P.; Zonana, H.

PROGRAM AND EDUCATION COMMITTEE MEMBER DISCLOSURES

The following meeting planners have indicated that they have no relevant financial relationships with any commercial interests or, if a financial relationship was disclosed they have agreed to recuse themselves from discussions where a potential bias could exist.

Anfang, S.; Billick, S.; Campbell, Casanova-Pelosi, C.; W.; Christopher, P.; Cobb, T.; Fozdar, M.; Frierson, R; Gold, L.; Henry, S.; Hogan, E.; Holzer, J.; Kaye, N.; Keram, E.; LeBourgeois II, HW.; Leong, G.; Merideth, P.; Newman, A.; Noffsinger, S.; Osinowo, T.; Ostermeyer, B.; Parker, G.; Pinals, D.; Pozios, V.; Preven, D.; Price, M.; Recupero, P.; Resnick, P.; Rosmarin, D.; Schiffman, E.; Scott, C.; Sokolov, G.; Stolar, A.; Stanislaus, A.; Wills, C.; Wall, B.; Wylonis, L.

SPECIAL EVENTS

THURSDAY, OCTOBER 23

Breakfast for current fellows only in Forensic Psychiatry Programs	7:00 a.m - 8:00 a.m.	St. Helens, Mezzanine Level
Past Presidents' Breakfast	7:00 a.m. - 8:00 a.m.	Whidbey, San Juan Level
Opening Ceremony - President's Address (open to all attendees)	8:00 a.m. - 10:00 a.m.	Grand 1, Grand Level
Association of Directors of Forensic Psychiatry Fellowships Reception (for fellowship program faculty, fellows, and potential applicants)	6:00 p.m. - 7:00 p.m. .	Fifth Avenue, Grand Level

FRIDAY, OCTOBER 24

Rappeport Fellows Breakfast (Rappeport Fellows and Committee)	7:00 a.m. - 8:00 a.m.	Whidbey, San Juan Level
Reception (for all meeting attendees)	6:00 p.m. - 7:30 p.m.	Grand II, Grand Level
Midwest Chapter Meeting	7:30 p.m. - 8:30 p.m.	Stuart, Mezzanine Level

SATURDAY, OCTOBER 25

Early Career Development Breakfast (Those in the first seven years after training)	7:00 a.m. - 8:00 a.m.	St. Helens, Mezzanine Level
AAPL Business Meeting (members only)	8:00 a.m. - 9:30 a.m.	Grand 1, Grand Level

COFFEE BREAKS WILL BE HELD IN THE GRAND 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-ninth Annual Meeting

OPENING CEREMONY

Thursday, October 23, 2008
8:00 a.m. - 10:00 a.m.

WELCOME, INTRODUCTIONS — Jeffrey S. Janofsky, MD, *President*

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

Craig A. Beach, MD, MSc *Columbia University*	Hygiea Casiano, BSc, MD *University of Manitoba*
Paul Christopher, MD *Brown University*	Jessica Ferranti, MD *University of California, Davis Medical Center*
Keelin Garvey, MD *Brown University*	Vasiilis K. Pozios, MD *University of Michigan*

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

Golden Apple Award
Robert Weinstock, MD

Seymour Pollack Award
Jonas R. Rapperport, MD

Red Apple Award
Debra A. Pinals, MD

Amicus Award
Barbara E. McDermott, PhD

Award for Outstanding Teaching in a Forensic Fellowship Program
Charles L. Scott, MD

Young Investigator Award — Robert Trestman, MD, *Chair, Research Committee*
Douglas R. Morris, MD

OVERVIEW OF THE PROGRAM — Debra A. Pinals, MD, *Program Chair*

INTRODUCTION OF THE PRESIDENT — Jonas R. Rappeport, MD

PRESIDENT'S ADDRESS — Jeffrey S. Janofsky, MD

ADJOURNMENT — Debra A. Pinals, 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.

ROBERT WEINSTOCK, MD

Robert Weinstock received his medical degree from New York University. After doing his internship at Montefiore Hospital, he did his adult and adolescent psychiatry residencies at the McLean Hospital Division of Harvard. He then completed a two-year research training fellowship at Boston University. Dr. Weinstock is Board Certified in Forensic Psychiatry, Addiction Psychiatry, and Geriatric Psychiatry. Since 1995, Dr. Weinstock has been a Clinical Professor of Psychiatry at the University of California in Los Angeles.

Dr. Weinstock has made significant contributions to the field of forensic psychiatry. He was the founding Chair of the AAPL Addiction and Geriatric Committees. He served as Chair of the AAPL Program Committee and was Chair of the AAPL Committee on Ethics for 8 years. As Chair of the Ethics Committee, he revised the ethics guidelines for AAPL. He also has served as Secretary of AAPL and is currently a Councilor. He has been President of the Association of Directors of Forensic Psychiatry Fellowships and President of the former Accreditation Council on Fellowship in Forensic Psychiatry. He has also been an Associate Editor of the Journal of AAPL. In addition, Dr. Weinstock has contributed to forensic psychiatry through his service to the American Psychiatric Association (APA) and the California Psychiatric Association (CPA). He has been a member and consultant to the APA Committee on Judicial Action and a member of the Corresponding Committee on Confidentiality. At the CPA, he has been Chair of the Committee on Judicial Action since 2000. He was instrumental in getting California law changed in 2007 to deal with Tarasoff duties and to clarify and revise the official jury instructions.

Dr. Weinstock has written more than 100 book chapters and peer-reviewed papers and is the co-author of a recent book on "Forensic Ethics." He also was section editor for two sections in both editions of Rosner's textbook "Principles and Practice of Forensic Psychiatry."

For his significant contributions to the field of forensic psychiatry, the American Academy of Psychiatry and the Law present, the 2008 Golden AAPL Award to Dr. Robert Weinstock.

SEYMOUR POLLACK DISTINGUISHED ACHIEVEMENT AWARD

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

JONAS R. RAPPEPORT, MD

Dr. Jonas Rappeport has had a long and distinguished career in forensic psychiatry. He received his undergraduate and medical degrees from the University of Maryland and completed his psychiatric residency at the University of Maryland and Sheppard Pratt Hospital. Dr. Rappeport directed the forensic fellowship program at the University of Maryland from 1967 to 1995. He has been a Clinical Professor of Psychiatry at the University of Maryland School of Medicine, an Associate Professor of Psychiatry at Johns Hopkins University, and an Adjunct Professor of Law at the University of Maryland School of Law. He continues to teach as a faculty member in the forensic fellowship program.

Dr. Rappeport was Chief Medical Officer of the Medical Service of the Circuit Court for Baltimore City for 25 years, from 1967 to 1992. For 21 years, Dr. Rappeport directed the Special Offenders Clinic at the University of Maryland, and for 14 years, he directed the coordinating team at the Maryland State Pre-Trial Screening Program. He was the senior consultant for forensic psychiatry to Sheppard and Enoch Pratt Hospital for 28 years, senior consultant to the Baltimore County Employee Health Services for 20 years, and consultant to the Maryland State Police Employee Health Services for 10 years.

In 1976, Dr. Rappeport became the Founding Director of the American Board of Forensic Psychiatry. He then served as its Medical Director for 12 years and its President for two years. From 1969-1971, Dr. Rappeport served as the first President of the American Academy of Psychiatry and the Law and was its Medical Director for 14 years. Dr. Rappeport was also the Managing Editor of the Journal of American Academy of Psychiatry and the Law for 16 years. In 1979, he received a special recognition award as Founder of AAPL and in 1984, he received the Isaac Ray Award for his outstanding contributions to law and psychiatry. Dr. Rappeport has testified in 20 jurisdictions, has written 16 book chapters, and has authored 33 publications. He has edited two books, including "The Mental Health Professional and the Legal System."

For his distinguished and superb contributions to education in the field of forensic psychiatry, the American Academy of Psychiatry presents the 2008 Seymour J. Pollack Award to Dr. Jonas Rappeport.

RED AAPL OUTSTANDING SERVICE AWARD

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

DEBRA A. PINALS, MD

Dr. Pinals received her MD at Ohio State University and then did her medical internship at Lenox Hill Hospital in NY, her general psychiatry residency at Massachusetts Mental Health Center in Boston, and her forensic fellowship at Bridgewater State Hospital and Harvard Medical School. She served as Director of the Forensic Psychiatry Fellowship Program at the University of Massachusetts Medical School from 1998 to 2008. This past year she has taken on the position of Assistant Commissioner of Forensic Services for the Department of Mental Health in Massachusetts. She is also an

Associate Professor of Psychiatry and is Director of Forensic Education of the Law and Psychiatry Program at the University of Massachusetts Medical School. Dr. Pinals has received multiple awards, including awards for Resident-Faculty Academic Collaboration, teaching awards from the Psychiatry Residency Program at the University of Massachusetts, and medical student teaching awards at Case Western Reserve University. At the American Psychiatric Association, she is an active and productive member of the Council on Psychiatry and the Law and is an APA Assembly representative from Massachusetts. She was Chair of the Psychiatry and the Law Committee of the Group for the Advancement of Psychiatry from 2001 to 2007. She has authored or co-authored 13 book chapters and nearly 30 publications in peer-reviewed journals. She also has edited a 2007 book on "Stalking: Psychiatric Perspectives and Practical Approaches."

In terms of AAPL service, Dr. Pinals is currently Treasurer of AAPL and Co-Chair of the Education Committee. She is also Chair of the Program for the current annual AAPL meeting in Seattle. In addition, Dr. Pinals was an AAPL Councilor and Chair of the Council Task Force to Revise AAPL Ethical Guidelines. She currently serves as a member of the Association of Directors of Forensic Psychiatry Fellowships and as a member of the Law Enforcement Liaison Committee.

For her devoted service and numerous contributions over many years to AAPL, the American Academy of Psychiatry and the Law presents the 2008 Red AAPL Outstanding Service Award to Dr. Debra Pinals.

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.

CHARLES L. SCOTT, MD

Charles Scott completed his internship and adult psychiatry residency at Walter Reed Army Medical Center. He did his fellowship in child and adolescent psychiatry at the University of California San Francisco and his forensic psychiatry fellowship at Case Western Reserve University. He has his subspecialty boards in child and adolescent, addiction, and forensic psychiatry. After completing his forensic fellowship, Dr. Scott joined the faculty at Tulane University and was co-director of the forensic psychiatry fellowship, achieving the program's first time accreditation by the ACGME. In 1998, Dr. Scott moved to the University of California Davis and became the director of forensic psychiatry training and a clinical assistant professor. Since January 2002, Dr. Scott has been chief of the division of psychiatry and the law at UC Davis. He is also psychiatric consultant to Sacramento County Jail and Napa State Hospital.

Dr. Scott's fellows have said the following: "In addition to Dr. Scott's ability to teach, he has an uncanny ability to make his trainees want to learn"…"Dr. Scott's style engenders so much sincerity and respect that you desire not to disappoint him and it is made all the more genuine in that he consistently leads by example. Not only does Dr. Scott incite a desire to learn and excel, he always meets your hard work with honest praise and appreciation"…"Dr. Scott has shown himself to be one of the most decent and honest human beings that I have ever met. He not only cares that his fellows learn material specific to forensic psychiatry but that they are truly happy as individuals"…"Because I believe that Dr. Scott performs the duty of Training Director above and beyond what would be considered standard practice, I nominate him for this award."

In recognition of this outstanding teaching in a fellowship program, the American Academy of Psychiatry and the Law presents this award to Dr. Charles Scott.

AMICUS AWARD

The Amicus Award is presented in recognition of devoted service and numerous contributions over many years to AAPL by a non-member of the Academy.

BARBARA E. MCDERMOTT, PhD

Dr. Barbara McDermott received her Bachelors Degree in nursing and her PhD in clinical psychology at the University of Cincinnati. She joined the faculty at Tulane University in 1988 and worked as a clinical psychologist at the Jefferson Parish Human Services Authority, as an applied researcher in the Office of Mental Health, as a consultant to the Forensic Division of Eastern Louisiana, and as a consultant to the Juvenile Court.

Dr. McDermott is currently a Professor in the Division of Psychiatry and the Law at UC Davis and works as Research Director at Napa State Hospital and as Forensic Consultant to the Sacramento County Jail Psychiatric Services. Since 1996, Dr. McDermott has co-authored at least 1 presentation at every annual meeting of the American Academy of Psychiatry and the Law. The topics have included juvenile offenders, prediction of juvenile violence, death penalty evaluations, release of insanity acquitees, confessions, female forensic inpatients, conditional release programs, chronically aggressive state hospital patients, assessment of malingering in jails, the aging forensic population and ethics of research on prisoners.

In recognition of all of Dr. McDermott's outstanding educational presentations at AAPL meetings over the last 12 years, the American Academy of Psychiatry and the Law presents the 2008 Amicus Award to Dr. Barbara McDermott. learn and excel, he always meets your hard work with honest praise and appreciation"…"Dr. Scott has shown himself to be one of the most decent and honest human beings that I have ever met. He not only cares that his fellows learn material specific to forensic psychiatry but that they are truly happy as individuals"…"Because I believe that Dr. Scott performs the duty of Training Director above and beyond what would be considered standard practice, I nominate him for this award."

In recognition of this outstanding teaching in a fellowship program, the American Academy of Psychiatry and the Law presents this award to Dr. Charles Scott.

DISTINGUISHED LECTURERS

Thursday, October 23

JOHN C. GUNN, CBE, MD, FRCPsych

Shipman: Is He A Special Case?

Professor John Gunn is Emeritus Professor of Forensic Psychiatry at the Institute of Psychiatry (IOP), King' College London. Professor Gunn is a significant founder of forensic psychiatry in the U.K. He was the Head of the Section of the Department of Forensic Psychiatry at the IOP from 1978 until his retirement in 2002. He worked at Bethlem Royal and Maudsley Hospital where he was active clinically and established a number of inpatient services. He participated in the Royal Commission on Criminal Justice from 1991 to 1993. He was an advisor on special committees for the House of Commons. He has served on governmental advisory committees such as those examining restricted patients and prison mental health care and research. He has been on Senior Committees of the Royal College of Psychiatrists. Professor Gunn worked on a volunteer basis to establish the Effra Trust, a hostel project for men with mental disorders leaving prison, and established the Gent Group, which aims to bring together national standards in forensic psychiatry in the U.K. He has been on the editorial staff of several respected psychiatric journals and remains editor of *Criminal Behaviour and Mental Health*. He has consulted in China, Japan, New Zealand, and to the APA. Professor Gunn has authored books and numerous peer-reviewed articles on violence, mental disorder and crime, and prison mental health care. He serves on the Parole Board of England and Wales. Professor Gunn has participated in several official governmental inquiries, including the inquiry into the Shipman case.

Friday, October 24

RICHARD J. BONNIE, LLB

The Political Dynamics of Mental Health Law Reform: The Virginia Experience

Mr. Bonnie is Harrison Foundation Professor of Medicine and Law, Professor of Psychiatry and Neurobehavioral Science, and Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia. He has published countless scholarly works over his career. His public service has included his roles as Secretary of the first National Advisory Council on Drug Abuse (1975- 80); chair of Virginia's State Human Rights Committee responsible for protecting rights of persons with mental disabilities (1979-85), and chief advisor for the ABA Criminal Justice Mental Health Standards Project (1981-88). Professor Bonnie has served as an advisor to the APA Council on Psychiatry and Law since 1979, received the APA's Isaac Ray Award in 1998 and a special presidential commendation in 2003 for his contributions to American psychiatry. He has also served on the MacArthur Foundation Research Network on Mental Health and the Law (1988-96) and is currently participating in MacArthur Foundation work on Mandated Community Treatment and a new Initiative on Neuroscience and Law. In 1991, Professor Bonnie was elected to the Institute of Medicine of the National Academies. He received the Yarmolinsky Medal in 2002 for his contributions to the IOM and the National Academies. In 2006 he was appointed as Chair of a Commission on Mental Health Law Reform at the request of the Chief Justice of Virginia. In 2007, he received the University of Virginia's highest honor, the Thomas Jefferson Award.

Saturday, October 25

RICHARD A. LEO, PHD, JD

Police Interrogation and False Confessions

Richard A. Leo, Ph.D., J.D. is an Associate Professor of Law at the University of San Francisco and formerly an Associate Professor of Psychology and Criminology at the University of California, Irvine. He is a leading, internationally recognized authority on police interrogation practices, false confessions, and wrongful convictions. He is the author four books, including of *Police Interrogation and American Justice* (Harvard University Press, 2008) and, with Tom Wells, of *The Wrong Guys: Murder, False Confessions and the Norfolk 4* (The New Press, 2008). His many articles have appeared in leading legal and scientific journals. Dr. Leo has won many awards including those for research excellence from the American Psychological Association, and the American Academy of Forensic Psychology. He has appeared in the media and his research has been cited by numerous appellate courts (including the U.S. Supreme Court). In the last 12 years, he has consulted on more than 900 cases of disputed interrogation and/or disputed confession in 45 states (as well as in Japan, Germany and Canada). He has testified as an expert witness more than 160 times in state, federal and military courts in 23 states. Dr. Leo has worked on many high profile cases involving false confessions, including the cases of Michael Crowe, Earl Washington, two of the Central Park Jogger defendants among others.

THURSDAY, OCTOBER 23, 2008

POSTER SESSION #1 — 7:15 AM – 8:00 AM/ 9:30 – 10:15 AM — **GRAND FOYER**

T1 ***Effects of Age Dementia on Restoration of Competence to Stand Trial***
Douglas R. Morris, MD, Columbia, SC
George F. Parker, MD, Indianapolis, IN

T2 ***Mandated Treatment of Dual Diagnoses in Native American Youth***
Christopher M. Davidson, MD, Sioux Falls, SD
Michael C. Harlow, MD, JD, Sioux Falls, SD
Umesh C. Chakunta, MD, (I) Sioux Falls, SD
Charles L. Scott, MD, Sacramento, CA

T3 ***Internet Chat Rooms: Who Solicits Children?***
Gregg R. Dwyer, MD, Columbia, SC
Donna M. Schwartz-Watts, MD, Columbia, SC
William Burke, PhD, (I) Summervile, SC

T4 ***Diagnostic Issues in a Historical Case of Lycanthropy***
J. Arturo Silva, MD, San Jose, CA
Douglas Tucker, MD, Berkeley, CA

T5 ***Pro re nata Medication: Effect on High Dose Calculus***
Tony Adiele, M.B., (I) Manchester, England

T6 ***Antipsychotic Medication Use in the Rhode Island Prison System***
Keelin A. Garvey, MD, Providence, RI
Ali Kazim, MD, Providence, RI
Bree Derrick, MA, (I) Cranston, RI
Erin Boyar, MS, (I) Craston, RI
Christine Ryan, PhD, (I) Cranston, RI

T7 ***Malingering PTSD for Service Connection- Is There a Correlation?***
Todd N. Palumbo, MD, Cincinnati, OH
Kathleen M. Chard, PhD, (I) Cincinnati, OH
Barbara Beimish, MA, (I) Cincinnati, OH

T8 ***Use of Technology in Law Enforcement Education: Simulated Hallucinations***
Jason G. Roof, MD, Sacramento, CA

T9 ***Recidivism Rates of Juveniles in Adult Correctional Systems***
Jessica Talley, MD, (I) Greenville, NC
Peter Ash, MD, Atlanta, GA

T10 ***Mentally Disordered? Sentencing Options Abroad***
Fintan Larkin, MB, (I) Berkshire, England

T11 ***Gender and the Experience of Providing Expert Testimony***
Aimee C. Kaempf, MD, Worcester, MA
Debra A. Pinals, MD, Worcester, MA
Ira Parker, PhD, (I) Worcester, MA
Prudence Baxter, MD, (I) Cambridge, MA

T12 ***Factors That Affect Recidivism In Jail Mental Health Diversion Programs***
Joseph D. Browning, MD, Atlanta, GA
Peter Ash, MD, Atlanta, GA
Amy R. Simon, JD, (I) Decatur, GA
Winston P. Bethel, BAS, JD, (I) Decatur, GA

OPENING CEREMONY — 8:00 AM - 10:00 AM — **GRAND 1**

T13 ***Reducing Inpatient Suicide Risk: Improving Observation Practices***
Jeffrey Janofsky, MD, Timonium, MD

COFFEE BREAK **GRAND FOYER**

A/V SESSION 10:15 AM - 12 NOON **GRAND I**

T14 An Antihero of Our Time: Mass Shooters, Who Are They?

Zachary B. Stroud, MD, Charleston, SC
Rikki Lynn Halavonich, MD, Charleston, SC
Susan C. Knight, PhD, (I) Charleston, SC
Leonard W. Mulbry, MD, Charleston, SC

DEBATE 10:15 AM - 12 NOON **CASCADE I**

T15 Treating DSPDs- A Waste Of Money?

Fintan Larkin, MB, BCh, BAO, MRCPsych, DPM, (I) Berkshire, England
Anthony Maden, MD, MRCPsych, (I) Berks, UK
Callum Ross, MB, BS, MRCPsych, (I) Berks, UK
Ian Cumming, MBBS, MRCPsych, (I) London, UK
Toby MacKinnon, MB, BS, MRCPsych, (I) Berks, UK

PANEL 10:15 AM - 12 NOON **CASCADE II**

T16 Risk Management Strategies in Correctional Psychiatry

Angeline A. Stanislaus, MD, St. Louis, MO
Anasseril E. Daniel, MD, Columbia, MO
David L. Vlach, MD, Kansas City, MO

PANEL 10:15 AM - 12 NOON **GRAND CRESCENT**

T17 Doing No Harm: Historical Lessons

Kenneth J. Weiss, MD, Bala Cynwyd, PA
Robert L. Sadoff, MD, Jenkintown, PA
Peter N. Barboriak, MD, PhD, Raleigh, NC
Andrew G. Nanton, MD, Durham, NC

PAPER SESSION #1 10:15 AM - 12 NOON **ELLIOT BAY**

T18 The Work Environment of Correctional Psychiatrists

Cecilia H. Leonard, MD, Syracuse, NY
James L. Knoll, MD, Syracuse, NY
Bruce B. Way, PhD, (I) Marcy, NY

T19 Jackson's Indiana: State Hospital Competence Restoration in Indiana

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

T20 Sell and the Legal System's Misconceptions about Psychiatry

Daniel M. Mayman, MD, Ann Arbor, MI
Melvin J. Guyer, PhD, JD, (I) Ann Arbor, MI
Craig A. Lemmen, MD, Ann Arbor, MI

LUNCH (TICKET REQUIRED) 12 NOON - 2:00 PM **GRAND II**

T21 Shipman: Is He A Special Case?

John Gunn, CBE, MD, FRCPsych, (I) Bromley, UK

PANEL 2:15 PM - 4:00 PM **GRAND I**

T22 Being the Victim: Beyond Sadism in Serial Sexual Murderers

James L. Knoll, MD, Syracuse, NY
Robert R. Hazelwood, M.S., (I) Manassas, VA
Scott Turpin, MD, Bridgewater, MA

PANEL 2:15 PM - 4:00 PM **CASCADE I**

T23 Isaac Ray Award Lecture: The AAPL Ethics Guidelines: What Makes Them Right?

Richard Rosner, MD, New York, NY
Robert Weinstock, MD, Los Angeles, CA
Richard J. Ciccone, MD, Rochester, NY

WORKSHOP — 2:15 PM - 4:00 PM — **CASCADE II**

T24 Racially Motivated Workplace Violence

Robert T.M. Phillips, MD, PhD, Annapolis, MD
Ezra E.H. Griffith, MD, New Haven, CT
William F. Blair, JD, (I) Brandon, MS

PANEL — 2:15 PM - 4:00 PM — **GRAND CRESCENT**

T25 Terrorism and Crisis Negotiation: UK Perspectives: International Relations Committee

Kenneth G. Busch, MD, Chicago, IL
Richard Taylor, MBBS, MRCPsych, Middlesex, UK
Ian Cumming, MBBS, MRCPsych, (I) London, UK
Fintan Larkin, MBChB, BAO, MRCPsych, (I) Berks, UK
John Hayward, FZS, (I) Oxon, UK

PANEL — 2:15 PM - 4:00 PM — **ELLIOTT BAY**

T26 Psychological Test in CST Assessments: Useful or Superfluous?

Gergory Sokolov, MD, Davis, CA
Douglas Mossman, MD, Dayton, OH
Patricia Zapf, PhD, (I) New York, NY

COFFEE BREAK — **4:00 PM - 4:15 PM** — **GRAND FOYER**

WORKSHOP — 4:15 PM - 6:15 PM — **GRAND I**

T27 Campus Risk Assessment: Challenges and Barriers

Kelley M. Adams, MD, Chapel Hill, NC
Eric B. Elbogen, PhD, (I) Chapel Hill, NC
Maureen Windle, PsyD, (I) Chapel Hill, NC
Winston Crisp, JD, (I) Chapel Hill, NC
Sally Johnson, MD, Chapel Hill, NC

WORKSHOP — 4:15 PM - 6:15 PM — **CASCADE I**

T28 Forensic Evaluations of Special Population Sex Offenders Sexual Offenders Committee

Gregg R. Dwyer, MD, EdD, Columbia, SC
Dean M. De Crisce, MD, Avenel, NJ
Paul J. Fedoroff, MD, Ottawa, ON, Canada
John M.W. Bradford, MB, MBChB, DPM, FFPsych, Brockville, ON, Canada
Fabian Saleh, MD, Boston, MA

PANEL — 4:15 PM - 6:15 PM — **CASCADE II**

T29 Forensic Sampler: Fires, Firesetters and Investigating Experts Liasion with Forensic Sciences Committee

Alan R. Felthous, MD, St. Louis, MO
Robert Weinstock, MD, Los Angeles, CA
Thomas P. Shefchick, B.S.E.E., P.E., (I) Sunnyvale, CA
Suzanne Yang, MD, Cleveland, OH
Carol Henderson, JD, (I) Gulfport, FL

WORKSHOP — 4:15 PM - 6:15 PM — **GRAND CRESCENT**

T30 Teaching Forensic Psychiatry: Not Whether, but When, What and How Much? Early Career Psychiatry Committee

Avram H. Mack, MD, Washington, DC
Thomas G. Gutheil, MD, Brookline, MA
Alyson Kuroski-Mazzei, DO, Chapel Hill, NC
Alan Newman, MD, Washington, DC
Jill C. Volin, MD, Chapel Hill, NC

RESEARCH IN PROGRESS #1 — 4:15 PM - 6:15 PM — **ELLIOTT BAY**

T31 Standardized Risk Assessment of Child Abuse: Influences on Judgement

Cheryl Regehr, PhD, (I) Toronto, ON Canada
Vicki LeBlanc, PhD, (I) Toronto, ON Canada
Aron Shlonsky, PhD, (I) Toronto, ON Canada
Marion Bogo, MSW, (I) Toronto, ON Canada

T32 ***The Stalking Harm: A New Guide To The Risk Management Of Stalking***

Graham D. Glancy, M.B, Ch.B., F.R.C., Psych, Etobicoke, ON Canada
Christine Hayos, MSW, RSW, (I) Ontario, Canada
Phillip J. Resnick, MD, Cleveland, OH
Debra A. Pinals, MD, Worcester, MA

T33 ***The Use of the COVR in a Forensic Inpatient Setting***

Barbara E. McDermott, PhD, (I) Sacramento, CA
Cameron D. Quanbeck, MD, Sacramento, CA
David Busse, MA, (I) Napa, CA
Kalynn Yastro, BA, (I) Napa, CA
Renoir Welch, BA, (I) Napa, CA
Charles L. Scott, MD, Sacramento, CA

T34 ***Functional Risk Measure in Forensic Services***

Michael Norko, MD, New Haven, CT
Michael Greenspan, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Josephine Buchanan, BA, (I) New Haven, CT

MOCK TRIAL 7:30 PM - 9:00 PM **GRAND I**

T35 ***Sell issues presented by the State of Utah v. Brian David Mitchell***

Jeffrey L. Metzner, MD, Denver, CO
Heidi Buchi, JD, (I) Salt Lake City, UT
Michael J. Finkle, JD, MBA, (I) Seattle, WA
The Honorable Edward Ross, (I) Bellingham, WA
James K. Wolfson, MD, Springfield, MO
Patrick W. Corum, JD, (I) Salt Lake City, UT

T1 EFFECTS OF AGE DEMENTIA ON RESTORATION OF COMPETENCE TO STAND TRIAL

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

EDUCATIONAL OBJECTIVE

Little is known about factors associated with successful restoration to competence (RTC) to stand trial. This presentation will attempt to advance this knowledge by highlighting recent research involving the relationship of age and diagnosis of dementia on RTC efforts.

SUMMARY

For a fair trial, criminal defendants must be able to understand the legal proceedings against them and assist an attorney in their defense. If the court determines that a defendant is lacking in at least one of these areas, he is found incompetent to stand trial (ICST) and hospitalized for restoration to competence (RTC). To better identify factors associated with successful RTC, we analyzed an Indiana Department of Mental Health and Addiction database of individuals admitted for RTC from 1988-2004. Having previously identified older age at admission as a negative predictor of RTC, we sought to determine if this relationship would remain after correcting for diagnosis of dementia. A multiple logistic regression model was created to evaluate the effects of admission age and diagnosis of dementia on RTC while holding other diagnostic and demographic measures constant. During the study period, 1380 individuals were referred to Indiana state hospitals for RTC. Forty-seven (3.4%) individuals were diagnosed with dementia; thirty-one (2.2%) were not diagnosed with dementia but were age 65 or older at admission. As expected, dementia was associated with a decreased probability of RTC. Increased age at admission remained a significant negative RTC predictor, even after correcting for diagnosis of dementia.

REFERENCES

Mossman D: Predicting restorability of incompetent criminal defendants. J Am Acad Psychiatry Law 35:34-43, 2007
Powchik P, Davidson M, Haroutunian V, et al: Postmortem studies in schizophrenia. Schizophrenia Bull 24(3):325-41, 1998

SELF ASSESSMENT QUESTIONS

1. Which of the following best describes the relationship of age at admission and diagnosis of dementia on state hospital restoration to competence (RTC) to stand trial?

a. Increased age, but not diagnosis of dementia, is associated with unsuccessful RTC.
b. Diagnosis of dementia, but not increased age, is associated with unsuccessful RTC.
c. Increased age, but not diagnosis of dementia, is associated with successful RTC.
d. Both increased age and diagnosis of dementia are independently associated with unsuccessful RTC.
e. Both increased age and diagnosis of dementia are independently associated with successful RTC.

ANSWER: d

2. Correlations of antemortem cognitive assessments and autopsy studies of elderly patients with schizophrenia deficits show:

a. Most elderly patients with schizophrenia show little evidence of significant cognitive dysfunction.
b. Most cases of dementia in schizophrenia can be attributed to Alzheimer's disease and other common dementing diseases.
c. Elderly patients with schizophrenia are not inordinately prone to development of Alzheimer's disease or to increased senile plaques or neurofibrillary tangle formation in the brain.
d. Schizophrenia cases as a group show prominent cholinergic deficits.

ANSWER: c

T2 MANDATED TREATMENT OF DUAL DIAGNOSES IN NATIVE AMERICAN YOUTH

Christopher M. Davidson, MD, Sioux Falls, SD
Michael C. Harlow, MD, JD, Sioux Falls, SD
Umesh C. Chakunta, MD, (I) Sioux Falls, SD
Charles L. Scott, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

To examine the relationship between substance use, mental illness, criminal behavior, and the role of traditional culture in Native American adolescents.

SUMMARY
Mental illness among American Indian adolescents is a public health crisis. In a study of Great Plains Native American youth, 23% met criteria for a mental illness, and 9% met criteria for two or more disorders. Studies indicate the most prevalent mental illnesses include depression, anxiety, alcohol abuse, and polysubstance dependence. While studies of mental illness in Native American adolescents have revealed high levels of psychiatric pathology, such studies are relatively few in number. The impact of Native American adolescent culture on respective mental illnesses has yet to be clearly defined. The comorbid Native American adolescent stressors of substance abuse, mental illness, and life frustrations manifest themselves in increased criminogenicity. This poster presents the findings of a preliminary investigation of the relationship between traditional values, substance use, criminal behaviors, and psychiatric diagnoses in 200 American Indian adolescents. The relationship between substance abuse disorders, criminal history, and psychiatric illness in Native American adolescents receiving judicially mandated substance abuse treatment will be examined. In this retrospective data analysis, study subjects' results on the Millon Adolescent Clinical Inventory (MACI) and the Substance Abuse Subtle Screening Inventory (SASSI), with criminal risk sub-scales, and the Michigan Alcohol Screening Test (MAST) will be correlated for significance.

REFERENCES
Whitbeck LB, Johnson KD, Hoyt DR, Walls ML: Prevalence and co-morbidity of mental disorders among American Indian children in the Northern Midwest. J Adolescent Health 39:427-434, 2006
Beauvais F: Cultural identification and substance use in North America - an annotated bibliography. Substance Use & Misuse 33(6):1315-1336, 1998

SELF ASSESSMENT QUESTIONS
1. In one study of Great Plains Native American adolescents what percentage met criteria for mental illness?
a. 1-10%
b. 10-20%
c. 20-30%
d. 30-40%
ANSWER: c

2. Which of the following psychological tests have scales that address the risk of criminal behavior?
a. MACI
b. SASSI
c. SASSI and MACI
d. None of the above
ANSWER: c

T3 **INTERNET CHAT ROOMS: WHO SOLICITS CHILDREN?**

Gregg R. Dwyer, MD, Columbia, SC
Donna M. Schwartz-Watts, MD, Columbia, SC
William Burke, PhD, (I) Summervile, SC

EDUCATIONAL OBJECTIVE
This presentation will inform attendees of the characteristics of persons who have used Internet chat rooms to solicit sex from others they believed were children. Implications for use of research findings in forensic evaluations, treatment planning, and developing public safety strategies will be presented.

SUMMARY
As benefits of the Internet have expanded in volume, variety, and accessibility, so has the potential for danger to those seeking its treasures. Such danger is particularly evident for children with their often trusting and inquisitive natures. Consider the Internet chat room where people can take on any persona they choose regardless of its connection to reality. A child entering such an environment becomes vulnerable to the manipulations of adults. A major television network has in recent years highlighted this danger by conducting police-like operations to catch adults using Internet chat rooms to solicit children for sexual purposes. Who are these adults with the frequent media label of "Internet Predators? Based on 107 cases, this research provides an answer to that question for one state initially, using publicly available data sources of the state's attorney general, corrections department, sex offender registry, and various media services. Additionally, as research-in-progress, study data will include up-to-date forensic evaluation results and dispositions for cases adjudicated or for which data is otherwise released. Besides basic demographics, information under study includes education, employment, general medical, mental health, criminal justice, and sex offense histories. Descriptive and inferential statistical results with associated forensic evaluation implications will be presented.

REFERENCES
Quayle E, Taylor M: Model of problematic internet use in people with a sexual interest in children. Cyber Psychology & Behavior 6(1):93-106, 2003
Wolak J, Finkelhor D, Mitchell KJ, Ybarra ML: Online "predators" and their victims. Myths, realities, and implications for prevention and treatment. Am Psychologist 63(2):111-28, 2008

SELF ASSESSMENT QUESTIONS
1. Based on published research, most victims of Internet-initiated sex crimes are from which age group?
a. 7-10 years
b. 10-13 years
c. 13-15 years
d. 15-17 years
ANSWER: c

2. From the research in progress study, what percentage of persons caught using Internet chat rooms to solicit sex from children was on the state's sex offender registry at the time of their chat room activity?
a. <5%
b. 10-20%
c. 20-40%
d. >50%
ANSWER: a

T4 **DIAGNOSTIC ISSUES IN AN HISTORICAL CASE OF LYCANTHROPY**

J. Arturo Silva, MD, San Jose, CA
Douglas Tucker, MD, Berkeley, CA

EDUCATIONAL OBJECTIVE
To provide an overview of lycanthropy; to introduce forensic-psychiatrists to the psychohistorical study of serial killing behavior; and to explore claims about lycanthropy and various diagnostic issues raised by the 19th century case of Spanish serial killer Manuel Blanco Romasanta.

SUMMARY
In this presentation we will focus on the case of 19th century serial killer Manuel Blanco Romasanta. We will explore in some detail the notion that Romasanta believed that he was a werewolf, that is, part man and part wolf. The phenomenon of lycanthropy, the belief in human-to-wolf transformations, will be explored from a variety of perspectives. We will first discuss beliefs about lycanthropy from both psychosociocultural and historical viewpoints. The idea that lycanthropy may be a metaphor of serial killing behavior prior to the twentieth century will be discussed. We will then provide an overview of lycanthropic beliefs and similar ideas from a psychiatric perspective. We will also discuss lycanthropic beliefs from various psychiatric-legal viewpoints. We will attempt to show that the multifaceted approach that we used in the analysis of serial killer Manuel Blanco Romasanta may be necessary if we hope to develop a comprehensive understanding of serial killing behavior. We will also make some recommendations for further research.

REFERENCES
Oates C: Metamorphosis and lycanthropy in Franche-Comte, 1521-1643, in Fragments for a History of the Human Body. Edited by Feher M. New York: Urzsone, 1989, pp 304-363
Berbell C, Ortega S: Psicopatas Criminales: Los Mas Importantes Asesinos en Serie Espanoles. Madrid: La Esfera de los Libros, 2003

SELF ASSESSMENT QUESTIONS
1. Lycanthropy
a. may be associated with psychotic symptoms
b. is a subset of therioanthropy
c. may involve beliefs unrelated to mental illness
d. a and c
e. a, b and c
ANSWER: e

2. Serial killing behavior has been most extensively and systematically studied
a. from a historical perspective
b. from a neuropsychiatric perspective
c. via criminological paradigms
d. via psychiatric paradigms
ANSWER: c

T5 PRO RE NATA MEDICATION: EFFECT ON HIGH DOSE CALCULUS

Tony Adiele, MB, (I) Manchester, England

EDUCATIONAL OBJECTIVE

High dose antipsychotic prescription may be associated with increased dangers for forensic psychiatry service users, hence heightening the responsibilities placed on their prescribers. This poster aims to increase awareness of the influence of the less known pro re nata antipsychotic prescription on high dose status of patients.

SUMMARY

Antipsychotic medication has revolutionized the treatment of mental disorders since the efficacy of chlorpromazine in the treatment "excitation and agitation states" was reported in 1950s. However too much of a good thing may not be that good. It has been suggested that one quarter of psychiatric in-patients receive high doses of antipsychotics. The figure may even be higher in forensic units. High dose antipsychotics lead to increased side effects, particularly akathisia which is associated with increased violence. There remains a dearth of studies on the influence and usefulness of routine *pro re nata* prescription. We performed a multi-point retrospective survey of prescription charts of all patients in the forensic unit. Percentages of all antipsychotics (against the British National Formulary maximal dose) were calculated and the sum of percentages of antipsychotic medication for each patient was analyzed to assess impact of *pro re nata* prescription. Of 99 patients surveyed (16 females and 83 males), 11.1% were regularly prescribed high dose antipsychotics. However when *pro re nata* prescription was taken into consideration, nearly a quarter of the patients were additionally prescribed high dose antipsychotics.

REFERENCES

Delay J, Deniker P, Harl JM: Utilisation en therapeutique psychiatrique d'une phenothiazine d'action centrale elective. Ann Med Psychol 110(2:1): 112-7, 1952

Harrington et al: The results of a multi-centre audit of prescribing of antipsychotic drugs for in-patients in the UK. Psychiatric Bull 26: 414-418, 2002

SELF ASSESSMENT QUESTIONS

1. Which of the following has been suggested as a good method for assessing high dose antipsychotic prescription?

a. Presence of side effects
b. Higher than maximal equivalent dose of chlorpromazine
c. Using the Percentage Method
d. Presence of neuroleptic malignant syndrome

ANSWER: c

2. What proportion of psychiatric inpatients currently receive high dose medication either regularly or with additional *pro re nata* prescription?

a. Less than 5%
b. Less than 10%
c. Over 50%
d. About 25%

ANSWER: d

T6 ANTIPSYCHOTIC MEDICATION USE IN THE RHODE ISLAND PRISON SYSTEM

Keelin A. Garvey, MD, Providence, RI
Ali Kazim, MD, Providence, RI
Bree Derrick, MA, (I) Cranston, RI
Erin Boyar, MS, (I) Craston, RI
Christine Ryan, PhD, (I) Cranston, RI

EDUCATIONAL OBJECTIVE

To provide data on trends in antipsychotic prescribing in one state's prison system; to highlight potential off-label use of antipsychotic medications in the correctional system; and to compare antipsychotic prescribing trends across a variety of demographic and criminal history variables.

SUMMARY

Background: Significant changes in the United States' mental health system over the last several decades have transferred to the criminal justice system a significant portion of the responsibility to provide mental health services to the nation's mentally ill. Despite this reality, there is limited data on the treatment provided in correctional facilities, including the use of antipsychotic medications. Methods: Antipsychotic prescribing practices in Rhode Island's

only state prison were examined over a one-year period, for a total sample size of 330 inmates. Specific medications prescribed were obtained from a review of pharmacy data, and analyzed with respect to demographic variables, diagnosis, and criminal history. Results: 69.30% of sentenced inmates prescribed an antipsychotic medication during the specified study period had been assigned a psychotic or bipolar diagnosis by a prescribing physician, compared with 30.70 % who had not received such a diagnosis. Inmates with nonviolent criminal histories were just as likely to receive antipsychotic prescriptions without a bipolar or psychotic diagnosis as inmates with histories of violent crime (χ^2= 0.33, df= 1, p= 0.567). A comparison of antipsychotic prescriptions across several demographic variables revealed significance, with 88.18% of female inmates prescribed atypical antipsychotics exclusively vs. 31.02% of male inmates receiving only this class (χ^2= 95.27, df= 1, p< 0.001). Similarly, 59.47% of white inmates received atypical antipsychotic medications exclusively compared with 37.50 % of non-white inmates (χ^2= 15.31, df= 1, p< 0.001). There was no difference in age between inmates prescribed atypical antipsychotic medications exclusively (mean= 36.55, SD= 8.43) and those prescribed typical antipsychotics or a combination of both (mean= 35.25, SD= 8.98), with p= 0.179. Conclusions: Nearly one third of Rhode Island inmates prescribed antipsychotics have not been assigned a psychotic or bipolar diagnosis by a prescribing physician, highlighting a possible trend toward off-label prescribing that does not appear to be linked to criminal history. Trends toward differential prescribing across race and gender, highlighted in other state prison systems, can also been seen in Rhode Island, though differences across age ranges were not seen here.

REFERENCES

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Lamb HR, Weinberger LE: The shift of psychiatric inpatient care from hospitals to jails and prisons. J Am Acad Psychiatry Law 33(4): 529-534, 2005

SELF ASSESSMENT QUESTIONS

1. What 2 demographic variables were most closely associated with being prescribed atypical antipsychotic medications exclusively?

a. Hispanic, female
b. Age <40, female
c. Caucasian, female
d. Caucasian, male
e. Age <40, male

ANSWER: c

2. This study's demographic findings were similar to antidepressant prescribing data from the following state's correctional system:

a. Texas
b. Iowa
c. Florida
d. Massachusetts
e. California

ANSWER: a

T7 **MALINGERING PTSD FOR SERVICE CONNECTION – IS THERE A CORRELATION?**

Todd N. Palumbo, MD, Cincinnati, OH
Kathleen M. Chard, PhD, (I) Cincinnati, OH
Barbara Beimish, MA, (I) Cincinnati, OH

EDUCATIONAL OBJECTIVE

A diagnosis of PTSD can result in service connection through the Veteran's Administration hospital system. Due to this system of service connection and possible financial gain, malingering symptoms may occur. This poster will attempt to look at this possibility by analyzing specific test measures for a group of veterans.

SUMMARY

The relationship between service connection status and malingering has long been a concern for clinicians attempting to diagnose and treat posttraumatic stress disorder (PTSD) in patients presenting at Veteran's Administration hospitals. The service connection paradigm pays patients a portion of income based on a percentage that is meant to reflect the patient's degree of impairment. A portion of patients seeking care may already be service connected to a degree and they may not be seeking to change their status, while others may be seeking initial service connection or an increase in service connection amount. In this study 154 male patients receiving residential treatment

for PTSD at a VA hospital were evaluated before and after completing seven weeks of intensive cognitive therapy for PTSD. The Clinician Administered PTSD Scale (CAPS) and the PTSD Checklist (PCL) were administered to patients at pre and post treatment. Scores on both measures relative to service connection status were evaluated using regression analyses to determine the effect that service connection has on clinician reported and paper and pencil measures of PTSD before and after treatment. Results of these analyses and implications of the findings will be discussed in the poster.

REFERENCES

Hall RC, Hall RC: Malingering of PTSD: forensic and diagnostic considerations, characteristics of malingerers and clinical presentations. J Forensic Sciences 3:717-725, 2007
Freeman T, Powell M, et al: Measuring symptom exaggeration in veterans with chronic posttraumatic stress disorder. Psychiatry Research doi:10.1016/j.psychres.2007.04.002, 2008

SELF ASSESSMENT QUESTIONS

1. What is the estimated lifetime prevalence of PTSD in the general adult population?
ANSWER: 6.8%

2. The CAPS-1 (Clinician-Administered PTSD Scale) was intended to assess symptoms of PTSD
a. exclusively for current trauma
b. for any lifetime occurrence of trauma
c. both
ANSWER: both

T8 USE OF TECHNOLOGY IN LAW ENFORCEMENT EDUCATION: SIMULATED HALLUCINATIONS

Jason G. Roof, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

Mental health professionals will be introduced to a novel use of technology designed to educate law enforcement officers about mental illness. This project will provide an enhanced educational experience for law enforcement to understand and better interface with mentally ill individuals.

SUMMARY

Law officers are often the first professionals to make contact with unstable mentally ill individuals. Law enforcement programs such as "The Crisis Intervention Team" started in Memphis, Tennessee, and California's Commission on Peace Officer Standards and Training (POST) course entitled "Police Response to People with Mental Illness or Developmental Disability" have educated officers about mental illness and allowed development of "a more intelligent, understandable, and safe approach to mental crisis events." When law officers become familiar with characteristics of mentally ill individuals, methods which reduce risk of injury both to the mentally ill individual and the law officer are more likely to be utilized in the field. While multimedia tools employing non-interactive audio, video and text are mainstays in the field of education, innovative uses of technology are available to facilitate an improved understanding of mental illness. One such innovative use of technology is an accurate simulation of auditory hallucination. Law officers who participate will increase their understanding of psychiatric symptomatology and mental illness on a personal level and be more likely to utilize this knowledge in the field based on the novelty of their personalized experience. Questionnaires will be administered before and after the experience to measure effect.

REFERENCES

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Compton MT, Esterberg ML, McGee R, Kotwicki RJ, Oliva JR: Brief reports: crisis intervention team training: changes in knowledge, attitudes, and stigma related to schizophrenia. Psychiatr Serv 57(8):1199-202, 2006

SELF ASSESSMENT QUESTIONS

1. What is the most common type of hallucination in a mentally ill population?
ANSWER: Auditory hallucination.

2. If an auditory hallucination issues commands, what is the most common theme?
ANSWER: Injury to self

T9 RECIDIVISM RATES OF JUVENILES IN ADULT CORRECTIONAL SYSTEMS

Jessica Talley, MD, (I) Greenville, NC
Peter Ash, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE

To become familiar with data on the recidivism rates of juveniles placed in adult correctional facilities as well as the methodological difficulties associated with the research.

SUMMARY

With studies showing increased recidivism among juveniles placed in an adult correctional system, the transfer of juveniles to adult court has become more of a topical and controversial issue. However, these studies are not without methodological flaws. There is difficulty matching youth in the adult system with youth retained in the juvenile justice system and selection bias can become an issue as youth in the adult system are often considered to be more violent offenders. North Carolina remains one of only a couple of states that automatically transfer all 16- and 17-year-olds to the adult justice system. This poster will examine the recidivism data of North Carolina juveniles placed in the adult correctional system and compare it to data previously obtained in other states.

REFERENCES

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North Carolina Sentencing and Policy Advisory Commission. Correctional Program Evaluation: Offenders Placed on Probation or Released from Prison in Fiscal Year 2001/02. http://www.nccourts.org/courts/crs/councils/spac. April 2006.

SELF ASSESSMENT QUESTIONS

1. Regarding juveniles placed in adult correctional facilities, what do the recidivism data show?
ANSWER: Generally, higher rates of recidivism are seen in youth placed in adult correctional facilities than in those placed in juvenile facilities.

2. What types of methodological problems make studying the recidivism rates of youth placed in adult correctional facilities difficult?
ANSWER: Matching youth in the adult system with youth retained in the juvenile system; and selection bias of youth in the adult system.

T10 MENTALLY DISORDERED? SENTENCING OPTIONS ABROAD

Fintan Larkin, MB, (I) Berkshire, England

EDUCATIONAL OBJECTIVE

Sentencing approaches to mentally disordered offenders vary considerably. This poster examines systems in place in England and Holland. This poster should help improve forensic psychiatrists' knowledge of sentencing approaches and outcomes, and may be of particular relevance to those who wish to contribute to developments in their own jurisdictions.

SUMMARY

There are many approaches to sentencing mentally disordered offenders, and results are mixed. Forensic psychiatrists should be aware of policies and their advantages and disadvantages not only in their own jurisdictions, but also in others, in case there are lessons to be learned. This poster compares and contrasts systems in place in two European countries: England and Holland. This poster should help improve forensic psychiatrists' knowledge of sentencing approaches and outcomes and may be of particular relevance to those who wish to contribute to changes or developments in their own jurisdictions. The history of the Dutch (Terbeschikkingstelling) TBS system, and the current UK system of legislation and management are discussed. There are sentencing differences, e.g., the Dutch approach includes different lengths of correctional sentence dependent upon the crime and level of responsibility determined at sentencing, followed automatically by compulsory hospital treatment with no defined end date. The English system uses a correctional or health service choice at the time of sentencing. It retains an option to move from the prison placement to a hospital placement when necessary. There are also service provision differences, which are also discussed.

REFERENCES

Feeney A: Dangerous severe personality disorder. Advances in Psychiatric Treatment 9: 349-358, 2003
De Ruiter C, Tresteman, RL: Prevalence and treatment of personality disorders in Dutch forensic mental health services. J Am Psychiatry Law 35:1:92-97, 2007

SELF ASSESSMENT QUESTIONS

1. In Holland a mentally disordered offender who receives a typical TBS disposal:

a. receives mental health treatment for a specified period of time in the hospital before completing their sentence in prison.
b. receives mental health treatments in the hospital until they are deemed sufficiently well to complete their punishment portion of the sentence in prison.
c. receives all their mental health treatments in prison, which counts towards their sentence as time served.
d. usually serves a punishment period of the prison sentence before being transferred to the hospital where they will remain until they are deemed well enough, and have demonstrated sufficient risk reduction to be gradually released back into the community.

ANSWER: d

2. In England, mentally disordered offenders:

a. who receive any institutional sentence must, prior to release eligibility and once deemed well enough to do so, completed a prison correctional portion.
b. can be sentenced directly to a hospital disposal, bypassing the prison system entirely, for mental illness only (but not if the diagnosis is solely a personality disorder).
c. who commits serious offenses, and whose only diagnosis is personality disorder, can receive hospital disposals/sentences that require no time served in the prison system before release to the community.
d. who receive sentences (or are transferred for treatment) to hospital institutions are automatically restricted (i.e. they cannot be discharged back to the community without involvement of the Ministry of Justice).

T11 GENDER AND THE EXPERIENCE OF PROVIDING EXPERT TESTIMONY

Aimee C. Kaempf, MD, Worcester, MA
Debra A. Pinals, MD, Worcester, MA
Ira Parker, PhD, (I) Worcester, MA
Prudence Baxter, MD, (I) Cambridge, MA

EDUCATIONAL OBJECTIVE

By attending this poster session, participants will gain insight into how the experience of providing expert witness testimony varies by gender.

SUMMARY

Testifying is an essential and often anxiety-provoking aspect of practicing forensic psychiatry and forensic psychology. Literature has shown that women and men may experience their interactions within the legal system and their work as forensic experts differently. Specifically, women experts are more likely than their male counterparts to perceive sexual bias in the medico-legal context. Reasons for this discrepancy remain unclear. Studies of courtroom interaction have found that female attorneys report more frequent exposure to courtroom incivility and gender-based inappropriate behavior than their male counterparts. The goal of this study is to determine if this observation holds true for mental health experts. The authors suspect that, like female attorneys, female psychiatry and psychology expert witnesses will report being subject to courtroom incivility more commonly than male experts. The hypothesis is that female mental health experts are exposed to higher rates of courtroom incivility and higher levels of anxiety and self-criticism related to testimony. This study will provide insight into factors significant for expert witnesses of both genders to be familiar with and identify areas of focus for forensic psychology and forensic psychiatry training to help improve practice satisfaction and effectiveness.

REFERENCES

Ednie KJ: Challenges for women in forensic psychiatry New Direct Mental Health Serv 69:43-8, 1996
Price M, Recupero PR, Strong DR, et al: Gender differences in the practice patterns of forensic psychiatry experts. J Am Acad Psychiatry Law 32:250-8, 2004

SELF ASSESSMENT QUESTIONS

1. Surveys of professionals in fields related to forensic psychiatry have shown

a. Women consistently perceive more gender bias than men.
b. Men consistently perceive more gender bias than women.
c. Men and women consistently perceive equal amounts of gender bias.

ANSWER: a

2. Which of the following statements are true? In a survey of AAPL members published in 2004 by Price et al.
a. Women were shown to perform fewer categories of evaluation than men.
b. Women were shown to do less criminal work than men.
c. Gender was not a significant factor in determining hourly rate.
d. 80% of women surveyed thought gender was a consideration in the selection of an expert.
e. All of the above
ANSWER: e

T12 **FACTORS THAT AFFECT RECIDIVISM IN JAIL MENTAL HEALTH DIVERSION PROGRAMS**

Joseph D. Browning, MD, Atlanta, GA
Peter Ash, MD, Atlanta, GA
Amy R. Simon, JD, (I) Decatur, GA
Winston P. Bethel, BAS, JD, (I) Decatur, GA

EDUCATIONAL OBJECTIVE
To describe factors that influence recidivism in jail mental health diversion programs.

SUMMARY
The goal of a jail diversion program is to divert mentally ill offenders from the criminal justice system to the mental health system and decrease recidivism. A variety of strategies have been employed to reduce recidivism, but little data exists on what strategies are effective in reducing re-entrance into the criminal justice system. The DeKalb Diversion Treatment Court (DTC), a pre-conviction mental health diversion program in Metro Atlanta, Georgia (DeKalb County), has been in operation since 2001. Data show that recidivism in clients served has been reduced from the program's early years (2001-2003) and 2007. This study examines the difference in recidivism rates between those years in DeKalb County and also examines what variables are associated with the change. Information about what strategies the courts use to reduce recidivism will be collected from the DTC as well as from a literature review. This data can provide other jail diversion programs throughout the country with valuable information on how to maximize service and improve efficiency.

REFERENCES
Hoff RA, Baranosky MV, Buchanan J, Zonana H, Rosenheck RA. The effects of a jail diversion program on incarceration: a retrospective cohort study. J Am Acad Psychiatry Law 27(3):377-386, 1999
Steadman HJ, Naples M: Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. Behav Sci Law 23(2):163-170, 2005

SELF ASSESSMENT QUESTIONS
1. What are the 3 main goals of diverting mentally ill defendants away from criminal sanctions?
ANSWER: Decreased recidivism, decreased cost, and decreased morbidity from mental illness.

2. What is the major weakness of studies on the effectiveness of jail diversion?
ANSWER: Very few studies use randomized control groups to assess intervention effects.

T13 **OPENING CEREMONY**
PRESIDENT'S ADDRESS - REDUCING INPATIENT SUICIDE RISK: IMPROVING OBSERVATION PRACTICES

Jeffrey Janofsky, MD, Timonium, MD

EDUCATIONAL OBJECTIVE
Participants will understand how a human factors approach can improve inpatient observation practices, and can reduce potential critical errors that could lead to completed inpatient suicide.

SUMMARY
Medical errors can best be reduced by focusing on systems improvements rather than individual provider mistakes. One such approach applies human factors analysis to health care systems. Since 1996, The Joint Commission has required that hospitals report reviewable sentinel events as a condition of maintaining accreditation. Inpatient suicide has consistently been the most common sentinel event reported to The Joint Commission. The Joint Commission emphasizes the need for around-the-clock observation for inpatients assessed as at high risk for suicide. However, there is sparse literature on the observation of psychiatric patients, and no systematic studies or recommendations for best practices. There is not even agreement as to what to name or how to describe various patient observation levels. The author describes how Failure Modes and Effects Analysis (FMEA) was used proac-

tively by an inpatient psychiatric treatment team to improve psychiatric observation practices by identifying and correcting potential observation process failures. FMEA risk reduction strategies can be shared in detail across institutions, without the fear of legal discoverability or litigation associated with sentinel event analysis. Collection and implementation of specific and effective patient observation risk reduction strategies across health care systems will be necessary to discover best practices and to reduce inpatient suicides.

REFERENCES:

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SELF ASSESSMENT QUESTIONS

1. Medical errors can best be reduced by
ANSWER: focusing on system improvements

2. An adverse event is
ANSWER: an injury caused by medical management

T14 AN ANTIHERO OF OUR TIME: MASS SHOOTERS, WHO ARE THEY?

Zachary B. Stroud, MD, Charleston, SC
Rikki Lynn Halavonich, MD, Charleston, SC
Susan C. Knight, PhD, (I) Charleston, SC
Leonard W. Mulbry, MD, Charleston, SC

EDUCATIONAL OBJECTIVE

To look at several examples of mass shooters and try to understand what drives them to kill; what are their similarities; and what mental illnesses are most common to them.

SUMMARY

Following the Columbine shootings in 1999, the Secret Service and the Department of Education published a report based on previous school shootings that attempted to identify patterns in these shooters to help with the prevention of future attacks. As expected, there was no absolute logarithm found among these individuals. There were, however, certain patterns of behavior and mental health issues that surfaced more than others, most notably depression, easy access to firearms, multiple references to previous shooters, and the mentioning of their future crimes to other individuals. Through the use of video, pictures, and other media, we would like to examine some selected individual shooters who exhibit the most common patterns noted in the report. Our session will focus heavily on Charles Whitman, Kimveer Gill, and Robert Hawkins but will include others as well.

REFERENCES

Newman K, Fox C, Roth W, Mehta J, Harding D: Rampage: The Social Roots of School Shootings. New York: Basic Books, 2005
Lieberman J: The Shooting Game: The Making of School Shooters. Cabin John, MD: Seven Locks Press, 2006

SELF ASSESSMENT QUESTIONS

1. Which of the following is not a major behavior pattern seen in mass shooters?
a. obsession with or easy access to guns
b. history of mental illness, most notably depression
c. persecutory delusions
d. mentioning intent and plan of crime to other people before they act
ANSWER: c

2. List the four individuals below in chronological order (oldest to newest) of when they perpetrated their crimes
a. Robert Hawkins
b. Seung-Hui Cho
c. Charles Whitman
d. Eric Harris and Dylan Klebold
ANSWER: c, d, b, a

T15 TREATING DSPDS - A WASTE OF MONEY?

Fintan Larkin, MB, BCh, (I) Berkshire, England
Anthony Maden, MD, MRCPsych, (I) Berks, UK
Callum Ross, MB, BS, MRCPsych, (I) Berks, UK
Ian Cumming, MB,BS, MRCPsych, (I) London, UK
Toby MacKinnon, MB, BS, (I) Berks, UK

EDUCATIONAL OBJECTIVE
The management of severely personality-disordered individuals is problematic in many ways. This debate will expand attendees' knowledge of the legal, ethical, service, and practical issues, and the pros and cons of the current, and previous, UK approaches.

SUMMARY
Managing severely personality-disordered patients who have offended, whether through correctional institutions, or health care approaches, is enormously resource hungry. It raises issues around personal and criminal responsibility, ability to consent to or refuse treatments, and powers of governments to detain based on perceived risks rather than reactively to completed and convicted offenses. Forensic psychiatrists remain divided on whether they have a role at all, and if they do, on which are the best approaches. Funding departments are concerned about the costs involved. Different countries have taken very different approaches to similar problems.
Professor A. Maden and Dr. F. Larkin will debate the issues against Dr. I. Cumming and Dr. C. Ross. All four forensic psychiarists have considerable experience with this group of patients: three currently work in a maximum security hospital's Dangerous Severe Personality Disorder Service, with the fourth regularly working in a maximum security prison setting. The debate will cover the above issues and include discussion on previous government strategies, other government's approaches, and what is known about the costs, benefits and outcomes of each.

REFERENCES
Barrett B, Byford S: Collecting service use data for economic evaluation in DSPD populations. Brit J Psychiatry 190: s75-s78 doi: 10.1192/bjp.190.5s75, 2007
Griffith E, Delphin M, Norko M: An American cultural view of the British DSPD proposals. J Am Acad Psychiatry Law 32:124-131, 2004

SELF ASSESSMENT QUESTIONS
1. Do psychiatrists have any business treating personality disordered patients?
ANSWER: There is limited evidence of efficacy of treating and debate about the quality of that evidence. One team will argue that there is no evidence. The other that the evidence is limited, but promising. There will also be argument about ethical issues and whether they are sufficiently strong to transcend any notion of deciding based on efficacy alone.

2. Does more money spent now reduce the lifetime costs on the taxpayer of managing this group?
ANSWER: There is limited evidence on cost effectiveness in both the short and long term, and debate about the reliability of that evidence. One team will argue that it is a waste of limited resources that should be better spent elsewhere. The other will argue that even with finite resources, proper resourcing and targeting of treatments will save the taxpayer money, an issue of interest to a variety of agencies and policy makers.

T16 RISK MANAGEMENT STRATEGIES IN CORRECTIONAL PSYCHIATRY

Angeline A. Stanislaus, MD, St. Louis, MO
Anasseril E. Daniel, MD, Columbia, MO
David L. Vlach, MD, Kansas City, MO

EDUCATIONAL OBJECTIVE
Learn to identify situations with high risk for negative clinical outcome in the correctional setting and manage them effectively using the tools available within the correctional system.

SUMMARY
There has been a progressive increase in the number of seriously mentally ill inmates in correctional settings. In fact, the prisons are referred to by the media as the mental asylums of the twenty-first century. This change has resulted in the need for provision of adequate psychiatric care in the prisons, with emphasis on the prevention of negative outcomes like suicide or homicide from inadequate mental health care. Correctional psychiatrists face the challenge of providing adequate psychiatric care within the punitive environment of a correctional facility. In this panel presentation, the three presenters will address risk management strategies in correctional psychiatry. Anasseril Daniel, M.D. will address risk factors for suicide in prison along with identification of early signs and their effective management using the tools available within the correctional system to reduce the risk of suicide. David

Vlach, M.D. will address the problem of prolonged segregation placement of the seriously mentally ill in prison and the challenges and solutions for management of their psychiatric and behavioral problems within the restraints of the segregation unit. Angeline Stanislaus, M.D. will address the issue of involuntary administration of psychotropic medications in prisons and discuss the associated legal, clinical, and ethical issues.

REFERENCES

Daniel AE: Preventing suicide in prison – a collaborative responsibility of administrative, custody and clinical staff. J Am Acad Psychiatry Law 34:165-75, 2006
Vlach DL, Daniel AE: Evolving toward equivalency in correctional mental health care – a view from the maximum security trenches. J Am Acad Psychiatry Law 35:436-8, 2007

SELF ASSESSMENT QUESTIONS

1. Characteristics of offenders who attempt suicide in prisons are likely to be:
a. property offenders
b. serving less than ten years in prison
c. suffering from depression
d. experiencing significant psychosocial stressors
e. all of the above
ANSWER: e

2. The landmark case that addressed the issue of involuntary administration of psychotropic medication in prison is:
a. Farmer v. Brennan
b. Ruiz v. Estelle
c. Washington v. Harper
d. Vitek v. Jones
ANSWER: c

T17 **DOING NO HARM: HISTORICAL LESSONS**

Kenneth J. Weiss, MD, Bala Cynwyd, PA
Robert L. Sadoff, MD, Jenkintown, PA
Peter N. Barboriak, MD, PhD, Raleigh, NC
Andrew G. Nanton, MD, Durham, NC

EDUCATIONAL OBJECTIVE

The attendee will develop a deeper understanding of the historical trends that shaped forensic practice, in a way that will enhance sensitivity to the harm we may do inadvertently to the subjects of our work.

SUMMARY

Psychiatrists have an ethical duty to "do no harm" to patients; but does this extend to forensic evaluations and correctional settings? Removing the mentally ill from jails and almshouses and into therapeutic environments was a major goal of pioneers such as Dorothea Dix and Isaac Ray. But in the century that followed, questions arose as to whether our methods—which included restricting patients' freedom—were doing more harm than good. Based on Dr. Sadoff's scholarship in fulfilling the APA's 2006 Isaac Ray Award, the panel will explore the roots of forensic psychiatric ethics and practices and trace the development of key themes. These include the right to treatment and to refuse it, civil commitment, correctional psychiatry and informed consent. The panelists will explore ethical differences in forensic versus clinical work, including role, agency, and the pursuit of truth versus health. Residual issues include invasive brain imaging, medications with serious side effects, the number of mentally ill in our jails, and forcible administration of drugs to restore competency in legal proceedings and executions. Ultimately, we will examine how our evolved practices, in contrast with those of the nineteenth century, have realized a robust ethical framework.

REFERENCES

Appelbaum, PS: A theory of ethics for forensic psychiatry. J Am Acad Psychiatry Law 25:233-47, 1997
Ray, I: Project of a law for determining the legal relations of the insane. Am J Insanity 7:215-34, 1851

SELF ASSESSMENT QUESTIONS

1. What is an important similarity in society's disposition of the chronically mentally ill between the nineteenth and twenty-first centuries?
ANSWER: The criminalization of the mentally ill and the use of jails instead of asylums.

2. What was the ethical basis of Isaac Ray's civil commitment "project"?
ANSWER: That doctors and patients' families were on the side of doing what was in the patient's overall best interest.

T18 THE WORK ENVIRONMENT OF CORRECTIONAL PSYCHIATRISTS

Cecilia H. Leonard, MD, Syracuse, NY
James L. Knoll, MD, Syracuse, NY
Bruce B. Way, PhD, (I) Marcy, NY

EDUCATIONAL OBJECTIVE
Participants will learn about the evolution of the concept of vicarious traumatization in various professions. Participants will be familiar with the range of manifestations of vicarious traumatization. Participants will be able to analyze the subjective reports of correctional psychiatrists and compare those working in prisons with those working in jails.

SUMMARY
The forensic clinician must be able to maintain a healthy attitude toward work in order to provide a consistent and competent clinical presence. Therefore, it is imperative that the clinician make conscious efforts to recognize and avoid professional burnout. "Compassion fatigue" and "vicarious traumatization" are terms used to describe the negative emotional and cognitive impact of the therapeutic engagement on therapists. Correctional and forensic psychiatry have been slow to investigate the phenomenon. This is in spite of the recommendations of an AAPL Presidential Address in 2002 that forensic psychiatry should increase attention to the effects of occupational stress. This scientific paper session will discuss the results of a study conducted at the 37th Annual AAPL Meeting in 2007. The study: "A Survey of Work Environment Attitudes Among Correctional Psychiatrists," was the winner of the Richard Rosner Award for best research paper by a forensic fellow. Results suggesting potential solutions for preventing burnout will be discussed, and audience participation will be solicited.

REFERENCES
Thomas RB, Wilson, JP: Issues and controversies in the understanding and diagnosis of compassion fatigue, vicarious traumatization, and secondary traumatic stress disorder. Int J Emerg Ment Health 6(2): 81-92, 2004
Nurse, J, Woodcock P, Ormsby J: Influence of environmental factors on mental health within prisons: focus group study. Brit Med J, 30: 1-5, 2003

SELF ASSESSMENT QUESTIONS
1. Vicarious traumatization is a common in which of the following occupations?
a. Police Officers
b. Nurses
c. Therapists of Holocaust Survivors
d. Therapists of Violent Sexual Predators
e. All of the above
ANSWER: e

2. Which of the following is a synonym for vicarious traumatization?
a. Compassion fatigue
b. Type II countertransference
c. Secondary Traumatic Stress Reaction
d. Burnout
e. All of the above
ANSWER: e

T19 JACKSON'S INDIANA: STATE HOSPITAL COMPETENCE RESTORATION IN INDIANA

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

EDUCATIONAL OBJECTIVE
There is relatively little research on restoration to competence (RTC) to stand trial. Through discussion of a large study of individuals hospitalized for RTC, this presentation will highlight the state of RTC research, trends in referrals for RTC, and advances in identifying factors associated with RTC success or failure

SUMMARY
Restoration to competence (RTC) of mentally disordered defendants has become increasingly important for state hospitals. In Indiana, most RTC admissions are sent to one primarily forensic state hospital, but many are admitted to other state hospitals. A state 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. Regression models were developed to identify factors associated with RTC success. Analysis of 1,475 RTC admissions showed increased annual

admissions over the study period. While the forensic hospital restored a higher percentage of individuals than the other state hospitals, the percentage of RTC success decreased over time in all hospitals. Admission to the forensic hospital, female gender, and mood disorder diagnosis were associated with increased restoration success. Older age, psychotic disorder, and mental retardation diagnoses were associated with a decreased likelihood of restoration. Race was not significantly associated with RTC at six months, but white defendants were less likely to be restored within one year.

REFERENCES

Mossman D: Predicting restorability of incompetent criminal defendants. J Am Acad Psychiatry Law, 35:34-43, 2007
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

SELF ASSESSMENT QUESTIONS

1. Barrier(s) to competence restoration research include?
a. Additional safeguards required by institutional review boards (IRBs) and federal guidelines for research involving "prisoners"
b. Obtaining adequate informed consent
c. Difficulty developing research protocols that minimize potential confounding variables
d. Difficulty developing clear outcome measures that determine success or failure of proposed interventions
e. All of the above
ANSWER: e

2. Which of the following factors is/are associated with decreased restoration to competence (RTC) success?
a. Psychotic disorder diagnosis
b. Mental retardation diagnosis
c. Older age
d. Non-African-American ethnicity
e. All of the above
ANSWER: e . These factors have all been associated with decreased RTC in recent studies.

T20 **SELL AND THE LEGAL SYSTEM'S MISCONCEPTIONS ABOUT PSYCHIATRY**

Daniel M. Mayman, MD, Ann Arbor, MI
Melvin J. Guyer, PhD, JD, (I) Ann Arbor, MI
Craig A. Lemmen, MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE

This presentation will encourage thoughtful reflection on the jurisprudence related to involuntary antipsychotic medication and suggest reasons for courts' misconceptions about psychiatry, psychiatric medications, and the mentally ill.

SUMMARY

Courts in the United States have been quite ambivalent—at best—about involuntary antipsychotic medications. Jurists have equated their use with electroconvulsive therapy, psychosurgery, and even torture. Legal scholarship and opinions have referred to antipsychotic medications as "mind-altering drugs" and "chemical straightjackets" and their effects as "synthetic sanity" and "artificial competency." They are seemingly imbued with the power of mind control, to "change thoughts." The Supreme Court reluctantly sanctioned involuntary medication for the sole purpose of restoring trial competency in Sell v. United States and provided a standard for the court to follow when balancing individual and government interests. In this three part presentation, the authors will first briefly review the Sell decision, its antecedents, and an overview of its legal progeny. Next, each of the four Sell factors will be examined in light of subsequent Appellate Court opinions to clarify issues such as the standard of proof required and the standard of appellate review. In the final section, the authors will argue that Sell is a useful lens through which longstanding misconceptions in the legal field about psychiatry, psychiatric patients and diagnoses, and antipsychotic medications can be viewed. Issues addressed include the recent conflation of antipsychotic medications with the death penalty; overlooking positive medication effects and consequences of not treating psychosis; Sell's unprecedented reversal of roles in which physicians are asked to balance fundamental constitutional rights, and judges to consider specific medications, side effects, and maximum permissible doses. Ultimately, stigma against the mentally ill and those who treat them will be considered as a reason for seemingly intransigent misconceptions.

REFERENCES

Sell v. United States, 539 U.S. 166 (2003)
Gutheil TG, Appelbaum PS: "Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication. Hofstra L Rev 12: 77-120, 1983

SELF ASSESSMENT QUESTIONS

1. The Supreme Court's reasoning in Sell v. U.S. was based on which of the following Landmark cases (choose all that apply)?

a. Plessy v. Ferguson, 163 U.S. 537 (1896)
b. Washington v. Harper, 494 U.S. 210 (1990)
c. Bush v. Gore, 531 U.S. 98 (2000)
d. Riggins v. Neveda, 504 U.S. 127 (1992)
e. Singleton v. Norris, 540 U.S. 832 (2003)

ANSWER: Washington v. Harper (Choice B) allowed the forcible medication of inmates found dangerous, provided it is in their medical interest, and in Riggins v. Nevada (Choice D) the Court reversed a death sentence ruling that less intrusive means of restoring competency must be considered before involuntary medication can be ordered. Plessy upheld the constitutionality of racial segregation in public accommodations (Choice A) and Bush v. Gore ultimately upheld the Florida election results delivering a victory to Bush in the presidential race (Choice C). In Singleton v. Norris, the Eighth Circuit lifted a stay of execution, finding that the state was under an obligation to administer antipsychotic medication to Singleton because it was appropriate medical care—even if it would lead to his execution; the Supreme Court refused to hear the case (Choice E).

2. The Supreme Court considers one's liberty interest in freedom from antipsychotic medications as:

a. the same as one's liberty interest in freedom from any other medical treatment
b. greater interest for antipsychotic medications than other medical treatments
c. greater for other medical treatments than for antipsychotic medications

ANSWER: b, perhaps due to misconceptions about psychosis and antipsychotic medications.

T21 **SHIPMAN: IS HE A SPECIAL CASE?**

John C. Gunn, CBE, MD, FRCPsych, Bromley, UK

EDUCATIONAL OBJECTIVE

At the end of this presentation, participants will be able to describe unique aspects of the Shipman case and the inquiry surrounding the facts of this case, as well be able to describe aspects of serial killings by healthcare professionals.

SUMMARY

Over the years, stories of healthcare professionals who committed serial murder in the United States, France, Zimbabwe and England, to name a few, have been reported. The case of Dr. Harold Shipman represents the worst (in terms of numbers of victims, which totaled over 200 people across 23 years of medical practice) known serial killer in British history, possibly in world history, if politicians are excluded. Dr. Shipman had been a general practice physician at Hyde, near Manchester, England, who was arrested in 1998 after reports emerged of excessive death rates of his patients. In early 2000, the British government authorized a special private investigation, chaired by Dame Janet Smith, DBI, a High Court Judge, to help identify how patients could be protected from such atrocity in the future. As part of the inquiry, four highly regarded forensic psychiatrists were asked to provide consultation. Ultimately the government authorized the inquiry reports to be made public, and the final report was published in 2005. In this presentation, the history of the case and some of its details will be described. The results of the public enquiry into the case will be mentioned briefly. Some thoughts will be given to possible causes of this criminal behavior. The question of its uniqueness will be discussed.

REFERENCES

Yorker BC, Kizer KW, Lampe P, Forrest AR, Lannan JM, Russell DA: Serial murder by healthcare professionals. J Forensic Sci 51:1362-1371, 2006

Kaplan R. The clinicide phenomenon: an exploration of medical murder. Australasian Psychiatry 15:299-304, 2007

SELF ASSESSMENT QUESTIONS

1. In a study by Yorker, et al., examining serial murders committed by healthcare professionals, which type of professional was most likely to have committed serial murders?

a. physicians
b. nurses
c. physician's assistants
d. social workers

ANSWER: b

2. Which of the following best fits the definition of 'clinicide'?
a. the killing of specific clinicians by patients
b. the purposeful commission of negligent patient care
c. the killing of patients by specific clinicians
d. none of the above
ANSWER: c

T22 **BEING THE VICTIM: BEYOND SADISM IN SERIAL SEXUAL MURDERERS**

James L. Knoll, MD, Syracuse, NY
Robert R. Hazelwood, MS, (I) Manassas, VA
Scott Turpin, MD, Bridgewater, MA

EDUCATIONAL OBJECTIVE
Participants will learn the historical origins, controversies and forensic implications of sadomasochism in serial sexual homicide; become familiar with theories on sadomasochism from both forensic psychiatry and psychoanalytic perspectives; and be able to analyze and formulate various hypotheses for the serial murderer's sadistic indentification with the victim.

SUMMARY
The behavior and characteristics of sexually sadistic serial murderers have been described primarily in relation to their paraphilic arousal to control and torture their victims. Sadistic sexual murderers who demonstrate both sadism and masochism during their offenses have been described, but less is known about this type of offender. A forensic psychiatrist/psychoanalyst will present current psychoanalytic theories on sadomasochism. Next, forensic research on sadistic sexual offenders will be discussed, leading up to hypotheses about serial offenders who demonstrate both sadism and masochism during their offenses. Finally, a nationally known FBI Supervisory Agent (ret.) with special expertise in the area of serial sexual offenders will present a detailed case from his file which demonstrates the issue of sadomasochism. Panelists will describe several cases demonstrating an unusual phenomenon in which the offender assumes the very identity of the victim to enhance sexual gratification. It is proposed that these cases represent a grandiose form of sadism in which the offender extends his control of the victim beyond mere life or death. This form of sadism will be distinguished from sadomasochism, and its possible implications will be discussed.

REFERENCES
Hazelwood R, Michaud S: Dark Dreams. St. Martin's Press: New York, 2001
Warren J, Hazelwood R, Dietz P: The sexually sadistic serial killer. J Forensic Sci 6: 970-4, 1996

SELF ASSESSMENT QUESTIONS
1. Enacting both "roles" allows the sadomasochistic sexual murderer to:
a. enhance sadistic pleasure during future offenses by better understanding what his victims are feeling
b. experience sexual gratification from both sides of the power differential
c. transcend the boundaries of himself
d. bolster his self-concept and self-esteem
e. all of the above
ANSWER: e

2. Which of the following have been observed in sadistic sexual murderers?
a. childhood behavioral problems
b. multiple paraphilias
c. autoerotic asphyxiation
d. long duration of offenses
e. all of the above
ANSWER: e

T23 **ISAAC RAY AWARD LECTURE:THE AAPL ETHICS GUIDELINES: WHAT MAKES THEM RIGHT?**

Richard Rosner, MD, New York, NY
Robert Weinstock, MD, Los Angeles, CA
Richard J. Ciccone, MD, Rochester, NY

EDUCATIONAL OBJECTIVE
To address constructively the gap between meta-ethical foundations and the normative ethical rules of the AAPL Ethics Guidelines. This paper will present two non-justifying explanations of normative ethical rules and five justifications for normative ethical rules. It argues that the AAPL Ethics Guidelines should be presented as grounded in at least two meta-ethical foundations for normative rules.

SUMMARY
This paper presents two non-justifying explanations of ethical rules: (1) Ethical relativism states each profession's ethical rules are based on the internal acceptance of those rules by the members of each specific profession. (2) Ethical subjectivism holds that all ethical rules are subjective expressions of approval and/or disapproval or are imperative commands to act or not to act. The paper considers five justifications for ethical rules: (1) The Divine Command theory states that what makes something objectively right or wrong is that God commands it or forbids it. (2) The Natural Law theory states that humans deduce what is right and wrong from the facts of the world we live in. (3) Consequentialism states that what is right produces the most good for the most people. (4) Deontology states that maximizing good is not always right. (5) Feminist ethical theory states that what is right enhances human caring and connectedness. The AAPL Ethics Guidelines should be grounded in meta-ethical foundations for normative rules.

REFERENCES
Frankena, W: Ethics, 2nd Edition. Englewood Cliffs, NJ: Prentice-Hall , 1973
Rachels, J: The Elements of Moral Philosophy, 4th Edition. New York: McGraw Hill, 2003

SELF ASSESSMENT QUESTIONS
1. What is Ethical Consequentialism?
ANSWER: The theory that maximizing good for the most people is what makes something right.

2. What is Ethical Deontology?
ANSWER: The theory that maximizing the good for most people is not always the right course of action.

T24 **RACIALLY MOTIVATED WORKPLACE VIOLENCE**

Robert T.M. Phillips, MD, PhD, Annapolis, MD
Ezra E.H. Griffith, MD, New Haven, CT
William F. Blair, JD, (I) Brandon, MS

EDUCATIONAL OBJECTIVE
To examine racial harassment and fatal workplace violence in the context of an employment discrimination case. To review the laws governing potential redress for victims of such violence. To outline employer strategies that have been proposed to reduce the risk or probability of racially motivated workplace violence.

SUMMARY
In 2003, a white employee killed six co-workers (four African-American) and injured nine before committing suicide at the Lockheed Martin plant in Meridian, Mississippi. The employee was "known to harbor extreme racial hatred toward his African-American co-workers." A federal EEOC investigation determined that the shooter created a "racially charged atmosphere at the plant." Race discrimination distinguishes this case from other incidents of workplace violence. Surviving victims and their families claimed that management knew of the threat to kill black workers but did little to prevent the violence. Workplace killings can arise from other sources, such as domestic violence and violent robberies. Legal claims are often limited to fines under the Occupational Safety and Health Act and recovery under state law claims, such as negligent hiring and retention. In cases involving racially motivated violence, federal antidiscrimination laws provide remedies for injured individuals. A federal appeals court denied the Lockheed plaintiffs the right to sue the company, ruling that the exclusivity bar of workers' compensation law prohibits a lawsuit. Plaintiff's counsel and forensic experts explore racially motivated workplace violence by examining the Lockheed shootings; an ABC News Primetime investigative report; laws governing redress and employers' response nationally to reduce the risk of such occurrences.

REFERENCES
Tanks v. Lockheed-Martin Corp., 332 F. Supp. 2d 953, 956-64 (S.D. Miss. 2004)
Fagan TJ, Ax RK (editors): WorkplaceViolence From Individual to Institution: Correctional Mental Health Handbook. Thousand Oaks: Sage Publications, 2003, pp 220-228

SELF ASSESSMENT QUESTIONS
1. The ability to identify potentially violent individuals and the early warning signs of violent behavior can help reduce the risk of tragic incidents in the workplace. In response, proactive employers are establishing:
a. specific zero-tolerance policies
b. response procedures
c. employee training
d. crisis response teams
e. all of the above
ANSWER: e

2. In addition to racially motivated, other categories of violence that occur in the workplace include:
a. emotionally enraged
b. angry spouse
c. violence against law enforcement
d. terrorism/other hate crimes
e. all of the above
ANSWER: e

T25 **TERRORISM AND CRISIS NEGOTIATION: UK PERSPECTIVES**
INTERNATIONAL RELATIONS COMMITTEE

Kenneth G. Busch, MD, Chicago, IL
Richard Taylor, MBBS, MRCPsych, Middlesex, UK
Ian Cumming, MBBS, MRCPsych, (I) London, UK
Fintan Larkin, MBChB, BAO, MRCPsych, (I) Berks, UK
John Hayward, FZS, (I) Oxon, UK

EDUCATIONAL OBJECTIVE
To learn the social and psychological impact of detention without trial on terrorism suspects in the UK; the psychological characteristics of UK radicalized Muslim terrorist suspects/convicts; and the principles of managing the "Golden First Hour" negotiations in hostage, barricade, and other serious incidents.

SUMMARY
Part I: Terrorism. In the wake of the 2005 London terrorist bombing attacks, a new group of detainees, generally young, UK-born radicalized Muslim men, have been received into custody. Psychiatric examination of some individuals in this group has revealed vulnerabilities for depression and altered mental status that may be related to psychological vulnerabilities relevant to radicalization and recruitment. Part II: Crisis Negotiation. Psychiatrists may find themselves involved in crisis situations, including hostage-taking, barricading, and other protests. In these situations, our decisions can make a major difference to the outcome. The panelists will draw on the experiences and recommendations of a number of agencies involved in these dangerous occurrences, and consider the underlying research and theory. Both panelists are involved in policy setting and training. Dr. Larkin is the Lead Clinician for Broadmoor Hospital's Hostage and Serious Incident Management Committee. Mr. Hayward is a former senior Metropolitan Police Officer and is a senior trainer in the field.

REFERENCES
Robbins I, MacKeith J, Taylor R, et al: Psychiatric problems of detainees under the Anti-Terrorism Crime and Security Act 2001. Psychiatric Bulletin 29: 407-409, 2005
Vecchi GM, Van Hasselt VB, Romano SJ: Crisis (hostage) negotiation: current strategies and issues in high-risk conflict resolution. Agression and Violent Behavior 10: 533-551, 2005

SELF ASSESSMENT QUESTIONS
1. What has been the social and psychological impact of detention without trial of terrorism suspects in the UK?
ANSWER: Deterioration in mental status has been documented. Direct causality in relation to detention indefinitely without trial is not established. There has been significant public and legal debate about detention without trial.

2. What sensible actions should one take on witnessing a colleague being dragged into a room by a person brandishing a knife, who then barricades the door?
ANSWER: Raise the alarm in a calm manner. Communicate calmly with the prisoner (unless there is someone more appropriate around to do so). Ask if everyone is OK in there. Be polite and personal to the perpetrator and victim. Use first names if allowed. Focus on the perpetrator. Keep the perpetrator talking politely; let him or her speak. Make no promises you cannot keep. Defer decisions when appropriate. Find a common interest. Establish trust early; it will be crucial later. Do not make insincere promises and facile comments that damage that fragile trust. Let the perpetrator explain what he or she wants.

T26 **PSYCHOLOGICAL TEST IN CST ASSESSMENTS: USEFUL OR SUPERFLUOUS?**

Gergory Sokolov, MD, Davis, CA
Douglas Mossman, MD, Dayton, OH
Patricia Zapf, PhD, (I) New York, NY

EDUCATIONAL OBJECTIVE
At the conclusion of this presentation, audience members will report a better understanding of various psychological tests available for use in evaluations of competence to stand trial (CST), and describe the possible benefits and limitations of psychological testing in preparing reports and giving testimony about CST.

SUMMARY
Each year, U.S. courts order 50,000-60,000 criminal defendants to undergo evaluations of competence to stand trial (CST). Forensic mental health professionals uniformly agree that personally interviewing the defendant, collateral data-gathering and examining records are key components of any CST assessment. Psychiatrists and psychologists disagree, however, on the importance and value of structured CST assessment instruments and adjunctive psychological testing. The 2007 AAPL Practice Guidelines on CST evaluations states, "Examiners can usually ascertain the crucial psychological data relevant to functioning as a competent criminal defendant directly from interviewing defendants" and from collateral sources. By contrast, some psychologists believe conventional psychological testing is "essential" in CST evaluations. A 2003 study found that most forensic psychologists recommended the Wechsler IQ and MacCAT-CA for CST assessments; they also recommended the MMPI-2 and the SIRS when evaluating possible malingering. This debate-style presentation addresses the issue: "Resolved: Psychological testing should play an important role in most evaluations of competence to stand trial." An overview of structured CST assessments will be provided, followed by a forensic psychologist's discussion of benefits of psychological testing, including personality and cognitive measures, in CST evaluations. A forensic psychiatrist will then discuss limitations and potential disadvantages of psychological testing in CST evaluations.

REFERENCES
Mossman D, Noffsinger SG, Ash P, et al: AAPL Practice Guidelines for the Forensic Psychiatric Evaluation of Competence to Stand Trial. J Am Acad Psychiatry Law 35:S3-S72, 2007
Lally SJ: What tests are acceptable for use in forensic evaluations? A survey of experts. Professional Psychology: Research and Practice 34:491-498, 2003

SELF ASSESSMENT QUESTIONS
1. All of the following are structured assessment of CST instruments except?
a. GCCT
b. CAI
c. MMPI-2
d. MacCAT-CA
e. ECST-R
ANSWER: c

2. All of the following tests are frequently useful to detect malingering except?
a. SIRS
b. MMPI-2
c. SIMS
d. M-FAST
e. CAST-MR
ANSWER: e

T27 CAMPUS RISK ASSESSMENT: CHALLENGES AND BARRIERS

Kelley M. Adams, MD, Chapel Hill, NC
Eric B. Elbogen, PhD, (I) Chapel Hill, NC
Maureen Windle, PsyD, (I) Chapel Hill, NC
Winston Crisp, JD, (I) Chapel Hill, NC
Sally Johnson, MD, Chapel Hill, NC

EDUCATIONAL OBJECTIVE
To facilitate discussion of the challenges and barriers faced by colleges and universities in effectively and safely managing potentially high-risk students, and to review the roles of forensic mental health professionals as consultants in risk assessment and treatment planning.

SUMMARY
While acts of large-scale violence on college/university campuses are fortunately rare, they evoke fear locally and nationally. Recent tragedies have caused colleges and universities to re-evaluate how risk assessment and management of potentially high-risk students is provided. In the wake of the tragedy of Wendell Williamson's January 1995 killing of two strangers and wounding of a police officer on a crowded street in downtown Chapel Hill, the University of North Carolina (UNC) developed a systematic approach to risk assessment and management. The Emergency Evaluation and Action Committee (EEAC) was established as a multi-disciplinary committee to review cases on conduct as opposed to condition, promote communication among necessary campus departments and psychiatric facilities, and avoid punitive actions. With a focus on the health and safety of both students and the community, their goal is to allow those students who are motivated to continue their education to safely remain part

of the university. This workshop will use UNC's decade of experience to open a dialogue about innovative options for risk assessment and management on college/university campuses, emphasizing the increasing role of forensic experts. It will include discussion of empirically validated risk assessment tools and development of individualized crisis plans via psychiatric advance directives.

REFERENCES

Schuman M: Falling through the cracks – Virginia Tech and the restructuring of college mental health services. N Engl J Medicine 357:105-110, 2007

Swanson J, Swartz M, Ferron J, Elbogen E, Van Dorn R: Psychiatric advance directives among public mental health consumers in five U.S. cities: prevalence, demand, and correlates. J Am Acad Psychiatry Law 43:43-57, 2006

SELF ASSESSMENT QUESTIONS

1. Which of the following is/are true of psychiatric advance directives?

a. Provide advance instructions that express the patient's preferences regarding treatment
b. Can include specific prescriptions and proscriptions
c. Can designate a proxy decision maker or "mental health power of attorney" who has legal authority to make decisions should the individual become incompetent to decide on his/her own
d. All of the above

ANSWER: d

2. Which of the following represent barriers to effective risk assessment and management on college/university campuses?

a. Ambiguity and subjective interpretation of HIPAA and FERPA
b. Poor communication between college departments
c. Poor communication between treating facilities and university personnel
d. Understaffing of university counseling centers
e. All of the above
f. None of the above

ANSWER: e

T28 FORENSIC EVALUATIONS OF SPECIAL POPULATION SEX OFFENDERS

SEXUAL OFFENDERS COMMITTEE

Gregg R. Dwyer, MD, EdD, Columbia, SC
Dean M. De Crisce, MD, Avenel, NJ
Paul J. Fedoroff, MD, Ottawa, Ontario, Canada
John M.W. Bradford, MB, ChB, Brockville, Ontario, Canada
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE

Participants will be able to identify and apply methods unique to the forensic evaluation and treatment of special populations among persons who engage in sexually offending and problem behaviors. These populations include adolescents, women, the elderly, persons with developmental disorders, persons with major mental illnesses, and sadistic and homicidal offenders.

SUMMARY

What do we know about the evaluation and treatment of persons other than the typical young adult men who engage in sexual offending and problem behaviors? Does the plethora of literature about these adult male offenders apply equally well to adolescents, women, the elderly, those with developmental disorders, persons with major mental illnesses, and the extremely high risk sadistic and homicidal offenders? Although the approaches to assessment and treatment planning for these special populations are similar to those for the typical adult male offender, there are significant differences. This panel will present key issues to consider when conducting forensic evaluations and providing treatment setting and content recommendations for these special populations. Specifically, panelists will address applicability of standardized assessments, use of specialized instruments, physiological testing, content of evaluation interviews, unique historical data to review, recidivism risks factors, and indicators and contraindications for various psychological and biological treatment modalities. Practical application for forensic evaluators and treatment providers will be highlighted with scenario-based exercises performed by participants and facilitated by the workshop presenters.

REFERENCES
Longo RE: Emerging issues, policy changes, and the future of treating children with sexual behavior problems. Annals of the New York Academy of Science 989:502-14, 2003
Doren DM: What do we know about the effects of aging on recidivism risk for sexual offenders? Sexual Abuse: A Journal of Research and Treatment 18(2):137-57, 2006

SELF ASSESSMENT QUESTIONS
1. Which sexual recidivism risk assessment instrument(s) has/have a research base supporting their use with women?
a. Static-99
b. RRASOR
c. MnSOST-R
d. a and b
e. none of the above
ANSWER: e

2. Which of the following are reported to be risk factors for juvenile sexual recidivism?
a. negative peer pressure
b. poor emotional self-regulation
c. poor general self-regulation
d. all the above
e. a and b only
ANSWER: d

T29 **FORENSIC SAMPLER: FIRES, FIRESETTERS AND INVESTIGATING EXPERTS LIASION WITH FORENSIC SCIENCES COMMITTEE**

Alan R. Felthous, MD, St. Louis, MO
Robert Weinstock, MD, Los Angeles, CA
Thomas P. Shefchick, BSEE (I) Sunnyvale, CA
Suzanne Yang, MD, Cleveland, OH
Carol Henderson, JD, (I) Gulfport, FL

EDUCATIONAL OBJECTIVE
To impart: 1) how forensic engineers investigate fires and help determine whether they were caused by humans; 2) motivations and mental states of firesetters; and 3) how trial attorneys discover adverse information about opposing experts.

SUMMARY
Thomas Shefchick, BSEE, PE, from the Engineering Section of AAFS, will present a case of an apparent electrical fire. No defects were found in the electrical system of the building. Further examination of the fire scene revealed that a flammable liquid and a heat source had been utilized in an attempt to make it appear that electricity had caused the fire. Following a brief overview of the cultural symbolism of fire, Suzanne Yang, MD, will examine the psychopathology of firesetting. Stereotypic, repeat firesetting will be contrasted with the opportunistic choice of fire as an expression of psychopathology. After summarizing current knowledge regarding differential diagnosis in criminal acts involving fire, Dr. Yang will explore the issue of whether firesetting should be considered a form of interpersonal violence. Representing the Jurisprudence Section, Carol Henderson, JD, President of the American Academy of Forensic Sciences, will reveal how trial lawyers investigate expert witnesses. Particular attention is given to uncovering information that will adversely reflect upon the competence or credibility ("dirt" in the vernacular) of opposing experts. Awareness of sources of such information should better prepare the experts themselves for cross-examination.

REFERENCES
Icove DJ, DeHaan, JD: Forensic Fire Scene Reconstruction. Saddle River, NJ: Brady-Pearson Prentice Hall, 2004
Ritchie EC, Huff TG: Psychiatric aspects of arsonists. J Forensic Sci 44 (4):733-40, 1999

SELF ASSESSMENT QUESTIONS
1. How do you determine if an electrical item caused a fire?
a. It was burned beyond recognition
b. It was located in an area where the fire started
c. There are no other sources of heat in the fire damaged area
d. It was burned from the inside out
ANSWER: d

2. Which of the following psychiatric diagnoses is least frequently observed among persons evaluated for charges of arson?
a. Schizophrenia
b. Cannabis abuse or dependence
c. Bipolar disorder
d. Pyromania
e. Personality disorder
ANSWER: d

T30 **TEACHING FORENSIC PSYCHIATRY: NOT WHETHER, BUT WHEN, WHAT, AND HOW MUCH? EARLY CAREER PSYCHIATRY COMMITTEE**

Avram H. Mack, MD, Washington, DC
Thomas G. Gutheil, MD, Brookline, MA
Alan Newman, MD, Washington, DC
Jill C. Volin, MD, Chapel Hill, NC

EDUCATIONAL OBJECTIVE
To foster discussion regarding optimal matches between the amount and content of education on forensic psychiatry issues with level of training in medicine and psychiatry.

SUMMARY
The education of trainees in undergraduate and graduate medical education should include some forensic psychiatry topics, but there is little clarity as to what, how much, and when specific topics should be taught, and variation appears to exist among educational institutions. All future physicians need to be aware of the law, but to what degree? Different topics and exposures may have varying effects on trainees—ranging from increasing or decreasing interest in psychiatry, to the provision of practical advice on basic medico-legal topics, to the fulfillment of voyeuristic interests. Led by experts in education of forensic psychiatry and early career forensic psychiatrists, this workshop will provide a setting in which different academic practices are discussed, compared, and contrasted. The workshop panelists will each begin with a short presentation of experiences and ideas which will be followed by an interactive exchange with the workshop attendees. The risks and benefits of various exposures and approaches to teaching this subject matter at different points in medical education will be considered. The discussion may produce consensus on ideas regarding education about psychiatry and the law or it may demonstrate that consensus is not desired nor possible.

REFERENCES
Gabbard GO: Epilogue, in The Mental Health Practitioner and the Law. Edited by Lifson LE, Simon RI. Cambridge, MA: Harvard University Press, 1998
Arikan R, Appelbaum P: A day in the life of a psychiatrist in-the-making, Psychiatrist-in-the making: Rasim Arikan, M.D., PhD. Mentor: Paul Appelbaum, M.D. Acad Psychiatry 29(4):383-4, 2005

SELF ASSESSMENT QUESTIONS
1. Exposing medical students to forensic psychiatry cases may lead to what, among other outcomes?
ANSWER: Increased or decreased interest in becoming psychiatrists, fulfillment of voyeuristic interests, and/or an increase in awareness of the need for safety/risk management precautions.

2. Some "Landmark Cases" pertinent to non-forensic psychiatric education include what?
ANSWER: In Re Gault, Parham v. J.R., Tarasoff v. Regents of University of California, Scholndorf v. Society of New York Hospital

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T31 **STANDARDIZED RISK ASSESSMENT OF CHILD ABUSE: INFLUENCES ON JUDGEMENT**

Cheryl Regehr, PhD, (I) Toronto, Ontario Canada
Vicki LeBlanc, PhD, (I) Toronto, Ontario, Canada
Aron Shlonsky, PhD, (I) Toronto, Ontario, Canada
Marion Bogo, MSW, (I) Toronto, Ontario, Canada

EDUCATIONAL OBJECTIVE
To understand the influence of evaluator stress and previous trauma exposure as well as clinical context factors on professional decision-making regarding future risk of violence in cases of child abuse.

SUMMARY
Despite improvements in recent years in standardized risk assessment measures, considerable controversy continues regarding their reliability. Further, previous attempts to examine reliability and validity have relied primarily on retrospective reviews and have not assessed variabilities that may occur in lifelike clinical situations. This study investigates the degree to which the previous experiences of the evaluator and his or her pre-existing emotional and

physiological state interacts with the context variables in the clinical situation and in turn influences professional judgment regarding the acute risk of child abuse. An experimental design study was conducted with 100 child welfare workers whose work involves the assessment of future risk of child abuse. All workers were presented with two simulated clinical interviews involving typical child welfare intake cases. Parents were portrayed by specially trained standardized patients. Measures included pre-scenario administration of standardized measures addressing prior trauma exposure, current PTSD symptoms and depression symptoms; and psychological and physiological stress responses (heart rate, cortisol) before, during and after the simulated clinical interview. After the interviews, workers completed standardized risk assessment measures used in their daily practice. This presentation will focus on initial data analysis and the implications for forensic examiners charged with predicting future risk.

REFERENCES

Camasso MJ, Jagannathan, R: Modeling the reliability and predictive validity of risk assessment in child welfare. Children and Youth Services Review 22 (11/12): 873-896, 2000
Shlonsky A, Wagner D: The next step: integrating actuarial risk assessment and clinical judgment into an evidence-based practice framework in CPS case management. Children and Youth Services Review 27(3): 409-427, 2005

SELF ASSESSMENT QUESTIONS

1. Does previous trauma exposure of the evaluator affect appraisal of children's risk of abuse on standardized risk assessment measures?

ANSWER: yes

2. Is there a relationship between heart rate, subjective stress and appraisal of children's risk of abuse on standardized risk assessment measures?

ANSWER: yes

T32 THE STALKING HARM: A NEW GUIDE TO THE RISK MANAGEMENT OF STALKING

Graham D. Glancy, MB, ChB, Ontario, Canada
Christine Hayos, MSW, RSW, (I) Ontario, Canada
Phillip J. Resnick, MD, Cleveland, OH
Debra A. Pinals, MD, Worcester, MA

EDUCATIONAL OBJECTIVE

Participants will learn and review the salient factors relevant to risk management in stalking, and learn about a new guided clinical aid to improve their accuracy in managing risk.

SUMMARY

Stalking is an increasingly recognized problem that has engendered significant research over the last 20 years. Clinicians are often involved in the risk management of stalking and have to assess two questions: 1) Will the stalking continue? and 2) Will the victim be harmed? The Stalking Harm is a guide to clinical assessment that turns the assessor's mind to the significant issues that will serve as an aid to answering these questions.

REFERENCES

Resnick, P: Stalking risk assessment, in Stalking: Psychiatric Perspectives and Practical Approaches. Edited by Pinals D. New York: Oxford, 2007, pp 61-84
Mullen PE, Mackenzie R, Ogloff JRP, Pathé M, McEwan T, Purcell R: Assessing and managing the risks in the stalking situation. J Am Acad of Psychiatry Law 34:439-450, 2006

SELF ASSESSMENT QUESTIONS

1. Which of the following increases the risk of continued stalking?

a. Substance Abuse
b. A history of serious violence
c. The stalker is an ex-intimate
d. All of the above

ANSWER: d

2. Which of the following is particular to celebrity stalkers?

a. Owns a weapon
b. Is often depressed
c. Is psychopathic
d. Has a sense of own uniqueness

ANSWER: d

T33 THE USE OF THE COVR IN A FORENSIC INPATIENT SETTING

Barbara E. McDermott, PhD, (I) Sacramento, CA
Cameron D. Quanbeck, MD, Sacramento, CA
David Busse, MA, (I) Napa, CA
Kalynn Yastro, BA, (I) Napa, CA
Renoir Welch, BA, (I) Napa, CA
Charles L. Scott, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
The attendee will understand the use of the COVR in identifying those patients who are at highest risk of exhibiting certain types of aggressive behavior in an institutional setting.

SUMMARY
The prediction of violent behavior has long been considered one of the primary tasks in forensic psychiatry and psychology. A substantial amount of research has been conducted in past decades indicating that actuarial assessments are more accurate in identifying those individuals who may be at greater risk of exhibiting violent behavior. Recently, a new actuarial assessment, the Classification of Violence Risk (COVR) has been published which implements the classification tree methodology used in the MacArthur study of violence risk. The COVR is an interactive software program designed to estimate the risk that an acute psychiatric patient will be violent over the next several months. Because the algorithm was developed using civil psychiatric patients and for the prediction of community violence, it is unclear if the COVR will be useful in identifying which patients in a forensic inpatient facility will exhibit aggression. There has been abundant research suggesting that the predictors of community and institutional violence are quite different. We prospectively followed 100 patients in a forensic facility who were administered the COVR and documented their incidents of physical aggression. The relationship between the estimate of risk generated by the COVR and observed aggression will be presented, with a discussion of the utility and limitations of this software in a forensic setting.

REFERENCES
Monahan J, Steadman HJ, Appelbaum PS et al: The classification of violence risk. Behav Sci Law 24: 721-730, 2006
Walters GD: Predicting institutional adjustment and recidivism with the Psychopathy Checklist factor scores: a meta-analysis. Law Hum Behav 27: 541-558, 2003

SELF ASSESSMENT QUESTIONS
1. Which of the following factors has not been found to be a predictor of community violence in the MacArthur study of violence risk?
a. violent thoughts and fantasies
b. seriousness of arrest
c. father's drug use
d. mother's drug use
ANSWER: d

2. Which of the following factors has been shown to be a weak predictor of institutional aggression?
a. positive symptoms of psychosis
b. the PCL-R
c. anxiety
d. anger
ANSWER: b

T34 FUNCTIONAL RISK MEASURE IN FORENSIC SERVICES

Michael Norko, MD, New Haven, CT
Michael Greenspan, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Josephine Buchanan, BA, (I) New Haven, CT

EDUCATIONAL OBJECTIVE
Attendees will learn the functional risk assessment model; review a risk measure used in jail diversion, parole, and probation; consider the results of the measure as predictor of re-arrests and hospitalizations; and explore the merits of functional assessment tool in a high risk population.

SUMMARY
Risk assessment research has improved both actuarial and dynamic risk measures. The utility of these measures in clinical management and the measurable connection between clinical treatment and risk reduction remain challenges for both research and treatment. In this investigation, a functional assessment tool tracking the change in

cognitive functioning, modulation of mood, and behavioral control was evaluated for both feasibility and effectiveness in identifying change in risk levels. In a jail diversion program, 109 outpatient clients were evaluated weekly over a four-month period using the measure to track cognitive, mood, and behavioral symptom change. Clients who showed decreased function in specific areas were more likely to be rearrested or rehospitalized during the following week. The assessment identified fluctuating levels of functioning in response to both treatment and non-treatment (social, family, legal) factors and helped to identify client vulnerability as a factor in the eruption of disruptive behavior. A preliminary model for identifying and reducing precursors to risk will be presented in addition to implications for incorporating a functional assessment measure as a component of risk assessment and methods of refining clinical assessment of risk-related symptoms.

REFERENCES

Norko MA, Baranoski MV: The state of contemporary risk assessment research. Canadian J Psychiatry 50:18-26, 2005
Norko MA, Baranoski MV: The prediction of violence; detection of dangerousness. Brief Treatment and Crisis Intervention 8:73-91, 2008

SELF ASSESSMENT QUESTIONS

1. Dynamic measures of risk:
a. are sensitive to effects of treatment
b. require extensive collateral data
c. are superior to actuarial measures for long-term risk
d. are more appropriate for sex offenders than for persons with Axis I disorders
ANSWER: a

2. Advantages of functional risk assessment include all of the following except:
a. its usefulness in clinical decision-making
b. its specificity in identifying effects of treatment
c. its superiority over actuarial measures in long-term risk assessment
d. its correlation to clinical symptoms
ANSWER: c

T35 MOCK TRIAL: SELL ISSUES PRESENTED BY THE STATE OF UTAH V. BRIAN DAVID MITCHELL

Jeffrey L. Metzner, MD, Denver, CO
Heidi Buchi, JD, (I) Salt Lake City, UT
Michael J. Finkle, JD, MBA, (I) Seattle, WA
The Honorable Edward Ross, (I) Bellingham, WA
James K. Wolfson, MD, Springfield, MO
Patrick W. Corum, JD, (I) Salt Lake City, UT

EDUCATIONAL OBJECTIVE

To provide a summary of relevant elements of the Sell criteria; and to illustrate the controversies regarding the Sell criteria in the context of a defendant who is incompetent to proceed related to the presence of a delusional disorder.

SUMMARY

The U.S. Supreme Court has recognized that the Constitution permits the involuntary administration of antipsychotic medication to a criminal defendant for the purpose of rendering the defendant competent to stand trial, if the state has shown a need for that treatment sufficiently important to overcome the defendant's protected interest in refusing it. During March 2003, it is alleged that defendant Mitchell kidnapped 14-year-old E.S. and proceeded to commit multiple sex offenses against her during the ensuing year until she was able to escape and return to her family during March 2003. Defendant Mitchell was found to be mentally ill and incompetent to proceed to trial during July 26, 2005, and was committed to the Utah State Hospital. On December 14, 2006, the Department of Human Services filed a notification that Defendant Mitchell was not responding to treatment, and was unlikely to be restored to competency without the involuntary administration of psychotropic medication. This mock trial will highlight issues related to the Sell four-part test and treatment issues related to defendants with a delusional disorder.

REFERENCES

Sell v. United States, 539 U.S. 166, 179, 183 (2003)
Siegel D: Involuntary psychotropic medication to competence: no longer an easy Sell. 12 MSU J of Medicine and Law, 2008

1. Which of the following legal rationales does not support the legal use of involuntary medications?
a. police power
b. parens patriae
c. establishing competence to stand trial
d. establishing competence to be executed
ANSWER: d

2. Which if the following criteria are applicable to the Sell decision?
a. The medication must be medically appropriate.
b. The medication must be necessary—alternative, less intrusive treatments are unlikely to substantially achieve the same results.
c. The medication must be necessary to significantly further important governmental interests, (i.e., administration of the drugs is substantially likely to render the defendant competent to stand trial).
d. The medication must significantly further important governmental interests.
e. All of the above
ANSWER: e

FRIDAY, OCTOBER 24, 2008

POSTER SESSION #2 — 7:15 AM – 8:00 AM/ 9:30 AM – 10:15 AM — **GRAND FOYER**

F1 ***The Innocent Seduced? Comic Books, Juvenile Delinquency, and Psychiatry***
Vasilis K. Pozios, MD, Washington, DC
Praveen Kambam, MD, Los Angeles, CA

F2 ***Expert Witness And The Death Penalty***
Gagan Dhaliwal, MD, Huntsville, AL
J. Arturo Silva, MD, San Jose, CA
Neelam Varshney, MD, New York, NY
Margaret Goni, MD, Elmhurst, NY

F3 ***Competence To Stand Trial: Assessment of Pre-Trial Defendants***
Anasuya Salem, MD, MPH, Syracuse, NY
Bruce Way, PhD, (I) Marcy, NY
James Knoll, MD, Syracuse, NY

F4 ***Dangerous Offender Statutes: A Transatlantic Perspective***
Andy R. Bickle, MD, MBChB, Leicester, England
Paul C. Stankard, MBchB, Leicester, England

F5 ***Men Who Sexually Attack Their Mothers***
J. Arturo Silva, MD, San Jose, CA
Gregory B. Leong, MD, Tacoma, WA
Douglas A. Tucker, MD, Berkeley, CA
Michelle M. Ferrari, (I) San Jose, CA

F6 ***A Child Speaks: Protocols for Interviewing Children About Sexual Abuse***
Jamae Campbell, MD, (I) Columbia, SC
Bradley W. Freeman, MD, Columbia, SC

F7 ***Psychiatry: An Industry of Death?***
Fintan Larkin, MB, (I) Berkshire, England

F8 ***Forensic Fellowship's Effect on General Residents***
Jeremy A. Hinton, MD, Little Rock, AR
Carol R. Thrush, Ed.D, (I) Little Rock, AR
J. Benjamin Guise, MD, Little Rock, AR

F9 ***Sexual Predator Cases: Juvenile's Risk Factors***
Gregg R. Dwyer, MD, Columbia, SC
Geoffrey R. McKee, PhD, (I) Columbia, SC

F10 ***Theory of Mind Assessments in Forensic Psychiatry***
J. Arturo Silva, MD, San Jose, CA
Manish A. Fozdar, MD, Wake Forrest, TX

F11 ***Medicolegal Aspects of the Tarasoff Case***
Neelam Varshney, MD, New York, NY
Margaret Goni, MD, Elmhurst, NY
Gagan Dhaliwal, MD, Huntsville, AL

F12 ***Virginia Tech Shooting to Britney Spears: The Goldwater Rule Re-Examined***
Praveen R. Kambam, MD, Los Angeles, CA
Vasilis K. Pozios, MD, Washington, DC

WORKSHOP 8:00 AM- 10:00AM **GRAND I**

F13 Assessing Confession Evidence: Police Coercion or Valid Admissions of Guilt?

Todd N. Palumbo, MD, Cincinnati, OH
Scott A. Bressler, PhD, (I) Cincinnati, OH
Emily A. Keram, MD, Santa Rosa, CA
Steven A. Drizin, JD, (I) Chicago, IL

COURSE (TICKET REQUIRED) 8:00 AM - 12 NOON **ELLIOTT BAY**

F14 Psychological Testing for Forensic Psychiatrists

William H. Campbell, MD, MBA, San Antonio, TX
Madelon V. Baranoski, PhD, (I) New Haven, CT

PANEL 8:00 AM - 10:00 AM **CASCADE I**

F15 Mandated Outpatient Care in NYC: Two Roads More Traveled By

Merrill R. Rotter, MD, Bronx, NY
Steven K. Hoge, MD, New York, NY
Scott Rogge, MD, Bronx, NY
Jeffrey Janofsky, MD, Timonium, MD

PANEL 8:00 AM - 10:00 AM **CASCADE II**

F16 Ethics Training in Forensic Psychiatry

Richard Rosner, MD, New York, NY
Robert Weinstock, MD, Los Angeles, CA
Charles Scott, MD, Sacramento, CA
Jeremy Colley, MD, New York, NY

PAPER SESSION# 2 8:00 AM - 10:00 AM **GRAND CRESCENT**

F17 Oregon's Juvenile Psychiatric Security Review Board

Stewart S. Newman, MD, Beaverton, OR

F18 Decision-Making About Inpatient Civil Commitment

Andrew R. Kaufman, MD, Durham, NC
Marvin S. Swartz, MD, Durham, NC
Jedidiah J. Perdue, MD, MPH, (I) Durham, NC

F19 Do Protection Orders Protect?

Christopher T. Benitez, MD, San Francisco, CA

F20 An Empirical Study of Juvenile Stalkers

Rosemary Purcell, BA, M.Psych, (I) Victoria, Australia
Paul E. Mullen, M.B.B.S., Fairfield, Australia

COFFEE BREAK **10:00 AM - 10:15 AM GRAND FOYER**

WORKSHOP 10:15 AM - 12 NOON **GRAND I**

F21 Topics in Forensic Neuropsychiatry I: Forensic Neuropsychiatry Committee

Hal Wortzel, MD, Denver, CO
Joseph Baskin, MD, Baltimore, MD
Robert Granacher, MD, MBA, Lexington, KY
Mohan Nair, MD, Los Alamitos, CA

PANEL 10:15 AM - 12 NOON **CASCADE I**

F22 Neonaticide: Phenomenology, Prevention and the Law: Gender Issues Committee

Susan J. Hatters Friedman, MD, Cleveland Heights, OH
Philip Resnick, MD, Cleveland, OH
Renee` Sorrentino, MD, Quincy, MA
Cheryl Wills, MD, Cleveland, OH

PANEL 10:15 AM - 12 NOON **CASCADE II**

F23 Methamphetamine, Psychosis, and Violence in Criminal Forensic Psychiatry: Addiction Psychiatry Committee

Mace Beckson, MD, Los Angeles, CA
Joseph R. Simpson, MD, PhD, Long Beach, CA
David Y. Kan, MD, San Francisco, CA

PANEL — 10:15 AM - 12 NOON — **GRAND CRESCENT**

F24 ***Cultural Formulation in Forensic Psychiatry: Cross-Cultural Committee***

Jagannathan Srinivasaraghavan, MD, Anna, IL
James Boehnlein, MD, Portland, OR
J. Arturo Silva, MD, San Jose, CA
Alberto M. Goldwaser, MD, Hackensack, NJ
Donna M. Norris, MD, Wellesley, MA

LUNCH (TICKET REQUIRED) — 12 NOON - 2:00 PM — **GRAND II**

F25 ***The Political Dynamics of Mental Health Law Reform: The Virginia Experience***

Richard J. Bonnie, LLB, (I) Charlottesville, VA

A/V SESSION — 2:15 PM - 4:00 PM — **GRAND I**

F26 ***A Near-Suicide: Experts Differ on Just About Everything: Peer Review Committee (AAPL MEMBERS ONLY)***

David Rosmarin, MD, Harvard, MA
Thomas G. Gutheil, MD, Brookline, MA
Robert Wettstein, MD, Pittsburgh, PA
Howard V. Zonana, MD, New Haven, CT

COURSE (TICKET REQUIRED) — 2:15 PM - 6:00 PM — **ELLIOTT BAY**

F27 ***The Expert Witness in Psychiatric Malpractice Cases***

Philip J. Resnick, MD, Cleveland, OH

WORKSHOP — 2:15 PM - 4:00 PM — **CASCADE I**

F28 ***Risk Management in Child/Forensic Psychiatry***

Lee H. Haller, MD, and Potomac, MD
Peter Ash, MD, Atlanta, GA
Stephen Billick, MD, New York, NY
Donna Vanderpool, MBA, JD, (I) Arlington, VA

PANEL — 2:15 PM - 4:00 PM — **CASCADE II**

F29 ***Risks of Forensic Use of Trauma-Specific Tests: Trauma & Stress Committee***

Stuart B. Kleinman, MD, New York, NY
Jeremy R. Butler, MD, New York, NY
Daniel A. Martell, PhD, (I) Newport Beach, CA

RESEARCH IN PROGRESS# 2 — 2:15 PM - 4:00 PM — **GRAND CRESCENT**

F30 ***Psychiatry Residents' Experience Performing Disability Evaluations***

Paul P. Christopher, MD, Providence, RI
Robert Boland, MD, (I) Providence, RI
Katharine Philips, MD, (I) Providence, RI
Patricia Recupero, JD, MD, Providence, RI

F31 ***Use of "Forensic" Countertransference in Forensic Psychiatry***

Pirzada S. Sattar, MD, Omaha, NE
Marium Garuba, MD, Omaha, NE
Fang Qui, MS, (I) Omaha, NE

F32 ***Plaintiff/Defense Bias in Malpractice Cases?***

H.W. LeBourgeois III, MD, Baton Rouge, LA
Gina Manguno-Mire, PhD, (I) New Orleans, LA

COFFEE BREAK — **4:00 PM - 4:15 PM** — **GRAND FOYER**

PANEL — 4:15 PM - 6:15 PM — **GRAND I**

F33 ***Evaluating Chronic Pain and Disability in Civil Litigation***

Roy J. O'Shaughnessy, MD, FRCP, Vancouver, BC Canada
Paul Janke, MC, FRCP, BC, Canada
Kulwant Riar, MB, FRCP, BC, Canada

PANEL 4:15 PM– 6:15 PM **CASCADE I**

F34 ***Forensic Psychiatry and the Internet: Untangling the Web***

Charles L. Scott, MD, Sacramento, CA
Jennifer Chaffin, MD, (I) Sacramento, CA
Michael Harlow, MD, Sacramento, CA
Soroush Mohandessi, MD, (I) Sacramento, CA

WORKSHOP 4:15 PM - 6:15 PM **CASCADE II**

F35 ***Adjudicative Competence: A Primer on Difficult Cases***

Andrei T. Nemoianu, MD, Pittsburgh, PA
Christine A. Martone, MD, Pittsburgh, PA
Robert Wettstein, MD, Pittsburgh, PA
Douglas Mossman, MD, Dayton, OH
LaRissa M. Chism, MD, Pittsburgh, PA

RESEARCH IN PROGRESS# 3 4:15 PM - 6:15 PM **GRAND CRESCENT**

F36 ***The Diminished Capacity Defense: An Updated Survey***

Brian C. Shelby, MD, JD, (I) New Haven, CT

F37 ***Use of Force in Treatment to Restore Trial Competency***

Daniel M. Mayman, MD, Ann Arbor, MI
Carol E. Holden, PhD, (I) Ann Arbor, MI
Craig A. Lemmen, MD, Ann Arbor, MI

F38 ***Child Abuse Reporting Laws: Implications for Forensic Psychiatrists***

Reena Kapoor, MD, New Haven, CT
Howard V. Zonana, MD, New Haven, CT

F39 ***Psychiatrists' Understanding of Duty to Protect Laws***

Jason J. Buckland, DO, Columbia, SC
Richard L. Frierson, MD, Columbia, SC

F1 THE INNOCENT SEDUCED? COMIC BOOKS, JUVENILE DELINQUENCY, AND PSYCHIATRY

Vasilis K. Pozios, MD, Washington, DC
Praveen Kambam, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE
To better understand the role and evolution of paternalism in psychiatry, particularly with regard to issues pertaining to juvenile justice. To better understand juvenile crime statistics and trends.

SUMMARY
Seduction of the Innocent, a book written by forensic psychiatrist Fredric Wertham, M.D. and published in 1954, decried the portrayal of sex, drugs, and violence in comic books and labeled them a serious cause of juvenile delinquency. Both overt and covert depictions of adult content in comics were cited, asserting that this material encouraged similar behavior in children and seriously impacted childhood development. A U.S. Congressional inquiry into comic books soon followed. An historical account of the incident is given, placed in the context of the depiction of sex, drugs, and violence in modern mass media. Juvenile crime statistics from the mid-20th century and early 21st century, as well as pictures of the comic book covers and panels in question, are presented. According to Uniform Crime Report statistics, the total number of juvenile delinquency cases in the United States has risen since the 1950s. Violent crimes perpetrated by those under the age of 18 as a percentage of total crimes (2.6% in 1954 vs. 4.3% in 2006) have remained relatively stable over time. These preliminary data may appear to support the position that media influence may be a gateway to violence; a clear causality cannot be established.

REFERENCES
Beaty B: Fredric Wertham and the Critique of Mass Culture. Jackson: University Press of Mississippi, 2005
Nyberg AK: Seal of Approval: The History of the Comics Code. Jackson: University Press of Mississippi, 1998

SELF ASSESSMENT QUESTIONS
1. What was the total number of arrests for those under age 18 in the United States in 1954 versus 2006?
ANSWER: 163,666 in 1954; 1,382,848 in 2006.

2. What does the Department of Justice consider to be a "violent crime"?
ANSWER: Violent crimes are offenses of murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault.

F2 EXPERT WITNESS AND THE DEATH PENALTY

Gagan Dhaliwal, MD, Huntsville, AL
J. Arturo Silva, MD, San Jose, CA
Neelam Varshney, MD, Worcester, MA
Margaret Goni, MD, Elmhurst, NY

EDUCATIONAL OBJECTIVE
To discuss the role of expert testimony in capital punishment cases involving the mentally ill. We will review cases to understand the impact of the expert testimony in death penalty cases with focus on the Panetti v. Quarterman and the Yates v. State of Texas cases.

SUMMARY
Our review of literature including search on LexisNexis revealed that the courts have yet to clarify clear cut standards on executing the mentally ill. The power ascribed to expert testimony in death penalty cases varies from case to case. This presentation, through self-explanatory photos, graphs, and brief written text, will explore the historical perspectives of expert witnesses in death penalty cases. We will discuss the landmark decisions in Estelle v. Smith, Eddings v. Oklahoma, Ford v. Wainright and State v. Perry that have solid implications for future court decisions regarding criminal acts in the mentally ill. A close look at the Supreme Court decisions with regard to the Panetti v. Quarterman case has once again shown that courts have failed to refine clear standards in deciding death penalty cases in the mentally ill. Yates v. State of Texas will show the importance and implication of expert testimony in death penalty cases. Finally, ethical dilemmas surrounding psychiatrists' participation in capital punishment cases will be discussed briefly.

REFERENCES
Appelbaum PS: Law & psychiatry: death row delusions: When is a prisoner competent to be executed? Psychiatr Serv 58(10):1258-60, 2007
Panetti v. Quarterman, 127 S Ct 2842 (2007)
Yates v. State of Texas, 171 S.W.3d 215 (Tex. Ct. App. 2005)

SELF ASSESSMENT QUESTIONS

1. Which recent U.S. Supreme Court case has implications for the death penalty for mentally ill prisoners?
ANSWER: Panetti v. Quarterman

2. In which case involving a potential death penalty sentence did forensic psychiatric testimony become grounds for appeal?
ANSWER: Yates v. The State of Texas

F3 COMPETENCE TO STAND TRIAL ASSESSMENT OF PRE-TRIAL DEFENDANTS

Anasuya Salem, MD, MPH, Syracuse, NY
Bruce Way, PhD, (I) Marcy, NY
James Knoll, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

To examine the prevalence of incompetence to stand trial; the differences between competent and incompetent defendants; and the mean duration of days required for competency restoration.

SUMMARY

Background: A defendant's ability to assist his or her attorney is a right guaranteed by the United States Constitution. To assess this ability, courts rely on an examination by a forensic psychiatrist. A competence to stand trial examination is requested in approximately 5-7.5% of all cases, and about 16% of the defendants examined are adjudicated as incompetent to stand trial. Despite the importance of competence exams, very few research studies have been conducted, and what has been done has produced conflicting results. Study Objectives: To examine the prevalence of incompetence to stand trial, the differences between competent and incompetent defendants, and the mean duration of days required for competency restoration. Methods: To extract information from the psychiatrist's competence exam for defendants who receive a court ordered assessment at Onondaga Justice Center, Syracuse, New York between July 2007 and June 2008. The expected sample size is 50. No defendant identifiers will be extracted. Final Approval by SUNY Upstate Medical University IRB is pending. Study data include age, gender, ethnicity, legal charges, referral for the examination, psychiatric diagnosis and treatment, and duration of competency restoration. Clinical Significance: Results of this study could improve competence assessment methods.

REFERENCES

Competence to Stand Trial, MIMH Policy Brief, June 2003
Warren J, Murrie D, Stejskal W, et al: Opinion formation in evaluating the adjective competence and restorability of criminal defendants – a review of evaluation of 8000 defendants. Behav Sci Law 24: 113–132, 2006

SELF ASSESSMENT QUESTIONS

1. What is the prevalence of incompetence to stand trial among defendants?
a. 30%
b. 50%
c. 19%
d. 60%
ANSWER: c

2. What is the mean duration required for competency restoration?
a. 120 days
b. 30 days
c. 90 days
d. 180 days
ANSWER: c

F4 DANGEROUS OFFENDER STATUTES: A TRANSATLANTIC PERSPECTIVE

Andy R. Bickle, MD, MBChB, Leicester, England
Paul C. Stankard, MBChB, Leicester, England

EDUCATIONAL OBJECTIVE
To inform AAPL members of international developments in law and practice concerning the forensic psychiatric assessment of dangerous offenders. We hope this will stimulate delegates to reflect on their own practice and perhaps consider which good aspects the UK could adopt as best practice.

SUMMARY
Introduction: "Dangerous Offender Statutes" can be defined as laws that apply at sentencing for convicted criminal offenders, allowing courts to impose a more severe sentence than would otherwise be possible. Such laws are well-established in the USA and Canada and pertain to several legal decisions. In contrast, a statutory assessment of dangerousness was not enacted in England and Wales until 2003. Importantly, the assessment identifies repeat violent or sexual offenders as dangerous unless that assumption can be rebutted. Aim: To investigate how medicolegal practice in England is adapting to dangerous offender statute law. Method: Surveys of forensic psychiatrists and medicolegal referrals in the East Midlands region of England. Results: A majority of forensic psychiatrists (17/27 - 63.0%) were not aware of the new statutory assumption of dangerousness. Only a minority felt sufficiently informed about the dangerous offender statute (7/27 - 25.9%). Only 11/51 (21.6%) of relevant legal referrals requested risk or dangerousness assessment and even fewer (3/51 – 5.9%) cited the statutory assessment. Conclusion: New dangerous offender statute which brings English and Welsh law closer to transatlantic common law counterparts appears poorly understood by forensic psychiatrists and lawyers. Practice might be improved by studying approaches in other jurisdictions.

REFERENCES
Heilbrun K, Ogloff JRP, Picarello K: Dangerous offender statutes in the United States and Canada. Int J Law Psychiatry 22(3-4): 393-415, 1999
Leiberman JD, Krauss DA, Kyger MK, Lehoux M: Determining dangerousness in sexually violent predator evaluations: cognitive-experiential self-theory and juror judgments of expert testimony. Behav Sci Law 25: 507-526, 2007

SELF ASSESSMENT QUESTIONS
1. How can "Dangerous Offender Statutes" be defined?
ANSWER: As laws that apply at sentencing for convicted criminal offenders, allowing courts to impose a more severe sentence than would otherwise be possible for the index offense which has been committed.

2. In England and Wales a "Statutory Assumption of Dangerousness" has been introduced. To whom does this apply?
ANSWER: Adult offenders committing a second or subsequent violent or sexual offense which would otherwise attract a maximum sentence of two or more years' imprisonment.

F5 MEN WHO SEXUALLY ATTACK THEIR MOTHERS

J. Arturo Silva, MD, San Jose, CA
Gregory B. Leong, MD, Tacoma, WA
Douglas A. Tucker, MD, Berkeley, CA
Michelle M. Ferrari, (I) San Jose, CA

EDUCATIONAL OBJECTIVE
To introduce a subset of men who sexually attack their mothers; to compare these men with men who engage in sexually coercive behaviors against non-maternal females; and to present a representative case of sons who sexually attack their mothers.

SUMMARY
The problem of rape and other sexually coercive behaviors will be briefly discussed. However, in this presentation we will focus on men who perpetrate sexually coercive attacks against their mothers. Dynamic factors associated with mother-son dyads in which the mother becomes the victim of a sexually violent son will be discussed. We will provide a brief psychiatric overview of these perpetrators, and will contrast them with men whose sexual attacks are directed at non-maternal figures. We will propose a tentative typology of men who sexually attack their mothers. The case of a man who sexually attacked his biological mother will be presented in some detail. We will also make some recommendations for further research in this area.

REFERENCES
Lalumiere ML, Harris GT, Quinsey VL, Rice ME. The Causes of Rape: Understanding Individual Differences in Male Propensity for Sexual Aggression. Washington , DC: American Psychological Association, 2003
Hazelwood RR, Burges AW (editors): Practical Aspects of Rape Investigation: A Multidisciplinary Approach. Boca Raton: CRC Press, 2001

SELF ASSESSMENT QUESTIONS

1. All of the following have been implicated in men who sexually attack their mothers except:
a. psychiatric disorders with serious cognitive deficits
b. psychotic disorders
c. alcohol or other drug intoxication
d. attention deficit and hyperactivity disorder
ANSWER: d

2. Sexually coercive behaviors of men against their mothers are most likely to be associated with:
a. personality disorders
b. alcohol and illicit drug use
c. cognitive abnormalities
d. divorced marital status
ANSWER: c

F6 A CHILD SPEAKS: PROTOCOLS FOR INTERVIEWING CHILDREN ABOUT SEXUAL ABUSE

Jamae Campbell, MD, (I) Columbia, SC
Bradley W. Freeman, MD, Columbia, SC

EDUCATIONAL OBJECTIVE

The purpose of this poster is to gain a better understanding of the current practice of interviewing child sexual abuse victims including their strengths and weaknesses, and the psychological impact on the child.

SUMMARY

In cases of alleged child sexual abuse, children are often the only available source of information. Over the past two decades, highly publicized cases in the United States have increased concern that appropriate interviewing techniques are utilized to avoid contamination of children's statements. Various standardized interview protocols have been developed in an attempt to maximize the amount of information obtained as well as the accuracy of that information. However, protocols vary widely with respect to content, training, evidence based support, and utilization in different areas of the country. This poster compares forensic child interview protocols based on existing research and seeks to establish salient characteristics when choosing a protocol.

REFERENCES

Lamb M, et al: A structured forensic interview protocol improves the quality and informative ness of investigative interviews with children: a review of research using the NICHD Investigative Interview Protocol. Child Abuse and Neglect 31:1201-1231, 2007
Orbach Y, et al: Assessing the value of structured protocols for the forensic interview of alleged child abuse victims. Child Abuse and Neglect 24: 733-752, 2000

SELF ASSESSMENT QUESTIONS

1. What is the best protocol for interviewing a child victim of sexual abuse?
ANSWER: There is no one best protocol but rather the interview should remain as unbiased as possible, be consistent with the developmental age of the child, and maintain a "child first" approach to minimize the traumatic impact.

2. How reliable are children with their responses?
ANSWER: This is highly dependent on the rapport between the child and the interviewer, the environment in which the child is living, the developmental age of the child, and the length of time since the alleged offense among other variables as well.

F7 PSYCHIATRY: AN INDUSTRY OF DEATH?

Fintan Larkin, MB, (I) Berkshire, England

EDUCATIONAL OBJECTIVE

The anti-psychiatry movement has been around for decades. The information age has seen organizations such as the Scientology movement produce well scripted and moving documentaries, exhibitions and booklets. This poster presents many of the anti-psychiatry arguments that may concern our patients, and that psychiatrists should be aware of and understand.

SUMMARY
The name of the poster springs from a DVD and Exhibition attributed to the Scientology movement, and the Citizens Commission on Human Rights (www.cchr.org), entitled: "Psychiatry: An industry of death." It is a well filmed and moving film, and a powerful exhibition, and they summarize much of the more extreme anti-psychiatry concerns and arguments that may appeal to, or concern, frightened reluctant patients, their carers or indeed other professionals. The poster will summarize the facts and arguments proffered to argue that psychiatry is the cause of racism, crime, mental disturbance, the holocaust, community disintegration, erosion of the effectiveness of the criminal justice system and many other ills in society, and that psychiatrists are deceitful lying money makers who abuse, rape and exploit the vulnerable for their own ends (whereas the scientology organization is merely trying to help the vulnerable and is not interested in taking their money). The anti-psychiatry arguments are well presented but unconvincing, nevertheless they have convinced many, some of whom may need treatment at some point in their lives, and so in order to best help such patients, psychiatrists need to be aware of their views and concerns.

REFERENCES
Rissmiller DJ, Rissmiller JH: Evolution of the Antipsychiatry Movement Into Mental Health Consumerism. Psychiatr Serv 57:863-866 doi: 10.1176/appi.ps.57.6.863, 2006
Wiseman B: Psychiatry: The Ultimate Betrayal. PsycCRITIQUES 41(12):1222-1223, 1996

SELF ASSESSMENT QUESTIONS
1. Recent documentaries have:
a. shown evidence that the president of the World Psychiatric Association was also leading invasive research into US and Canadian subjects, without informed consent from them, which permanently damaged their memory.
b. shown evidence that several psychiatrists held leading roles in the Nazi Eugenics and Ethnic Cleansing programs.
c. aired an interview with a psychology professor (Margaret Horgan) who says that psychiatry has "no reliability of diagnosis…no science…it's just pseudoscience, it's pretend science."
d. advised individuals not to take any psychiatric treatments.
ANSWER: e

2. The CCHR website:
a. airs an interview with an unspecified doctor (Gary Null) stating that "it is one of the most open secrets in America…that nothing (in psychiatry)…is being done that is legitimate, and they are billing for it."
b. states that studies show that at least 10% of psychiatrists admit to sexually abusing their patients.
c. airs an interview with Dr. Mark Filidei stating that psychiatrists are "dreaming (diagnoses)…up…creating…new diseases simply to publish papers with their names on them."
d. promotes a view that school shootings were caused by psychiatric drugs and would not have occurred if the drugs were not taken.
e. states that antidepressants cause suicides (a video about a child states antidepressants have caused an estimated 63,000 suicides.
f. discourages individuals from trusting psychiatrists or obtaining psychiatric treatment.
g. all of the above
ANSWER: g

F8 **FORENSIC FELLOWSHIP'S EFFECT ON GENERAL RESIDENTS**

Jeremy A. Hinton, MD, Little Rock, AR
Carol R. Thrush, EdD (I) Little Rock, AR
J. Benjamin Guise, MD, Little Rock, AR

EDUCATIONAL OBJECTIVE
This session will provide an overview of our forensic fellowship curriculum and program evaluation research to examine the effects of the addition of a forensic fellowship on general psychiatry residents' PRITE scores.

SUMMARY
Researchers have examined factors that may influence in-training exam scores and whether the presence of a fellowship program influenced patient outcomes, but none have examined whether the presence of a fellowship program has a measurable effect on educational outcomes. In this study, we examine whether the addition of a forensic fellowship has a measurable effect on general psychiatry residents' scores on the Psychiatry Resident In-Training Examination (PRITE). We examined four years of PRITE scores (2 years prior to and 2 years after implementation of the fellowship program) for general psychiatry residents at our institution, to compare changes in forensic PRITE sub-scores relative to changes in all other sub-scores. Preliminary analysis reveals that among the 13 subscales and 2 global scales measured by the PRITE, means improved on 10 and declined on 5 of the scales. The average mean difference was greatest for forensic sub-scores, which improved an average of 93 points (almost one normed

standard deviation higher) in the 2 years following implementation of the fellowship. Statistical analyses will be presented. External indicators of program outcomes (standardized exam scores) may provide a useful indication of the effects that an educational fellowship program can have on general psychiatry education.

REFERENCES

Godellas CV, Hauge LS, Huang R: Factors affecting improvement on the American Board of Surgery In-Training Exam (ABSITE). J Surg Res 91:1-4, 2000

Peets AD, Boiteau P, Doig C: Effect of critical care medicine fellows on patient outcome in the intensive care unit. Acad Med 81: Suppl:S1-S4, 2006

SELF ASSESSMENT QUESTIONS

1. PRITE scores are an example of what type of evaluation data?
a. internal program data
b. external program data
c. subjective data
d. non-standardized data
ANSWER: a

2. This study supports the conclusion that fellowship programs may impact:
a. clinical outcomes
b. board scores
c. educational outcomes
d. quality of forensic evaluations
ANSWER: c

F9 SEXUAL PREDATOR CASES: JUVENILE'S RISK FACTORS

Gregg R. Dwyer, MD, Columbia, SC
Geoffrey R. McKee, PhD, (I) Columbia, SC

EDUCATIONAL OBJECTIVE

Participants will learn which factors are considered by a non-clinical legally-mandated screening committee to indicate increased risk of sexual recidivism in juvenile sex offenders.

SUMMARY

In keeping with the ruling of the United States Supreme Court in Kansas v. Hendricks, 19 states have passed "Sexually Violent Predator" (SVP) laws permitting the post-incarceration civil commitment of convicted sex offenders who may have a high risk to re-offend with sexual crimes. Because thousands of sex offender inmates might be eligible for SVP commitment, many states have developed screening systems to identify those at highest risk to recidivate. By 2007, more than 2,700 persons had been civilly committed as SVPs. The purpose of this ongoing research is to identify the demographic, educational, general medical, mental health, criminal justice, and sex offense historical factors employed by a state statutory screening committee to refer certain juvenile sex offenders for further judicial review as SVPs. Since the study state's SVP law was passed in 1998, 4,317 adult and adolescent cases have been reviewed. Of those, 57 of 328 juveniles (17.4%) were referred by the screening committee for judicial review. Descriptive and inferential statistical results with associated forensic evaluation and clinical implications will be presented for a sample of those cases.

REFERENCES

Kansas v. Hendricks 521 U.S. 346 (1997)

Davey M, Goodnough A: Doubts rise as states hold sex offenders after prison. The New York Times, March 4, 2007, http://www.nytimes.com/2007/03/04/

SELF ASSESSMENT QUESTIONS

1. In the United States, approximately how many persons have been civilly committed as Sexually Violent Predators?
a. <1000
b. 1100-1500
c. 1600-2000
d. 2100-2500
e. 2600-3000
ANSWER: e

2. Among juvenile sex offenders in the research study, approximately what percentage is considered at high risk to be Sexually Violent Predators?
a. <10%
b. 10-20%
c. 25-30%
d. 40-60%
e. >60%
ANSWER: b

F10 **THEORY OF MIND ASSESSMENTS IN FORENSIC PSYCHIATRY**

J. Arturo Silva, MD, San Jose, CA
Manish A. Fozdar, MD, Wake Forrest, TX

EDUCATIONAL OBJECTIVE
To introduce the Theory of Mind paradigm; to provide a discussion of the Theory of Mind Paradigm and its association to empathy; and to introduce Theory of Mind methods in forensic–psychiatric assessments of cases involving criminal behavior.

SUMMARY
This presentation will provide a brief introduction of the Theory of Mind construct. We will discuss the Theory of Mind Paradigm and its potential connection to the concept of empathy. We will provide an overview of methods that have been used to assess Theory of Mind and empathy in psychiatric-legal criminal settings. This presentation will encompass approaches derived from both psychological and neuropsychiatric perspectives. We will present two cases in order to illustrate the use of Theory of Mind and empathy measures in psychiatric-legal evaluations involving criminal behaviors. We will provide a discussion regarding future research directions in this important emerging area of forensic neuropsychiatry.

REFERENCES
Saxe R: Four brain regions for one theory of mind, in Social Neuroscience: People Thinking About People. Edited by Cacioppo JT, Visser PS, Pickett CL. Cambridge, MA: The MIT Press, 2006, pp 83-101
Bechara A, Bar-On R: Neurological substrates of emotional and social intelligence: evidence from patients with focal brain lesions, in Social Neuroscience: People Thinking About People. Edited by Cacioppo JT, Visser PS, Pickett CL. Cambridge, MA: The MIT Press, 2006, pp 13-40

SELF ASSESSMENT QUESTIONS
1. All of the following are true about Theory of Mind models except:
a. Theory of Mind abilities includes cognitive, perceptual and affective components.
b. Empathic abilities are likely to require important Theory of Mind components.
c. The two most important psychiatric disorders involving significant Theory of Mind deficits are Asperger's Disorder and Antisocial Personality Disorder.
d. Several approaches are currently available for the assessment of Theory of Mind in criminal-legal settings.
ANSWER: c

2. All of the following are true of Theory of Mind constructs except:
a. Psychopaths tend to score within normal limits in Theory of Mind measures.
b. The Theory of Mind paradigm was initially proposed as a useful model for the study of non-human primate behavior.
c. Theory of Mind may be genetically determined.
d. The Theory of Mind paradigm has become an important object of study in autism and cognitive disorders but not for psychotic disorders
ANSWER: d

F11 MEDICOLEGAL ASPECTS OF THE TARASOFF CASE

Neelam Varshney, MD, Worcester, MA
Margaret Goni, MD, Elmhurst, NY
Gagan Dhaliwal, MD, Huntsville, AL

EDUCATIONAL OBJECTIVE
To understand the terms confidentiality, therapeutic privilege, and duty to protect by discussing in particular the Tarasoff case and its relevance to psychiatric practice today.

SUMMARY
Medicolegal responsibility for the dangerous patient was first addressed in the famous “Tarasoff case.” Psychiatrists are expected to play the role of “fortune tellers” in predicting dangerousness in the mentally ill. It is rather disappointing that there are no set standards for risk assessments. An extensive review of literature shows that the Tarasoff case is one of the most cited cases and has a unique impact on law and psychiatry. This poster with brief written texts and visual media will discuss the landmark cases pertaining to confidentiality and therapeutic privilege with focus on the Tarasoff case. It will highlight the aftermath of the case with its progeny, misapplications, and its effect on the delicate issue of the justified breach of confidentiality. Has the Tarasoff case led to therapists’ being mere social protectors? Is it a doctrine that has been extended to impose protective obligations on the mentally ill, driving cases, and patients with infectious diseases? The Tarasoff decision is and will remain the seed for future cases involving dangerousness and violent risk assessment in the mentally ill. The ethical dilemmas surrounding the case have warranted that each risk assessment be tailored to the distinct facts of the case.

REFERENCES
Tarasoff v. Regents, 17 Cal. 3d 425, 551 P.2d 334,131 Cal. Rptr. 14 (1976)
Gutheil TG: Moral justification for Tarasoff-type warnings and breach of confidentiality: a clinician’s perspective. Behav Sci Law 19:197-206, 2001

SELF ASSESSMENT QUESTIONS
1. Which of the following cases is a driving case extension of the Tarasoff doctrine?
a. Lipari v. Sears
b. Jaffe v. Redmond
c. Roe v. Doe
d. Naidu v. Laird
ANSWER: d

2. Which of the following cases treated property as a victim?
a. Peck v. Counseling Service of Addison County
b. Jablonski v. United States
c. Whalen v. Roe
d. Peterson v. State of Washington
ANSWER: a

F12 VIRGINIA TECH SHOOTING TO BRITNEY SPEARS: THE GOLDWATER RULE RE-EXAMINED

Praveen R. Kambam, MD, Los Angeles, CA
Vasilis K. Pozios, MD, Washington, DC

EDUCATIONAL OBJECTIVE
To review the historical context surrounding "the Goldwater Rule," discuss ethical considerations in the application of and adherence to the rule, and present instances of competing considerations to its use.

SUMMARY
From the Virginia Tech shootings to Britney Spears, psychiatrists continue to be called upon by the media to offer professional opinions about individuals who have come to receive public scrutiny. Unfortunately, in psychiatric training and continuing education, there is limited exposure and discussion of ethics principles to help navigate these types of interactions. Section 7 of the APA Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry outlines directions on ethics requirements for communication with the media. Competing considerations including duty to educate the public, advocate for the profession, combat stigma, and assist government decision making, leave instances of application of principles behind "the Goldwater Rule" fuzzy at times. A psychiatrist's motivation for participating in such media or other interactions may assist in determining ethical conduct.

However, it is difficult to assess from the perspective of an external observer. Moreover, no clear guidelines regarding duties of psychiatrists to report violations of the rule exist. Psychiatrists should familiarize themselves with ethics considerations in the application of "the Goldwater Rule."

REFERENCES

American Psychiatric Association: The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. Washington DC: Author, 2006
American Psychiatric Association: Guidelines for psychiatrists working with the communications media. Am J Psychiatry 134(5): 609-611, 1977

SELF ASSESSMENT QUESTIONS

1. The "Goldwater Rule" stipulates:
a. a psychiatrist may offer a professional opinion to the media regarding a celebrity not examined provided the psychiatrist clearly indicates diagnoses offered are provisional
b. a psychiatrist may share with the media his or her expertise regarding psychiatric issues in general
c. a psychiatrist may not participate in torture
d. a psychiatrist has an ethical duty to report violations of the "Goldwater Rule"
ANSWER: b

2. Out of the American Psychiatric Association members responding to the Fact magazine survey about the fitness of 1964 presidential candidate Barry Goldwater, approximately what percentage appropriately responded that they did not know enough about Goldwater to answer the question?
a. 75%
b. 50%
c. 35%
d. 25%
e. 10%
f. 5%
ANSWER: d

F13 **ASSESSING CONFESSION EVIDENCE:POLICE COERCION OR VALID ADMISSIONS OF GUILT?**

Todd N. Palumbo, MD, Cincinnati, OH
Scott A. Bresler, PhD, (I) Cincinnati, OH
Emily A. Keram, MD, Santa Rosa, CA
Steven A. Drizin, JD, (I) Chicago, IL

EDUCATIONAL OBJECTIVE

Through a detailed review of a recent case in which a defendant appears to have been coerced into admitting culpability to a double homicide, the workshop will provide a forum for clinical assessment and academic discussion of the elements entailed in an examination of the suspected false confessor and the reliability of his/her confession.

SUMMARY

This workshop examines a case of double homicide and the subsequent police investigation, which centered on a low-functioning male relative of the murder victims. Two presenters of the workshop were involved with the evaluation and/or legal proceedings pertaining to the case; there are no pending criminal matters as the true assailants have been arrested and convicted. Three segments of police video will be presented in which interrogation techniques are analyzed. In addition, participants will see segments of coercive police interrogation with a suspected witness as well as the actual killers. The concept of "interrogative suggestibility" and how it is measured will be thoroughly examined. The case will be considered in the context of other documented false confession cases as well as seminal case law. The participants will gain knowledge of the following three foci: the research and case law relevant to a defendant suspected of being a false confessor; the tools and methodologies used in assessing the reliability of a confession; and the legal issues that emerge from the early phases of evidentiary challenges to confessions after interrogation.

REFERENCES

Kassin SM, Gudjonsson, GH: The psychology of confessions: a review of the literature and issues. Psychological Science in the Public Interest 5:33-67, 2004
Drizin, SD, Leo, RA: The Problem of False Confessions in the Post-DNA World. North Carolina L Rev 82:891-1004, 2004

SELF ASSESSMENT QUESTIONS

1. Police investigators are not allowed to say or do which of the following in the interrogation of a suspect (after hearing and fully accepting their Miranda rights)?

a. Lie to the suspect (e.g., indicating that he/she has failed the polygraph)
b. Tell the suspect that police have material evidence linking them to the crime scene, when they do not
c. Impress on the suspect that confessing is their "last chance to save themselves"
d. Provide the suspect with a legal (e.g. self-defense or provocation) or a moral (you stole the money to feed your family) excuse for committing the crime
e. Threatening to harm the suspect

ANSWER: e

2. What percentage of confessions given to police are to be determined false?

a. 10%
b. 50%
c. cannot be determined
d. 1%
e. less than 1%

ANSWER: c

F14 PSYCHOLOGICAL TESTING FOR FORENSIC PSYCHIATRISTS

William H. Campbell, MD, MBA, San Antonio, TX
Madelon V. Baranoski, PhD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will learn the value and limitations of psychological testing for forensic evaluations.

SUMMARY

Psychological testing is often requested by forensic psychiatrists to inform and support diagnostic conclusions and to bolster written opinions and testimony. This course is designed for the forensic psychiatrist as a consumer of psychological testing. Topics will include what questions can and cannot be answered, what to ask for, what to expect of the testing, and how to use it. The faculty will review the process of psychological testing, the applicability and limitations of the various tests for diagnostic and forensic questions, and their vulnerability to Daubert challenges. Cognitive, personality, sexual deviance, and risk assessment measures (including actuarial tests), and methods of assessing malingering will be reviewed, as well as the process for choosing tests, the characteristics of relevant interpretation, and the merits of different ways to incorporate psychological results in a written forensic report and testimony. A series of case studies that focus on common forensic scenarios will illustrate the advantages and limitations of psychological testing, the process of collaboration between forensic psychiatrist and psychologist, and methods of preparation for cross-examination when psychological tests are used. The course includes didactic presentation and interactive participation to highlight challenges and ethical issues.

REFERENCES

Melton GB, Petrila J, Poythress NG, Slobogin C: Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers. Third Edition. New York: The Guilford Press, 2007
Strauss E, Sherman EMS, Spreen O: A Compendium of Neuropsychological Tests: Administration, Norms, and Commentary. Third Edition. New York: Oxford University Press, 2006

SELF ASSESSMENT QUESTIONS

1. In the assessment of intelligence:

a. Intelligence tests are based on the assumption that intellectual abilities are distributed normally.
b. The Stanford-Binet test is the most widely used intelligence test.
c. The IQ is a measure of future potential
d. The highest divisor in the IQ formula is 25.

ANSWER: a

2. The Minnesota Multiphasic Personality Inventory (MMPI) is:
a. Composed of over 500 statements.
b. A good diagnostic tool.
c. A good indication of a subject's disorder when the person scores high on one particular clinical scale.
d. In the form of ten clinical scales, each of which was derived empirically from heterogeneous groups.
ANSWER: a

F15 **MANDATED OUTPATIENT CARE IN NYC: TWO ROADS MORE TRAVELED BY**

Merrill R. Rotter, MD, Bronx, NY
Steven K. Hoge, MD, New York, NY
Scott Rogge, MD, Bronx, NY
Jeffrey Janofsky, MD, Timonium, MD

EDUCATIONAL OBJECTIVE
To enhance participants' understanding of various types, challenges, and uses of court ordered outpatient treatment and their respective indices of success.

SUMMARY
With each new article about the apparent failure of outpatient psychiatric care to prevent a serious violent incident in the community, there are calls for strengthening the ability to force individuals into treatment. Every new lawsuit about prison conditions for the mentally ill brings increased focus on improving the structure of outpatient treatment for mentally ill offenders and avoiding incarceration altogether, if possible. Two court mandated mechanisms seek to address these trends: the civil process of court-ordered treatment (Assisted Outpatient Treatment, AOT) and the criminal mechanism of the mental health court. In this panel we compare and contrast the populations served by three such programs: a correctional population and a civil population referred for AOT, and the offender population served by the Bronx Mental Health Court. Dr. Rotter will review the pathways to mandated treatment and present data from the Bronx Mental Health Court. Dr. Hoge will describe the cohort of patients referred from Rikers Island Detention Facility for AOT, and Dr. Rogge will present data from the community-based Bronx AOT program. Dr. Janofsky will discuss mandated outpatient treatment and its potential for addressing unmet needs for successful community treatment for mentally ill individuals, while enhancing public safety.

REFERENCES
Monahan J, Bonnie RJ, Appelbaum PS, et al: Mandated community treatment: beyond outpatient commitment. Psychiatr Serv 52: 1198–1205, 2001
Konigsberg E, Farmer A: Father Tells of Slaying Suspect's Long Ordeal. New York Times, February 20, 2008, http://nytimes.com/2008/02/20/

SELF ASSESSMENT QUESTIONS
1. Assisted Outpatient Treatment always includes which of the following mandates?
a. Intensive case management
b. Supportive psychotherapy
c. Decanoate medication
d. Public assistance
ANSWER: a

2. Sanctions for noncompliance in mental health court include?
a. increased court appearances
b. jail remand
c. hospitalization
d. prison sentence
e. all of the above
ANSWER: e

F16 ETHICS TRAINING IN FORENSIC PSYCHIATRY

Richard Rosner, MD, New York, NY
Robert Weinstock, MD, Los Angeles, CA
Charles Scott, MD, Sacramento, CA
Jeremy Colley, MD, New York, NY

EDUCATIONAL OBJECTIVE
To discuss how training in ethics is currently being done in forensic psychiatry residency programs and to discuss how it should be done.

SUMMARY
The ACGME requires forensic psychiatry residency programs to teach ethics. The AGGME does not clearly define the content of such training, nor how it should be accomplished (e.g., how much time for training in ethics, or what relevant background for the persons who teach ethics to the trainees.) There is variation in duration, contents, methodology, and teacher qualifications between existing programs. Reading must include more than the Codes of Ethics of the AMA, APA, and AAPL. Teachers' qualifications must be more than that they have participated in professional organizations' ethics committees. Sufficient time must be allocated to teaching ethics so that forensic psychiatry residents are equipped to teach introductory ethics courses to psychiatrists and non-psychiatrists. The goals of training in ethics include preparing forensic psychiatry residents both to understand moral philosophy and to apply it in forensic contexts. Programs must evaluate whether forensic psychiatry residents have learned what was taught. This panel will consider whether or not the existing forensic psychiatry residency programs are attaining those standards.

REFERENCES
Rosner R, Weinstock R: Ethical Practice in Forensic Psychiatry. New York: Plenum Publishing Corporation, 1990
Candilis P, Martinez R, Weinstock R, Szanton A (editors): Forensic Ethics and the Expert Witness. New York: Springer-Verlag, 2007

SELF ASSESSMENT QUESTIONS
1. Name a good introductory book on moral philosophy?
ANSWER: Rachels J, Rachels S: The Elements of Moral Philosophy. New York: McGraw Hill, 2007
Frankena W: Ethics. Engelwood Cliffs, NJ: Prentice-Hall, 1973
Gensler H: Ethics: A Contempory Introduction. New York: Routledge, 1998

2. Whose training makes them experts in ethics?
a. attorneys
b. clergy
c. all of the above
d. none of the above
ANSWER: d

F17 OREGON'S JUVENILE PSYCHIATRIC SECURITY REVIEW BOARD

Stewart S. Newman, MD, Beaverton, OR

EDUCATIONAL OBJECTIVE
The participant will gain familiarity with the Psychiatric Security Review Board system in Oregon and the recent development of a board for juvenile offenders.

SUMMARY
In 2005, the Oregon Legislature passed a bill modifying the existing Psychiatric Security Review Board (PRSB) statute, creating a juvenile panel for management of juvenile insanity acquittees. Statutory language was also modified to create a plea of "responsible except for insanity" for juveniles in Oregon. The presenter will review the historical development of the Psychiatric Security Review Board (PSRB) system in Oregon and explain the purpose and function of the PSRB for adult offenders who are successful with an insanity defense. The presenter will then review in detail the statute creating the Juvenile PSRB and its unique characteristics in comparison to its adult PSRB progenitor. A review of the implementation of the Juvenile PSRB and the first year experiences will conclude the presentation.

REFERENCES
Newman SS, et al: Oregon's Juvenile Psychiatric Security Review Board, J Am Acad Psychiatry Law 35:247-52, 2007
Rogers JL, Bloom JD: The insanity sentence: Oregon's Psychiatric Security Review Board. Behav Sci Law 3:69-84, 1895

SELF ASSESSMENT QUESTIONS

1. Juveniles in the Oregon legal system can be made ineligible for the jurisdiction of the Juvenile PSRB if they commit a crime defined by a state mandatory sentencing bill known as what?

ANSWER: Oregon's Measure 11

2. The original language of the statute creating the Juvenile PSRB excluded a specific population of offenders, citing budgetary concerns. What population was this?

ANSWER: Offenders with developmental disabilities or mental retardation

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F18 DECISION-MAKING ABOUT INPATIENT CIVIL COMMITMENT

Andrew R. Kaufman, MD, Durham, NC
Marvin S. Swartz, MD, Durham, NC
Jedidiah J. Perdue, MD, MPH, (I) Durham, NC

EDUCATIONAL OBJECTIVE

To review the history of civil commitment law in the United States and explain the current statutory criteria; elucidate the effect of system constraints on decision-making in civil commitment proceedings as practiced by psychiatric residents in North Carolina; and explore general opinions about civil commitment and emergency psychiatry by North Carolina psychiatric trainees.

SUMMARY

Objective: Nearly all patients referred to state mental hospitals in North Carolina are placed under civil commitment and transported by law enforcement. This study examines possible factors in the decision-making and general attitudes toward civil commitment among resident psychiatrists in North Carolina. Methods: Psychiatric resident physicians from three teaching hospitals in North Carolina were contacted to participate in an electronic survey. A total of 61 responded and the collected data was analyzed. Results: Significant decision-making factors reported in hypothetical scenarios included importance of commitment criteria, lack of affordable community treatment alternatives, and need for transportation to the hospital of admission. Conclusions: Based upon hypothetical clinical vignettes, residents were more likely to commit patients with substance abuse, who are disproportionately uninsured, where there was a need for secure transportation to the hospital and a lack of affordable alternative treatment in the community. They were less likely to commit if they believed that meeting commitment criteria was important.

REFERENCES

Brooks RA: Psychiatrists' opinions about involuntary civil commitment: results of a national survey. J Am Acad Psychiatry Law 35 (2):219-228, 2007

Sattar SP, Pinals DA, Din AU, Appelbaum PS: To commit or not to commit: the psychiatry resident as a variable in involuntary commitment decisions. Academic Psychiatry 30 (3):191-195, 2006

SELF ASSESSMENT QUESTIONS

1. Are psychiatric residents more likely to commit patients with substance abuse or psychosis when commitment criteria are not clearly met?

ANSWER: substance abuse

2. What two factors contribute to the likelihood that residents will commit patients with substance abuse for inpatient treatment in North Carolina?

ANSWER: Lack of community treatment alternatives, and need for secure transport to the hospital of admission

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F19 DO PROTECTION ORDERS PROTECT?

Christopher T. Benitez, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

This study synthesizes the current literature in an effort to determine whether and when protection orders may be more likely to be successful. In addition, this study attempts to identify the factors that might suggest such situations.

SUMMARY

Protection orders are legal interventions intended to reduce the risk of future harm by one person considered to be a threat to another. There are many situations when protection orders are considered as a part of a threat management strategy. Among experts, there has been controversy about when and whether such orders might be useful. This paper reviews the empirical literature on the topic. Application of the research findings to decision-making regarding the use of protection orders is limited by methodological issues, heterogeneity of study groups, the types

of legal orders involved, a lack of comparison groups, variable duration of studies, and differing operational definitions or measurement techniques. Nevertheless, this review summarizes the literature, describes the evidence regarding the effectiveness of protection orders, and also reports on factors the literature suggests are important in weighing whether an order will be effective or counterproductive. Despites limitations of the existing literature, the author concludes that available empirical evidence supports that protective orders can be effective in reducing the risk of harm, and the author identifies factors to consider before recommending such an order.

REFERENCES

Logan TK, Shannon L, Walker R, Faragher TM: Protective orders: questions and conundrums. Trauma, Violence, and Abuse. 7:175-205, 2006

Holt VL, Kernic MA, Lumley T, Wolf ME, Rivara FP: Civil protection orders and risk of subsequent police-reported violence. JAMA 288; 589-594, 2002

SELF ASSESSMENT QUESTIONS

1. What are some of the characteristics of the victim and the abuser, which may be important to consider in considering a protection order?
ANSWER: socioeconomic status, biological children between the victim and defendant, race, prior drug use by the victim, prior criminal records, substance abuse, unemployment, and resistance to the placement of the protection order.

2. List several legal system factors that may impact the effectiveness of protective orders.
ANSWER: incidence of arrest, perceived adequacy of protection orders and prosecution.

F20 AN EMPIRICAL STUDY OF JUVENILE STALKERS

Rosemary Purcell, BA, MPsych, (I) Victoria, Australia
Paul E. Mullen, MBBS, Fairfield, Australia

EDUCATIONAL OBJECTIVE

Information regarding juvenile stalkers is limited, including what motivates their behavior, and the impacts of their offending on victims. This presentation will advance knowledge by examining why juveniles stalk, their methods of stalking and propensity for violence, and the effectiveness of restraining orders for managing stalking in this population.

SUMMARY

This study examines the characteristics, nature and impacts of stalking among juvenile perpetrators. The sample was drawn from a review of consecutive court applications for a restraining order against a juvenile between January 1 2004 – November 30, 2006. Over the study period 299 juveniles met the criteria for stalking. The majority of perpetrators were male (64%) and their victims predominantly female (69%). Most pursued a previously known victim (98%), typically a school peer, estranged friend or ex-partner. Juvenile stalkers favored direct means of intrusion, usually via unwanted approaches and telephone calls. The rates of associated violence were high, with 75% threatening and 50% physically assaulting the victim. Stalking emerged in several contexts, most commonly as an extension of bullying (28%), retaliation for a perceived harm (22%) and rejection following the termination of a relationship (22%). In 5% the stalking was sexually predatory, with 2% motivated by infatuation. This study demonstrates that juvenile stalkers differ from their adult counterparts in terms of the contexts in which the stalking emerges, as well as the greater involvement of female perpetrators, and higher propensity for violence. The seriousness that is afforded to adult forms of stalking should similarly apply to juveniles.

REFERENCES

McCann JT: A descriptive study of child and adolescent obsessional followers. J of Forensic Sci 45: 195-199, 2000

Scott CL, Ash P, Elwyn T: Juvenile aspects of stalking, in stalking: Psychiatric Perspectives and Practical Approaches. Edited by Pinals DA. Oxford: Oxford University Press 2007, pp 195-211

SELF ASSESSMENT QUESTIONS

1. What factors motivate stalking in juveniles?
ANSWER: A range of factors may operate, including bullying, rejection, resentment, infatuation and sexual predation.

2. Is juvenile stalking a serious form of offending, or merely an (albeit inappropriate) developmental phase?
ANSWER: Juvenile stalking should be afforded seriousness, given the propensity for violence in this group and the potentially devastating impact on young victims.

F21 **TOPICS IN FORENSIC NEUROPSYCHIATRY I: FORENSIC NEUROPSYCHIATRY COMMITTEE**

Hal Wortzel, MD, Denver, CO
Joseph Baskin, MD, Baltimore, MD
Robert Granacher, MD, MBA, Lexington, KY
Mohan Nair, MD, Los Alamitos, CA

EDUCATIONAL OBJECTIVE
To stimulate discussion on, and increase awareness of, how the fields of neuroscience and neuropsychiatry may be relevant to forensic psychiatric practice.

SUMMARY
This workshop will involve presentations by four speakers with audience participation: 1) Amnesia and Crime: Dr. Wortzel will review the neurobiology and clinical aspects of memory, as related to the use of amnesia as a defense or strategy in the forensic or court setting, and discuss how a better understanding of memory functions can assist the court in these types of cases. 2) Neurobiology of Psychopathology: Dr. Baskin will review the neuroscience aspects of psychopathy, including anatomy, neurochemistry, cognitive issues, and the clinical association to autism spectrum disorders. 3) Blast/Explosion Overpressure Trauma: Dr. Granacher will review a newly seen form of major brain injury now being reported in the battlefield in Iraq and Afghanistan. He will describe the potential forensic implications of this type of injury, including disability and personal injury TBI claims in personnel returning from combat, and criminal competency and responsibility. 4) TBI and Sexual Violence: Dr. Nair will review what is understood about the relationship between sex offending behavior and TBI, and discuss possible underlying mechanisms involved in sexually-related crimes in those offenders who are identified as brain injured.

REFERENCES
Freedman D, Beck JC: Institutional failure in the life histories of men condemned to death. J Am Acad Psychiatry Law 28:86-88, 2000
Mesulam MM: Notes on the cerebral topography of memory and memory distortion: a neurologist's perspective. in Memory Distortion. Edited by Schacter DL, Coyle JT, Fischback GD, Mesulam MM, Sullivan LE. Cambridge, MA: Harvard University Press, 1995, pp 379-385

SELF ASSESSMENT QUESTIONS
1. Concerning memory:
a. Encoding is hippocampus-dependent.
b. Retrieval of previously learned information is frontal system dependent.
c. Impairment, in the context of neurological disorders, psychological trauma, or ego defenses, has a neurobiological basis.
d. All of the above.
ANSWER: d

2. Blast overpressure trauma is associated with which of the following?
a. high-powered gunshot wounds to the head seen in combat
b. high-powered explosives with multiple occult organ injury
c. being a purely military concern with no psychiatric forensic component
d. being commonly reported in major trauma such as car crashes and falls
ANSWER: b

F22 **NEONATICIDE: PHENOMENOLOGY, PREVENTION AND THE LAW: GENDER ISSUES COMMITTEE**

Susan J. Hatters Friedman, MD, Cleveland, OH
Philip Resnick, MD, Cleveland, OH
Renée Sorrentino, MD, Quincy, MA
Cheryl Wills, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE
Participants will be able to: describe commonalities among perpetrators of neonaticide, define denial of pregnancy, and understand the intersection of denial of pregnancy/ neonaticide and the law in arenas other than sanity, including Safe Haven laws and judicial bypass evaluations.

SUMMARY
Neonaticide, murder of the infant in the first day of life, is distinct from other filicides. Neonaticide offenders often are poor, relatively young, single women free of major psychiatric disorders, who did not seek prenatal care. They often denied or concealed pregnancy. Also intricately related to neonaticides are judicial bypass evaluations for abortion, Safe Haven laws, and insanity/ diminished capacity evaluations. Mandated parental notification laws, before a minor can obtain an abortion, exist in many states. Teenage girls who commit neonaticide because they cannot face their parents (due to shame) may not procure a lawful abortion. Dr. Wills will discuss "judicial bypass" psychiatric evaluations, also known as "Jane Doe evaluations", which are considered controversial by some. An American response to the problem, Safe Haven laws, will be discussed. Mothers depositing infants in Safe Havens often remain anonymous with reduced risk of prosecution. Neonaticide occurs before the usual onset of postpartum psychosis or postpartum depression. Maternal suicide attempts are quite uncommon in conjunction with neonaticides. However, in some cases, insanity or diminished capacity defenses may be raised. Illustrative cases will be presented. Dr. Resnick, who coined the term "neonaticide", will discuss motivations for the crime, and act as discussant for the panel.

REFERENCES
Hatters Friedman S, Horwitz S, Resnick P: Child murder by mothers: a critical analysis of the current state of knowledge and a research agenda. Am J Psychiatry 162: 1578-1587, 2005
Hatters Friedman S, Resnick P: Maternal neonaticide: phenomenology and prevention. Int J Law Psychiatry, 2008, in press

SELF ASSESSMENT QUESTIONS
1. Which of the following is not a common characteristic of neonaticide offenders?
a. unmarried
b. low socio-economic status
c. experienced denial of pregnancy or concealment of pregnancy
d. good social support
ANSWER: d

2. Define "Safe Haven" laws?
ANSWER: Most Safe Haven laws allow anonymous legal abandonment of unharmed newborns at designated sites. At least 45 states have some form of a Safe Haven law.

F23 METHAMPHETAMINE, PSYCHOSIS, AND VIOLENCE IN CRIMINAL FORENSIC PSYCHIATRY: ADDICTION PSYCHIATRY COMMITTEE

Mace Beckson, MD, Los Angeles, CA
Joseph R. Simpson, MD, PhD, Long Beach, CA
David Y. Kan, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE
To understand the research on psychotic and violent behavioral consequences of methamphetamine use in criminal settings in order to improve forensic psychiatric practice in criminal cases of violent offenses.

SUMMARY
Methamphetamine, particularly smoked crystal methamphetamine, has recently become a major drug of abuse in the United States, where it is manufactured domestically and relatively inexpensive. Users experience euphoria from this psychostimulant, which lasts longer than crack cocaine and does not require repeated re-dosing to maintain the high. However, methamphetamine is perhaps the most neurotoxic drug of abuse. Methamphetamine may cause agitation, confusion, irritability, and impulsivity. Methamphetamine also causes prolonged insomnia. Paranoid psychosis is a complication of chronic heavy methamphetamine use. Delusional thinking may fuel violence aimed at those believed to be threatening harm. There are a variety of indications that use of methamphetamine and related drugs may lead to increased sexual and nonsexual aggression. The evidence for this hypothesis will be examined, with conclusions which have utility in the forensic psychiatric analysis of violent crimes.

REFERENCES
Sekine Y, Ouchi Y, Takei N, et al: Brain serotonin transporter density and aggression in abstinent methamphetamine abusers. Arch Gen Psychiatry 63:90-100, 2006
Beckson M, Bartzokis G, Weinstock R: Substance abuse and addiction, in Principles and Practice of Forensic Psychiatry, 2nd Edition. Edited by Rosner R. London: Arnold, 2003

SELF ASSESSMENT QUESTIONS

1. Methamphetamine may lead to nonsexual violence as a result of?
a. stimulant-related disinhibition
b. paranoid delusions
c. comorbid psychiatric disorder or substance abuse
d. personality or illicit drug-using lifestyle
e. all of the above
ANSWER: e

2. Complications of methamphetamine use may include?
a. insomnia
b. agitation
c. psychosis
d. aggression
e. all of the above
ANSWER: e

F24 **CULTURAL FORMULATION IN FORENSIC PSYCHIATRY: CROSS-CULTURAL COMMITTEE**

Jagannathan Srinivasaraghavan, MD, Anna, IL
James Boehnlein, MD, Portland, OR
J. Arturo Silva, MD, San Jose, CA
Alberto M. Goldwaser, MD, Hackensack, NJ
Donna M. Norris, MD, Wellesley, MA

EDUCATIONAL OBJECTIVE

At the end of this workshop participants should be able to discuss the relevance of cultural issues in forensic evaluations, and they should be able to summarize the essential elements of the cultural psychiatric formulation relevant to comprehensive forensic evaluations.

SUMMARY

In the twenty-first century our society is becoming more diverse culturally and ethnically. Culture is a complex system of symbols possessing subjective dimensions such as values, feelings and ideas and objective dimensions including beliefs, traditions and behavioral prescriptions articulated into laws and rituals. Ethnicity connotes groups of individuals sharing a sense of common ancestry and shared beliefs and history. DSM-V requires cultural formulation to be included in all psychiatric evaluations. Symptom patterns of disorders vary across cultures. So do cultural factors that figures in the maintenance and reduction of symptoms and the belief system the group holds about mental disorders. Understanding symptoms, behavior, specific cultural traditions, values, norms that impact behavior, mitigation, language and access to a trained interpreter, specific history of culture/country of origin, marital and family dynamics including child custody may all be relevant in court proceedings. The panelists will emphasize, using case examples, the relevance and importance of cultural formulation and make recommendations in assessing specific cultural questions attorneys may want answered, assessing the knowledge of relevant parties in court, and making sound cultural formulation as part of forensic evaluation. There will be discussion of pitfalls such as overemphasis on culture, minimization of language fluency, ignoring demographic variables and degree of acculturation.

REFERENCES

Boehnlein JK, Schaefer MN, Bloom JD. Cultural considerations in the criminal law. The sentencing process. J Am Acad Psychiatry Law 33:335-41, 2005
Kirmayer LJ, Rousseau C, Lashley M: The place of culture in forensic psychiatry. J Am Acad Psychiatry Law 35: 98-102, 2007

SELF ASSESSMENT QUESTIONS

1. Cultural formulation is important as part of psychiatric evaluation because
a. symptom patterns of disorders vary across cultures
b. cultural factors play a part in the maintenance and reduction of symptoms
c. belief systems the group holds in understanding mental disorders vary across cultures
d. all of the above
e. none of the above
ANSWER: d

2. What are the pitfalls to be avoided in cultural formulation?
a. overemphasis of culture
b. minimizing the role of cultural fluency
c. ignoring demographic variables
d. degree of acculturation
e. all of the above
ANSWER: e

F25 **THE POLITICAL DYNAMICS OF MENTAL HEALTH LAW REFORM: THE VIRGINIA EXPERIENCE**

Richard J. Bonnie, LLB, (I) Charlottesville, VA

EDUCATIONAL OBJECTIVE
To familiarize participants with the problems being addressed by the mental health law reform commission in Virginia, the elements of comprehensive reform, the changes adopted in the wake of the tragic shootings at Virginia Tech, and the challenge of sustaining the effort in the face of recession and competing public priorities.

SUMMARY
Changes in mental health law and policy are often driven by tragic events that galvanize public attention and political response. Unfortunately, tragedy-driven change may be ineffective or even harmful because it is premised on a distorted understanding of the problem, represents a hasty and ill-conceived response to perceived public pressure for action, or makes more carefully crafted policies less likely to be adopted. Virginia's response to the Virginia Tech shootings on April 16, 2007 represents a potentially informative case study of changes in mental health policy and law enacted in the shadow of tragedy. In this presentation, Professor Bonnie, who chairs the Commission on Mental Health Law Reform established by the Supreme Court in the fall of 2006, will place the changes adopted by the legislature in 2008 in the context of the Commission's overall goals and will reflect on the prospects for achieving comprehensive reform in the years ahead.

REFERENCES
Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform (December, 2007). http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf.
Civil Commitment Practices in Virginia: Perceptions, Attitudes and Recommendations (April 2007). http://www.courts.state.va.us/cmh/civil_commitment_practices_focus_groups.pdf

SELF ASSESSMENT QUESTIONS
1. Identify two of the key changes adopted by the Virginia General Assembly in 2008.
ANSWER: Loosening the "dangerousness" criterion for civil commitment, specifying necessary elements of an adequate commitment evaluation, assuring confidentiality of disclosures of health information made in connection with the commitment process, and establishing a detailed procedure for monitoring mandatory outpatient treatment.

2. Identify two key additional changes to the mental health code favored by the Commission on Mental Health Law Reform.
ANSWER: Lengthening the period of emergency hospitalization before a commitment hearing from two days to four or five days, reducing reliance on police to provide transportation to people in custody for evaluation or commitment, and empowering individuals to execute advance directives relating to mental health care.

F26 **A NEAR-SUICIDE: EXPERTS DIFFER ON JUST ABOUT EVERYTHING: PEER REVIEW COMMITTEE (AAPL MEMBERS ONLY)**

David Rosmarin, MD, Harvard, MA
Thomas G. Gutheil, MD, Brookline, MA
Robert Wettstein, MD, Pittsburgh, PA
Howard V. Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE
This presentation will permit the audience to view and analyze the testimony of Thomas Gutheil, MD in a complex outpatient suicide attempt case.

SUMMARY
This presentation may be attended by AAPL members only. Because it is peer review, attendance signifies agreement that the case will be confidential and not discussed outside of the session. In a case that involved opposing nationally known experts, Dr. Gutheil testified for the defendant psychiatrist in an outpatient suicide attempt case. The case ultimately reached the Florida Supreme Court. Previously, a line of Florida cases, beginning with Paddock v. Chacko (1988), held that as a matter of law, a psychiatrist has no duty to involuntarily hospitalize an outpatient—not the sole issue in this case, but important. It is expected that by the time of this presentation, the legal outcome will be known.

REFERENCES
Gutheil TG: Liability issues and liability prevention in suicide, in The Harvard Medical School Guide to Assessment and Intervention in Suicide. Edited by Jacobs, D. Cambridge MA: Harvard University Press, 1999
Simon RI: Assessing and Managing Suicide Risk: Clinically-Based Risk Management. Washington DC: American Psychiatric Publishing Inc., 2004

SELF ASSESSMENT QUESTIONS
1. In general, are psychiatrists expected to accurately predict suicide?
ANSWER: No, but they are expected to perform a suicide risk assessment that comports with the standard of care.

2. How do many authorities address patients' concealing suicide intent?
ANSWER: This is viewed as poor treatment alliance, hampering assessments, but still requiring the physician to discount patients' statements and make risk judgments and treatment based on available data.

F27 **THE EXPERT WITNESS IN PSYCHIATRIC MALPRACTICE CASES**

Philip J. Resnick, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE
To learn some practical pitfalls of being an expert witness in malpractice litigation and to practice writing malpractice opinions.

SUMMARY
This workshop will focus on practical aspects of serving as a psychiatric expert witness in malpractice litigation. The workshop will cover the initial contact with the attorney, data collection, case analysis, report writing and preparation for discovery depositions. Instruction will be given in identifying the correct standard of care, use of the defendant psychiatrist's perspective, and avoidance of the hindsight bias. Dr. Resnick will draw case examples from his experience of evaluating more than 150 malpractice cases. Principles of writing malpractice reports will be explicated. The differences in plaintiff and defense expert reports will be explored. For example, defense reports are only expected to address deviations from the standard of care identified by plaintiff's experts. In preparing for expert witness depositions, participants will be advised about what to remove from their file, the importance of not volunteering anything, and that nothing is "off the record." Handouts will include 64 suggestions for discovery depositions. Each participant will write an opinion about an actual suicide malpractice case. Participants will defend their opinions in mock cross-examination.

REFERENCES
Knoll J, Gerbasi J: Psychiatric malpractice case analysis: striving for objectivity. J Am Acad Psychiatry Law 34:215-23, 2006
Binder RL: Liability for the psychiatric expert witness. Am J Psychiatry 159:11, 2002

SELF ASSESSMENT QUESTIONS
1. Common errors in analyzing malpractice cases include all of the following except?
a. using an incorrect standard of care
b. agreeing to assess damages
c. failing to address causation
d. identifying too many deviations
e. having a hindsight bias
ANSWER: b

2. Common errors in malpractice depositions include all of the following except?
a. lack of preparation
b. volunteering information
c. listening too carefully to the question
d. acknowledging articles as authoritative
e. loss of temper
ANSWER: c

F28 **RISK MANAGEMENT IN CHILD/FORENSIC PSYCHIATRY**

Lee H. Haller, MD, and Potomac, MD
Peter Ash, MD, Atlanta, GA
Stephen Billick, MD, New York, NY
Donna Vanderpool, MBA, JD, (I) Arlington, VA

EDUCATIONAL OBJECTIVE

This workshop is designed to help the audience avoid becoming the object of either a malpractice suit or an ethics complaint. It is specifically geared to those who practice child and adolescent psychiatry.

SUMMARY

Athough child psychiatry is at the lower end of the spectrum with regard to frequency of litigation, suits are filed against child and adolescent psychiatrists. The advent of managed care, the increase in split treatment, and shorter appointments for medication checks increase the likelihood that litigation will be filed against the child and adolescent psychiatrist. This workshop is designed to help practitioners avoid such suits, by increasing their awareness of potentially problematic areas. Dr. Haller will address risks inherent in the general practice of child psychiatry. Dr. Ash will address the risks involved in the practice of child and adolescent forensic psychiatry. Ms. Vanderpool will review the areas in which child and adolescent psychiatrists are sued. Dr. Billick will address problematic ethical concerns.

REFERENCES

Haller L: Child and Adolescent Clinics of North America, 11:4. Philadelphia: WB Saunders, 2002
Schetky DH, Benedek EP: Principles and Practice of Child and Adolescent Forensic Psychiatry. Washington, DC: American Psychiatric Publishing Inc., 2002

SELF ASSESSMENT QUESTIONS

1. When performing a child custody evaluation, it is necessary to do which of the following?
a. interview the parents
b. interview the child
c. interview significant others, such as nannies and daycare providers
d. review outside records
e. all of the above
ANSWER: e

2. Before treating the minor child of divorced parents who have joint legal custody one should do which of the following?
a. obtain permission only from the parent who has primary physical custody
b. obtain permission only from the parent who contacted you
c. obtain permission from both parents
ANSWER: c

F29 **RISKS OF FORENSIC USE OF TRAUMA-SPECIFIC TESTS: TRAUMA AND STRESS COMMITTEE**

Stuart B. Kleinman, MD, New York, NY
Jeremy R. Butler, MD, New York, NY
Daniel A. Martell, PhD, (I) Newport Beach, CA

EDUCATIONAL OBJECTIVE

To become aware of: the properties of various trauma specific tests which make them susceptible to being malingered; techniques individuals may use to detect them; and how evaluees may acquire means of defeating them.

SUMMARY

The diagnosis of PTSD is very appealing to plaintiffs as it directly links emotional harm and a specific major life event. Psychologic tests designed to assess PTSD in treatment and research settings are commonly utilized in forensic mental health settings. Of particular import to the forensic evaluator, few tests specific to the assessment of the impact of trauma have structural elements (i.e., validity scales) necessary for addressing malingering, and most which do possess problematic specificity and sensitivity in its identification. The panel will review such tests, e.g., PTSD Checklist, Trauma Symptom Inventory, Post-Traumatic Symptoms Scale, Impact of Events Scale, Mississippi Scale, CAPS, MMPI, PAI, etc., and the particular ways they are vulnerable to feigning. Presenters will also address how evaluees may obtain information from the internet and attorneys to significantly compromise the validity of these tests.

REFERENCES
Burges C, McMillan TM: The ability of naive participants to report symptoms of post-traumatic stress disorder. Br J Clin Psychol 40(Pt 2):209-14, 2001
Bury AS, Bagby RM: The detection of feigned uncoached and coached posttraumatic stress disorder with the MMPI-2 in a sample of workplace accident victims. Psychol Assess 14:414-484, 2002

SELF ASSESSMENT QUESTIONS
1. Name three psychologic tests which contain validity scales?
ANSWER: The Trauma Symptom Inventory, Personality Assessment Inventory, MMPI-II

2. Approximately what fraction of attorneys in one survey indicated believing that they should usually or always inform clients about validity scales before sending them for psychological evaluation?
ANSWER: One-half

F30 PSYCHIATRY RESIDENTS' EXPERIENCE PERFORMING DISABILITY EVALUATIONS

Paul P. Christopher, MD, Providence, RI
Robert Boland, MD, (I) Providence, RI
Katharine Philips, MD, (I) Providence, RI
Patricia Recupero, JD, MD, Providence, RI

EDUCATIONAL OBJECTIVE
To inform participants of the nature and extent of psychiatry residents' experience conducting disability evaluations and to highlight the potential role that forensic psychiatrists can play in helping to educate residents on how to perform these evaluations.

SUMMARY
Disability evaluations are among the most common nonclinical tasks performed by psychiatrists, and mental disorders (excluding mental retardation) rank highest among diagnostic categories as a reason for federal disability benefits. However, psychiatry residencies offer limited training on how to conduct evaluations of work-related impairment. To our knowledge, this is the first study to investigate how much exposure psychiatry residents have to conducting disability evaluations and how prepared they feel to perform them as soon-to-be practicing clinicians. We will present preliminary results from a survey study in which third-and fourth- year adult psychiatry residents reported how often they are requested to complete disability evaluations, how often they do complete them, whether they do so with their patients present, whether they discuss the limitations on confidentiality, and whether they seek guidance from supervisors when conducting these evaluations. Residents also rated their own ability in making accurate disability assessments and rated how well they feel their training has prepared them to meet this challenge.

REFERENCES
Anfang SA, Wall BW: Psychiatric Fitness-for-Duty Evaluations. Psychiatr Clin North Am 29:675–693, 2006
Mischoulon D: An approach to the patient seeking psychiatric disability benefits. Acad Psychiatry 23:128–136, 1999

SELF ASSESSMENT QUESTIONS
1. Mental disorders (excluding mental retardation) comprise what percentage of disabilities that are awarded federal benefits?
a. 10%
b. 20%
c. 30%
d. 40%
ANSWER: c

2. Which of the following is the greatest predictor of failure to return to work from short-term disability?
a. major depression
b. generalized anxiety
c. social phobia
d. alcohol abuse
ANSWER: a

F31 USE OF "FORENSIC" COUNTERTRANSFERENCE IN FORENSIC PSYCHIATRY

Pirzada S. Sattar, MD, Omaha, NE
Marium Garuba, MD, Omaha, NE
Fang Qui, MS, (I) Omaha, NE

EDUCATIONAL OBJECTIVE
To learn about opinions of forensic psychiatrists on the use of the modifier "forensic" to explain the essence of countertransference like feelings/emotions experienced in the practice of forensic psychiatry.

SUMMARY
The concepts of transference and countertransference are the bedrock of clinical psychiatry. However, some reluctance exists with using these terms due to clinical underpinnings of a doctor-patient relationship, which in a forensic examination does not exist. We had suggested that adding a modifier like “forensic” to countertransference may resolve this ambivalence. However, there is no research on possible ways to resolve this issue. In this study, we surveyed forensic psychiatrists’ opinions on using modifiers or introducing a new term to better embody the concept presently defined by “forensic countertransference.” A cross-sectional survey was conducted in 2003, in which members of the American Academy of Psychiatry and the Law that had their email published in the annual membership directory in 2002, were contacted by email and invited to complete a specially formulated survey instrument. The response rate was 12% (111 psychiatrists completed the survey). The results suggest that > 90% of the respondents were against the use of modifiers, whereas 60% were against the use of a new term to explain these concepts. Despite its limitations, the study's results are important as they suggest a need for further discussion, dialogue, and research for the continued development of forensic psychiatry.

REFERENCES
Sattar SP, Pinals DA, Gutheil T: Countering countertransference: a forensic trainee’s dilemma. J Am Acad Psychiatry Law: 30(1):65-9; discussion 70-3, 2002
Sattar SP, Pinals DA, Gutheil T: Countering countertransference, II: beyond evaluation to cross-examination. J Am Acad Psychiatry Law: 32 (2): 148-54, 2004

SELF ASSESSMENT QUESTIONS
1. What is countertransference?
ANSWER: It is the mix of emotions evoked in the psychiatrist in response to the patient's emotions and behavior.

2. What is forensic countertransference?
ANSWER: It is the mix of emotions evoked in the examiner in response to several examinee and non-examinee variables that can impact the objectivity of the examiner.

F32 PLAINTIFF/DEFENSE BIAS IN MALPRACTICE CASES?

H.W. LeBourgeois III, MD, Baton Rouge, LA
Gina Manguno-Mire, PhD, (I) New Orleans, LA

EDUCATIONAL OBJECTIVE
To present findings of a research study investigating whether psychiatrists are susceptible to biased opinions in mock malpractice cases, based on attorney referral source (i.e., plaintiff or defense attorney referral).

SUMMARY
Ethics guidelines direct forensic psychiatrists to perform objective evaluations. Yet, there are potential threats to objectivity such as the polarizing effect of adversarial legal proceedings, where it is sometimes assumed that experts tilt their opinions in favor of the retaining party. To further investigate this potential form of bias, we developed a study whereby 207 psychiatrists reviewed mock psychiatric malpractice cases; we informed half of the participants that the cases were referred for evaluation by a plaintiff’s attorney and the other half upon referral from a defense attorney. Participants provided opinions on whether a duty existed, whether the standard of care was met, and whether actions or failure to act on the part of defendant psychiatrists directly led to damages. We analyzed responses between groups to determine whether participants’ opinions diverged along the lines of attorney referral source, as we hypothesized that would indicate bias. We found no significant between-group differences on the above measures, suggesting that, at least in an experimental model, attorney referral source has no significant impact on opinions as might be provided during psychiatric malpractice cases. Results suggest that when differences of expert opinion occur in malpractice cases, factors other than attorney referral source are causative. This research was partially funded by a grant from the AAPL Institute of Education and Research.

REFERENCES
Dattilio FM, Commons ML, Adams KM, et al: A pilot Rasch Scaling of lawyers' perceptions of expert bias. J Am Acad Psychiatry Law, 34: 482–91, 2006
LeBourgeois HW III, Pinals DA, Williams VA, et al: Hindsight bias among psychiatrists. J Am Acad Psychiatry Law 35: 67-73, 2007

SELF ASSESSMENT QUESTIONS
1. To date, data-based research on expert opinion in malpractice cases most strongly supports which form of bias being potentially problematic?
a. bias due to financial incentive
b. hindsight bias
c. commonality of malpractice insurance bias
ANSWER: b. There are at least two studies examining the impact of hindsight bias on expert opinion as might be provided in malpractice cases, both indicating a potential for bias. Bias due to financial incentive is commonly discussed, but infrequently studied in a controlled manner. Commonality of malpractice insurance among the expert and defendant leading to bias has been mentioned in the literature by attorneys and allowed into evidence, but not systematically evaluated for impact on expert opinion.

2. A study of lawyers' perceptions of bias in experts revealed which of the following?
a. Experts repeatedly court-appointed, as opposed to hired by the opposing party, were held in lower regard.
b. Experts who work only one side were perceived as more credible, trustworthy, and loyal.
c. Experts who work only one side were perceived as less credible, trustworthy, and loyal.
ANSWER: c. Experts working for only one side (e.g., only for the plaintiff or only for the defense) were perceived as less credible, trustworthy, and loyal. Repeated court-appointment increased attorneys' regard for experts.

F33 EVALUATING CHRONIC PAIN AND DISABILITY IN CIVIL LITIGATION

Roy J. O'Shaughnessy, MD, Vancouver, BC Canada
Paul Janke, MC, FRCP, BC, Canada
Kulwant Riar, MB, FRCP, BC, Canada

EDUCATIONAL OBJECTIVE
To review the recent literature on chronic pain and pain disorder and current guidelines, and the definition of impairment and disability. The discussion will focus on the biological basis of chronic pain and psychological factors empirically identified in pain disorder. Forensic assessment of disability and evidence based assessment of malingering will be described.

SUMMARY
Chronic pain is a common syndrome associated with high rates of morbidity and reported disability. The transition from acute pain or nociception to chronic pain has been thought to be related to neuroplasticity centrally that has recently been partially affirmed with fMRI studies. Chronic pain syndrome is a problem facing all branches of medicine. The AMA Guidelines on the Evaluation of Permanent Impairment provide a useful framework for medical evaluation. In addition, psychiatrists focus on those psychological factors including mood and anxiety disorders, cognitive distortions and personal, social, and cultural factors subsumed under pain disorder that may play a decisive role in disability. Evaluation of disability in chronic pain patients presents unique challenges due to the subjective nature of the complaint. The presentation will focus on the forensic assessment and how to establish the factual base through detailed review of medical, work, and psychiatric records. The assessment requires knowledge of those psychological factors empirically shown to contribute to disability or that suggest exaggeration. Special emphasis will be placed on the assessment of malingering with a threshold model utilizing evidence-based factors derived from interview and psychometric data, review of functioning and surveillance that leads to increased scrutiny depending on clinical findings.

REFERENCES
Hainline, B: Chronic pain: physiological, diagnostic and management considerations. Psychiatric Clinics of North America, 28:3, 713-735, 2005
Young, G, Kane, A, Nicholson, K: Causality of Psychological Injury. New York: Springer, 2007

SELF ASSESSMENT QUESTIONS

1. Psychological factors associated with pain disorder include?
a. mood disorders
b. PTSD
c. sleep disorders
d. somatoform disorders
e. all of the above
ANSWER: e

2. Empirically supported factors suggesting malingering include?
a. lack of cooperation in interview
b. indiscriminant endorsement of symptoms
c. overt hostility at examination
d. symptoms reported as universally severe
e. b and d
ANSWER: e

F34 FORENSIC PSYCHIATRY AND THE INTERNET: UNTANGLING THE WEB

Charles L. Scott, MD, Sacramento, CA
Jennifer Chaffin, MD, (I) Sacramento, CA
Michael Harlow, MD, Sacramento, CA
Soroush Mohandessi, MD, (I) Sacramento, CA

EDUCATIONAL OBJECTIVE

The audience participant will learn emerging areas that involve the interface of forensic psychiatry and the Internet to include legal issues related to Internet addiction, cyberbullying, cyberstalking, and standards of mental health care provided over the Internet.

SUMMARY

The Internet has a profound impact on the way individuals in the United States lead their daily lives. Over 71% of U.S. adults and 87% of U.S. teens (ages 12-17 years) use the Internet. This panel will discuss four categories of forensic psychiatric evaluations that have emerged for the legal entanglement of people's thoughts and behaviors within the net of the World Wide Web. Michael Harlow, JD, MD will review the concept of "Internet Addiction" proposed definitions for this novel "diagnosis," assessment scales for problematic Internet use, and the legal use of "Internet Addiction," as an exculpatory psychiatric diagnosis. Jennifer Chaffin, MD will review criminal and civil liability issues related to child and adolescent victimization from Internet harassment and bullying. In addition, Dr. Chaffin will provide information on common websites and communication tools utilized by youth who access the Internet. Soroush Mohandessi, MD will discuss key issues related to cyber stalking to include statutes addressing electronic harassment, important components of the forensic psychiatric assessment, and recommended interventions. Dr. Scott will discuss psychiatric standards of care related to providers who perform Internet assessments and treatment. Dr. Scott will also review important components to consider when evaluating Internet malpractice claims.

REFERENCES

Mitchell KJ, Ybarra M, Finkelhor D: The relative importance of online victimization in understanding depression, delinquency and substance use: Child Maltreatment 12:314-327, 2007
Wells M, Mitchell KJ, Finkelhor D, Becker-Blease KA: Online mental health treatment: concerns and considerations, CyberPsychology & Behavior 10:453-459, 2007

SELF ASSESSMENT QUESTIONS

1. What percentage of the adult US population is engaged in routine use of the Internet?
a. 30%
b. 40%
c. 50%
d. 60%
e. 70%
ANSWER: e

2. What percentage of MMORPG players spend 21-40 hours a week gaming on the Internet?
a. 5%
b. 20%
c. 25%
d. 35%
ANSWER: d

F35 **ADJUDICATIVE COMPETENCE: A PRIMER ON DIFFICULT CASES**

Andrei T. Nemoianu, MD, Pittsburgh, PA
Christine A. Martone, MD, Pittsburgh, PA
Robert Wettstein, MD, Pittsburgh, PA
Douglas Mossman, MD, Dayton, OH
LaRissa M. Chism, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE
To enhance appreciation for difficulties encountered in the evaluation of adjudicative competence; and to assist the evaluator in applying AAPL guidelines to the assessment of ambiguous cases through expert and audience discussion of selected cases that have challenged the judicial system.

SUMMARY
Adjudicative competence is the most common evaluation psychiatrists perform for the courts. Applicable state laws and judicial precedents, in conjunction with professional practice guidelines, not only set standards for these assessments, but also help focus the examiner's attention on appraising requisite abilities. Despite these standards, these evaluations can prove difficult when a defendant's beliefs and associated decisions blur the distinction between impairment and unwillingness to demonstrate adjudicative capacities. Situations also arise when a defendant's inflexible personality traits and obstinacy become difficult to distinguish from grandiosity and delusionality. Likewise, distinctive personal or cultural views of the judicial system and government can overlap with overvalued ideas and delusions. Repeated firings of attorneys culminating in a pro se defense present yet another challenge. Through expert involvement and audience participation, we will explore the utility of the AAPL guidelines and certain assessment instruments in assisting the evaluation of troublesome cases. The audience will rate competency to stand trial of selected cases along specific dimensions using forms provided. The experts will engage the audience in a discussion of the cases and results.

REFERENCES
Mossman D, Noffsinger S, Ash P, et al: AAPL Practice Guideline: Forensic psychiatric evaluation of competence to stand trial. J Am Acad Psychiatry Law 35(Suppl):S3-S72, 2007
Melton GB and Petrila J: Psychological Evaluations for the Courts. 3rd Edition. New York: Guilford Press, 2007

SELF ASSESSMENT QUESTIONS
1. Which disorders can result in adjudicative incompetence?
a. substance-related disorders
b. personality disorders
c. deafness
d. all of the above
ANSWER: d

2. Which of the following are common errors in assessing adjudicative competence?
a. equating psychosis with incompetence to stand trial
b. determining severity of current psychopathology
c. determining that intellectual or developmental disability necessarily renders a defendant incompetent
d. a, b, and c
e. a and c
ANSWER: e

F36 **THE DIMINISHED CAPACITY DEFENSE: AN UPDATED SURVEY**

Brian C. Shelby, MD, JD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE
The goal of the presentation is to provide a brief background of the diminished capacity defense and present an updated survey of the current state of the law.

SUMMARY
The presentation concerns an updated look at the diminished capacity defense. It will touch briefly on the fundamental concept of mens rea and present the four main conceptions of the defense as it is understood in the different jurisdictions: 1) "homicide only" approach; 2) specific intent approach; 3) affirmative defense approach; and 4) negate any relevant criminal intent approach. In light of these four main approaches, the current state of the law in the fifty states will then be presented, including those jurisdictions that have chosen to reject the defense completely. Finally, the presentation will examine the trends over the last 25 years, looking at whether states have moved towards widening, narrowing or rejecting the diminished capacity defense.

REFERENCES
Morse S: Undiminished confusion in diminished capacity. J Crim. L & Criminology 75:1-55, 1984
American Bar Association: Criminal Justice Mental Health Standards. Washington, DC: American Bar Association, 1989, pp 347-375

SELF ASSESSMENT QUESTIONS
1. Mens Rea as it relates to a definition of a crime is
a. a "guilty mind"
b. nearly always necessary to be present for a crime to have been committed
c. the mental counterpart of Actus Reus
d. an element to be proven by the prosecution
e. all of the above
ANSWER: e

2. In most jurisdictions that allow it, the diminished capacity defense functions primarily to
a. prevent the prosecution from introducing damaging evidence of mental illness
b. always fully acquit defendant if the defendant proves mental illness beyond a reasonable doubt
c. allow mental illness to negate a mental state necessary to the definition of the crime
d. allow the judge to mitigate the defendant's sentence after hearing evidence of mental illness
e. all of the above
ANSWER: c

F37 USE OF FORCE IN TREATMENT TO RESTORE TRIAL COMPETENCY

Daniel M. Mayman, MD, Ann Arbor, MI
Carol E. Holden, PhD, (I) Ann Arbor, MI
Craig A. Lemmen, MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE
To be able to discuss the Supreme Court's view of involuntary antipsychotic medication, the Sell ruling, and how the empiric data presented on the rate of the use of force in administration of medications to restore defendants' competency to stand trial may inform this discussion.

SUMMARY
Use of involuntary medication to restore defendants' competency to stand trial has always been controversial. Part of the controversy may involve misconceptions about the use of force and coercion in psychiatric practice. The Supreme Court reluctantly sanctioned involuntary medication, in certain instances, for the sole purpose of restoring trial competency in Sell v. United States and provided a standard for balancing individual and government interests. Justice Michael Mukasey applied this standard to the government's request to involuntarily medicate a psychotic defendant in United States v. Lindauer. "[I]t is not inappropriate to recall in plain terms what the government seeks to do here, which necessarily involves physically restraining defendant so that she can be injected with mind-altering drugs. There was a time when what might be viewed as an even lesser invasion of a defendant's person – pumping his stomach to retrieve evidence – was said to 'shock the conscience' and invite comparison with the 'rack and the screw." Does a court order for involuntary medication necessarily involve physical restraint? Surprisingly, the literature revealed no empiric data on the frequencies of these outcomes. We hypothesized that force is rarely used to administer medications solely to satisfy a court order. A chart review was conducted to investigate the frequency of physical management and use of intramuscular antipsychotic medications in defendants admitted to a state forensic hospital for treatment to restore trial competency (n>200), each subject to a court order for involuntary medication. In the event that force or an intramuscular agent were used, the defendant's behavior was categorized as either dangerous or not; if not, it was assumed that the medication was administered solely to satisfy a court order. The data will be presented along with preliminary data examining what factors predict each outcome.

REFERENCES
Sell v. United States, 539 U.S. 166, 2003
Busch AB: Special Section on Seclusion and Restraint: Introduction to the Special Section. Psychiatr Serv 56: 1104, 2005

SELF ASSESSMENT QUESTIONS

1. According to Sell v. U.S., before ordering involuntary antipsychotic medication to restore trial competence a court should ordinarily consider what?

a. less intrusive treatments (e.g., psychotherapy)
b. less intrusive means of administering the drug (e.g., threat of contempt)
c. different purposes for forced medication (e.g., for dangerousness)
d. the specific kind of drug(s) proposed, their potential efficacy, and specific side effects
e. all of the above
ANSWER: e

2. Which of the following methods of administration of an antipsychotic medication are not coercive?

a. restraint to allow involuntary injection
b. a court order to take medication backed by the threat of contempt
c. enlisting help from the patient's loved ones to encourage compliance with medication
d. explaining the medical necessity and that there are no other options for treatment
e. coercion exists on a continuum and each choice above could be viewed as coercive.
ANSWER: e

F38 CHILD ABUSE REPORTING LAWS: IMPLICATIONS FOR FORENSIC PSYCHIATRISTS

Reena Kapoor, MD, New Haven, CT
Howard V. Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE
Participants will: review mandated reporting of child abuse statutes and data regarding their efficacy; explore the ethical conflict for forensic psychiatrists created by mandated reporting laws; and consider potential resolutions to this conflict.

SUMMARY
All 50 states currently require reporting of child abuse by physicians. Although data suggest that these laws effectively identify perpetrators of abuse, they also create a potential ethical conflict for psychiatrists working in the forensic setting. What happens in the case where the forensic psychiatrist, during the course of an evaluation requested by a defense attorney, learns about child abuse perpetrated by the evaluee? The forensic psychiatrist faces a complicated legal, ethical, and interpersonal dilemma. If he reports the abuse, he may contribute directly to further legal harm to the evaluee, as well as place a strain on the relationship with the attorney. However, if he does not report the abuse, he must ignore his legal mandate and possibly risk further harm to the child. We review the sparse legislation and case law related to this issue, identify potential strategies for resolving the dilemma, and examine the implications of each of these strategies.

REFERENCES
Appelbaum P: Child abuse reporting laws: time for reform? Psych Services 50: 27-29, 1999
75 Md. Op. Atty. Gen. 76, 1990

SELF ASSESSMENT QUESTIONS

1. Considerations for forensic psychiatrists when deciding whether to report suspected child abuse include which of the following?

a. statutory requirements of the jurisdiction in which the abuse is being reported
b. potential harm to the child by reporting or not reporting
c. potential harm to the alleged perpetrator of the abuse by reporting or not reporting
d. duty as an ethical physician
e. all of the above
ANSWER: e

2. Which of the following privileges are recognized in most states as an exception to mandated reporting of child abuse?
a. patient-physician privilege
b. attorney-client privilege
c. husband-wife privilege
d. clergy-penitent privilege
e. b and d
ANSWER: e

F39 PSYCHIATRISTS' UNDERSTANDING OF DUTY TO PROTECT LAWS

Jason J. Buckland, DO, Columbia, SC
Richard L. Frierson, MD, Columbia, SC

EDUCATIONAL OBJECTIVE

To review psychiatrists' understanding of the duty to protect in one jurisdiction; to identify the knowledge gap that exists in this area; and to reinforce that psychiatrists must not only be familiar with the Tarasoff ruling but also local rulings that establish or reject a Tarasoff duty in their state.

SUMMARY

A 1976 California Supreme Court ruling, Tarasoff v. Regents of the University of California, has been modified by subsequent case and statutory laws in many jurisdictions, including South Carolina. This research involves a survey of South Carolina psychiatrists on their knowledge of the duty to protect in South Carolina and their current practices when faced with a patient who threatens violence to an identified third party. The preliminary data from the study shows that 97% of responding psychiatrists (n=227) were familiar with Tarasoff, however only 19% of respondents were familiar with the South Carolina Supreme Court ruling that established a limited duty in South Carolina, Bishop v. South Carolina Department of Mental Health. Results indicate that a substantial knowledge deficit exists among psychiatrists practicing in South Carolina concerning S.C.'s partial adoption of the duty to protect. Furthermore, S.C. psychiatrists were not aware of a recent appellate decision regarding a duty to protect the motoring public from impaired patient driving. Psychiatrists practicing in an academic setting were more likely to be aware of this decision and the duty established. These results are likely representative of psychiatrists practicing in other states and would suggest that further education on this topic is needed.

REFERENCES

Herbert PB, Young KA: Tarasoff at twenty-five. J Am Acad Psychiatry Law 30: 275-81, 2002
Bishop v. South Carolina Department of Mental Health 502 S.E. 2d 78, 1998

SELF ASSESSMENT QUESTIONS

1. Psychiatrists in which practice setting are most likely to have encountered a person threatening violence?
a. private practice
b. academic setting
c. public institution
d. public outpatient clinic
ANSWER: d

2. Psychiatrist in which practice setting are most likely to have been threatened by a patient?
a. private practice
b. academic setting
c. public institution
d. public outpatient clinic
ANSWER: c

SATURDAY, OCTOBER 25, 2008

POSTER SESSION# 3 — 7:15 AM – 8:00 AM/ 9:30 AM – 10:15 AM — **GRAND FOYER**

S1 ***Child Crime, Adult Time***

Brett DiGiovanna, MD, Pittsburgh, PA
Christine A. Martone, MD, Pittsburgh, PA
Layla Soliman, MD, (I) Pittsburgh, PA

S2 ***Physician Reporting of Driving Impaired Seizure Patients***

Christopher M. Davidson, MD, Sioux Falls, SD
Michael C. Harlow, MD, JD, Sioux Falls, SD
Charles L. Scott, MD, Sacramento, CA

S3 ***Pervasive Development Disorders in Forensic Adolescent Mental Health***

Elizabeth A. Joseph, DO, Springfield, IL
Manisha Punwani, MD, (I) Springfield, IL

S4 ***Expert Testimony and the Death Penalty***

Neelam Varshney, MD, New York, NY
Gagan Dhaliwal, MD, Huntsville, AL
Margaret Goni, MD, Elmhurst, NY
J. Arturo Silva, MD, San Jose, CA

S5 ***The Forensic Psychiatry of Antiquarian Book Stealing***

J. Arturo Silva, MD, San Jose, CA

S6 ***Antecedents to Assaults Motivated By Psychosis***

Cameron D. Quanbeck, MD, Davis, CA
Barbard McDermott, PhD, (I) Sacramento, CA
Jason Lam, BA, (I) Sacramento, CA
Charles Scott, MD, Sacramento, CA
Jacob Wegelin, PhD, (I), Richmond, VA

S7 ***Contextual Risk Factors in Mandatory Risk Evaluations***

Miriam Kissin, PsyD, (I) Worcester, MA
Thomas Grisso, PhD, (I) Worcester, MA
Debra A. Pinals, MD, Worcester, MA
John J. Young, MD, Worcester, MA
Mathews Thomas, MD, West Roxbury, MA

S8 ***Psychiatry Training and the Paraphilias: Update***

Paul Noroian, MD, Worcester, MA
Crystal Kim, BA, (I) Washington, DC
Fabian Saleh, MD, Boston, MA

S9 ***Comparing METH-Induced Psychosis to Schizophrenia on the RBANS***

Jay S. Bondar, MSc, Port Coquitlam, BC, Canada
Daryl E.M. Fujii, PhD, (I) Honolulu, HI

S10 ***ADHD in Offenders: Comorbidities and Suicide Risk***

Patricia Westmoreland, MD, Oakdale, CA
Tracy D. Gunter, MD, Iowa City, IA
Bruce Sieleni, MD, (I) Oakdale, CA
Donald W. Black, MD, Iowa City, IA

S11 ***Effect of Addiction on Course of Treatment of NGRI Acquittees***

Katya Frischer, MD, New York, NY
Merrill R. Rotter, MD, Bronx, NY

COFFEE BREAK — **9:45 AM - 10:00 AM** — **GRAND FOYER**

WORKSHOP — 10:00 AM - 12 NOON — **GRAND I**

S12 ***Dementia and Estate Planning: Ethical Considerations***

Sally C. Johnson, MD, Raleigh, NC
Eric B. Elbogen, PhD, (I) Chapel Hill, NC
Bill D. Burlington, JD, (I) Raleigh, NC
David Watters, JD, (I) Raleigh, NC
Alyson R. Kuroski-Mazzei, DO, Raleigh, NC

PANEL — 10:00 AM - 12 NOON — **CASCADE I**

S13 ***Decoding Autistic-Spectrum Disorders for Forensics***

Howard Zonana, MD, New Haven, CT
Marc Woodbury-Smith, MD, PhD, MRCPsych, Devonshire, Bermuda
Madelon Baranoski, PhD, (I) New Haven, CT
Josephine Buchanan, BA, (I) New Haven, CT

PANEL — 10:00 AM - 12 NOON — **CASCADE II**

S14 ***Restoration of Trial Competency: A Performance Improvement Project***

Katherine Warburton, DO, (I) Napa, CA
Charles Scott, MD, Sacramento, CA
Barbara McDermott, PhD, (I) Sacramento, CA

PANEL — 10:00 AM - 12 NOON — **GRAND CRESCENT**

S15 ***Are AAPL's Ethics Guidelines of International Relevance? International Relations Committee***

Kenneth G. Busch, MD, Chicago, IL
Wade C. Myers, MD, Tampa, FL
John C. Gunn, MD, FRCPsych, (I) Kent, UK
Adrian T. Grounds, MD, FRCPsych, Cambridge, UK
Julio Arboleda-Florez, MD, FRCPC, Kingston, ON, Canada

RESEARCH IN PROGRESS# 4 — 10:00 AM - 12 NOON — **ELLIOTT BAY**

S16 ***Forensic Psychiatric Aspects of Clinical Vampirism***

J. Arturo Silva, MD, San Jose, CA
Gregory B. Leong, MD, Tacoma, WA
Marcia A. Miller, PsyD, (I) San Deigo, CA

S17 ***You Can Take the Patient Out of Prison, But...***

Merrill R. Rotter, MD, Bronx, NY
William A. Carr, MA, (I) Bronx, NY
Barry Rosenfeld, PhD, (I) Bronx, NY

S18 ***Juvenile Sex Offenders: A Community Setting Study***

Gregg R. Dwyer, MD, EdD, Columbia, SC
Jeanette M. Jerrell, PhD, (I) Columbia, SC

S19 ***Childhood Antecedents of Adult Violent Felonies in Women***

Catherine F. Lewis, MD, Farmington, CT

LUNCH (TICKET REQUIRED) — 12 NOON - 2:00 PM — **GRAND II**

S20 ***Police Interrogation and False Confession***

Richard A. Leo, PhD, JD, (I) San Francisco, CA

WORKSHOP — 2:15 PM – 4:00 PM — **GRAND I**

S21 ***Prison Research: Opportunities, Hurdles, Methods***

Kenneth L. Appelbaum, MD, Shrewsbury, MA
Robert L. Trestman, MD, PhD, Farmington, CT

COURSE (TICKET REQUIRED) — 2:15 PM - 6:00 PM — **ELLIOTT BAY**

S22 ***Understanding Risk Assessment and Management***

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

WORKSHOP — 2:15 PM - 4:00 PM — **CASCADE I**

S23 Detection of Malingering Disability Evaluations

Roger Z. Samuel, MD, Boca Raton, FL
Kyle Boone, PhD, (I) Torrance, CA
Henry Conroe, MD, Chicago, IL
Mark DeBofsky, JD, (I) Chicago, IL

PANEL — 2:15 PM - 4:00 PM — **CASCADE II**

S24 Landmark Case Updates: What's New in Law and Mental Health

Charles L. Scott, MD, Sacramento, CA
Phillip J. Resnick, MD, Cleveland, OH
Debra Pinals, MD, Worcester, MA

RESEARCH IN PROGRESS# 5 — 2:15 PM - 4:00 PM — **GRAND CRESCENT**

S25 SVPs: Who Do Psychiatrists Commit?

Gregg R. Dwyer, MD, EdD, Columbia, SC
Geoffrey R. McKee, PhD, (I) Columbia, SC

S26 Axis I and Axis II Disorders in Incarcerated Pedophiles

Michael C. Harlow, MD, JD, Sioux Falls, SD
Christopher M. Davidson, MD, Sioux Falls, SD
Fabian Saleh, MD, Boston, MA
Jessica Ferranti, MD, Sacramento, CA
Manish Sheth, MD, PhD, Sioux Falls, SD

S27 Deconstructing Pornography

J. Arturo Silva, MD, San Jose, CA
Douglas Tucker, MD, Berkeley, CA

COFFEE BREAK — 4:00 PM - 4:15 PM — CASCADE FOYER

WORKSHOP — 4:15 PM - 6:15 PM — **GRAND I**

S28 Informed Consent in Controversial Situations Psychopharamacology Committee

Philip J. Candilis, MD, Worcester, MA
Gary Chaimowitz, Ancaster, ON, Canada
John Paul Fedoroff, MD, Ottawa, ON, Canada
James K. Wolfson, MD, Springfield, MO

PANEL — 4:15 PM - 6:15 PM — **CASCADE I**

S29 Update from the APA Council on Psychiatry and Law

Debra A. Pinals, MD, Worcester, MA
Stuart Anfang, MD, Northampton, MA
Steven K. Hoge, MD, New York, NY
Jeffrey Metzner, MD, Denver, CO
Howard Zonana, MD, New Haven, CT

WORKSHOP — 4:15 PM - 6:15 PM — **CASCADE II**

S30 Computers and Technology in Forensic Psychiatry: Computers and Forensic Psychiatry

Mark J. Hauser, MD, Newton, MA
Alan W. Newman, MD, Washington, DC
Cheryl Wills, MD, Cleveland, OH

PAPER SESSION# 3 — 4:15 PM - 6:15 PM — **GRAND CRESCENT**

S31 Murder-Suicide: A Review of the Recent Literature

Scott A. Eliason, MD, San Francisco, CA

S32 Suicide Among Incarcerated Veterans: A Systematic Review

Hal S. Wortzel, MD, Denver, CO
Ingrid A. Binswanger, MD, MPH, (I) Aurora, CO
Alan C. Anderson, MD, (I) Denver, CO
Lawrence E. Adler, MD, (I) Denver, CO

S33 ***Contracting for Safety: Clinical Practice and Forensic Implications***

Keelin A. Garvey, MD, Providence, RI
Joseph V. Penn, MD, Huntsville, TX
Angela L. Campbell, JD, (I) Des Moines, IA
Christianne Esposito-Smythers, PhD, (I) Providence, RI
Anthony Spirito, PhD, (I) Providence, RI

S34 ***Employment and Disability Among Survivors of Major Disasters***

Sarah S. Rasco, MD, Dallas, TX
Carol North, MD, MPE, (I) Dallas, TX

S35 ***Hamdan In Guantanamo: The First Military Commissions Trial***

Emily A. Keram, MD, Santa Rosa, CA
Brian L. Mizer, JD, (I) Washington, DC
Harry H. Schneider, Jr., JD, (I) Seattle, WA
Joseph M. McMilliam, JD, (I) Seattle, WA

S1 CHILD CRIME, ADULT TIME

Brett DiGiovanna, MD, Pittsburgh, PA
Christine A. Martone, MD, Pittsburgh, PA
Layla Soliman, MD, (I) Pittsburgh, PA

EDUCATIONAL OBJECTIVE
To discuss challenges encountered by psychiatrists evaluating children for "transfer back" to the juvenile court; and to address various factors that can help predict the effectiveness of this process.

SUMMARY
In most states juveniles accused of homicide are charged as adults. In many states, including Pennsylvania, these youth are evaluated and can be "transferred back" to the juvenile courts. We assessed four cases of previously non-violent juveniles referred to us by the court. Some of them were transferred back, while others were retained in the adult system. We elected to investigate whether a previously proposed typology of youth murderers could be utilized to understand transfer status. The cases can all be classified under the conflict typology constructed by Cornell. No cases were in the psychotic or crime group. None of the juveniles had a previous criminal history. Weapon types included firearm, hammer, and no weapon. Ages ranged from 13-16 years old. Younger juvenile age was not associated with transfer back, while the case involving a female was transferred. Psychiatric syndromes may have been significant in two of the cases. We also completed a literature search related to this topic and learned that factors such as age, prior criminal history, weapon choice, psychiatric history or demographics of the defendant may have predictive value. Future research is warranted to develop more specific predictors for transfer back in juvenile murders.

REFERENCES
Cornell DG, Benedek EP, Benedek DM: Juvenile homicide: prior adjustment and a proposed typology. Am J Orthopsychiatry. 57: 383-393, 1987
Jordan KL, Myers DL: The decertification of transferred youth: examining the determinants of reverse waiver. Youth Violence and Juvenile Justice 5:188-206, 2007

SELF ASSESSMENT QUESTIONS
1. All of the following are typologies of youth murderers except
a. psychotic
b. abused
c. conflict
d. crime
ANSWER: b

2. All of the following have been associated with transfer back to juvenile court except
a. younger age
b. less past criminality
c. use of private attorney
d. use of weapon other than firearm
ANSWER: c

S2 PHYSICIAN REPORTING OF DRIVING IMPAIRED SEIZURE PATIENTS

Christopher M. Davidson, MD, Sioux Falls, SD
Michael C. Harlow, M.D., JD, Sioux Falls, SD
Charles L. Scott, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
To examine the legal issues of confidentiality, liability, and duty to warn for physicians reporting driving impaired seizure patients; and to explore the national diversity and application of state reporting laws.

SUMMARY
Mr. B. is a male in his forties with a history of alcohol dependence and depression who presents to a chemical dependency treatment facility. His medications included bupropion SR and tramadol. Upon presentation Mr. B. suffered a witnessed tonic-clonic seizure event. While physician-patient confidentiality is an essential element in a physician treatment relationship, physician breach of confidentiality is permissible in order to prevent patient harm of others. This physician duty to warn extends to seizure patients at increased risk of causing injury and death due to impaired driving. While virtually all states allow physicians the option to report their patients as impaired drivers, only six states require physicians to inform a state about patients who suffer from seizures. Twenty-six states provide legal protection to physicians who break physician–patient confidentiality to report a seizure patient as an impaired driver. Also, 26 states provide reporting physicians liability immunity as a result of a seizure patient's motor vehicle accident.

This poster will review the scope of required physician reporting in states with mandatory reporting laws, the various state levels of physician legal protection and immunity, and emerging case law on this issue.

REFERENCES

Krumholz A: To drive or not to drive: the 3-month seizure-free interval for people with epilepsy. Mayo Clin Proc 78:817-818, 2003
American Medical Association. Physician's Guide to Assessing and Counseling Older Drivers. Chapter 8: State Licensing Requirements and Reporting Laws 77-146, 2003

SELF ASSESSMENT QUESTIONS

1. How many states require physicians to report seizure patients who are impaired drivers?
a. 0
b. 6
c. 10
d. 20
ANSWER: b

2. How many states provide legal protection to physicians for breaking physician-patient confidentiality in order to report a driving impaired seizure patient?
a. 5
b. 21
c. 26
d. 34
ANSWER: c

S3 PERVASIVE DEVELOPMENT DISORDERS IN FORENSIC ADOLESCENT MENTAL HEALTH

Elizabeth A. Joseph, DO, Springfield, IL
Manisha Punwani, MD, (I) Springfield, IL

EDUCATIONAL OBJECTIVE

To recognize the prevalence of pervasive developmental disorders in the forensic adolescent mental health setting, its impact on the multidisciplinary team, and the possible treatment interventions.

SUMMARY

A case report of a seventeen-year-old male in a forensic adolescent mental health setting with a diagnosis of pervasive developmental disorder which went unrecognized and untreated. He presented with aggression, social isolation, poor interpersonal social skills, marked inability to care for self, and was a target of peer victimization, the implications of which resulted in behavioral as well as educational limitations. Pervasive developmental disorder is often not recognized and therefore untreated in a forensic adolescent mental health setting because of the acute behavioral and legal issues of the adolescent. This poster will explore possible diagnostic tools that can be used to screen for these disorders in a juvenile forensic setting. It will also highlight the needed interventions to provide social, academic, and psychiatric stabilization to improve the overall functioning of individuals with pervasive developmental disorder in the forensic adolescent mental health setting.

REFERENCES

Tiffin, P et al: Diagnosing Pervasive Developmental Disorder in a forensic mental health setting. Brit J of Forensic Practice 9:31-40, 2007
Murrie D, Warren J, et al: Asperger's Syndrome in forensic settings. Inter J Forensic Mental Health 1:59-70, 2002

SELF ASSESSMENT QUESTIONS

1. What treatment interventions are available for adolescents diagnosed with PDD in the forensic adolescent mental health setting?
a. medications
b. social skills
c. behavior management
d. independent living skills
e. all of the above
ANSWER: e

2. What factors should be considered when integrating PDD assessments with risk appraisal?
a. communication
b. behavioral flexibility
c. environmental risk
d. historical information
e. all of the above
ANSWER: e

S4 EXPERT TESTIMONY AND THE DEALTH PENALTY

Neelam Varshney, MD, Worcester, MA
Gagan Dhaliwal, MD, Huntsville, AL
Margaret Goni, MD, Elmhurst, NY
J. Arturo Silva, MD, San Jose, CA
Jacob Wegelin, PhD, (I), Richmond, VA

EDUCATIONAL OBJECTIVE

To discuss the role of expert testimony in capital punishments in the mentally ill. We will review cases to understand the impact of the expert testimony in death penalty cases with a focus on the Panetti v. Quarterman and the Yates v. State of Texas cases.

SUMMARY

Our review of the literature, including a search on LexisNexis, revealed that the courts are yet to clarify clear cut standards on executing the mentally ill. The power ascribed to expert testimony in death penalty cases varies from case to case. This presentation, through self-explanatory photos, graphs and brief written text, will explore the historical perspectives of expert witnesses in death penalty cases. We will discuss the landmark decisions in Estelle v. Smith, Eddings v. Oklahoma, Ford v. Wainright, State v. Perry that have solid implications for future court decisions regarding criminal acts in the mentally ill. A close look at the Supreme Court decisions with regard to Panetti v. Quarterman has once again implied that courts have failed to refine clear standards for deciding death penalty cases involving the mentally ill. Yates v. State of Texas will throw light on the importance and implication of expert testimony in death penalty cases. Finally, ethical dilemmas surrounding psychiatrists' participation in capital punishment will be discussed briefly.

REFERENCES

Appelbaum PS: Law and psychiatry: death row delusions: When is a prisoner competent to be executed? Psychiatr Serv 58(10):1258-60, 2007
Panetti v. Quarterman, 127 S Ct 2842, 2007

SELF ASSESSMENT QUESTIONS

1. Which recent U.S. Supreme Court case has implications on the death penalty in the mentally ill prisoners?
ANSWER: Panetti v. Quarterman

2. In which case did the court decide against giving the death penalty based on false testimony provided by a forensic psychiatrist?
ANSWER: Yates v. The State of Texas

S5 THE FORENSIC PSYCHIATRY OF ANTIQUARIAN BOOK STEALING

J. Arturo Silva, MD, San Jose, CA

EDUCATIONAL OBJECTIVE

An introduction to the study of antiquarian book stealing behavior, introducing the psychiatric specialist to basic criminological and psychiatric-legal aspects of persons who steal antiquarian books. This presentation of cases will highlight important characteristics of persons who engage in antiquarian book stealing.

SUMMARY

This presentation will provide an introduction to criminal behavior involving the robbery of antiquarian books and other related materials, including rare documents, maps, book plates and rare book title pages. An overview of bibliomania and bibliokleptomania will be provided. A typology of motivations associated with book stealing behavior will be presented from a criminological perspective. Both formal crimes and psychiatric disorder crimes associated with antiquarian book stealing behavior will be reviewed. Three well known cases will be presented in detail in order to highlight important psychiatric-legal factors associated with persons that steal antiquarian books and related materials. Case presentations will highlight: 1) perpetrators who steal books for profit; and 2) perpetrators who steal in association with psychopathologies closely associated with the acquisition and collection of books.

REFERENCES
Basbanes NA: A Gentle Madness: Bibliophiles, Bibliomanes, and the Eternal Passion for Books. New York: Henry Holt and Company, 1995
Barlett AH: The man who loves book too much, in The Best American Crime Reporting. Edited By Fairstein L. New York: Harper Perennial, 2007

SELF ASSESSMENT QUESTIONS
1. Antiquarian book stealing behavior has been associated with the following except
a. team oriented perpetrators
b. bibliomania
c. frequent severe sentences
d. stealing numerous books from libraries in major universities
ANSWER: c

2. Which of the following is generally not true of persons who engage in stealing antiquarian books?
a. Their illicit book acquisitions often involve serious violent behaviors.
b. Perpetrators are frequently professional thieves.
c. They may suffer from obsessive-like psychopathologies.
d. Some of their crimes may be classified as crimes of opportunity.
ANSWER: a

S6 ANTECEDENTS TO ASSAULTS MOTIVATED BY PSYCHOSIS

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Charles Scott, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
To present research findings from a project designed to identify clinical antecedents to psychotic decompensation and assault in long-term psychiatric inpatients who commit assaults motivated by psychosis. The results may help clinicians working with this population to decrease violence risk in this patient population.

SUMMARY
Most past research on violence has focused on identifying long-term predictors of violence based on static variables. Little is known about when the violence will occur. There is a need to identify dynamic variables such as transient symptoms, behaviors, and situations that predict violence in the short term. If clinicians are aware of particular clinical antecedents to assault, interventions can be taken that may prevent an assault from occurring. It appears that progress in this area has been hampered by a homogenous view of inpatient violence. Past research has proceeded as if one act of violence were equivalent to another for the purpose of prediction. A recent study has indicated that inpatient aggression is a more complex phenomenon and that assaults can be classified by their motivation as impulsive, organized, or psychotic. We are conducting a study that focuses on warning signs of violence in patients with schizophrenia whose violence is motivated by psychosis. Schizophrenia is a remitting-relapsing illness whose clinical course is marked by periods of relative stability and periods of slow decompensation. Identifying the precursors that signal psychotic exacerbation in the days, weeks, and months prior to an assault may permit sufficient time for effective clinical intervention.

REFERENCES
Nolan KA, Volavka J, Czobor P, et al: Aggression and psychopathology in treatment-resistant inpatients with schizophrenia and schizoaffective disorder. J Psychiatr Res 39(1):109-15, 2005
Quanbeck CD, McDermott BE, Lam J, Sokolov G, Eisenstark H, Scott CL: Categorization of assaultive acts committed by chronically aggressive state hospital patients. Psychiatric Serv 58 (4): 521-8

SELF ASSESSMENT QUESTIONS
1. In patients with a history of psychosis-motivated violence, which of the following symptoms may indicate a risk of imminent violence?
a. paranoid delusions
b. grandiose delusions
c. somatic delusions
d. disorganized speech
e. pressured speech
ANSWER: a

2. The appearance of which of the following symptoms may be the first indicator that a patient with schizophrenia is beginning to experience a psychotic decompensation?
a. auditory hallucinations
b. loose associations
c. hypersexuality
d. poor impulse control
e. dysphoric mood
f. hostility
ANSWER: a

S7 **CONTEXTUAL RISK FACTORS IN MANDATORY RISK EVALUATIONS**

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Debra A. Pinals, MD, Worcester, MA
John J. Young, MD, Worcester, MA
Mathews Thomas, MD, West Roxbury, MA

EDUCATIONAL OBJECTIVE
At the end of this presentation, participants will be able to discuss what variables forensic clinicians rely upon in clinical risk assessments and compare these to standardized historical, clinical and risk management risk factors for violence.

SUMMARY
Forensic clinicians commonly conduct violence risk assessments as a mechanism to aid treatment decisions and make recommendations regarding appropriate levels of supervision. These assessments may be utilized as a mechanism for clinical risk management. One tool that has been utilized in conducting these assessments is the HCR-20: Assessing Risk for Violence (Version 2), which captures an array of risk factors in a systematic manner. In this study we review randomly selected Mandatory Forensic Review (MFR) evaluations that have been mandated by Massachusetts Department of Mental Health policy, conducted when patients are thought to be ready for increased privileges or discharge. We review them to assess the degree to which the individualized clinical assessments by senior forensic evaluators captured criteria adapted from the HCR-20. We are specifically interested in comparing clinicians' use of contextual factors, as represented by the HCR-20 Risk Management Factors. We hypothesized that HCR-20 Risk Management factors were used at a lower rate than HCR-20 Historical and Clinical risk factors in the conceptualization sections of the MFR reports. This presentation will describe pilot qualitative data and some quantitative data trends.

REFERENCES
Webster CD, Douglas KS, Eaves D, Hart SD: (HCR-20: Assessing Risk for Violence, (Version 2). Burnaby, British Columbia: Mental Health Law & Policy Institute, Simon Fraser University, 1997
Monahan J, Steadman HJ: Violence risk assessment: a quarter century of research, in The evolution of Mental Health Law. Edited by Frost Le, Bonnie RJ. Washington DC: American Psychological Association, 2001, pp 195-211

SELF ASSESSMENT QUESTIONS
1. Which heading is not used in the HCR-20 use to organize risk factors for violence?
a. risk management
b. psychosocial
c. historical
d. clinical
ANSWER: b

2. Is the HCR-20 used to predict violence?
ANSWER: No. The HCR-20 helps the evaluator or clinician assess a level of risk for violence and can be used to help organize interventions to reduce the risk or in the recommendation of placement.

S8 **PSYCHIATRY TRAINING AND THE PARAPHILIAS: UPDATE**

Paul Noroian, MD, Worcester, MA
Crystal Kim, BA, (I) Washington, DC
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
To update participants on the training psychiatry residents receive in the assessment and treatment of paraphilic disorders.

SUMMARY
Sexual disorders, including the paraphilias, represent a major source of psychiatric morbidity. Patients with sexual disorders are at risk for comorbid mood and anxiety disorders, and may be at greater risk to engage in sex offending behaviors. The DSM-IV-TR devotes one chapter to sexual disorders. The treatment of patients with sexual disorders poses special challenges to clinicians. Practicing clinicians should have familiarity with assessments used to diagnose the disorders. Clinicians should also be prepared for doing assessments of the risks associated with these disorders. The topic of how psychiatrists are trained to diagnose and treat patients with sexual disorders has not received much attention in the literature. The authors surveyed psychiatry residency programs in the United States, to assess whether an individual program offers didactics and/or clinical supervision, relevant to the treatment of paraphilias and other sexual disorders. The survey and some initial results of this study were presented in poster form at the 2007 AAPL meeting. This poster presents an update of the results based on new data. Conclusions and recommendations based on data received to date are reviewed.

REFERENCES
Krueger RB, Kaplan MS: The paraphilic and hypersexual disorders: an overview. J Psychiatric Practice 7(6):391-403, 2001
Bradford JMW: The neurobiology, neuropharmacology, and pharmacological treatment of the paraphilias and compulsive sexual behavior. Can J Psychiatry 46:26-33, 2001

SELF ASSESSMENT QUESTIONS
1. The paraphilias include all of the following disorders except?
a. fetishism
b. gender identity disorder
c. frotteurism
d. exhibitionism
ANSWER: b

2. Assessments of patients with sexual disorders should include?
a. substance abuse history
b. suicide/violence risk assessment
c. medical history
d. legal history
e. all of the above
ANSWER: e

S9 COMPARING METH-INDUCED PSYCHOSIS TO SCHIZOPHRENIA ON THE RBANS

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Daryl E.M. Fujii, PhD, (I) Honolulu, HI

EDUCATIONAL OBJECTIVE
To increase knowledge of neuropsychological deficits in both methamphetamine-induced psychosis and schizophrenia, and highlight the forensic relevance.

SUMMARY
Methamphetamine (METH) has been shown to produce persistent psychotic symptoms in some patients who abuse the drug. The symptom profile appears similar to that seen in schizophrenia or schizoaffective disorder (SCZ/A). Neuropsychological deficits have been demonstrated in both METH dependent and SCZ/A patients, but cognition in subjects with METH induced psychosis (MIP) has not been evaluted. This study examined performance on the Repeated Battery for Assessment of Neuropsychological Status (RBANS) of MIP (n of 25) inpatients at a forensic facility compared the results to a published database for patients with SCZ/A. The patients with MIP demostrated better performance on one test of psychomotor speed attention but worse performance on measures of immediate memory when compared with a population of SCZ/A. Such results could have important implications for the assessment, treatment, and management of addiction and psychotic symptoms in this patient population.

REFERENCES
Flashman LA, Green MF: Review of cognition and brain structure in schizophrenia: profiles, longitudinal course, and effects of treatment. Psychiatric Clinics of North America 27:1-18, 2004
Scott JC, Woods SP, Matt GE, Meyer RA, Heaton RK, Hampton-Atkinson J, Grant I: Neurocognitive effects of methamphetamine: a critical review and meta-analysis. Neuropsychological Review 17:275-297, 2007

SELF ASSESSMENT QUESTIONS

1. According to a meta-analysis of methamphetamine-dependent subjects, what are the three cognitive domains showing maximal deficits in this population?

ANSWER: Learning, executive functions and memory.

2. In which cognitive domain do methamphetamine-induced psychotic patients demonstrate worse performance than schizophrenic subjects?

a. visuospatial skills
b. language
c. delayed memory
d. immediate memory
e. gross motor skills

ANSWER: d

S10 ADHD IN OFFENDERS: COMORBIDITIES AND SUICIDE RISK

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Tracy D. Gunter, MD, Iowa City, IA
Bruce Sieleni, MD, (I) Oakdale, CA
Donald W. Black, MD, Iowa City, IA

EDUCATIONAL OBJECTIVE

To understand the prevalence of attention deficit disorder in offenders plus comorbid mental illnesses and risk for suicide.

SUMMARY

Background: Attention Deficit Hyperactivity Disorder (ADHD) in young adults is associated with comorbid mental health diagnoses and with antisocial behaviors that often lead to criminality. In contrast to studies of ADHD in the community, studies of ADHD in offenders are limited. The objective of this study is to estimate the prevalence of ADHD in offenders admitted to the Iowa Department of Corrections. We also compared characteristics of offenders with and without ADHD. Methods: A random sample of 320 offenders was evaluated using a version of the Mini International Neuropsychiatric Interview (MINI), the Medical Outcome Survey Short Form-36 Health Survey (SF-36), and the Level of Service Inventory-Revised (LSI-R). Results: ADHD was present in 69 subjects (21.6%). Offenders with ADHD were more likely to report problems with emotional and social functioning. Offenders with ADHD had higher rates of mood, anxiety, psychotic, and somatoform disorders (especially body dysmorphic disorder), as well as borderline and antisocial personality disorders. Suicide risk score was increased more than twofold ($p<0.001$) in offenders with ADHD. Conclusions: ADHD is common among offenders admitted to the prison system, and is strongly associated with mental health diagnoses and with decrements in functioning and a substantial risk of suicide.

REFERENCES

Rösler M, Retz M, Retz-Junginger P, et al: Prevalence of attention deficit-/hyperactivity disorder (ADHD) and comorbid disorders in young prison inmates. Eur Arch Psychiatry Clin Neurosci 254:365–71, 2004
James A, Lai FH, Dahl C: Attention deficit hyperactivity disorder and suicide: a review of all possible associations. Acta Psychiatr Scand 110(6): 408-415, 2004

SELF ASSESSMENT QUESTIONS

1. ADHD is commonly associated with which Axis II disorders?

ANSWER: Antisocial and Borderline Personality Disorders

2. Suicide risk is increased by how much in offenders with ADHD?

ANSWER: Two fold

S11 EFFECT OF ADDICTION ON COURSE OF TREATMENT OF NGRI ACQUITTEES

Katya Frischer, MD, New York, NY
Merrill R. Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE

To determine if the course of treatment of "Not Guilty by Reason of Insanity" (NGRI) acquitees who were under the influence of drugs or alcohol at the time of the offense is different from those NGRIs who were not.

SUMMARY
This poster presents a chart review of 50 NGRI acquittees previously and currently hospitalized at Bronx Psychiatric Center who had been diagnosed with drug or alcohol abuse or who were under the influence of drugs or alcohol at the time of the instant offense and compares them to those who do not have a history of abuse and to those who were not under the influence at the time of the offense. Data collected will include demographic characteristics, psychosocial features, diagnosis, charges, medications, length of stay, revocation of order of conditions, existence of order of conditions, incidents while at BPC, past legal history, past hospitalizations, use of a weapon, demographics of the victim and the nature of the crime. The poster will outline how a history of drug and alcohol dependence and use of drugs and alcohol during the commission of a crime may influence the course of treatment for these subpopulations of NGRI acquittees.

REFERENCES
Meloy R: Voluntary intoxication and the insanity defense. J Psychiatry Law. Winter: 439-457, 1992
Arendt M, et al: Cannabis induced psychosis and subsequent schizophrenia -spectrum disorders: follow-up study of 535 cases. Brit J Psychiatry 187: 510-515, 2005

SELF ASSESSMENT QUESTIONS
1. Does the use of drugs/alcohol at the time of the crime affect the length of stay of NGRI acquittees in a state psychiatric facility?
ANSWER: no

2. Does the use of drugs/alcohol at the time of the crime affect the level of violence of NGRI acquittees during hospitalizations?
ANSWER: no

S12 DEMENTIA AND ESTATE PLANNING: ETHICAL CONSIDERATIONS

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Alyson R. Kuroski-Mazzei, DO, Raleigh, NC

EDUCATIONAL OBJECTIVE
To raise awareness among clinicians and attorneys of the increasingly important need to address capacity issues in a variety of legal transactions involving the elderly.

SUMMARY
This workshop provides an overview of how mental disorders, especially dementia, affect a person's legal capacity to execute documents. It will begin with a discussion of the concept of capacity and look at how standards for capacity differ for various transactions such as deeds, wills, power of attorney designations, healthcare power of attorney designations and advance directives. The program will provide a brief update on dementia, including the current state of clinical evaluation for dementia and tips for a more practical nonmedical assessment. It will address the use of neuropsychological and competency testing with elderly clients suspected of dementia, and examine how the results of these tests may be used in assisting lawyers and the courts in determining a client's mental capacity. The session will include suggestions regarding how attorneys can guard against subsequent challenges to documents executed by elderly clients and how competent clients might assure that their capacity is upheld at a later point in time. It will explore ethical obligations of attorneys representing elderly clients who have diminished mental capacity and ethical obligations of clinicians evaluating or treating this population.

REFERENCES
Spar JE, Garb AS: Assessing competency to make a will. Am J Psychiatry 149:169-174, 1992
Schulman KI, Cohen CA, Kirsh FC, Hull IM, Champine PR: Assessment of testamentary capacity and vulnerability to undue influence. Am J Psychiatry 164:722-727, 2007

SELF ASSESSMENT QUESTIONS
1. What percent of the population in the United States over 85 is likely to suffer from dementia?
a. 10%
b. 20%
c. 30%
d. >40%
e. > 70%
ANSWER: d

2. Which statement(s) about mild cognitive impairment is /are true?
a. involves memory loss
b. may progress to dementia
c. may not progress to dementia
d. all of the above
e. none of the above
ANSWER: d

S13 **DECODING AUTISTIC-SPECTRUM DISORDERS FOR FORENSICS**

Howard Zonana, MD, New Haven, CT
Marc Woodbury-Smith, MD, PhD, MRCPsych, Devonshire, Bermuda
Madelon Baranoski, PhD, (I) New Haven, CT
Josephine Buchanan, BA, (I) New Haven, CT

EDUCATIONAL OBJECTIVE
Participants will learn: 1) the distinctive features of cognitive functioning in the autistic-spectrum disorders; 2) the application of spectrum deficits to state-of-mind and competency assessments; and 3) effective explanations of the disorders in writing forensic reports and giving testimony.

SUMMARY
Burgeoning research on autistic-spectrum disorders, including neuroimaging, provides a foundation for understanding their characteristics, including the thought processes that mediate intentionality, planning, and apparent maliciousness. The prevalence of autistic-spectrum disorders ranges from 0.5 to 1.3% in the adult population, with estimates ranging from 1.2 to 2.3% in incarcerated populations. Persons with autistic-spectrum disorders (Asperger's disorder and the adult sequelae of pervasive developmental disorder) present unique challenges for forensic psychiatrists in terms of the assessment of cognitive vulnerabilities, the analysis of the impact of the deficits, and the education of the trier of fact about the often puzzling and contradictory abilities and deficits. Through a case presentation, the panel will discuss the assessment and formulation of the case, the use of cognitive assessment, and the issues of intent and appreciation. Dr. Woodbury-Smith, an expert on autistic-spectrum disorders, will review the theory and research on the disorders and their relevance to forensic psychiatry.

REFERENCES
Woodbury-Smith MR, Clare ICH, Holland AJ, et al: The 1ccognitive phenotype of men and women with high functioning autistic spectrum disorders who offend: a case-control study. J Forensic Psychiatry and Psychology 16:747-63, 2005
Woodbury-Smith MR, Clare ICH, Kearns A, et al: High functioning autistic spectrum disorders and offending: findings from a community sample. J Forensic Psychiatry and Psychology 17:1-13, 2006

SELF ASSESSMENT QUESTIONS
1. The cognitive deficits in autism
a. are similar to those in mental retardation
b. vary by gender in type and severity
c. include difficulty in processing social cues and language idioms
d. universally improve with neuroleptic medication
ANSWER: c

2. The primary cognitive deficits in Asperger's disorder include all of the following except
a. attention deficit
b. lack of integrated language
c. limited processing speed
d. impaired facial recognition
ANSWER: a

S14 **RESTORATION OF TRIAL COMPETENCY: A PERFORMANCE IMPROVEMENT PROJECT**

Katherine Warburton, DO, (I) Napa, CA
Charles Scott, MD, Sacramento, CA
Barbara McDermott, PhD, (I) Sacramento, CA

EDUCATIONAL OBJECTIVE
To share the knowledge gained, challenges faced and goals reached during an extensive forensic performance improvement project geared toward competency restoration.

SUMMARY
The assessment of adjudicative competence has been termed "the bread and butter" of forensic psychiatry and psychology and much has been written on the assessment of this type of competence. However, very little has been written on the methods of restoration for such incompetent individuals. Although Jackson v. Indiana limited the total length of commitment for such individuals, the average length of stay for incompetent defendants is approximately three months. This panel will discuss a performance improvement project designed for the rapid assessment and appropriate placement of individuals admitted as incompetent to stand trial. Dr. Warburton will discuss the development and implementation of such a strategy in a large forensic facility charged with providing a recovery model of treatment. Such discussion will include the triage process to determine probable malingering, probable restorability and probable non-restorability, as well as those individuals who arrived competent. Dr. McDermott will present the challenges associated with the rapid assessment of patients on admission to make these determinations and the assessments used to assist in this regard. Dr. Scott will discuss the incorporation of novel methods for the detection of malingering into standard treatment programming. These methods may prove useful when standard assessments yield equivocal results.

REFERENCES
Mossman, D: Predicting restorability of incompetent criminal defendants. J Am Acad Psychiatry Law 35:34-42, 2007
Mumley D, Tillbrook C, Grisso T: Five-year research update: evaluations for competence to stand trial. Behav Sci Law 21:329-350, 2003

SELF ASSESSMENT QUESTIONS
1. Which of the following is not recommended as a rapid assessment tool for triage in a competency program?
a. M-Fast
b. SIMS
c. MacCAT-CA
d. GCCT-MSH
ANSWER: c

2. What is the overall rate of successful restoration for felony defendants?
a. 25%
b. 50%
c. 75%
d. 100%
ANSWER: c

S15 ARE AAPL'S ETHICS GUIDELINES OF INTERNATIONAL RELEVANCE? INTERNATIONAL RELATIONS COMMITTEE

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Wade C. Myers, MD, Tampa, FL
John C. Gunn, MD, FRCPsych, (I) Kent, UK
Adrian T. Grounds, MD, FRCPsych, Cambridge, UK
Julio Arboleda-Florez, MD, FRCPC, Ontario, Canada

EDUCATIONAL OBJECTIVE
To present different international perspectives on AAPL's ethical principles for the practice of forensic psychiatry, and to discuss the potential scope for working towards a code of ethics that could attract an international consensus.

SUMMARY
AAPL's Code of Ethics for the Practice of Forensic Psychiatry is a unique achievement that has been developed and revised through many years of rigorous work. It does not have an equivalent in other jurisdictions, although there is a common interest in ensuring high standards of practice in the areas covered in AAPL's Code (confidentiality, consent, honesty and striving for objectivity, qualifications, handling complaints of unethical conduct), and the Forensic Section of the World Psychiatric Association has been working towards the development of some consensus statements. There are additional topics, not covered in the AAPL text, that are likely to be relevant in jurisdictions where forensic psychiatry is predominantly a specialist clinical treatment service. The participants will give perspectives on the international relevance of the AAPL Code of Ethics, and discuss the desirability and prospects for a code of international applicability. The participants will review the context in which the AAPL Code has developed; the case for separate sets of principles for forensic and clinical work; the issue of whether, in a cross-cultural context, forensic psychiatrists can be objective or only strive for objectivity; and the organizational and political challenges of securing international consensus.

REFERENCES
Zonana H: AAPL's New Ethics Guidelines. AAPL Newsletter 31: 5,9, 2005
Arboleda-Florez J: Forensic psychiatry: contemporary scope, challenges and controversies. World Psychiatry 5: 87-91, 2006

SELF ASSESSMENT QUESTIONS
1. Which of the following professional bodies has published ethics guidelines specifically for the practice of forensic psychiatry?
a. American Academy of Psychiatry and the Law
b. The Royal College of Psychiatrists
c. The Royal Australian and New Zealand College of Psychiatrists
d. The Association of European Psychiatrists
e. all of the above
ANSWER: a

2. Which of the following professional bodies has published ethical guidelines covering consent, confidentiality, and the preparation of medico-legal reports?
a. American Academy of Psychiatry and the Law
b. The Royal College of Psychiatrists
c. The Royal Australian and New Zealand College of Psychiatrists
d. The Association of European Psychiatrists
e. a, b, and c
f. all of the above
ANSWER: e

S16 FORENSIC PSYCHIATRIC ASPECTS OF CLINICAL VAMPIRISM

J. Arturo Silva, MD, San Jose, CA
Gregory B. Leong, MD, Tacoma, WA
Marcia A. Miller, PsyD, (I) San Deigo, CA

EDUCATIONAL OBJECTIVE
To provide a psychohistorical review of clinical vampirism to assist in elucidating the infrequent but often complex phenomenon of clinical vampirism.

SUMMARY
Vampiristic behavior continues to evoke the interest of U.S. mainstream culture. Yet beyond the popular culture, vampiristic behaviors, although infrequently reported, often represent substantial psychopathology and, in addition, can have significant forensic psychiatric relevance. In this presentation, we will introduce the phenomenon of blood-seeking behavior and an important conceptual subset known as clinical vampirism. The objectives of this presentation are to provide an overview of the phenomenon of clinical vampirism from psychosocial, psychohistorical and forensic-psychiatric perspectives. We will also present the preliminary results of a meta-analytic study of 52 cases of clinical vampirism, culled from the relevant literature. This presentation will discuss demographic, diagnostic and psychiatric-legal aspects of clinical vampirism. A typology of clinical vampirism will be proposed. Two cases will be presented to highlight important psychiatric-legal issues associated with clinical vampirism.

REFERENCES
Noll R: Vampires, Werewolves and Demons: Twentieth Century Reports in the Psychiatric Literature. New York: Brunner/Mazel, 1982
London S: True Vampires. Los Angeles: Feral House, 2004

SELF ASSESSMENT QUESTIONS
1. All of the following are true of vampiristic behavior except
a. frequently reported in the lay press
b. infrequently reported in the psychiatric literature
c. paraphilic behavior is a frequent association
d. usually associated with criminal behavior
ANSWER: d

2. Vampiristic behavior has been reported with all of the following except
a. dehydration
b. psychotic disorders
c. absence of blood seeking behavior
d. absence of autovampirism
ANSWER: c

S17 **YOU CAN TAKE THE PATIENT OUT OF PRISON, BUT...**

Merrill R. Rotter, MD, Bronx, NY
William A. Carr, MA, (I) Bronx, NY
Barry Rosenfeld, PhD, (I) Bronx, NY

EDUCATIONAL OBJECTIVE
This paper will examine the effects of incarceration on mentally-ill offenders and how it shapes behavior in subsequent clinical settings.

SUMMARY
Each year over 700,000 individuals with active symptoms of mental illness find their way into and out of correctional settings nationwide. In this study we use a 16-item assessment tool (SACA-R) to identify the attitudes and behaviors that follow the mentally-ill offender from the incarceration environment into the therapeutic setting where they often impede successful adjustment and engagement. The SACA-R rates variables including difficulty with trust and information sharing, isolation, meeting goals through intimidation and demanding respect. 146 male patients at a state hospital were studied, the SACA-R was scored, and its relationship to correctional history, symptoms, psychopathy and therapeutic alliance was analyzed. The total score was significantly associated with incarceration history, disciplinary tickets, and a poorer connection with the treatment team. Three sub-scales were identified: intimidation, isolation and manipulation. Intimidation and isolation were correlated with incarceration history and psychopathy score. Though an association between psychopathy and the total SACA-R score was significant as well, this correlation only partially explains the relationship between the jail experience and the clinical setting behavior measured by the SACA-R. Thus, the experience of incarceration appears to have a deleterious effect on adjustment to therapeutic settings. Implications for clinical treatment will be discussed.

REFERENCES
Rotter MR, Mcquistion HL, et al: The impact of incarceration on re-entry for adults with mental illness: a training and group treatment model. Psychiatr Serv 56: 265-267, 2005
Carr WA, Rotter MR, et al: Structured assessment of correctional adaptation: a measure of the impact of incarceration on the mentally ill in a therapeutic setting. Int J Offender Therapy and Compar Criminol 50 (5): 1-13, 2006

SELF ASSESSMENT QUESTIONS
1. The three sub-scales of the SACA-R include all of the following, except
a. intimidation
b. isolation
c. manipulation
d. hoarding
ANSWER: d

2. In this study we found that therapeutic alliance may be negatively impacted by the experience of incarceration because of which of the following factors?
a. difficulty with trust
b. stonewalling
c. doing own time
d. all of the above
ANSWER: d

S18 JUVENILE SEX OFFENDERS: A COMMUNITY SETTING STUDY

Gregg R. Dwyer, MD, EdD, Columbia, SC
Jeanette M. Jerrell, PhD, (I) Columbia, SC

EDUCATIONAL OBJECTIVE

This presentation will provide attendees with results of research on the characteristics of juveniles with sexual offending or problem behaviors, their victims, and the types of behaviors they exhibited. Implications for use of research findings in forensic evaluations and treatment planning will be presented.

SUMMARY

Juveniles account for approximately 23% of reported sex offenses, 33% of offenses against children, and 40% of offenses against victims under age six years (Snyder, 2000). Regardless of these percentages, sexual offending by juveniles is significant given the effects not only on the victims, but also on the offenders themselves. The American Academy of Child and Adolescent Psychiatry Committee on Juvenile Justice Reform of October 2005 recommended research to "better define subtypes of juvenile sexual offenders" and "support further development and assessment of treatment programs and their effectiveness" (Myers, 2005). A study of one state's community-based mental health treatment of juveniles with histories of sexual offending and problem behaviors was conducted to contribute to fulfilling those recommendations. This research study in progress consisting of 188 juveniles includes 54.3% males and 38.8% below the age of 13 years. Besides basic demographics, information under study includes education, general medical, mental health, substance use, victimization, family, criminal justice, sexual behavior, and victim characteristics. Descriptive and inferential statistical results with associated forensic evaluation and treatment implications will be presented. Included are comparisons by sex of offenders for differences in victim age, sex, and relationship to offenders; substance use; psychiatric diagnosis; abuse victimization; criminal charges.

REFERENCES

Snyder HN: Sexual assaults of young children as reported to law enforcement: victim, incident, and offender characteristics. U.S. Department of Justice Office of Justice Programs National Center for Juvenile Justice, NCJ 182990, 2000
Myers WC: Juvenile sex offenders, in The American Academy of Child and Adolescent Psychiatry Committee on Juvenile Justice Reform, Recommendations for Juvenile Justice Reform, 2nd Edition. Washington, DC: American Academy of Child and Adolescent Psychiatry, 2005, pp 91-97

SELF ASSESSMENT QUESTIONS

1. Juveniles are typically credited with approximately what percentage of sexual offenses?
a. 15%
b. 25%
c. 35%
d. 45%
ANSWER: b

2. Most juveniles exhibiting sexual offending or problem behaviors are age
a. <13 years
b. 14-15 tears
c. 14-17 years
d. 16-18 years
ANSWER: b

S19 CHILDHOOD ANTECEDENTS OF ADULT VIOLENT FELONIES IN WOMEN

Catherine F. Lewis, MD, Farmington, CT

EDUCATIONAL OBJECTIVE

To provide scientific data about childhood antecedents of later adult violent felonies in women. This data will be discussed regarding implications for treatment and evaluation of violent female felons.

SUMMARY

Objective: To describe childhood antecedents of adult violent felonies in women. Method: 136 female felons in the Connecticut DOC, with charges that included both violent and non-violent felonies were administered validated structured instruments (SSAGA II, SCID II, FHAM, TESI) for diagnosis, demographics, and data regarding childhood behavior and experience. All instruments are well validated and have established reliability. Variables included ages of onset of childhood trauma, behaviors associated with childhood conduct disorder, suicidal behavior, and detailed diagnostic data for all mental disorders including substance abuse/dependence. Ages of onset were recorded for each symptom/behavior. Statistical analysis included chi-square analysis, T tests, logistic regression, and linear regression. Results: Women who

commit violent felonies are significantly more likely to have had early onset of a cluster of severe conduct disordered symptoms in childhood, childhood trauma, an elevated suicide index, and more severe substance dependence. These findings were most significant among women convicted for robbery and assault and less so for those convicted of murder/manslaughter. Conclusion: Women convicted for violent felonies are likely to have childhoods with early onset conduct disorder and victimization. This finding is less significant for women convicted of murder versus other felonies. Implications and gender comparisons to male felons will be discussed.

REFERENCES

Warren JI, Burnette MI, South SC, et al.: Psychopathy in women: structural modeling and comorbidity. Law Psychiatry 26: 223-242, 2003
Strand S, Belfrage H: Gender differences in psychopathy in a Swedish offender sample. Behav Sci Law 23: 837-850, 2005

SELF ASSESSMENT QUESTIONS

1. Female felons convicted for murder were
a. more likely than those convicted of robbery to have experienced childhood abuse
b. more likely than those convicted of non-violent felonies to have more severe substance dependence
c. less likely than those convicted of non-violent felonies to have experienced childhood abuse
d. less likely than those convicted or robbery and assault to have conduct disorder in childhood
ANSWER: d

2. More than half of females convicted for felonies in this sample
a. had a substance dependence diagnosis
b. have committed a homicide
c. had an offense involving a family member
d. had Post Traumatic Stress Disorder
ANSWER: a

S20 POLICE INTERROGATION AND FALSE CONFESSIONS

Richard A. Leo, PhD, JD, San Francisco, CA

EDUCATIONAL OBJECTIVE

To educate the audience about research on police interrogation, psychological coercion, false confession, and wrongful conviction in the American criminal justice system.

SUMMARY

In this talk, I will discuss the history of police interrogation in America, the third degree in the 1920s and 1930s, the rise of behavioral lie detection as a form of interrogation (i.e., polygraphic interrogation) as well as the rise of interrogation training manuals in the 1940s, and the development and refinement of American psychological interrogation methods from the 1940s to the present. I will focus in particular on the social psychology of police interrogation techniques, and how and why they can, counter-intuitively, lead to false confessions from the innocent. Finally, I will discuss what we know more generally about the phenomenon of false confession and wrongful conviction in the American criminal justice system, and current issues and debates around policy reforms.

REFERENCES

Leo RA: Police Interrogation and American Justice. Cambridge MA: Harvard University Press, 2008
Kassin S, Gudjonsson G: The psychology of confessions: A review of the literature and issues. Psychological Science in the Public Interest 5: 35-67, 2004

SELF ASSESSMENT QUESTIONS

1. What are the different types of false confessions?
ANSWER: Voluntary, compliant, and persuaded (sometimes also called “internalized”)

2. What are false evidence ploys?
ANSWER: A police interrogation technique in which police lie about nonexistent evidence (e.g., fingerprints, DNA, etc.)

S21 PRISON RESEARCH: OPPORTUNITIES, HURDLES, METHODS

Kenneth L. Appelbaum, MD, Shrewsbury, MA
Robert L. Trestman, MD, PhD, Farmington, CT

EDUCATIONAL OBJECTIVE

Participants will recognize opportunities in correctional mental health research based on limitations in current knowledge, barriers to such research, and strategies for success.

SUMMARY

Given the far-reaching federal limitations placed on correctional medical research in the 1970's, subsequent research in correctional mental health has been sparse. Broad areas in current need of attention include epidemiology, research methodology, estimation of environmentally relevant function, efficacy of interventions, and safety. For example, existing prevalence data for general and specific disorders has questionable validity and generalizability, assessment instruments need validation for inmate populations, the correctional environment can exacerbate some symptoms and behaviors and mitigate others, and interventions such as rehabilitation therapies and segregation services have not been well studied. Further, crucial needs exist to improve the assessment and management of self-injurious behavior, suicide risk, and assaults. Barriers to correctional mental health research include poor funding, resistance of stakeholders, restricted access to subjects, limited information technology, ethical concerns and significant IRB restrictions and requirements. Implications of the Institute of Medicine report on research with prisoners will be introduced. This workshop will focus on the presenters' experience in correctional, mental-health, research, stakeholder engagement, project development, design, funding, and implementation. Workshop attendees will be engaged with discussion of specific concerns and perceived barriers. Exemplar step-by-step resolution processes will be described.

REFERENCES

Trestman RL: Research with prisoners, in Correctional Psychiatry, Practice Guidelines and Strategies. Edited by Thienhaus OJ, Piasecki M. Kingston, NJ: Civic Research Institute, 2007
Appelbaum KL: Correctional mental health research: opportunities and barriers. J Correctional Health Care, accepted for publication

SELF ASSESSMENT QUESTIONS

1. Recent recommendations regarding prisoner research from the Institute of Medicine include which of the following?
a. limit the definition of prisoner to only those in custodial detention
b. establish separate guidelines for studies funded by private, nongovernmental sources
c. exclude input from prisoners into research design and conduct
d. conduct research only in facilities with humane environments
ANSWER: d

2. A methodologically criticized December 2006 report by the Department of Justice, Bureau of Justice Statistics reported a prevalence of mental health problems among state prisoners of what percent?
a. 8%
b. 14%
c. 37%
d. 56%
e. 72%
ANSWER: d

S22 UNDERSTANDING RISK ASSESSMENT AND MANAGEMENT

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

EDUCATIONAL OBJECTIVE

Participants will understand: 1) research data underlying risk assessment; 2) statistical/analytical limits of such research; 3) distinctions between actuarial and clinical assessments of risk and the use of the appropriate techniques for specific purposes; 4) several critiques of risk assessment approaches; and 5) 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 valid and reliable risk assessment measures are defining the practice, policies, and standards for risk assessment. Familiarity with the relevant research, legal and clinical issues that shape practice and the relative merits and limitations (especially as applied to individuals) 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
Norko MA, Baranoski MV: The prediction of violence; detection of dangerousness. Brief Treatment & Crisis Intervention, Dec 2007; doi: 10.1093/brief-treatment/mhm025. Available at: http://brieftreatment.oxfordjournals.org/cgi/reprint/mhm025?ijkey=5yBa5vdXnp9q2oh&keytype=ref

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. cannot inform policy development and management of services
d. are not useful in sentencing evaluations
ANSWER: b

2. Limitations of the application of population-based actuarial risk assessment instruments to evaluations of individuals include all of the following, except
a. low positive predictive power of instruments
b. courts' misperceptions of meaning of risk data
c. low inter-rater reliability of actuarial instruments
d. perception of risk rating as characteristic of individual
ANSWER: c

S23 DETECTION OF MALINGERING IN DISABILITY EVALUATIONS

Roger Z. Samuel, MD, Boca Raton, FL
Wendy Marlowe, PhD, (I) Seattle, WA
Henry Conroe, MD, Chicago, IL
Mark DeBofsky, JD, (I) Chicago, IL

EDUCATIONAL OBJECTIVE

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

SUMMARY

While malingering has been estimated to occur in 7.5-33% of disability claimants, the assessment of malingering in such claimants can be very demanding. This workshop will utilize a disability case presentation to illustrate factors that are helpful in determining the presence or absence of malingering. A psychiatrist, Dr. Samuel, will review the definition and epidemiology of malingering, and present the case. Dr. Boone, a neuropsychologist, will review the psychological tests utilized in such cases, and present the findings in this case. Another psychiatrist, Dr. Conroe, and a disability attorney, Mr. DeBofsky, will act out the direct and cross examinations of an expert witness psychiatrist presenting the evidence in this case in a simulation of a courtroom setting. Dr. Samuel will then present the factors utilized in determining malingering. Mr. DeBofsky will next provide an attorney's perspective of disability issues and psychiatrist expert witness issues. Handouts summarizing the case, and the factors involved in detecting malingering, will be provided. Time will be assigned for questions, comments and discussion.

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 involve probable malingering and symptom exaggeration?
ANSWER: 30%

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

S24 LANDMARK CASE UPDATES: WHAT'S NEW IN LAW AND MENTAL HEALTH

Charles L. Scott, MD, Sacramento, CA
Phillip J. Resnick, MD, Cleveland, OH
Debra Pinals, MD, Worcester, MA

EDUCATIONAL OBJECTIVE
The audience participant will learn important emerging concepts from recent mental health law cases that have been recommended for the revised AAPL Landmark Cases. Key issues from important new cases in civil, criminal, correctional, and juvenile law will be presented.

SUMMARY
The practice of forensic psychiatry is inherently intertwined with those cases that address the relationship of law and mental health. To practice effectively, forensic psychiatrists must remain current in their knowledge of important court rulings. This panel reviews those key cases that have been recommended by the Association of Directors of Forensic Psychiatry Fellowships (ADFPF) to be included as an update to the prior list of AAPL Landmark cases. Each presenter will provide the historical background leading up to the case, an in-depth review of the case, the court's ruling, the reasoning for the ruling, and implications for future forensic psychiatric practice. Phillip Resnick, MD will review Clark v. Arizona and Panetti v. Quarterman; Debra Pinals, MD will discuss Hargrave v. State of Vermont and Aetna Health Inc. v. Davila; and Charles Scott, MD will present United States v. Georgia, Fare v. Michael, and Roper v. Simmons. The audience member will learn core concepts and "what's new" in important mental health law cases.

REFERENCES
Clark v. Arizona, 126 S. Ct. 2709 (2006)
United States v. Georgia, 546 U.S. 151; 126 S. Ct. 877 (2006)

SELF ASSESSMENT QUESTIONS
1. All of the following are true in United States v. Georgia except
a. Disabled inmate in a state prison can sue the state under the Federal ADA statute for conduct that violates the 14th Amendment.
b. The 11th Circuit noted that the inmate was a disabled inmate who had likely been subjected to cruel and unusual punishment in a violation of the 8th amendment.
c. Goodman was a mentally disordered offender who sued alleging deliberate indifference to his mental health needs.
d. Abrogation doctrine is a constitutional law doctrine expounding when and how Congress may waive a state's sovereign immunity and subject it to lawsuits that to which the state has not consented.
ANSWER: c

2. Which of the following answers is incorrect in the case of Panetti v. Quarterman?
a. Mr. Panetti shot and killed his wife's parents in front of his wife and daughter.
b. The US Supreme Court held that the state court failed to provide the procedures to which Mr. Panetti was entitled under the Constitution.
c. The US Supreme Court held that the Fifth Circuit employed an improperly restrictive test of competency to be executed when it considered Mr. Panetti's claim of incompetency.
d. The US Supreme Court articulated a clear standard when evaluating competency to be executed.
e. The US Supreme Court cited their prior ruling in Ford v. Wainwright.
ANSWER: d

S25 SVPS: WHO DO PSYCHIATRISTS COMMIT?

Gregg R. Dwyer, MD, EdD, Columbia, SC
Geoffrey R. McKee, PhD, (I) Columbia, SC

EDUCATIONAL OBJECTIVE
Participants will be able to discuss those factors identified through inferential statistical analysis as correlated with a forensic examiner's decisions to recommend civil commitments under a state's SVP act. They will also be able to discuss the implications of those factors in forensic evaluations and for mental health system management.

SUMMARY
With Kansas v. Hendricks (1997), the United States Supreme Court allowed for civil commitment of persons convicted of sex offenses after criminal incarceration. By 2007's end, nineteen states enacted laws to civilly commit persons typically identified as Sexually Violent Predators (SVPs). How are decisions reached in deciding to civilly commit SVPs for an indeterminate period of time? At least one state uses a seven-step process culminating in a civil trial with a jury option. By January 2008,

in the study state, 510 persons reached the pre-trial stage during which persons under commitment consideration were evaluated by a forensic psychiatrist for a commitment opinion. Of those, 506 were evaluated and 198 were referred for trial. This research identifies differences between persons recommended for commitment and those not recommended at the evaluation stage of a state's SVP commitment process. Information compared includes demographic, education, general medical, mental health, criminal justice, and sex offense data. Descriptive and inferential statistical results with associated forensic evaluation and mental health system implications for a sample of those cases will be presented.

REFERENCES

Kansas v. Hendricks 521 U.S. 346 (1997)
Jackson RL, Hess DT: Evaluation for civil commitment of sex offenders: a survey of experts. Sexual Abuse: A Journal of Research and Treatment 19(4):425-48, 2007

SELF ASSESSMENT QUESTIONS

1. In which case did the United States Supreme Court allow for the civil commitment of persons convicted of sex offenses after criminal incarceration?

a. Kansas v. Hendricks
b. Kansas v. Crane
c. Doe v. Marion
d. Commonwealth of Pennsylvania v. Robin Shrawder
ANSWER: a

2. In previous research, what factors have been identified as affecting decisions to civilly commit under an SVP act?

a. more than three sex offense convictions
b. history of sexual offending
c. personality disorder or paraphilia indicating volitional impairment
d. all of the above
e. b and c
ANSWER: e

S26 AXIS I AND AXIS II DISORDERS IN INCARCERATED PEDOPHILES

Michael C. Harlow, MD, JD, Sioux Falls, SD
Christopher M. Davidson, MD, Sioux Falls, SD
Fabian Saleh, MD, Boston, MA
Jessica Ferranti, MD, Sacramento, CA
Manish Sheth, MD, PhD, Sioux Falls, SD

EDUCATIONAL OBJECTIVE

To convey the prevalence of AxisI/ Axis II disorders in incarcerated pedophiles; to examine the correlations of AxisI/ Axis II disorders in this study group of incarcerated pedophiles; to contrast findings with published data of Axis I/ Axis II disorders in non-incarcerated pedophiles; and to compare data with comorbidities of incarcerated general child sex offenders.

SUMMARY

Among child sex offender typologies, pedophilia is of prime note as pedophiles exhibit a primary sexual interest towards children and display with high levels of co-morbid psychiatric disorders. In one study of non-incarcerated pedophile sex offenders, 93% of subjects displayed a minimum of one lifetime DSM-IV Axis I disorder with mood disorders (76%) most prevalent. Incarcerated general offenders against minors also demonstrate heightened comorbidities. In one study of incarcerated general sex offenders against minors, subjects exhibited elevated levels of personality disorders, with Avoidant Personality Disorder (41%) the most prevalent. In an effort to better understand the co-morbid psychiatric disorders of incarcerated pedophiles, 70 pedophiles imprisoned in the South Dakota Prison System were administered the Millon Clinical Multiaxial Inventory, Third Edition (MCMI-III). Co-morbid Axis I disorders occurred in 67% of subjects, with 37% meeting criteria for multiple Axis I disorders. The most common Axis I disorders were alcohol abuse (30%) and Generalized Anxiety Disorder (27%). Co-morbid Axis II disorders occurred in 41% of subjects with 13% displaying multiple Axis II disorders. The predominant DSM-IV Axis II disorder was Avoidant Personality Disorder (15%). Assessment of bi-variate associations using Spearman Rank Correlation and Chi Squared tests, revealed associations of significance for Axis I and Axis II disorders.

REFERENCES

Ahlmeyer SA, Kleinsasser D, Stoner J: Psychopathy of incarcerated sex offenders. J Personality Disorders 17: 306-318, 2003
Raymond N, Coleman E, Ohlerking F, et al.: Psychiatric comorbidity in pedophiliac sex offenders. Am J Psychiatry 156: 786, 1999

SELF ASSESSMENT QUESTIONS

1. In one study of incarcerated sex offenders against minors, what was the most common personality disorder diagnosis?
a. antisocial
b. avoidant
c. narcissistic
d. histrionic
ANSWER: b

2. In a study of non-incarcerated pedophile sex offenders what percentage of subjects displayed a lifetime history for mood disorder?
a. 0-20%
b. 20-40%
c. 40-60%
d. 60-80%
ANSWER: d. (76%)

S27 **DECONSTRUCTING PORNOGRAPHY**

J. Arturo Silva, MD, San Jose, CA
Douglas Tucker, MD, Berkeley, CA

EDUCATIONAL OBJECTIVE

To provide a brief introduction to the problem of pornography; to provide an introduction of the visual perceptual nature of pornography; and to introduce some visuo-constructional approaches for the assessment of pornography.

SUMMARY

Pornography is generally conceptualized as a media-oriented process which involves the explicit depiction of sexual subject matter created for the purpose of causing sexual stimulation. Pornography may include semantic-based media such as fictional literature as well as perceptual-based media. During the last few decades, the emergence of the internet and home based technologies such as the VCR, coupled with the increasing sophistication of visual-based media such as photography, animation, and film, has resulted in the emergence of a multibillion dollar pornographic industry. The recent growth of the pornography industry has attracted substantial attention from behavioral and forensic scientists, and from forensic psychiatrists. In spite of our increased understanding of pornography, our fundamental knowledge of this area remains limited. In this presentation we will introduce the study of pornography from a visual-perceptual perspective. We will analyze a specific sample of commercial pornographic images in order to highlight the multiplicity of factors and challenges associated with the study of pornography. We will briefly discuss the potential benefits of studying the visual-perceptual characteristics of pornography for forensic psychiatry and other areas of scientific endeavor.

REFERENCES

Cooper A: Cybersex: The Dark Side of the Force. Philadelphia: Taylor and Francis, 2000
Loftus D: Watching Sex: How Men Really Respond to Pornography. New York: Thunder's Mouth Press, 2002

SELF ASSESSMENT QUESTIONS

1. Modern pornography may involve all of the following except
a. substantial reliance on visual-perceptual technologies
b. live sexual entertainment
c. a close association with the Internet
d. a multibillion dollar industry
ANSWER: b

2. The visual perception of pornographic images
a. may be implicated in some mental disorders
b. may be affected by face-ism
c. may involve compartmentalization
d. a and b are true of pornography
e. a, b and c are true of pornography
ANSWER: e

S28 **INFORMED CONSENT IN CONTROVERSIAL SITUATIONS: PSYCHOPHARAMCOLOGY COMMITTEE**

Philip J. Candilis, MD, Worcester, MA
Gary Chaimowitz, MB, CHB Ontario, Canada
John Paul Fedoroff, MD, Ontario, Canada
James K. Wolfson, MD, Springfield, MO

EDUCATIONAL OBJECTIVE
Attendees will participate in a workshop to raise their awareness of the application of informed consent in certain controversial situations.

SUMMARY
This workshop, presented by the Psychopharmacology Committee, will discuss some aspects of the doctrine of informed consent in a variety of controversial, distinctive situations, including outpatient commitments, restoration of competency and administering sex-drive reducing meds (possibly) as part of a court order or parole. We will invite participants not only to discuss these situations, but to raise their own issues in analogous situations. It is anticipated that participants will come prepared for challenging discussions.

REFERENCES
Griffith EEH: Ethics in forensic psychiatry: a response to Stone and Appelbaum. J Am Acad Psychiatry Law 26: 174-184, 1998
Candilis P, Weinstock R, Martinez R: Robust professionalism: beyond roles, in Forensic Ethics and the Expert Witness. New York: Springer, 2007

SELF ASSESSMENT QUESTIONS
1. What ethical frameworks have been proposed for addressing the frequent tension of clinical and forensic roles?
a. strict role theory
b. principlism
c. robust professionalism
d. narrative ethics
e. all of the above
ANSWER: e

2. Which of the following cases is precedent setting with relevance to restoration of competency to stand trial?
a. Canterbury v. Spence (1972)
b. Sell v. United States (2002)
c. Jaffee v. Redmond (1996)
d. Dusky v. United States (1960)
ANSWER: b

S29 **UPDATE FROM THE APA COUNCIL ON PSYCHIATRY AND LAW**

Debra A. Pinals, MD, Worcester, MA
Stuart Anfang, MD, Northampton, MA
Steven K. Hoge, MD, New York, NY
Jeffrey Metzner, MD, Denver, CO
Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE
At the end of this presentation, participants will be able to describe recent developments related to psychiatry and the law considered by the APA Council on Psychiatry and the Law and gain familiarity with actions taken by the APA in these areas of interest.

SUMMARY
The APA Council on Psychiatry and Law reviews topics of interest related to the legal regulation of psychiatric practice and forensic psychiatry. This presentation will review topics that have recently been discussed and debated within Council and the APA. It is anticipated that the areas to be covered will include a presentation by Dr. Pinals regarding considerations for APA responses to the recently amended federal registry law related to firearm acquisition that involves maintenance of databases of persons with particular mental health histories. Dr. Metzner will present for the Committee on Judicial Action, recent cases such as Indiana v. Edwards, which focuses on competence to legally represent oneself, and amicus briefs pertaining to gay marriage. Dr. Hoge will discuss a planned resource document on outpatient services that aim to decrease the likelihood of criminal justice system involvement for persons with mental illness. Dr. Anfang

will review the recently approved APA position statement on the release of patient information to state medical boards. Dr. Zonana will provide an update on legal issues and college mental health. Participants will be able to discuss topics presented and gain a greater understanding of current APA perspectives on areas relevant to law and psychiatry.

REFERENCES

Norris DM, Price M, Gutheil T, Reid WH: Firearm laws, patients, and the roles of psychiatrists. Am J of Psychiatry 163:1392-1396, 2006

Lamberti JS, Weisman R, Faden DI: Forensic assertive community treatment: preventing incarceration of adults with severe mental illness. Psychiatric Services 55:1285-1293, 2004

SELF ASSESSMENT QUESTIONS

1. Attempts to reduce the likelihood of re-incarceration or entrance into incarceration for persons with mental illness have included?

a. forensic assertive community treatment
b. jail diversion programs
c. mental health and drug courts
d. all of the above

ANSWER: d

2. Which of the following represent arguments for and against firearm registry laws?

a. Registry laws provide a way to distribute names of persons with mental illness to the public to allow for reporting of illegal gun access/ registry laws do nothing to reduce firearm acquisition.
b. Registry laws could prevent violence/ registry laws have not been proven to prevent firearm violence by persons with mental illness.
c. Registry laws are designed to identify groups of higher risk individuals and limit their firearm access/ registry laws operate utilizing often antiquated and derogatory terms related to mental illness and group individuals without attention to individual assessments of violence risk.
d. b and c

ANSWER: d

S30 **COMPUTERS AND TECHNOLOGY IN FORENSIC PSYCHIATRY: COMPUTERS AND FORENSIC PSYCHIATRY COMMITTEE**

Mark J. Hauser, MD, Newton, MA
Alan W. Newman, MD, Washington, DC
Cheryl Wills, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

Participants will learn ways to improve forensic psychiatry practice utilizing the latest technology, will become familiar with benefits of computer hardware, software and peripheral devices, will gain a detailed understanding of software useful for teaching and learning forensic psychiatry, and will become aware of various useful websites.

SUMMARY

The Computers and Forensic Psychiatry Committee hosts an annual workshop for participants to learn about the use of computer hardware and software, and connected gadgets, that can enhance training in, and the practice of, forensic psychiatry. Presenters will be available with laptop computers, an array of gadgets, and a live internet connection to demonstrate selected computer software applications and discuss their usefulness. For the beginner, there will be a review of some computer basics, including the importance of backup strategies and the efficiency of speech recognition software. The presenters will review various internet based tools, some that can be useful for teaching and learning forensic psychiatry, others being used for collaboration with colleagues, for example to facilitate committee work as an alternative to live meetings. The presenters will demonstrate the use of video and podcasts to teach psychiatry, the use of web-based research to enhance forensic psychiatry practice, and a review of resources of interest to the forensic psychiatrist. We will discuss the experience of using on-line collaboration software, pro and con, by the members of the Computers and Forensic Psychiatry Committee. The audience is encouraged to bring questions and share their relevant experience to enable dialogue with the presenters.

REFERENCES

1.8 million pages of U.S. Case Law Available Now http://public.resource.org
Web Site of the American Academy of Psychiatry and the Law: http://www.aapl.org

SELF ASSESSMENT QUESTIONS

1. Which of the following statements is most accurate regarding the use of a reliable backup strategy?
a. best left up to the other guy
b. only necessary after a hard drive crash
c. can be put off indefinitely
d. is best done regularly, and before it is too late
ANSWER: d

2. Over the last several years, speech recognition software
a. has remained difficult to use
b. is too expensive
c. requires obscure prerequisites
d. has become more accurate, less expensive, and is easy to use
ANSWER: d

S31 MURDER-SUICIDE: A REVIEW OF THE RECENT LITERATURE

Scott A. Eliason, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

To help attendees become familiar with the characteristics and incidence of murder-suicide. To improve clinical and forensic risk assessments so that they include not only homicide and suicide risk factors, but also murder-suicide risk factors as well.

SUMMARY

There has been recent widespread media coverage of events that involve murder-suicide. In this paper, the author does an extensive literature review of studies about murder-suicide, especially those that have been written since 1992, the time that the last review article was published on this topic. The purpose is to determine whether the incidence of murder-suicide is increasing and what its risk factors are. The results of this review show that the incidence of murder-suicide remains at under 0.001%. Risk factors for murder-suicide are based on relationship between perpetrator and victims, history of domestic violence, sex of perpetrator and victim, age of perpetrator and victim, substance use by perpetrator, previous criminal history of perpetrator, employment status of perpetrator, presence of divorce/separation, use of weapon, and history of mental illness. This paper shows that the incidence of murder-suicide is low, stable, and similar to what has been reported in the past. Most murder-suicides can be grouped into five typologies, and there are many shared risk factors for homicide, suicide, and murder-suicide. There are, however, some distinct risk factors for murder-suicide including: substance abuse (not as common), mostly male perpetrators, depression (more common), and older male caregivers are at risk.

REFERENCES

Marzuk P, Tardiff K, Hirsch C: The epidemiology of murder-suicide. JAMA 267:3179-3183, 1992
Coid J: The epidemiology of abnormal homicide and murder followed by suicide. Psychol Med 13:855-60, 1983

SELF ASSESSMENT QUESTIONS

1. Who is most likely to commit murder-suicide?
a. a recently separated husband
b. a recently separated wife
c. a bullied adolescent
ANSWER: a

2. What is the incidence of murder-suicide?
a. 1%
b. 0.1%
c. <0.001%
d. 0.01%
ANSWER: c

S32 SUICIDE AMONG INCARCERATED VETERANS: A SYSTEMATIC REVIEW

Hal S. Wortzel, MD, Denver, CO
Ingrid A. Binswanger, MD, MPH, (I) Aurora, CO
Alan C. Anderson, MD, (I) Denver, CO
Lawrence E. Adler, MD, (I) Denver, CO

EDUCATIONAL OBJECTIVE
To identify the combining risk factors placing incarcerated veterans at increased risk for suicide, to explore the neuropsychiatric status of this population, and to offer directions for future research and clinical implications.

SUMMARY
Both veterans and jail/prison inmates face an increased risk for suicide. The incarcerated veteran sits at the intersection of these two groups, yet little is known about this subpopulation, particularly its risk for suicide. A Pubmed/Medline/PsycINFO search anchored to incarcerated veteran suicide, veteran suicide, suicide in jails/prisons, and incarcerated veterans for the years 2000 to the present was performed. The presently available literature does not reveal the suicide risk of incarcerated veterans, nor does it enable meaningful estimates. However, striking similarities and overlapping characteristics link the data on veteran suicide, inmate suicide, and incarcerated veterans, suggesting that the veteran in jail or prison may face a level of suicide risk beyond that conferred by either veteran status or incarceration alone. There is a clear need to better characterize the incarcerated veteran population and the suicide rate faced by this group. Implications for clinical practice and future research are offered.

REFERENCES
Kaplan MS, Huguet N, McFarland BH, Newsom JT: Suicide among male veterans: a prospective population-based study. J Epidemiol Community Health 61(7):619-24, 2007
Hoge CW: Deployment to the Iraq war and neuropsychological sequelae. JAMA 296(22):2678-9, 2006

SELF ASSESSMENT QUESTIONS
1. Which of the following inmate characteristics have been associated with suicide risk?
a. violent offense
b. drug abuse
c. homelessness
d. all of the above
ANSWER: d

2. Which of the following are true of incarcerated veterans?
a. they tend to be poorly educated
b. they lie at the intersection of two populations with elevated suicide risk
c. they are usually combat veterans
d. they are a well characterized subpopulation of inmates
ANSWER: b

S33 CONTRACTING FOR SAFETY: CLINICAL PRACTICE AND FORENSIC IMPLICATIONS

Keelin A. Garvey, MD, Providence, RI
Joseph V. Penn, MD, Huntsville, TX
Angela L. Campbell, JD, (I) Des Moines, IA
Christianne Esposito-Smythers, PhD, (I) Providence, RI
Anthony Spirito, PhD, (I) Providence, RI

EDUCATIONAL OBJECTIVE
To review empirical literature supporting the practice of "contracting for safety," focusing on adolescent patients; to explore potential limitations to employing this practice with adolescents, including neurobiological immaturity and informed consent; and to review and highlight legal cases involving the use of contracting to provide information on the legal relevance of the practice.

SUMMARY
The "contract for safety" is a procedure used in the management of suicidal patients, and has significant patient care, risk management, and medico-legal implications. We conducted a literature review to assess the empirical support for this procedure, with an emphasis on the use of these agreements with adolescents, explored related issues of informed consent and adolescent neurobiological immaturity, and reviewed legal cases in which this practice was employed to examine its effect on outcome. Studies obtained from a PubMed search were reviewed, and consisted mainly of opinion-based surveys and retrospective reviews. Overall, empirically based evidence to support

the use of the contract for safety in adolescent populations is very limited. A legal review revealed that contracting for safety is never sufficient to protect against legal liability, and may lead to adverse consequences for the clinician and patient. Contracts should only be considered in patients who are deemed capable of giving informed consent, and even in these circumstances, should be used with caution. A contract should never replace a thorough assessment of a patient's suicide risk factors. Further empirical research is needed to determine if contracting for safety merits consideration as a future component of the suicide risk assessment.

REFERENCES

Lee JB, Barlett ML: Suicide prevention: critical elements for managing suicidal clients and couselor liability without the use of no-suicide contract. Death Studies 29:847-865, 2005
Simon RI: The suicide prevention contract: clinical, legal, and risk management issues. J Am Acad Psychiatry Law 27(3):445-450, 1999

SELF ASSESSMENT QUESTIONS

1. The majority of research on the effectiveness of the contract for safety exists in the form of
a. randomized controlled trials
b. opinion-based surveys and retrospective reviews
c. case series and case reports
d. there has been no research done in this area
e. prospective studies
ANSWER: b

2. In the case of Peoples Bank v. Damera, the Illinios court ruled that a suicide case differs from a typical medical malpractice case, in which the plaintiff's own negligence is taken into account and compared to that of the defendant. What is legal concept called?
a. gross negligence
b. professional negligence
c. preponderance of evidence
d. contributory negligence
e. immunity
ANSWER: d

S34 EMPLOYMENT AND DISABILITY AMONG SURVIVORS OF MAJOR DISASTERS

Sarah S. Rasco, MD, Dallas, TX
Carol North, MD, MPE, (I) Dallas, TX

EDUCATIONAL OBJECTIVE

To understand the employment patterns of disaster survivors in the three years following trauma exposure.

SUMMARY

It is important to understand whether trauma survivors return to work so that policymakers who prepare for the aftermath of major disasters, as well as war, can anticipate rates of occupational disability and the consequent needs of communities and individual survivors. Additionally, such information would benefit psychiatrists who perform disability assessments and who are asked to predict future capacity for work. This study was designed to clarify the relationship between trauma exposure, PTSD, and future employment. Survivors of seven different disasters and their history of employment were prospectively followed over three post-disaster years. Results include that 86% of the sample were employed at the time of disaster and 84% of the sample were employed at three-year follow up. Those whose employment was disrupted had a significantly higher prevalence of PTSD, major depression, alcohol use disorder, and any psychiatric disorder during the follow-up period compared to those whose employment status was uninterrupted. Rates of psychiatric disorders were not higher among those who were unemployed at three years compared to those who had resumed working. Similar studies which examine survivors of other types of trauma are needed to supplement these results.

REFERENCES

Sareen J, Cox BJ, Stein MB, et al: Physical and mental comorbidity, disability, and suicidal behavior associated with posttraumatic stress disorder in a large community sample. Psychosomatic Medicine 69(3):242-8, 2007
Ormel J, VonKorff M, Ustun TB, et al: Common mental disorders and disability across cultures. Results from the WHO Collaborative Study on Psychological Problems in General Health Care. JAMA 272(22):1741-1748, 1994

SELF ASSESSMENT QUESTIONS

1. What is the general trend of employment following disaster?
a. Most employed disaster victims return to work
b. Most employed disaster victims suffer occupational disability and are unable to return to work
c. Approximately half of employed disaster victims return to work
ANSWER: a

2. The diagnosis of PTSD correlated with what kind of employment trend?
a. change in employment status to total occupational disability
b. continuous employment without change or disruption
c. disrupted/ discontinuous employment
ANSWER: c

S35 HAMDAN IN GUANTANAMO: THE FIRST MILITARY COMMISSIONS TRIAL

Emily A. Keram, MD, Santa Rosa, CA
Brian L. Mizer, JD, (I) Washington, DC
Harry H. Schneider, Jr., JD, (I) Seattle, WA
Joseph M. McMillian, JD, (I) Seattle, WA

EDUCATIONAL OBJECTIVE

Participants will gain familiarity with the Military Commissions, including judicial and legislative history, jurisdiction, and admissibility of statements obtained by torture and coercion.

SUMMARY

The first military commissions trial of a Guantanamo detainee concluded in August 2008. Salim Hamdan, who had admitted to being Osama bin Laden's driver, was found guilty of providing material support to terrorism. He was acquitted of conspiracy and sentenced to 66 months, with 61 months credit for time served. From 2004 until trial this summer, Hamdan's military and civilian defense counsel simultaneously prepared for the criminal trial while challenging the military commissions process via the federal courts. Their efforts included the 2006 US Supreme Court case Hamdan v. Rumsfeld, a landmark case on the separation of powers.
The panel, Hamdan's defense counsel and a forensic psychiatrist retained by the defense, present various aspects of Hamdan's case.

Joe McMillan will summarize the challenges made to the military commissions process via the federal courts. LCDR Brian Mizer will discuss deviations from the Uniform Code of Military Justice and the Geneva Conventions enacted by the Military Commissions act of 2006. Harry Schneider will discuss the defense strategy at trial in light of the rules of the military commissions. Emily Keram, MD, will discuss her trial testimony regarding conditions of confinement, suppression of evidence obtained through coercive interrogation practices, and mitigation at sentencing.

REFERENCES

Hamdan v. Rumsfeld, 548 U.S. 557, 2006
Bloche MG, Marks JH: Doctors and interrogators at Guantanamo Bay N Engl J Med 335(1):6-8, 2005

SELF ASSESSMENT QUESTIONS

1. The Military Commission Act of 2006 allows statements obtained by torture for December 30, 2005 in which the degree of coercion idisputed to be admitted at trial only if the military judge finds that:
a. the totality of the circumstances renders the statement reliable and possessing sufficient probative value
b. the interests of justice would best be served by admission of the statement into evidence
c. the accused did not suffer enduring physical or psychological harm as a result of the alleged coercion
d. statements obtained through the use of torture are never admissible regardless of the degree of coercion
e. a and b
f. a, b, and c
ANDWER: e

2. In Hamdan v. Rumsfeld
a. the USSC held that the administration did not have authority to set up the original military commissions without congressional authorization, because they did not comply with the Uniform Code of Military Justice (UCMJ) and the Geneva Convention
b. the USSC held that deviations from the UCMJ included the provision that the defendant and the defendant's attorney may be forbidden to view certain evidence against the defendant, and the defendant's attorney may be forbidden to discuss certail evidence with the defendant
c. the government argues that the USSC did not have jurisdiction to hear the case
d. all deficiencies founded by the USSC in the original military commissions were rehabilitated in the Military Commissions Act of 2006
e. a and b
f. b and d
g. a, b and c
h. all of the above
ANSWER: g

SUNDAY, OCTOBER 26, 2008

WORKSHOP — 8:00 AM - 10:00 AM — **CASCADE I**

Z1 ***Innovative Approaches to Forensic Education***

Cheryl D. Wills, MD, Cleveland, OH
Debra A. Pinals, MD, Worcester, MA
Barbara A. Justice, MD, Los Angeles, CA
Jeffrey Janofsky, MD, Timonium, MD

WORKSHOP — 8:00 AM - 10:00 AM — **CASCADE II**

Z2 ***High Stakes Bluff: Malingered Adjudicative Incompetence***

Sherif Soliman, MD, Cleveland, OH
Cathleen A. Cerny, MD, Cleveland, OH

WORKSHOP — 8:00 AM - 10:00 AM — **ELLIOTT BAY**

Z3 ***Working With Lawyers***

Lawrence K. Richards, MD, Champaign, IL
Roger Peele, MD, Rockville, MD
Bruce J. Winick, JD, (I) Coral Gables, FL
Harold Eist, MD, (I) Bethesda, MD
Thomas G. Gutheil, MD, Brookline, MA

PANEL — 8:00 AM - 10:00 AM — **GRAND CRESCENT**

Z4 ***"Deinstitutionalization" in Corrections? Prospects, Obstacles, Consequences***

Suzanne Yang, MD, Cleveland, OH
Bandy Lee, MD, M. Div., (I) New Haven, CT
Peter Ibarra, PhD, (I) Syracuse, NY
James L. Knoll, IV, MD, Syracuse, NY

RESEARCH IN PROGRESS# 6 — 8:00 AM - 10:00 AM — **FIFTH AVENUE**

Z5 ***Community Corrections: Learning More to Enhance Outcomes***

Tracy D. Gunter, MD, Iowa City, IA

Z6 ***FACT: Partnering With Probation***

Alison Deem, MD, (I) Rochester, NY
Steven J. Lamberti, MD, (I) Rochester, NY
Robert Weisman, DO, (I) Rochester, NY

Z7 ***Massachusetts Mental Health- Criminal Justice Cohort Study***

Albert J. Grudzinskas Jr., JD, (I) Worcester, MA
William H. Fisher, PhD, (I) Worcester, MA
Kristen Roy-Bujnowski, MA, (I) Worcester, MA
Jonathan C. Clayfield, MA, (I) Worcester, MA
Lorna Simon, MA, (I) Worcester, MA

Z8 ***Mental Health Attitude Survey for Police***

Jonathan C. Clayfield, MA, (I)Worcester, MA
Deepak Dev, MD, (I) Worcester, MA
Albert J. Grudzinskas Jr., JD, (I) Worcester, MA

COFFEE BREAK — **10:00 PM - 10:15 PM** — **CASCADE FOYER**

PANEL — 10:15 AM - 12:15 PM — **CASCADE I**

Z9 ***Chemical and Surgical Castration: Ethics and Efficacy***

Elena del Busto, MD, Philadelphia, PA
Charles Scott, MD, Sacramento, CA
Humberto Temporini, MD, Sacramento, CA
Douglas Tucker, MD, Berkeley, CA

WORKSHOP 10:15 AM - 12:15 PM **CASCADE II**

Z10 Suicide Prevention PI in Corrections: The Six Sigma Method

Steven J. Helfand, PsyD, (I) Farmington, CT
Robert L. Trestman, PhD, MD, Farmington, CT

PANEL 10:15 AM - 12:15 PM **ELLIOTT BAY**

Z11 NGI Evaluations Under California Case Law: Clarification or Confusion?

Jeff Gould, MD, San Francisco, CA
Melissa Nelken, JD, (I) San Francisco, CA

PANEL 10:15 AM - 12:15 PM **GRAND CRESCENT**

Z12 Mental Health Courts: Therapeutic or Jurisprudent?

Merrill R. Rotter, MD, Bronx, NY
Madelon Baranoski, PhD, (I) New Haven, CT
The Honorable Arthur Chapman, Seattle, WA
Fred Osher, MD, (I) Bethesda, MD

WORKSHOP 10:15 AM - 12:15 PM **FIFTH AVENUE**

Z13 Rebels, Rapists and Rifles: Risk Assessment of Troubled Teens: Child and Adolescent Psychiatry Committe

Dean M. De Crisce, MD, Avenel, NJ
Peter Ash, MD, Atlanta, GA
Fabian Saleh, MD, Boston, MA
Gregg Dwyer, MD, EdD, Columbia, SC
Stephen B. Billick, MD, New York, NY

Z1 INNOVATIVE APPROACHES TO FORENSIC EDUCATION

Cheryl D. Wills, MD, Cleveland, OH
Debra A. Pinals, MD, Worcester, MA
Barbara A. Justice, MD, Los Angeles, CA
Jeffrey Janofsky, MD, Timonium, MD
Annette L. Hanson, MD, Baltimore, MD

EDUCATIONAL OBJECTIVE
Novel methods used to educate psychiatrists about the practice of forensic psychiatry will be introduced to participants, who will be encouraged to share their techniques and experiences. Multidisciplinary approaches and modern technology will be used to illustrate education techniques in forensic and child forensic psychiatry.

SUMMARY
In the 21st century, the medical profession has been subject to increased restrictions on how clinical data are disseminated for educational and other functions. Videotaping of patient interviews, for example, requires more detailed consent forms than previously, and some institutions require IRB approval of case-based reports before they are published or presented for educational purposes. Despite these restrictions, forensic psychiatrists employ many innovative methods that are not subject to regulatory and legal restrictions, or that successfully work within the specified parameters, to develop valuable educational resources for forensic psychiatrists and trainees. The panel will introduce several current approaches to forensic education that: integrate evidence-based methods of forensic assessment into the learning process; use current technology to illuminate and to reinforce key concepts; and provide educational resources for future generations of forensic psychiatrists and trainees. Examples will include: interactive case-based learning; using a standard curriculum to review fundamental concepts in forensic psychiatry; evaluating cognitive impairment and traumatic brain injury; and using forensic psychiatry education to enhance clinical skills and to cultivate interest in forensic psychiatry among psychiatrists and trainees. Use of these techniques to educate practicing forensic psychiatrists will also be discussed.

REFERENCES
Pinals DA: Forensic psychiatry fellowship training: developmental stages as an educational framework. J Am Acad Psychiatry Law 33:317-23, 2005
Lewis CF: Teaching forensic psychiatry to general psychiatry residents. Acad Psychiatry 28:40-6, 2004

SELF ASSESSMENT QUESTIONS
1. Consent forms for videotaping evaluees for teaching purposes generally must adhere to
a. HIPAA or state laws related to confidentiality
b. the principle of "No False Exposure"
c. the ethical principle of showing respect for persons
d. a and c
ANSWER: d

2. Forensic educators should design presentations that are
a. interesting
b. clear and relevant
c. stimulate further discussion among participants
d. all of the above
ANSWER: d

Z2 HIGH STAKES BLUFF: MALINGERED ADJUDICATIVE INCOMPETENCE

Sherif Soliman, MD, Cleveland, OH
Cathleen A. Cerny, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE
After this presentation, the audience will understand the scope of the problem of malingered adjudicative incompetence, be able to identify recent legal decisions, and learn about techniques to detect malingered adjudicative incompetence in outpatient and inpatient settings.

SUMMARY
Competence to stand trial is the most frequent criminal forensic evaluation with approximately 60,000 annual referrals. Malingering is not a rarity during these evaluations. Its estimated prevalence is 8 to 12.7%. The purpose of this presentation is to review techniques for the general detection of malingering with an emphasis on the unique challenges of detecting malingered adjudicative incompetence. Recent cases including U.S. v. Binion (8th Cir., 2005) and U.S. v. Batista (3rd Cir., 2007) have upheld sentence enhancements based upon malingering during competence evaluations. A systematic team

approach to the inpatient detection of malingered adjudicative incompetence will be presented. This approach combines serial evaluations with semi-structured observation by unit staff. An "observation checklist" addressing functional abilities, knowledge of basic legal material and malingered symptoms will be presented. The presenters will review structured instruments designed to detect malingered adjudicative incompetence as well as recent data examining tests of malingering in defendants referred for competence evaluations. The presentation will include an interactive case presentation.

REFERENCES

U.S. v. Batista, 448 F.3d 237, 238 (3d Cir. 2007)
Resnick PJ: Malingering, in Principles and Practice of Forensic Psychiatry. Edited by Rosner R. London: Arnold 543-554, 2003

SELF ASSESSMENT QUESTIONS

1. In U.S. v. Batista, malingering was used to enhance sentencing because it constituted what?
a. an aggravating factor in the offense
b. an obstruction of justice
c. perjury
d. none of the above
ANSWER: b

2. What is the prevalence of malingered incompetence to stand trial?
a. 25-50%
b. 5-10%
c. 15-25%
d. 8-13%
ANSWER: d

Z3 WORKING WITH LAWYERS

Lawrence K. Richards, MD, Champaign, IL
Roger Peele, MD, Rockville, MD
Bruce J. Winick, JD, (I) Coral Gables, FL
Harold Eist, MD, (I) Bethesda, MD
Thomas G. Gutheil, MD, Brookline, MA

EDUCATIONAL OBJECTIVE

Collaboration with lawyers is already of major importance for physicians of all specialties. The dynamics of collaboration will vary with the case, the individuals, and the jurisdiction. All exist whether the physician is client or expert witness. This presentation will give in-depth education of the dynamic possibilities.

SUMMARY

Using the APA W/S format the educational process will equally serve audience and presenters through the delivery of information and the stimulation and exchange of ideas and professional memories. This in itself is collaboration. Collaboration in the treatment of patients comes easily enough to physicians, and easily enough between attorneys as they protect their collegial relationships. Collaboration encompasses dynamic phenomena, and in both law and medicine these vary with the case, the individuals, and the place of occurrence: e.g., medical clinic versus court room, or which province or nation. Questions addressed include: Will the client / patient come in second to collegial relationships? What happens when the methods of reasoning between law and medicine clash, does the latter alter the effectiveness of the expert witness? Discussion will include the alterations when the psychiatrist is the client seeking advocacy, and when the lawyer seeks consultation with a psychiatrist, not for the purpose of obtaining an expert witness or a report to the court, but for assistance in adjusting to, understanding, or managing the attorney-client relationship. The current status of the latter within the legal profession and which psychiatric specifics are most likely to occur are discussed as well.

REFERENCES

Winick BJ: A Legal Autopsy of the Lawyering in Schiavo. 61 U. Miami Law Review: 595-664, 2007
Gutheil TG, Simon RI: Attorneys' pressures on the expert witness: early warning signs of endangered honesty, objectivity and fair compensation. J Am Acad Psychiatry Law 27:546-553, 1999

SELF ASSESSMENT QUESTIONS

1. Emerging areas of legal/psychiatric collaboration include which of the following?

a. lawyers consulting psychiatrists concerning clients who may have personality disorders to develop strategies of dealing with the client
b. lawyers consulting psychiatrists for advice about dealing with denial in the attorney/client relationship
c. lawyers consulting psychiatrists concerning how to deal with psychological barriers to settlement of civil disputes
d. all of the above
e. none of the above

ANSWER: d

2. When an attorney discloses your name to the other side as an expert, or claims you have been retained when you have not, this is called what type of phenomenon?

a. attorney misconduct
b. phantom expert
c. barratry
d. none of the above

ANSWER: b

Z4 "DEINSTITUTIONALIZATION" IN CORRECTIONS? PROSPECTS, OBSTACLES, CONSEQUENCES

Suzanne Yang, MD, Cleveland, OH
Bandy Lee, MD, (I) New Haven, CT
Peter Ibarra, PhD, (I) Syracuse, NY
James L. Knoll, IV, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

The panel will examine issues that are raised by the advent of electronic monitoring (EM) via GPS, a mobile technology that has introduced robust possibilities for alternatives to prison. Are the goals intended for psychiatric deinstitutionalization finally also possible in the realm of corrections?

SUMMARY

Recent decisions by judges to assign life sentences under EM suggest that GPS monitoring may become the state's preferred means for confining, incapacitating and preventing recidivism in a large number of offenders. GPS technology offers the possibility of increasing the rate of participation in programs intended for rehabilitation rather than punishment, while assuaging the disruptive effects of incarceration by maintaining placement in the individual's social context. We will critically assess the literature on the psychical impact of imprisonment. The implications of a future deinstitutionalization of prisons will be hypothesized, drawing upon experience with community case management of psychiatric patients. The panel will outline current evidence-based practices for the prevention of future violence in offenders, through a case study and review of existing research on pre- and post-release programming. The panel will then address the subjective experience of detention under electronic monitoring, relying on field work studying the use of electronic bracelets. Through a comparison of pre-trial detainees and convicted offenders serving sentences under electronic monitoring, the panel will examine contrasting subjective interpretations of the parameters of constraint and the function of these individual perceptions in the experience of punishment, inside and outside the walls of a prison.

REFERENCES

Ibarra PR, Erez E: Victim-centric diversion? The electronic monitoring of domestic violence cases. Behav Sci Law 23: 259-76, 2005

Gilligan J, Lee B: The Resolve to Stop the Violence Project: reducing violent recidivism in the community through a jail-based initiative. J Public Health 27:143-148, 2005

SELF ASSESSMENT QUESTIONS

1. Principles learned from psychiatric deinstitutionalization that are likely to be pertinent to the case management of offenders serving sentences under electronic monitoring include what?

a. cultural relevance of services
b. continuity of care
c. individualized treatment planning
d. access to stable housing
e. all of the above

ANSWER: e

2. The essential characteristics of a successful violence prevention program include all of the following except?
a. intensity
b. universality
c. retribution
d. comprehensiveness
ANSWER: c

Z5 COMMUNITY CORRECTIONS: LEARNING MORE TO ENHANCE OUTCOMES

Tracy D. Gunter, MD, Iowa City, IA

EDUCATIONAL OBJECTIVE

To present research data that will inform future community corrections programming so that it can effectively address the needs of offenders and reduce recidivism.

SUMMARY

The adult community corrections system supervised over five million individuals during 2006. Regardless of separation by probation or parole status, most offenders supervised by community corrections have been convicted of nonviolent offenses. Despite intensive attempts to investigate the causes of recidivism and construct programming to reduce recidivism, the number of individuals successfully completing supervision has remained dismally low. Only 57% of probationers and 44% of parolees successfully complete supervision nationally. The current study examines 300 individuals supervised by the community corrections office of Iowa's Sixth Judicial District. In this study we collected extensive demographic information and administered a battery of instruments including structured interviews, self-report instruments, and a cognitive screening battery. We then followed the course of supervision for up to one year following enrollment in the study and recorded the outcome as completion of the study period without a change in supervision status, successful completion of supervision, or evidence of recidivism (defined as rearrest, revocation, or incarceration). This research in progress presentation will summarize our findings regarding the demographic composition of the population, frequencies of mental health disorders, and outcomes of supervision with a discussion of future directions in community corrections programming.

REFERENCES

Glaze LE, Bonczar TP: Probation and parole in the United States, 2006 (NCJ 220218). Washington, DC: Department of Justice, Bureau of Justice Statistics, December 2007
Durose MR, Mumola CJ: Profile of nonviolent offenders exiting state prisons (NCJ 207081). Washington, DC: Department of Justice, Bureau of Justice Statistics, October 2004

SELF ASSESSMENT QUESTIONS

1. The community corrections population is
a. the fastest growing segment of the correctional population
b. highly successful in completing its goals and objectives
c. relatively young and healthy with few specialized needs
ANSWER: a

2. Recidivism within the community corrections population is
a. inevitable
b. a serious and expensive public health problem
c. due to moral deficiency in affected individuals
ANSWER: b

Z6 FACT: PARTNERING WITH PROBATION

Alison Deem, MD, (I) Rochester, NY
Steven J. Lamberti, MD, (I) Rochester, NY
Robert Weisman, DO, (I) Rochester, NY

EDUCATIONAL OBJECTIVE

To describe the collaboration between probation officers and forensic assertive community treatment (FACT) teams in the care of severely mentally-ill offenders, identify success factors and barriers to effective collaboration, and assess the potential for this collaboration to reduce criminal recidivism.

SUMMARY

Forensic Assertive Community Treatment (FACT) is a model of care involving collaboration between mental health and criminal justice professionals in the treatment of severely mentally ill offenders. Probation is arguably the most common point of interface between criminal justice and mental health systems, yet little is known about how proba-

tion officers and FACT teams collaborate. Six hundred eight-one community behavioral health directors were contacted through the National Association of County Behavioral Health Directors. They were asked to identify FACT teams, defined as assertive community treatment teams who serve only severely mentally ill offenders and collaborate directly with criminal justice representatives. FACT programs incorporating probation officers as team members were selected to participate. Each program completed a semi-structured survey to assess program characteristics, caseload demographics, role of probation officers on the team, special training of the probation officers, impact on hospitalization and arrest rates, and barriers and challenges to having probation officers on each treatment team. By examining FACT teams that incorporate probation officer(s) as team members, we will describe the collaboration between probation and mental health professionals, identify success factors and barriers to effective collaboration, and assess the potential for this novel collaboration to reduce criminal recidivism among severely mentally ill offenders.

REFERENCES

Lamberti JS, Weisman RL, Faden DI: Forensic assertive community treatment: preventing incarceration of adults with severe mental illness. Psych Services 55(11):1285-93, 2004

Cuddeback GS, Morrissey JP, Cusack KJ: How many forensic assertive community treatment teams do we need? Psychiatr Serv 59(2):205-8, 2008

SELF ASSESSMENT QUESTIONS

1. What makes forensic assertive community treatment (FACT) different from assertive community treatment (ACT)?

a. Teams are run by forensic psychiatrists.

b. Patients must be involved with the criminal justice system.

c. Probation officers are members of the treatment teams.

ANSWER: b

2. A primary goal of forensic assertive community treatment of severely mentally ill adults is to

a. reduce rates of arrest and incarceration.

b. provide continuity of care for clients while incarcerated.

c. prevent high-risk persons with severe mental illness from ever becoming involved with the criminal justice system.

ANSWER: a

Z7 MASSACHUSETTS MENTAL HEALTH- CRIMINAL JUSTICE COHORT STUDY

Albert J. Grudzinskas Jr., JD, Worcester, MA
William H. Fisher, PhD, (I) Worcester, MA
Kristen Roy-Bujnowski, MA, (I) Worcester, MA
Jonathan C. Clayfield, MA, (I) Worcester, MA
Lorna Simon, MA, (I) Worcester, MA

EDUCATIONAL OBJECTIVE

This program will help establish realistic baseline figures for criminal behavior among persons with serious mental illness, thereby assisting with risk analysis and policy determination. The objective of the presentation is to assist practitioners to evaluate risk factors effectively.

SUMMARY

Understanding how persons with severe mental illness interact with the criminal justice (CJ) system is crucial to risk assessment, formulating policy, and planning services. This presentation describes research now in progress, which utilizes the application of "trajectory analysis." The methodology is used to identify age-related patterns of offending over time in a developmental framework, and to analyze temporal patterns of CJ involvement among a statewide cohort (N=13,876) who received services (case management, residential and/or inpatient services) from the Massachusetts Department of Mental Health in 1991. Their arrests were tracked for 10 years. Persons with two or more arrests during that period (N=1,112) were analyzed using the Zero-Inflated Poisson (ZIP) trajectory analysis. This procedure yielded five "trajectories" of arrest over the period. All subjects were classified according their levels of intensity, patterns of change and charges associated with arrest. Each of these groups presents a pattern of CJ involvement that has different implications for risk assessment, and for developing services at the interface of the mental health and CJ systems. We will present an overview of the cohort's characteristics, a discussion of charges associated with arrests in the overall cohort and the charge categories used in the analysis.

REFERENCES

Grudzinskas AJ, Clayfield JC, Fisher WH, Roy-Bujnowski K, Richardson, MH: Integration of mental health treatment and criminal justice involvement: the Worcester experience. Behav Sci Law 23(2): 277-293, 2005

Fisher WH, Wolff N, Grudzinskas AJ, Roy-Bujnowski K, Banks S, Clayfield J: Drug arrests in a cohort of public mental health service recipients. Psychiatri Serv 58(11): 1448-1453

SELF ASSESSMENT QUESTIONS

1. What is the rate of offending of a state mental health program cohort over a ten year time span?
a. 27.9%
b. 3%
c. 50%
d. 22.6%
ANSWER: a

2. How many of the 13, 876 persons were arrested for a serious violent crime?
a. 23.6%
b. 41.6%
c. 3%
d. 16.7%
ANSWER: d

Z8 MENTAL HEALTH ATTITUDE SURVEY FOR POLICE

Jonathan C. Clayfield, MA, (I) Worcester, MA
Deepak Dev, MD, (I) Worcester, MA
Albert J. Grudzinskas Jr., JD, (I) Worcester, MA

EDUCATIONAL OBJECTIVE

This program will inform mental health professionals about the development of the MHASP, its use in measuring police attitudes towards mentally ill individuals, and its use in guiding the content and measuring the effects of crisis intervention and risk management training.

SUMMARY

As part of the Boston Police Study, our group is involved with training police in resolving issues during their interactions with mentally ill individuals. This presentation will focus on the creation of the Mental Health Attitude Survey for Police (MHASP), an instrument designed to measure police attitudes. The involvement of consumers in the creation of the MHASP will be highlighted. The process of psychometric validation of this instrument will be described, and data obtained from a pre- and post-training assessment using the MHASP to measure changes in attitudes will be discussed. The use of the tool to help inform the development of a 40-hour Crisis Intervention Team training curriculum, and an eight hour generalist training module for first responders will be addressed. Finally, a comparison of attitudes between police and non-mental-health emergency room personnel (using a variation of the MHASP) will be outlined as a means of assessing how frequency of contact with mentally ill individuals, as well as the background and training of different professions affects community attitudes.

REFERENCES

Clayfield, JC, Fletcher, KE: Issue Brief: Copping an Attitude? Assessing Police Attitudes about Persons with Mental Illness, Center for Mental Health Services Research, University of Massachusetts Medical School 3: 4, 2006
Cotton, D: The attitudes of Canadian police officers toward the mentally ill. Int J Law Psychiatry 27: 135-46, 2004

SELF ASSESSMENT QUESTIONS

1. What percentage of police believe that persons with mental illness are more dangerous than the general public?
a. 7%
b. 25%
c. 47%
d. 71%
ANSWER: c

2. What percentage of police involvement with mentally ill individuals who violate the law is nonofficial and results in a no-action disposition?
a. 8%
b. 26%
c. 48%
d. 72%
ANSWER: d

Z9 CHEMICAL AND SURGICAL CASTRATION: ETHICS AND EFFICACY

Elena del Busto, MD, Philadelphia, PA
Charles Scott, MD, Sacramento, CA
Humberto Temporini, MD, Sacramento, CA
Douglas Tucker, MD, Berkeley, CA

EDUCATIONAL OBJECTIVE
To educate participants regarding the current status of U.S. state statutes governing chemical and surgical castration of sex offenders and to discuss the proposed utility of castration in the management of sex offenders. The panelists will also review ethical issues and constitutional challenges to castration legislation.

SUMMARY
According to the U.S. Justice Department's Bureau of Justice Statistics, approximately 60 percent of the 234,000 convicted sex offenders under the care, custody or control of corrections officials in the United States are on parole or probation. Sexual offenders are considered a significant danger to society due to their reported high recidivism rates and limited treatment response to psychotherapeutic interventions alone. To address these concerns, several U.S. states have passed legislation providing voluntary or mandatory chemical and/or surgical castration. This panel will present an historical overview of the use of castration in Northern America and Europe. The biology and physiology of castration in decreasing male sexual drive will be discussed with updates on the most current pharmacotherapeutic interventions. We will provide data regarding castration's efficacy in reducing the recidivism rates of sexual offenders. The assessment process for evaluating sex offenders for castration will be reviewed with an emphasis on the mental health practitioner's role. A detailed analysis of current statutes governing both chemical and surgical castration will be given with a review of subsequent case law challenging the constitutionality of such legislation. Finally, the panel will discuss common ethical concerns that arise as a result of these recent legislative trends.

REFERENCES
Scott CL, Holmberg T: Castration of Sex Offenders: Prisoner's rights versus public protection. J Am Acad Psychiatry Law 31:494-501, 2003
Weinberger LE, Sreenivasan S, Garrick T, Osran, H: The impact of surgical castration on sexual recidivism risk among sexually violent predatory offenders. J Am Acad Psychiatry Law 33:16-36, 2005

SELF ASSESSMENT QUESTIONS
1. Which state(s) permit voluntary surgical castration as a treatment for sex offenders?
a. Texas and Louisiana
b. California and Florida
c. Iowa
d. a and b
e. a and c
f. all of the above
ANSWER: f

2. Which treatments are approved for chemical castration?
a. antiandrogens
b. gonadotropin releasing hormone analogues
c. leuteinizing hormone releasing agonists
d. a, c
e. all of the above
ANSWER: e

Z10 SUICIDE PREVENTION PI IN CORRECTIONS: THE SIX SIGMA METHOD

Steven J. Helfand, PsyD, (I) Farmington, CT
Robert L. Trestman, PhD, MD, Farmington, CT

EDUCATIONAL OBJECTIVE
Attendees will understand the framework for the Six Sigma process and DMAIC methodology for performance improvement as applied to suicide prevention service delivery in jails and prisons and will be able to develop a Failure Mode Effects Analysis to assess potential failure points in the system.

SUMMARY
Having experienced a suicide rate above the national average for a two-year period, the University of Connecticut Health Center- Correctional Managed Health Care and the Connecticut Department of Correction jointly embarked on a Suicide Prevention Performance Improvement process. A Six Sigma process was utilized that employed the DMAIC

process of Define, Measure, Analyze, Improve, Control to understand the issues facing the jail and prison system. A multi-agency and multidisciplinary team was set up and focused on identification of every potential step from admission through discharge. Potential failure points were identified. The result was a comprehensive flow chart that focuses on an inmate's progression through a correctional system. The study is unique in that it focused on systemic and operational decision points such as the admissions process. Each potential failure point was analyzed through a Failure Mode Effect Analysis (FMEA) that detailed the severity, detectability, and occurrence of each potential failure and highlighted potential failure effects, potential causes, and current process controls. Failures were then ranked, and recommendations were developed and are currently in the process of being implemented. This presentation will allow for active participation as examples of suicide can be quickly viewed through this flowchart and FMEA process.

REFERENCES

Smith DL: FMEA Preventing a Failure Before Any Harm Is Done. http://healthcare.isixsigma.com/library/content/c040317a.asp?action=print

Way BB, Miraglia R, Sawyer DA, Beer R, Eddy J: Suicide risk factors in New York state prisons. Int J Psychiatry Law 28:207-221, 2005

SELF ASSESSMENT QUESTIONS

1. An assessment of potential failure points that weighs severity, occurrence, and detectability is reflective of which Six Sigma DMAIC project tool?

ANSWER: Failure Mode Effects Analysis (FMEA)

2. While traditional efforts at suicide prevention have focused on individual risk factors, the process improvement project for the Connecticut jails and prisons found that potentially serious failures typically occur due to

ANSWER: Poor communication of past information from community to the corrections department for non-sentenced inmates; inability to communicate events that occurred in court for sentenced inmates; inability to assess contraindications for restrictive housing in a thorough and timely manner; interruptions in the orientation process, and improper housing placement of inmates.

Z11 NGI EVALUATIONS UNDER CALIFORNIA CASE LAW: CLARIFICATION OR CONFUSION?

Jeff Gould, MD, San Francisco, CA
Melissa Nelken, JD, (I) San Francisco, CA

EDUCATIONAL OBJECTIVE

Through this critical analysis and discussion of an ill-defined and difficult to interpret interface between psychiatry and the law in California, hopefully, the attendees will improve their ability to interpret similar case law in their own state.

SUMMARY

This presentation will address an ill-defined interface between psychiatry and the law that is often encountered in NGI evaluations in California. The pertinent, but often difficult to interpret, case law regarding moral wrongfulness in California will be reviewed. A case discussion will also be presented in which the defendant knew legal wrongfulness, but due to psychotic delusions, believed it was morally right to attack a famous holocaust survivor, Mr. Elie Wiesel. California utilizes a modified M'Naghten standard. People v. Skinner states that a defendant who thinks his/her criminal act is morally right may be found insane. Unfortunately, this decision did not differentiate between the personal beliefs of right and wrong held by an individual suffering from a mental disorder versus societal views of moral wrongfulness. People v. Stress held that the individual may not replace his/her own moral construct of right and wrong for that of generally accepted standards of society. This definition of moral wrong may be very close to the concept of legal wrongfulness, possibly negating the moral wrongfulness prong in many cases. However, subsequent appellate and trial court decisions do not always address the issue of individual versus society standards, or follow the holdings of Stress.

REFERENCES

People v. Skinner (1985) 39 Cal.3d 765, 777-784

People v. Stress (1988) 205 Cal.App.3d 1259, 1271-1274

SELF ASSESSMENT QUESTIONS

1. People v. Skinner established defendants' rights to be found not guilty by reason of insanity, if by a preponderance of the evidence, they

a. demonstrate that they believed that their criminal act was morally right.

b. demonstrate they knew only the nature/quality or wrongfulness of their act, thus negating the previous case law requirement to prove both prongs.

c. demonstrate they lacked the capacity to form the requisite specific intent for that criminal act.

ANSWER: a

2. People v. Stress held that defendants may be found not guilty by reason of insanity, if
a. due to a mental disease or defect, they replace their own moral construct of right and wrong for that of generally accepted standards of society.
b. due to a mental disease or defect, they do not know or appreciate that their criminal act violates the generally accepted standards of right and wrong in society.
c. due to a mental disease or defect, they prove they did not know or appreciate that their criminal act violates both their own moral construct of right and wrong and generally accepted standards of right and wrong in society.
ANSWER: b

Z12 MENTAL HEALTH COURTS: THERAPEUTIC OR JURISPRUDENT?

Merrill R. Rotter, MD, Bronx, NY
Madelon Baranoski, PhD, (I) New Haven, CT
Lois Smith, MPA, (I) Seattle, WA
Fred Osher, MD, (I) Bethesda, MD

EDUCATIONAL OBJECTIVE

To enhance participants' understanding of the mental health court model of decriminalization efforts, with specific focus on varying views of these increasingly popular initiatives.

SUMMARY

The implementation of mental health courts as a model for meeting the needs of mentally ill offenders through diversion from criminal justice into treatment has grown exponentially over the past decade. Services research is also beginning to demonstrate the efficacy of this approach in the aggregate. However, as well-meaning as such efforts are, they are not without controversy, with opponents raising concerns about cost, competition for services, and ongoing criminal justice involvement for the mentally ill and stigmatization. In this panel, we present the experience of two longstanding mental health courts: one with a focus on misdemeanants and the other, felony offenders. The Bronx and Seattle Mental Health Courts will each describe their respective models and present data about participants, services delivered and indices of success and/or failure. Dr. Baranoski and Dr. Osher will then reflect on these programs and discuss the benefits and risks of these efforts for individuals with mental illness, for the community and for public mental health service delivery.

REFERENCES

Steadman HJ, Davidson S, Brown Collie: Mental health courts: their promise and unanswered questions. Psychiatri Serv 52: 457-458, 2001
Haimowitz S: Can mental health courts end the criminalization of persons with mental illness? Psychiatri Serv 53: 1226-1228, 2002

SELF ASSESSMENT QUESTIONS

1. The number of mental health courts in the U.S. is now what?
a. 27
b. 3
c. less than 50
d. over 100
ANSWER: d

2. According to Dr. Henry Steadman, if you've seen one mental health court, you've
a. seen them all
b. seen more than enough
c. seen one mental health court
d. got to get out more
ANSWER: c

Z13 **REBELS, RAPISTS AND RIFLES: RISK ASSESSMENT OF TROUBLED TEENS**
CHILD AND ADOLESCENT PSYCHIATRY COMMITTEE

Dean M. De Crisce, MD, Avenel, NJ
Peter Ash, MD, Atlanta, GA
Fabian Saleh, MD, Boston, MA
Gregg Dwyer, MD, EdD, Columbia, SC
Stephen B. Billick, MD, New York, NY

EDUCATIONAL OBJECTIVE

At the end of this workshop, participants will identify adolescents at particular risk for dangerous behavior, and will select evidence based strategies for risk assessment and intervention. Participants will describe screening for general violence, school related violence, sexual offending, substance abuse/dual diagnosis, and adolescents with family histories of mental illness.

SUMMARY

Recent media portrayal of alarming adolescent acts of violence has brought significant attention to the role of psychiatry in possible intervention and prevention of these tragedies. Despite the availability of school based and community mental-health-resources, some adolescents present a risk for self harm, violence and significant morbity. The need for effective intervention and risk assessment strategies remains high. This workshop will provide mental health evaluators with a framework for assessing adolescents who are at particular risk for morbidity. Specific issues to be addressed are general violence, school-related violence, sexual offending, substance abuse/dual diagnosis, and adolescents raised within families where a history of mental illness presides. Practical approaches to risk-assessment strategies, evidence-based interventions, and use of collateral information will be reviewed utilizing case presentations and audience participation.

REFERENCES

Murakami S, Rappaport N, Penn JV: An overview of juveniles and school violence. Psychiatr Clin North Am 29(3):725-41, 2006
Andrade JT, Vincent GM, Saleh FM: Juvenile sex offenders: a complex population. J Forensic Sci 51(1):163-7, 2006

SELF ASSESSMENT QUESTIONS

1. The second most common cause of adolescent death is?
a. motor vehicle accidents
b. suicide
c. homicide
d. cancer
e. none of the above
ANSWER: e

2. What percentage of sexual crimes are completed by adolescents?
a. 17%
b. 3%
c. 87%
d. 43%
e. 33%
ANSWER: a

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