American Academy of Psychiatry and the Law

40th Annual Meeting

October 29 - November 1, 2009
Baltimore, Maryland

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 31.75 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Fortieth Annual Meeting
American Academy of Psychiatry and the Law
October 29 - November 1, 2009
Baltimore, Maryland

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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

2009 ANNUAL MEETING CHAIR

Marilyn Price, MD, CM

EXECUTIVE OFFICES OF THE ACADEMY

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

Howard V. Zonana, MD
Medical Director

Jacquelyn T. Coleman, CAE
Executive Director

CALL FOR PAPERS 2010

The 41st Annual Meeting of the
American Academy of Psychiatry and the Law will be held in
Tucson, Arizona October 21-24, 2010

Inquiries may be directed to,
Peter Ash, MD, or Eraka Bath, MD Program Co-Chairs.

The Program Co-Chairs welcome suggestions for a mock trial or other special presentations well in advance of the submission date. Abstract submission forms will be posted online at www.AAPL.org.

The deadline for abstract submission is March 1, 2010

FUTURE ANNUAL MEETING DATES and LOCATIONS

42nd Annual Meeting

October 27-30, 2011
Park Plaza Hotel and Towers, Boston, Massachusetts

43rd Annual Meeting

October 26-29, 2012
Le Centre Sheraton, Montreal, QC, Canada

44th Annual Meeting

October 24-27, 2013
Hotel del Coronado, San Diego, California

45th Annual Meeting

October 23-26, 2014
Chicago Marriott Downtown, Chicago, Illinois

GENERAL INFORMATION

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REGISTRATION DESK

(Harborside Foyer, Harborside 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

Harborside Foyer, Harborside Level

MONDO DIGITAL SOLUTIONS, INC.

Harborside Foyer, Harborside 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. The RFP for educational and research grant proposals is available at the registration desk.

Support the AIER

AAPL Logo Shirt *	$35.00
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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.
   Need: Improvement in knowledge of civil, criminal, and correctional forensic psychiatry.
2. Lacking the knowledge of content or technique to teach psychiatrists the fundamentals of forensic psychiatry in the most effective ways.
   Need: Knowing new content and effective ways to teach forensic psychiatry.
3. Lacking the ability to conduct or assess research in forensic psychiatry.
   Needs: 1. Knowing how to do research or 2. Knowing the outcomes of research in forensic psychiatry and how to apply those outcomes to forensic practice.

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.

Participants will improve their competence or performance in forensic psychiatry in the following three areas:

1. Service, including treatment of forensic patients, development of service delivery strategies, and enhancement of consultative abilities at the interface of psychiatry and the legal profession;
2. Teaching, including new methods of training of forensic psychiatrists and classification of the tasks and functions of forensic psychiatrists; and
3. Research, gaining access to scientific data in area that form the basis for practice of discipline.

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, Marilyn Price, MD, CM and Cheryl Wills, 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 financial relationship pertaining to the content of their presentation:

Adetunji, B.; Adiele, T.; Akinkunmi, A.; Alaggia, R.; Allan, W.; Allen, T.; Allen, J.; Antoniak, S.; Appelbaum, P.; Appleby, B.; Ash, P.; Baez-Cabrera, L.; Baird, J.; Balaban, E.; Baranoski, M.; Barton, O.; Beck, J.; Beck, C.; Beckson, M.; Bender, H.; Benoit, T.; Berlin, F.; Bhandari, S.; Billick, S.; Binder, R.; Black, D.; Blume, J.; Bonnie, R.; Bowling, D.; Bradford, J.; Brendel, R.; Briken, P.; Brink, J.; Brody, K.; Buchanan, A.; Buchanan, J.; Bukhanovski, A.; Bunzel, M.; Busch, K.; Cadigan, R.; Campbell, J.; Candilis, P.; Carpenter, D.; Carter, L.; Carter, R.; Caruso, C.; Chaimowitz, G.; Champion, M.; Chern-Shnaidman, V.; Christopher, P.; Cleary, K.; Cohen, S.; Collins, G.; Conroe, H.; Courtney, K.; Crowley, B.; Cumming, I.; Daly, B.; Davidson, C.; Davis, E.; De Crisce, D.; DeBofsky, M.; Deem, A.; del Busto, E.; Desmarai, S.; Devine, S.; Dhaliwal, G.; DiGiovanna, B.; Dike, C.; Dwyer, R.; Easton, C.; Edersheim, J.; Edwards, L.; Farrell, H.; Faubion, M.; Fedoroff, J.; Feingold, E.; Felthous, A.; Femia, J.; Fernandez, A.; Ferranti, J.; First, M.; Fitch, L.; Ford, J.; Fozdar, M.; Francis, L.; Frazier, L.; Frierson, R.; Frischer, K.; Gabbard, G.; Garvey, K.; Gill, D.; Glancy, G.; Gleyzer, R.; Glezer, A.; Gold, L.; Gomez, G.; Goni, M.; Granacher, R.; Gratzer, T.; Greenspan, M.; Greiner, C.; Griffith, E.; Grounds, A.; Grudzinskas, A.; Gulrajani, C.; Gunter, T.; Gutheil, T.; Hall, R.; Harlow, M.; Harris, V.; Hashimoto, E.; Hauser, M.; Hill, C.; Hira-Brar, S.; Hobday, G.; Hoerchler, J.; Hogan, E.; Holmberg, T.; Holt, B.; Holzer, J.; Huettel, S.; Hung, E.; Janofsky, J.; Johnson, S.; Jones, T.; Justen Vo, E.; Kambam, P.; Kannan, M.; Kaufman, A.; Keeney, E.; Keller, K.; Kellermeyer, G.; Kelly, B.; Kenan, J.; Kennedy, P.; Keram, E.; Kesten, K.; Khadivi, A.; Khajuria, K.; Kim, C.; Klein, C.; Kleinman, S.; Knoll, J.; Krueger, R.; Kuroski-Mazzei, A.; Lamberti, J.; Larkin, F.; Lee, L.; Leistedt, S.; Leonard, C.; Leong, G.; Levin, A.; Lewis, C.; Linkowski, P.; Lion, J.; Loveless, P.; Lussier, L.; Lyddane, D.; Maislen, A.; Manis, S.; Margery-Bertoglia, S.; Marshall, W.; Martell, D.; Martin, T.; Martinez, R.; Martone, C.; May, Z.; McDermott, B.; McGavin, C.; McNiel, D.; Means, R.; Meffert, S.; Metzner, J.; Michals, T.; Morgan, C.; Morris, D.; Morse, S.; Mossman, D.; Mulvey, E.; Musalo, K.; Myers, W.; Myers, C.; Nanton, A.; Nair, M.; Neltner, M.; Nemoianu, A.; Newman, A.; Newman, W.; Nicholls, T.; Norko, M.; Noroian, P.; Norris, D.; Ogundipe, K.; Paoletti, S.; Parke, S.; Parker, G.; Pearlson, S.; Perlin, M.; Peykanu, J.; Phillips, R.; Pinals, D.; Post, J.; Pozios, V.; Price, M.; Prudic, J.; Quinn, M.; Rabin, A.; Raley, J.; Rand, J.; Recupero, P.; Reeves, R.; Regehr, C.; Remke Clary, K.; Resnick, P.; Richards, D.; Rodgers, C.; Roof, J.; Rosenbaum, K.; Rosmarin, D.; Ross, C.; Rotter, M.; Ryan, A.; Saeed, H.; Saini, M.; Saleh, F.; Salem, A.; Sampl, S.; Samuel, R.; Samuel, S.; Schouten, R.; Scott, M.; Scott, C.; Senninger, J.; Shah, M.; Shah, S.; Sharifi, N.; Shelton, D.; Shoemaker, A.; Shugarman, R.; Sieleni, B.; Silva, J.; Simakov, I.; Simon, R.; Simpson, S.; Singh, A.; Slobogin, C.; Smarty, S.; Smith, D.; Sokolov, G.; Soldatkin, V.; Soliman, L.; Soloway, S.; Soulier, M.; Srinivasaraghavan, J.; Stathopoulou, G.; Steinberg, J.; Strandberg, G.; Swallow, M.; Teitelbaum, C.; Thierry, P.; Thomas, P.; Thompson, C.; Tomita, T.; Trestman, R.; Troneci, L.; Tucker, D.; Ubelaker, D.; Viljoen, J.; Viswanathan, R.; Volin, J.; Wakai, S.; Wang, E.; Warburton, K.; Ward, N.; Way, B.; Wei, M.; Weinstock, R.; Weisman, R.; Westmoreland, P.; Williams, J.B.; Williams, J.; Wills, C.; Woodard, C.; Wortzel, H.; Xavier, S.; Yang, S.; Zerby, S.; Zhang, W.; 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.; Ash, P.; Bath, E.; Benedek, E.; Billick, S.; Campbell, W.; Casanova-Pelosi, C.; Christopher, P.; Fozdar, M.; Frierson, R.; Gold, L.; Henry, S.; Hogan, E.; Holzer, J.; Kaye, N.; Keram, E.; Kuroski Mazzei, A.; LeBourgeois, H.; Leong, G.; Newman, A.; Noffsinger, S.; Osinowo, T.; Ostermeyer, B.; Parker, G.; Pearlson, S.; Pinals, D.; Pozios, V.; Preven, D.; Price, M.; Resnick, P.; Rosmarin, D.; Schiffman, E.; Scott, C.; Sokolov, G.; Srinivasaraghavan, J.; A.; Stolar, A.; Wall, B.; Wills, C.; Wylonis, L.

SPECIAL EVENTS

THURSDAY, OCTOBER 29

Breakfast for current fellows only in Forensic Psychiatry Programs	7:00 a.m - 8:00 a.m.	Kent Harborside Level
Past Presidents' Breakfast	7:00 a.m. - 8:00 a.m.	Falkland Harborside Level
Opening Ceremony - President's Address (open to all attendees)	8:00 a.m. - 10:00 a.m.	Harborside A/B Harborside 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. .	Falkland Harborside Level

FRIDAY, OCTOBER 30

Rappeport Fellows Breakfast (Rappeport Fellows and Committee)	7:00 a.m. - 8:00 a.m.	Bristol Grand Level
Reception (for all meeting attendees)	6:00 p.m. - 7:30 p.m.	Harborside C Harborside Level

SATURDAY, OCTOBER 31

Early Career Development Breakfast (Those in the first seven years after training)	7:00 a.m. - 8:00 a.m.	Kent A/B Harborside Level
AAPL Business Meeting (members only)	8:00 a.m. - 9:30 a.m.	Harborside A/B Harborside Level

COFFEE BREAKS WILL BE HELD IN THE HARBORSIDE 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
Fortieth Annual Meeting

OPENING CEREMONY

Thursday, October 29, 2009
8:00 a.m. - 10:00 a.m.

WELCOME, INTRODUCTIONS — Patricia R. Recupero, MD, JD, *President*

PRESENTATION OF RAPPEPORT FELLOWS — Jeffrey S. Janofsky, MD, *Chair, Rappeport Fellows Committee*

Brian Barczak, MD
University of Kentucky

Elena del Busto, MD
Thomas Jefferson University Hospital

Peter Dell, MD
San Mateo County Behavioral Health

Nathan Kolla, MD
University of Toronto

Kristen Ochoa, MD
University of California, Davis Medical Center

Joshua Sonkiss, MD
University of Utah

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

Golden Apple Award
James C. Beck, MD, PhD

Seymour Pollack Award
Henry C. Weinstein, MD

Red Apple Award
Victoria Harris, MD, MPH

Award for Outstanding Teaching in a Forensic Fellowship Program
Merrill Rotter, MD

Young Investigator Award
Matthew F. Soulier, MD

Robert Trestman, MD, *Chair, Research Committee*

INTRODUCTION OF GRANTEES
AAPL INSTITUTE FOR EDUCATION AND RESEARCH — Larry Faulkner, MD, *President, AAPL Institute*

OVERVIEW OF THE PROGRAM — Marilyn Price, MD, CM, *Program Chair*

INTRODUCTION OF THE PRESIDENT — Donna M. Norris, MD

PRESIDENT'S ADDRESS — Patricia R. Recupero, MD, JD

ADJOURNMENT — Marilyn Price, MD, CM

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.

JAMES C. BECK, MD, PHD

Dr. James Beck received his PhD in psychology from Yale and his medical degree from Harvard. He completed his psychiatric residency at the Massachusetts Mental Health Center and since then, he has been on the faculty at Harvard. He is a currently a Professor at Harvard and also serves as the Associate Director of the Law and Psychiatry Service at Massachusetts General Hospital, the Associate Medical Director of the Office of Clinical Affairs for Massachusetts Medicaid, the Medical Director of the Boston Alcohol and Substance Abuse Program, and as Senior Staff Associate in a federally funded project to develop trauma treatment programs in shelters for illegal immigrant adolescents. Dr. Beck was acting Chair of the Harvard Department of Psychiatry at Massachusetts Mental Health for three years.

Dr. Beck has served as an expert witness for plaintiffs and defendants in over 400 civil cases. He has also worked for 17 years in the criminal courts assessing criminal defendants for competency, responsibility, mental illness and substance abuse.

Dr. Beck's research interests have been on the assessment of violence in persons with mental disorders, violence prevention, and personality characteristics of physicians experiencing professional difficulties. Dr. Beck has made lasting contributions to forensic psychiatry in the area of violence risk as well as through his comprehensive analysis of the *Tarasoff* decision and its implications. He has published over 40 peer reviewed articles and has edited or written scholarly books and monographs, such as "Confidentiality vs. the Duty to Protect: Foreseeable Harm in the Practice of Psychiatry" and "The Potentially Violent Patient and the *Tarasoff* Decision in Psychiatric Practice." He served as consultant to the World Health Organization on mental health legislation and was an advisor on forensic consequences of the DSM-IV section on mood disorders.

In recognition of his significant contributions to the field of forensic psychiatry, the American Academy of Psychiatry and the Law presents the 2009 Golden AAPL award to Dr. James Beck.

SEYMOUR POLLACK DISTINGUISHED ACHIEVEMENT AWARD

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

HENRY C. WEINSTEIN, MD

Dr. Weinstein received a Bachelor of Laws degree and a Masters of Laws degree from Columbia Law School and subsequently his MD from the NYU School of Medicine. He completed his psychiatry residency at Albert Einstein College of Medicine and his psychoanalytic training at the New York Psychoanalytic Institute. He co-founded the Fellowship Training Program in Psychiatry and the Law at the NYU School of Medicine, which is now in its 34th year.

Dr. Weinstein is currently a Clinical Professor at the NYU School of Medicine and the Director of the Program in Psychiatry and the Law at the NYU Medical Center and Bellevue Psychiatric Hospital.

Dr. Weinstein has been instrumental in influencing the American Psychiatric Association to become involved with the criminal justice system and corrections. He created the Caucus of Psychiatrists Practicing in Correctional Settings. He was the developer and Chair of the APA Committee on Jails and Prisons and chaired the two APA Task Forces that wrote the 1988 and 1999 editions of APA's "Psychiatric Services in Jails and Prisons" He is the APA representative and Chair of the Board of Directors of National Commission on Correctional Health Care and was the Chair of its Policy Committee. Dr. Weinstein was the Chair of the AAPL Ethics Committee, which developed the original AAPL Ethics Guidelines.

Dr. Weinstein continues to be an active teacher. For example, earlier this month at the APA Institute of Psychiatric Services he gave presentations on the effects of racism in the criminal justice system and on psychopharmacology in correctional facilities. At the National Commission on Correctional Health Care meeting in July 2009, he gave presentations about the effects of diversity on treatment and evaluation in jails and prisons and the ethical issues related to working in supermax prisons.

In recognition of his significant contributions to the teaching and educational functions of forensic psychiatry, especially in reference to persons with mental illness in the criminal justice system, the American Academy of Psychiatry and the Law presents the 2009 Seymour Pollack Distinguished Achievement Award to Dr. Henry C. Weinstein.

RED AAPL OUTSTANDING SERVICE AWARD

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

VICTORIA HARRIS, MD, MPH

Dr. Victoria Harris received her medical degree from the University of British Columbia and her Masters in Public Health from the University of Washington in Seattle. She completed her psychiatric residency at the University of Washington in Seattle, where she was chief resident. She subsequently joined the faculty at the University of Washington and is currently an Assistant Professor. Since 2006, she has been Medical Director of Psychiatric Services at Stevens Hospital in Edmonds, Washington. Dr. Harris was a Rappeport fellow in 1992. She has been a member of the American Board of Psychiatry and Neurology Forensic Recertification Committee and a member of the Isaac Ray Award Committee for the American Psychiatric Association. She has published 16 articles and two book chapters primarily related to HIV and mentally ill offenders.

Dr. Harris has provided much service to the American Academy of Psychiatry and the Law. She chaired the Research Committee for three years, was a Councilor for three years, and is currently Secretary. She has been a member of the Psychopharmacology Committee and the Rappeport Fellowship Committee. Most significantly, she served as Editor of the AAPL Newsletter from 2003-2008.

In recognition of her years of service to AAPL, especially in terms of her outstanding editorship of the AAPL Newsletter, the American Academy of Psychiatry and the Law presents the 2009 Red APPL Outstanding Service Award to Dr. Victoria Harris.

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.

MERRILL ROTTER, MD

Dr. Merrill Rotter received his medical degree from Boston University and completed his psychiatric residency at Columbia University College of Physicians and Surgeons. He did his forensic fellowship at Yale University and has been on the faculty at the Albert Einstein College of Medicine since 1992. He is currently Associate Clinical Professor, Director of the Division of Law and Psychiatry, and Director of the Forensic Fellowship Program at the Albert Einstein College of Medicine. He is also an Adjunct Assistant Professor at Mt. Sinai School of Medicine, Director of Forensic Services at Bronx Psychiatric Center, and Medical Director of the New York City "Treatment Alternatives to Street Crime" (TASC) Mental Health Programs.

Dr. Rotter's outstanding teaching abilities are described in his nomination letters in the following way: "Even after completing my fellowship, Dr. Rotter continues to provide me with professional guidance and mentorship aiding in my further professional development and expertise." "He is a gifted and highly motivated educator and practitioner." "Dr. Rotter is an example of commitment to training in forensic psychiatry…He not only stands ready to share his wealth of knowledge of forensic psychiatry, but does so with integrity, civility, good humor and genuine humility." "Over the course of the year, Dr. Rotter teaches fellows how to build a forensic formulation based on clinical understanding. His fellows graduate with the confidence to evaluate whatever new and unfamiliar forensic problems arise." "In the Tri-State AAPL landmark cases seminar, his knowledge and enthusiasm are appreciated and lauded by all the trainees in the New York City programs. His tireless enthusiasm for teaching forensic psychiatry is matched only by his patience and good humor as a colleague and mentor."

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

DISTINGUISHED LECTURERS

Thursday, October 29

STEPHEN J. MORSE, JD, PHD

The Neuroscientific Challenge To Criminal Responsibility

Dr. Stephen Morse is an expert in criminal and mental health law, whose work emphasizes individual responsibility and the relation of the behavioral and neurosciences to responsibility and social control. Dr. Morse has published Foundations of Criminal Law (Foundations Press, with Leo Katz and Michael S. Moore), and he is currently working on a book, Desert and Disease: Responsibility and Prediction. He is a Diplomate in Forensic Psychology of the American Board of Professional Psychology-Law Society, a recipient of the American Academy of Forensic Psychology's Distinguished Contribution Award, a member of the MacArthur Foundation Research Network on Mental Health and Law (1988-1996); a founding director of the Neuroethics Society, and a trustee of the Bazelon Center for Mental Health in Washington, DC (1995-Present). Prior to joining the Penn faculty in 1998, Morse was the Orrin B. Evans Professor of Law, Psychiatry and the Behavioral Sciences at the University of Southern California. He has served as a Visiting Professor at a number of institutions, including the California Institute of Technology, Cardozo School of Law, Georgetown Law Center, and University of Virginia School of Law.

Friday, October 30

CONGRESSMAN PATRICK J. KENNEDY

Mental Health Advocacy, Legislation, and Reform

Patrick J. Kennedy is serving his eighth term in Congress as the representative from the First District of Rhode Island. Kennedy was appointed to the House of Appropriations Committee in December 1998, but requested a leave of absence in order to fulfill a two-year term as the chairman of the Democratic Congressional Campaign Committee. With the term completed, Kennedy now sits on the powerful panel, which has authority over all of the federal government's discretionary spending. As a part of his Appropriations duties, Kennedy sits on the Subcommittees on Labor, Health and Human Services, and Education; Commerce, Justice, Science, and Related Agencies; and on Military Construction and Veterans Affairs. He is also a member of the Committee on Oversight and Government Reform. Kennedy has placed improvement of the nation's mental health at the top of his legislative agenda. Working with Senator Pete Domenici (R-NM) and others, he has led the fight to pass mental health parity in the House, ending discrimination in health insurance. He has introduced legislation to help states respond to the psychological effects of terrorism, to address crisis shortages of children's mental health providers, and to keep families with severely mental ill children from being broken up. Recognized as a national leader in mental health, Kennedy has received numerous awards for his advocacy on behalf of the mentally ill including the Society for Neuroscience Public Service Award, Eli Lilly & Co. Helping Move Lives Forward Reintegration Award, American Psychoanalytic Association President's Award, American Psychiatric Association Alliance Award, Depression and Bipolar Support Alliance Paul Wellstone Mental Health Award, and many other honors from professional organizations in this area.

Saturday, October 31

KYLE COURTNEY, ESQ.

Locating Persons and Finding Experts

Kyle Courtney, Esq. is both a law librarian and adjunct professor of law at Northeastern University School of Law where he teaches International and Foreign Legal Research. He has continued to design and teach seminars in legal research methods for the Law School's Program on Human Rights and the Global Economy. In addition, he also teaches an interdisciplinary course called Privacy, Ethics, and Digital Rights for Northeastern's graduate Computer Science program. Courtney also lectures on intellectual property and plagiarism for the graduate Communication Management program at Emerson College. He graduated with distinction for Suffolk University Law School, where he was accepted into the school's specialized Intellectual Property program. He received his MLS from Simmons College in Boston. He is a member of the American Association of Law Libraries, the Massachusetts Bar Association, and the Law Librarians of New England.

THURSDAY, OCTOBER 29, 2009

POSTER SESSION A — 7:15 AM – 8:00 AM/ 9:30 AM – 10:15 AM — **HARBORSIDE FOYER**

T1 ***Role of the Forensic Psychiatrist in the General Hospital***
Elizabeth A. Davis, MD, Boston, MA
Rebecca Brendel, MD, JD, Boston, MA
Fabian Saleh, MD, Boston, MA

T2 ***Female Genital Mutilation Asylum Cases and Forensic Psychiatry***
Kehinde Ogundipe, MD, Philadelphia, PA
Sarah Paoletti, JD, (I) Philadelphia, PA
Carla Rodgers, MD, Philadelphia, PA

T3 ***Validation of the Correctional Mental Health Screen***
Julian Ford, PhD, (I) Farmington, CT
Karen Kesten, MS, (I) Farmington, CT
Robert Trestman, MD, PhD, Farmington, CT
Wanli Zhang, PhD, (I) Farmington, CT

T4 ***Forensic Education in General Psychiatry Residency Training***
Joseph B. Williams, MD, (I) Burlington, NC
Alyson Kuroski-Mazzei, DO, Chapel Hill, NC
Jill Volin, MD, Chapel Hill, NC

T5 ***Antisocial Personality Disorder in Incarcerated Offenders***
Jeff Allen, PhD, (I) Iowa City, IA
Donald Black, MD, (I) Iowa City, IA
Tracy Gunter, MD, St. Louis, MO
Peggy Loveless, PhD, (I) Iowa City, IA
Bruce Sieleni, MD, (I) Coralville, IA
Patricia Westmoreland, MD, Oakdale, IA

T6 ***Child Pornography and Child Molestation: Is There a Relationship?***
R. Gregg Dwyer, MD, EdD, Columbia, SC
Fabian Saleh, MD, Boston, MA

T7 ***Elderly with Problem Sexual Behavior: Ethical/Clinical Issues***
R. Gregg Dwyer, MD, EdD, Columbia, SC
Crystal Kim, BA, (I) Washington, DC
Christopher Myers, MD, Wilmington, NC
Fabian Saleh, MD, Boston, MA

T8 ***Legal Regulation of Psychiatric Services in Russia***
Roman Gleyzer, MD, Seattle, WA
Alexander Bukhanovski, MD,PhD, (I) Rostov-on-Don, Russia
Igor Simakov, MD, (I) Rostov-on-Don, Russia

T9 ***The Case of a Franco-Belgian Serial Killer***
Samuel Leistedt, MD, Boston, MA
Xavier Bongaerts, MD, (I) Mons, Belgium
Paul Linkowski, MD, PhD, (I) Brussels, Belgium
Thierry Pham, MS, (I) Tournai, Belgium
Fabian Saleh, MD, Boston, MA

T10 ***Psychiatry and Hunger Strikers: Legal, Ethical, and Clinical***
Marlynn Wei, MD, JD, (I) Boston, MA
Rebecca Brendel, MD, JD, Boston, MA

T11 ***ECT in Texas, Legislative Oversight or Interference***
Luis Baez-Cabrera, MD, (I) San Antonio, TX
Matthew Faubion, MD, San Antonio, TX

T12 ***Physical Restraints for Medical and Psychiatric Purposes***
Anna Glezer, MD, Boston, MA
Rebecca Brendel, MD, JD, Boston, MA

T13 ***Josef Fritzl, Dungeon Master: Psychopathy and Sexual Sadism***
H. Eric Bender, MD, Los Angeles, CA
Praveen Kambam, MD, Los Angeles, CA
Vasilis K. Pozios, MD, Ann Arbor, MI

T14 ***Psychiatry Training and the Paraphilias: An Update Continued***
Paul Noroian, MD, Worcester, MA
Christopher Myers, MD, Boston, MA
Fabian Saleh, MD, Boston, MA

T15 ***FACT: Partnering with Probation***
Alison Deem, MD, Rochester, NY
J. Steven Lamberti, MD, (I) St. Louis, MO
Robert Weisman, DO, (I) St. Louis, MO

T16 ***Corporate Fraud: Psychiatric Analysis and Forensic Issues***
Gagan Dhaliwal, MD, Huntsville , AL
Margaret Goni, MD, Elmhurst , NY
Kavita Khajuria, MD, Los Angeles , CA
Swachetan Bajwa, MD, MS, (I) Edmond, OK

T17 ***Psychological Autopsy of Marquis de Sade: Forensic Perspectives***
Gagan Dhaliwal, MD, Huntsville , AL
Karen Rosenbaum, MD, New York , NY
Swachetan Bajwa, MD, MS, (I) Edmond, OK
Neelam Varshney, MD, Worcester, MA

T18 ***The Clinical Utility of Arresting Patients***
Elizabeth Feingold, MD, (I) New York, NY
Merrill Rotter, MD, Bronx, NY
Ali Khadivi, PhD, (I) Bronx, NY
Ronald Suarez, MD, Bronx, NY

T19 ***Racial Disparity: Diagnosis and Criminal Responsibility***
Timothy Allen, MD, Lexington, KY
Tyler Jones, MD, Odenton, MD
Matthew Neltner, MD, (I) Lexington, KY

OPENING CEREMONY 8:00 AM – 10:00 AM **HARBORSIDE A/B**

T20 ***The Mental Status Examination in the Age of the Internet***
Patricia R. Recupero, MD, JD, Providence, RI

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

PANEL 10:15 AM - 12:00 PM **LAUREL**

T21 ***A Critical Appraisal of Proposed DSM-V Paraphilic Diagnoses***
Sexual Offenders Committee
Richard Krueger, MD, New York, NY
Frederick Berlin, MD, PhD, Baltimore, MD
Paul Fedoroff, MD, Ottawa, ON, Canada
Howard Zonana, MD, New Haven, CT
Michael First, MD, New York, NY

PANEL 10:15 AM - 12:00 PM **HARBORSIDE A/B**

T22 ***Indiana v. Edwards: Limits on Rights to Self-Representation***
Paul S. Appelbaum, MD, New York, NY
Richard Bonnie, LLB, (I) Charlottesville, VA
Erica Hashimoto, JD, (I) Athens, GA
Debra Pinals, MD, Boston, MA

PANEL — 10:15 AM - 12:00 PM — **HARBORSIDE E**

T23 A Cold Shoulder: ICE and Detainee Psychiatric Services

Law Enforcement Liaison Committee

Vasilis Pozios, MD, Ann Arbor, MI
Michael Harlow, MD, JD, Sacramento, CA
Praveen Kambam, MD, Los Angeles, CA
Eric Balaban, JD, (I) Washington, DC
Keenan Keller, JD, (I) Washington, DC

WORKSHOP — 10:15 AM - 12:00 PM — **ESSEX**

T24 In the Lion's Den: Surviving Cross-Examination

Roger Z. Samuel, MD, New York, NY
Henry Conroe, MD, Chicago, IL
Mark DeBofsky, JD, (I) Chicago, IL

WORKSHOP — 10:15 AM - 12:00 PM — **HARBORSIDE D**

T25 Forensic Consultation to Inpatient Psychiatric Units

Rebecca Brendel, MD, JD, Boston, MA
Judith Edersheim, MD, JD, Boston, MA
Fabian Saleh, MD, Boston, MA
Ronald Schouten, MD, JD, Boston, MA

LUNCH (TICKET REQUIRED) — 12 NOON – 2:00 PM — **HARBORSIDE C**

T26 The Neuroscientific Challenge To Criminal Responsibility

Stephen J. Morse, JD, PhD, (I), Philadelphia, PA

RESEARCH IN PROGRESS #1 — 2:15 PM - 4:00 PM — **ESSEX**

T27 Survey of Judges – Competence to Represent Oneself

James Knoll, IV, MD, Syracuse, NY
Cecilia Leonard, MD, Syracuse, , NY
Bruce Way, MD, (I) Syracuse, NY

T28 Third Party Observers of Forensic Examinations

Timothy J. Michals, MD, Philadelphia, PA
Steven Samuel, PhD, (I) Philadelphia, PA

T29 The Elephant in Court:Transference, Lawyers, and Experts

Caren Teitelbaum, MD, New Haven , CT
Madelon Baranoski, PhD, (I) New Haven, CT

WORKSHOP — 2:15 PM - 4:00 PM — **HARBORSIDE A/B**

T30 Child Sexual Abuse Allegations in Custody Evaluations

Child and Adolescent Psychiatry Committee

Joseph N. Kenan, MD, Los Angeles, CA
Stephen Billick, MD, New York, NY
Dean De Crisce, MD, Jersey City, NJ
R. Gregg Dwyer, MD, EdD, Columbia, SC
Fabian Saleh, MD, Boston, MA
Christopher Thompson, MD, Los Angeles, CA

WORKSHOP — 2:15 PM - 4:00 PM — **HARBORSIDE D**

T31 Research on Young-Onset Dementia and Forensic Implications

Research Committee

Brian Appleby, MD, (I) Baltimore , MD
Ryan Hall, MD, Lake Mary, FL

PANEL — 2:15 PM - 4:00 PM — **LAUREL**

T32 A Revolving Door: Criminal Behavior in Prison and The Street

Criminal Behavior Committee

Michael Champion, MD, Santa Fe, NM
Don Gill, (I) Annapolis Junction, MD
Sally Johnson, MD, Chapel Hill, NC
Donald Lyddane, BS, (I) Washington, DC

COURSE (TICKET REQUIRED) — 2:15 PM - 6:00 PM — **HARBORSIDE E**

T33 The Detection of Malingered Mental Illness

Phillip J. Resnick, MD, Cleveland, OH

COFFEE BREAK **4:00 PM - 4:15 PM** **HARBORSIDE FOYER**

PAPER SESSION #1 4:15 PM - 6:15 PM **ESSSEX**

T34 ***Forensic Dilemmas in Internet and Pornography***

John R. Lion, MD, Baltimore, MD

T35 ***Covert Emergent Medications: Ever Ethically Permissible?***

Erick Hung, MD, San Francisco, CA
Renée Binder, MD, San Francisco, CA
Dale McNiel, PhD, (I) San Francisco, CA

T36 ***What Can We Learn from Recent Antipsychotic Drug Litigation?***

Douglas Mossman, MD, Cincinnati, OH
Jill Steinberg, JD, (I) Cincinnati, OH

T37 ***Treatment of Metabolic Syndrome at a Forensic Hospital***

Nader Sharifi, MD, (I) Port Coquitlam, BC, Canada

WORKSHOP 4:15 PM - 6:15 PM **LAUREL**

T38 ***Medical Decisional Capacity Assessment: Are There Standards?***

Ramaswamy Viswanathan, MD, Brooklyn, NY
Paul Appelbaum, MD, New York, NY
Rebecca Brendel, MD, JD, Boston, MA
Carolina Klein, MD, (I) Washington, DC
Howard Zonana, MD, New Haven, CT

PANEL 4:15 PM - 6:15 PM **HARBORSIDE A/B**

T39 ***Dissociative Identity Disorder and the Law: Disease or Drama?***

Jessica Ferranti, MD, Sacramento , CA
Keelin Garvey, MD, Providence, RI
Andrew Nanton, MD, Mebane, NC
Charles Scott, MD, Sacramento, CA

DEBATE 4:15 PM - 6:15 PM **HARBORSIDE D**

T40 ***Pedophilia: Intractable and Untreatable?***

Callum C Ross, MBChB, Berks, United Kingdom
Kevin Cleary, MB, (I) London, England
Fintan Larkin, MB, (I) Berks, United Kingdom

MOCK PANEL 7:00 PM – 9:00 PM **HARBORSIDE A/B**

T41 ***The Trial of John W. Hinckley Jr.: A Retrospective***

Alan W. Newman, MD, Washington, DC
Park E. Dietz, MD, MPH, PhD, Newport Beach, CA
William T. Carpenter, Jr., MD (I) Baltimore, MD
Roger M. Adelman, Esq., (I) Washington, DC
Robert T.M. Phillips, MD, PhD, Annapolis, MD

T1 ROLE OF THE FORENSIC PSYCHIATRIST IN THE GENERAL HOSPITAL

Elizabeth A. Davis, MD Boston, MA
Rebecca Brendel, MD, JD, Boston, MA
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE

The forensic psychiatrist has multiple roles in the general hospital that include addressing issues of decision making, privacy, ethics, and safety. This poster will help clinicians understand the kinds of questions that can be answered by a forensic specialist in the service of caring for patients, while also clarifying the limitations of this role.

SUMMARY

This poster illustrates the multiple services a practicing forensic psychiatrist can provide in a general hospital setting. The forensic psychiatrist can fulfill functions that are beyond the scope of consultation liaison psychiatrists, ethicists, and risk management. The role is primarily to educate staff regarding legal issues concerning hospitalized patients and to minimize risk to both patients and the institution. A forensic psychiatrist can help staff navigate a complicated legal system that, on the one hand, serves to protect patient autonomy and, on the other, interferes with the expedient delivery of clinical care. These conflicting needs and multiple pressures necessitate such a role. Frequently the forensic psychiatrist consults on matters of discharge planning involving dangerous and/or incompetent patients, limits of confidentiality, malpractice, treatment refusal, substitute decision-making, and informed consent. Functions also include petitioning for guardianships on behalf of patients who lack capacity, as well as risk management around transfers between medical and surgical departments and psychiatric units.

REFERENCES

Brendel BW, Schouten R: Legal concerns in psychosomatic medicine. Psychiatric Clinics of North America 30:663-76, 2007
Simon RI, Goetz S: Forensic issues in the psychiatric emergency department. Psychiatric Clinics of North America 22(4):851-64, 1999

SELF ASSESSMENT QUESTIONS

1. The following are true regarding the role of the forensic psychiatrist, except?
a. He/she can assist the medical team in filing for guardianship on behalf of a patient who lacks decision-making capacity.
b. He/she is significantly more skilled at predicting risk regarding future violent acts by a questionably violent patient.
c. The obligation to maintain privacy regarding the HIV+ status of a patient who is placing another individual at risk differs for a forensic psychiatrist as compared to other physicians.
d. He/she can apprise a medical team about informed consent standards in their particular jurisdiction.
ANSWER: b

2. When conducting a risk assessment regarding the dangerousness of a patient, the forensic psychiatrist is called upon to perform what function?
a. to predict likelihood that patient will commit a dangerous act after being discharged from the hospital.
b. to reduce risk of discharge of a patient to zero.
c. to advise the medical or psychiatric team which medications are indicated to reduce risk.
d. to help the clinical team determine the steps necessary through communication and documentation to ensure the safest discharge possible for a patient.
ANSWER: d

T2 FEMALE GENITAL MUTILATION ASYLUM CASES & FORENSIC PSYCHIATRY

Kehinde Ogundipe, MD, Philadelphia, PA
Sarah Paoletti, JD (I) Philadelphia, PA
Carla Rodgers, MD, Philadelphia, PA

EDUCATIONAL OBJECTIVE

To improve knowledge of basic US asylum law and specific requirements for granting of asylum in female genital mutilation cases.

SUMMARY
Female genital mutilation (FGM) is a term encompassing a wide range of procedures that involve the removal or alteration of a woman's genitalia for nonmedical reasons. The federal courts and the Board of Immigration Appeals (BIA) have classified FGM as a form of persecution, the showing of which can act as a basis for a successful asylum claim. However, the federal courts and the BIA have divergent views on how to handle applicants who have already undergone FGM. The federal courts that have dealt with this issue state that past infliction of FGM is a well-founded fear of persecution, and constitutes a "continuing harm" similar to forced sterilization. The BIA, however, has argued that FGM is a one-time procedure, which once inflicted cannot be repeated. The BIA, therefore, holds that since the applicant can no longer be persecuted with FGM, it cannot be a basis for asylum application. FGM has various physical and psychological sequelae. Forensic psychiatrists have been involved in a number of asylum cases involving women who have undergone FGM. These cases have cultural and credibility issues that influence forensic evaluations.

REFERENCES
WHO webpage on female genital mutilation. Available at http://who.int/reproductive-health/fgm/index.html. Accessed 19 February 2009
Kim Y: Female Genital Mutilation as Persecution: When Can It Constitute a Basis for Asylum and Withholding of Removal? CRS Report for Congress RL34587, October 10, 2008

SELF ASSESMENT QUESTIONS
1. Which of the following are eligibility criteria for asylum that FGM cases satisfy?
a. Proof of persecution or a well-founded fear of persecution.
b. Proof of belief in a political opinion.
c. Proof that poverty would pose a significant health risk.
d. Proof that the well-founded fear of persecution is "on account of" the applicant's economic wealth.
ANSWER: a

2. What is a way that cultural issues may influence forensic evaluation and court presentation?
a. Difficulty talking about experiences.
b. Showing off resilience.
c. Challenges working with interpreters.
d. Attempts to act seductively to influence evaluation.
ANSWER: c

T3 VALIDATION OF THE CORRECTIONAL MENTAL HEALTH SCREEN

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

EDUCATIONAL OBJECTIVE
Following this presentation, participants will recognize the value of validated mental health screening in jails, understand how an instrument is validated, and be able to identify appropriate criteria for its use.

SUMMARY
Objective. To cross-validate a brief mental health screening instrument for newly incarcerated adults. Methods: Women (N=360) and men (N=630), ages 18-64 years old 37% black, 22% Hispanic, and 40% white without severe mental impairment were randomly recruited upon entry to jail and administered the Correctional Mental Health Screen for women (CMHS-F) or men (CMHS-M). A randomly selected sub-sample (30 women, 106 men) subsequently completed research clinical diagnostic interviews. Results: Accuracy for the CMHS-F and CMHS-M (73-80%) for the identification of current axis I or II psychiatric disorders replicated results of an instrument development study and exceeded the accuracy levels reported for alternative brief mental health screening measures with incarcerated adults. Cut-points were identified maximizing positive or negative predictive power. Conclusions: This cross-validation demonstrates that the CMHS-F and CMHS-M are efficient accurate screens to identify newly incarcerated adults with undetected psychiatric disorders.

REFERENCES
Steadman HJ, Scott HE, Osher F, et al: Validation of the brief jail mental health screen. Psychiatr Serv 56:816-22, 2005
Ford JD, Trestman RL, Wiesbrock V, et al: Development and validation of a brief mental health screening instrument for newly incarcerated adults. Assessment 14:279-99, 2007

SELF ASSESMENT QUESTIONS

1. Cut-points in the CMHS refer to:
a. The time frame in which it should be used on admission to jail.
b. The time frame it should be used prior to discharge from prison.
c. The score used to determine when to refer for further evaluation.
d. The appropriate age range for administering the CMHS.
ANSWER: c

2. The Correctional Mental Health Screen:
a. Is identical for men and women.
b. Is a quick and valid way to screen for mental illness in jail.
c. Was developed in prison systems.
d. Will reliably screen for recidivism risk in potential parolees.
ANSWER: b

T4 FORENSIC EDUCATION IN GENERAL PSYCHIATRY RESIDENCY TRAINING

Joseph B. Williams, MD, (I) Burlington, NC
Alyson Kuroski-Mazzei, DO, Chapel Hill, NC
Jill Volin, MD, Chapel Hill, NC

EDUCATIONAL OBJECTIVE

To provide information on the current state of forensic psychiatry education within general residency training, and compare this with the ACGME education requirements and the most appropriate teaching practices described in the literature.

SUMMARY

Forensic psychiatry is a dynamic specialty within the field of psychiatry, and yet educational training and exposure are often minimized during general psychiatry residency training. The Accreditation Council for Graduate Medical Education (ACGME) has now outlined the importance of forensic psychiatry training within its specialty curriculum requirements for general residency training, and indeed there has been literature on the subject of how best to address this specialty within general training. Despite these guidelines and supporting literature, a lack of understanding about the requirements and practices of teaching forensic psychiatry within general residency training programs exists. Through the use of surveying, this study will look at the current state of forensic psychiatry training within general residency programs in the United States, and compare the current state of forensic psychiatry education with the specific ACGME requirements and the various educational recommendations described in the literature.

REFERENCES

Lewis CF: Teaching forensic psychiatry to general psychiatry residents. Acad Psychiatry 28:40-6, 2004
Mack A, Kuroski-Mazzei A, Volin J, Preven D, Newman A, Hogan E: Teaching forensic psychiatry: Not whether, but when, what, and how much? Early Career Psychiatry Committee Workshop. AAPL 2008 Annual Meeting, 2008

SELF ASSESMENT QUESTIONS

1. The ACGME general psychiatry program requirement for forensic psychiatry includes:
ANSWER: Resident exposure to evaluations such as patients facing criminal charges, establishing competency to stand trial, and criminal responsibility.

2. According to the literature, forensic psychiatry education during general training:
ANSWER: Optimally takes place during all four years of residency, with progressive exposure to forensic concepts most relevant to general psychiatry residents.

T5 ANTISOCIAL PERSONALITY DISORDER IN INCARCERATED OFFENDERS

Jeff Allen, PhD, (I) Iowa City, IA
Donald Black, MD, (I) Iowa City, IA
Tracy Gunter, MD, St. Louis, MO
Peggy Loveless, PhD, (I) Iowa City, IA
Bruce Sieleni, MD, (I) Coralville, IA
Patricia Westmoreland, MD, Oakdale, IA

EDUCATIONAL OBJECTIVE

To understand the impact of antisocial personality disorder on psychiatric comorbidity, quality of life, and risk for recidivism in newly incarcerated offenders.

SUMMARY
Background: We determined the frequency of antisocial personality disorder (ASPD) in offenders. We examined demographic characteristics, psychiatric comorbidity, and quality of life in offenders with and without ASPD. We also assessed a subset with attention deficit hyperactivity disorder (ADHD). Methods: A random sample of 320 newly incarcerated offenders was assessed using the Mini International Neuropsychiatric Interview (MINI), the Short Form-36 Health Survey (SF-36), and the Level of Service Inventory-Revised (LSI-R). Results: ASPD was present in 113 subjects (35.3%). There was no gender-based prevalence difference. Offenders with ASPD were younger and had higher suicide risk, higher rates of mood, anxiety, substance use, psychotic, and somatoform disorders, borderline personality disorder, and ADHD. Their quality of life was worse, and their LSI-R scores indicated a greater risk for recidivism. Those with ADHD had a higher suicide risk, higher rates of comorbid disorders, and their level of mental health functioning was worse. Conclusion: ASPD is relatively common among male and female offenders, and is associated with comorbid disorders, a higher suicide risk, and impaired quality of life. Those with comorbid ADHD were even more impaired. High rates of ASPD in prison have not as yet led to significant efforts to provide innovative treatment.

REFERENCES
Gunter TD, Arndt S, Wenman G, Allen J, Loveless P, Sieleni B, Black DW: Frequency of mental and addictive disorders among 320 men and women entering the Iowa prison system: use of the MINI-Plus. J Am Acad Psychiatry Law 36:27-34, 2008
Westmoreland P, Gunter T, Wenman G, Allen J, Loveless P, Sieleni BA, Black DW: Attention deficit hyperactivity disorder in men and women offenders newly committed to prison: clinical characteristics and quality of life. Int J Offender Ther Comparative Criminol, in press.

SELF ASSESMENT QUESTIONS
1. Is there a gender-based prevalence difference in ASPD in our sample?
ANSWER: no

2. Is ASPD associated with a higher suicide risk?
ANSWER: yes

T6 CHILD PORNOGRAPHY AND CHILD MOLESTATION: IS THERE A RELATIONSHIP?

R. Gregg Dwyer, MD, EdD, Columbia, SC
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
At the end of this presentation participants will be able to describe the current evidence correlating child pornography to child molestation, describe clinical characteristics of individuals arrested for internet crimes involving child pornography possession, and discuss treatment and risk management modalities pertaining to this population

SUMMARY
During 2000 to 2001, there were approximately 1713 arrests for internet crimes involving child pornography possession. Of those arrested 83% had images of prepubescent children, 80% had images of sexual penetration, and 21% had images of sexual violence. According to criminal victimization data, there were 260,940 rapes and sexual assaults during 2006, and the rate per 1,000 persons age 12-19 years was 5.9%. For all sexual assaults, 67% of the victims were under the age of 18 years. Of those, 34% were under age 12 years. What, if any, is the empirical evidence-base indicating a link between child pornography possession and sexual offending against children? Is such possession a factor for consideration in risk assessment? This poster presents a review of published empirical evidence to facilitate risk assessments of child molestation among persons who possess child pornography.

REFERENCES
Bureau of Justice Statistics. Criminal Victimization in the United States, 2006 Statistical Tables. Washington, DC: Bureau of Justice Statistics Office of Justice Programs U.S. Department of Justice, NCJ 223436, 2008

Wolak J, Finkelhor D, Mitchell KJ: Child-Pornography Possessors Arrested in Internet-Related Crimes: Findings from the National Juvenile Online Victimization Study. Alexandria, VA: National Center for Missing & Exploited Children, 2005

SELF ASSESMENT QUESTIONS
1. What age group accounts for the majority of persons arrested for internet-related child pornography possession?
a. 17 years and younger
b. 18 to 25 years
c. 26 to 39 years
d. 40 years and older
ANSWER: d

2. What age group accounts for over half of sexual assault victims?
a. 6 and younger
b. 12 and younger
c. 17 and younger
d. 25 and younger
ANSWER: c

T7 **ELDERLY WITH PROBLEM SEXUAL BEHAVIOR: ETHICAL/CLINICAL ISSUES**

R. Gregg Dwyer, MD, EdD, Columbia, SC
Crystal Kim, BA, (I) Washington, DC
Christopher Myers, MD, Wilmington, NC
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
This poster will inform the audience about the evidence base for management of the elderly who exhibit sexual problems and offending behaviors. This will facilitate forensic evaluations and treatment of this unique population about whom so little is reported in the peer-reviewed literature.

SUMMARY
The perpetration of sexual problem and offending behaviors is not limited to the young. Such behaviors that begin in adolescence or early adulthood may continue into the elderly age range. For some, the problematic behaviors don't begin until the onset of age-related cognitive deficits. What are the management concerns and options for the elderly perpetrators of sexual problem and offending acts? This poster presents a review of the evidence-based literature as it relates to the ethical and clinical considerations that are unique to treating this population. Specific attention is placed on risk assessment and medication management issues.

REFERENCES
Fazel S, Hope T, O'Donnell I, Jacoby R: Psychiatric, demographic and personality characteristics of elderly sex offenders. Psychological Medicine 32(2):219-26, 2002
Rayel MG: Elderly sexual offenders admitted to a maximum-security forensic hospital. J Forensic Sci 45(6):1190-2, 2000

SELF ASSESMENT QUESTIONS
1. Which of the following has been reported as being the most closely correlated with elderly sexual offenders?
a. Organic brain disease
b. Major mental illness (Axis I)
c. Personality disorders
d. Polysubstance use
ANSWER: c

2. Approximately what percent of persons arrested in 2007 for sex offenses other than forcible rape and prostitution were age 55 years or older?
a. 5%
b. 10%
c. 15%
d. 20%
ANSWER: b

T8 **LEGAL REGULATION OF PSYCHIATRIC SERVICES IN RUSSIA**

Roman Gleyzer, MD, Seattle, WA
Alexander Bukhanovski, MD, PhD, (I) Rostov-on-Don, Russia
Igor Simakov, MD, (I) Rostov-on-Don, Russia

EDUCATIONAL OBJECTIVE
Attendees will learn the history and current status of legal regulation of psychiatric services in Russia.

SUMMARY
Psychiatric services (PS) in Russia are regulated by several federal laws, two of them being most important. "Fundamental Principles of Health Care in the Russian Federation" regulate medical services in general. The law

"On Psychiatric Services and Guarantees of Human Rights" (LPS), first adopted in 1992, focuses specifically on mental health care. It complies with relevant United Nations Resolutions and regulates the relationship between patients, federal and local authorities, managing organizations and mental health care facilities. The primary intent of LPS is to make PS humane and democratic, and provide legal parity with other types of medical services. Introduction of legal justification for any involuntary intervention in psychiatry, as well as strong judicial supervision of all phases of treatment, significantly reduced the number of patients receiving involuntarily PS. The patients and their families are now better informed of their rights and existing legal protections. Psychiatric facilities also have more opportunities to provide social and legal assistance to the patients. Authors discuss legal aspects of PS in the Russian Federation and recent improvements in the preservation of patients' rights.

REFERENCES

Kim SN: Legal aspects of involuntary psychiatric hospitalization. Medical Law 2, 2006 (Russian)
Cimbal EL: Paradoxes of legal regulation in psychiatry, in Legal Regulation of Medical Services. Moscow: Jurist, 2003, pp 110-12 (Russian)

SELF ASSESMENT QUESTIONS

1. The main features of legal regulation of psychiatric services in Russia include:
a. confidentiality
b. observation of human rights
c. judicial supervision of involuntary interventions
d. informed consent
e. all of the above
ANSWER: e

2. Legal regulation of psychiatric services in Russia started in:
a. 1983
b. 1992
c. 1999
d. 2002
ANSWER: b

T9 THE CASE OF A FRANCO-BELGIAN SERIAL KILLER

Samuel Leistedt, MD, Boston, MA
Xavier Bongaerts, MD, (I) Mons, Belgium
Paul Linkowski, MD, PhD, (I) Brussels, Belguim
Thierry Pham, MS, (I) Tournai, Belguim
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE

At the end of this presentation, participants will be able to discuss current evidence related to the etiology, psychodynamic factors, differential diagnosis, risk assessment and evaluation of serial sexual killers, and describe ways in which this evidence is relevant in forensic settings.

SUMMARY

Since the case of Marc Dutroux in 1995, Belgian sexual serial killers have received considerable public and media attention. This poster will provide an in-depth description of the case of Michel Fourniret, a French serial killer who with his wife, Monique Olivier, confessed to kidnapping, raping and murdering at least 9 girls during the 1980s and the 1990s. Using this case, we will discuss the etiology of serial sexual homicide both from a neuropsychiatric and a developmental perspective. Interview, psychometric, and autopsy data will be used to explain and shed light on Michel Fourniret's personality and psychosexual proclivities.

REFERENCES

Hill A, Habermann N, Berner W, Briken P: Sexual sadism and sadistic personnality disorder in sexual homicide. J Pers Disord 20(6):671-84, 2006
Johnson BR, Becker JV: Natural born killers? The development of the sexually sadistic serial killer. J Am Acad Psychiatry Law 25 (3):335-48, 1997

SELF ASSESSMENT QUESTIONS
1. In order to meet the FBI definition of serial killer, the number of victims has to be :
a. at least 3
b. more than 5
c. at least 2 but in different places
d. at least 3 but at the same time
ANSWER: a

2. Generally, serial killers are:
a. white men with psychopathic personalities
b. white men with psychotic features
c. always totally socially isolated
d. often of low intelligence (IQ ‹ 90)
ANSWER: a

T10 **PSYCHIATRY AND HUNGER STRIKERS: LEGAL, ETHICAL, AND CLINICAL**

Marlynn H. Wei, MD, JD (I) Boston, MA
Rebecca Brendel, MD, JD, Boston, MA

EDUCATIONAL OBJECTIVE
To understand the role of psychiatrists in evaluating hunger strikers in correctional and detentional facilities, define and characterize types of hunger strikes, examine the legal cases and ethical implications of hunger strikes, and to identify the limitations of the psychiatric evaluation of hunger strikers.

SUMMARY
Psychiatrists play an instrumental role in the evaluation of hunger strikers in correctional and detention facilities. This poster focuses on the role that psychiatrists play in the evaluation of the competence of an individual who is voluntarily fasting. Theoretical and legal definitions of hunger strikes, including the criteria applied in federal and state prisons as well as in the detention center at the U.S. Naval Base at Guantanamo Bay are examined. Different conditions of voluntary fasting and hunger strikes are also considered. The poster also discusses the limitations of the psychiatric model including the professional values on death and suicide, the problem of access to information, the problem of normative judgment, and the issue of the use of psychiatry for nontreatment, government purposes.

REFERENCES
Annas, GJ: Hunger strikes at Guantanamo—medical ethics and human rights in a "legal black hole." New Engl J Med 355:1377-80, 2006
Nicholl, DJ: Forcefeeding and restraint of Guantanamo Bay hunger strikers. Lancet 367: 9513, 2006

SELF ASSESSMENT QUESTIONS
1. Which of the following is included in the Federal Bureau of Prisons guidelines regarding hunger strikes?
a. communication of intent to hunger strike and observation of inmate fasting for one week
b. staff observation of inmate fasting in excess of 72 hours
c. voluntary fasting with intent for protest or expression of freedom
d. voluntary fasting with medical changes found on medical evaluation
e. voluntary fasting with any clinical changes found on clinical exam
ANSWER: b

2. Which of the following is not a state interest weighed by courts when considering forcefeeding fasting inmates?
a. prevention of suicide
b. ethical integrity of medical profession
c. maintenance of orderly and secure penal institution
d. right to suicide
e. preservation of life
ANSWER: d

T11 ECT IN TEXAS, LEGISLATIVE OVERSIGHT OR INTERFERENCE

Luis Baez-Cabera, MD, (I) San Antonio, TX
Matthew Faubion, MD, San Antonio, TX

EDUCATIONAL OBJECTIVE
This presentation discusses the legislative oversight and restrictions governing administration of ECT and how such regulation may actually interfere with provision of appropriate psychiatric care.

SUMMARY
Electroconvulsive therapy (ECT) is considered a highly effective treatment of many psychiatric disorders and this very effective treatment is heavily regulated by Texas administrative codes, statutes and legislation. The Texas state statutes have particularly targeted the issue of consent, and Texas state statutes restrict a surrogate decision-maker from consenting to ECT on behalf of an incompetent patient. Harris suggested that the regulatory restrictions have been motivated by patient advocates and special interest groups, and that legislation may hinder delivery of this service rather than provide the intended oversight. The purpose of this poster presentation is to conduct a critical review of the Texas administrative codes, statutes and legislation that regulate the practice of ECT as well as the potential deleterious impact of such legislation on patient care in the state of Texas. This poster will focus on the aspects of informed consent and surrogate decision-making that relates to the provision of ECT in Texas.

REFERENCES
Harris,V: Electroconvulsive therapy: administrative codes, legislation and professional recommendations. J Am Acad Psychiatry Law 34:406-11, 2006
The following chapters from the Texas Health and Safety Code: Tex. Health and Safety Code Ann. § 313.004 (2007); Tex. Health and Safety Code Ann. § 313.005 (2007); Tex. Health and Safety Code Ann. § 578.002 (1993); Tex. Health and Safety Code Ann. § 578.003 (2005); Tex. Health and Safety Code Ann. § 578.004 (1993).

SELF ASSESSMENT QUESTIONS
1. What is the procedure to obtain consent for ECT in Texas for a patient that has been found to lack capacity to consent to such treatment?
a. consult the next of kin
b. petition the probate court for a judicial order mandating ECT
c. consent is unnecessary as this is an emergent procedure
d. obtain 2 other physicians' opinions; if all 3 concur, you may proceed with treatment
ANSWER: b

2. The Texas Health and Safety Code Chapter 313 lists several procedures that a surrogate decision-maker cannot consent to. This includes all of the following except:
a. voluntary inpatient mental health services.
b. ECT.
c. appointment of another surrogate decision-maker.
d. admission to a general medical facility.
ANSWER: d

T12 PHYSICAL RESTRAINTS FOR MEDICAL AND PSYCHIATRIC PURPOSES

Anna Glezer, MD, Boston, MA
Rebecca Brendel, MD, JD, Boston, MA

EDUCATIONAL OBJECTIVE
This poster will teach attendees to distinguish between the use of restraints for medical or psychiatric purposes and how to assess, implement, and manage risk in the use of restraints for medical purposes in psychiatric patients.

SUMMARY
Psychiatrists are generally familiar with the use of physical restraint for patients, who, due to mental illness, pose a risk of harm to themselves or to others. While efforts aimed at reducing physical restraint are underway, and psychiatric units and institutions are adopting no restraint policies, physical restraint remains commonplace in medical settings for the purpose of delivering medical care. Using physical restraint for the purpose of providing medical treatment for psychiatric patients may become conceptually and practically confusing in that it may be unclear which principles and regulations apply in a particular setting. This poster will analyze local, state, and federal regulations, laws, and policies pertaining to the use of restraint for psychiatric patients and also for medical patients. Case examples will be presented to explore areas of ambiguity. In light of prevailing law and practice, the authors

present a practical model for risk reduction in the use of physical restraint and propose specific areas of potential focus for law and policy makers.

REFERENCES

Annas, GJ: The last resort – the use of physical restraints in medical emergencies. New Engl J Med 34:1408-12, 1999
Gastmans, C, Milisen, K: Use of physical restraint in nursing homes: clinical-ethical considerations. J Med Ethics 32: 148-52, 2006

SELF ASSESSMENT QUESTIONS

1. Which of the following concepts are used in determining the appropriateness of physical restraint for psychiatric purposes?
a. capacity
b. imminent harm
c. least restrictive alternative
d. emergency
e. all of the above
ANSWER: e

2. Which of the following factors is often used as a central factor in determining the appropriateness of physical restraint for medical purposes but not for psychiatric purposes?
a. interruption of care
b. emergency
c. capacity
d. least restrictive alternative
e. imminent harm
ANSWER: a

T13 JOSEF FRITZL, DUNGEON MASTER: PSYCHOPATHY AND SEXUAL SADISM

H. Eric Bender, MD, Los Angeles, CA
Praveen Kambam, MD, Los Angeles, CA
Vasilis K. Pozios, MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE

To review the case of Josef Fritzl who imprisoned and repeatedly raped his daughter and fathered seven children by her; to review the terms "psychopathy" and "sexual sadism," DSM-IV TR criteria and comments, and explore divergence and overlap within these categories in context of the international case of Josef Fritzl.

SUMMARY

The world first heard of the atrocities committed by Josef Fritzl in April 2008. An Austrian man who held his daughter Elizabeth captive for 24 years in a basement dungeon, Fritzl fathered seven children by his daughter, some of whom he also held captive, others of whom he raised as "foundlings" and incorporated into a family with his wife upstairs. Fritzl's case was brought to light when Elizabeth convinced him to bring one of the children he fathered to the hospital for medical care. Suspicious of the situation, authorities learned of the basement dungeon and family living underground in the Fritzl home. This extreme case of depraved behavior provides a context in which to review the terms psychopathy and sexual sadism. Although certain distinctions between these categories suggest they are unrelated, certain similarities do exist. Primarily, this poster will review the absence of the word "psychopathy" from DSM-IV TR while attempting to provide an academic definition of psychopathy. Sexual sadism will be reviewed as a type of paraphilia as defined by DSM-IV TR. Similarities and differences will be explored. Finally, the actions of Fritzl will be examined as possibly falling into one, both, or neither of these categories.

REFERENCES

Kirsch LGG, Becker JV: Emotional deficits in psychopathy and sexual sadism: implications for violent and sadistic behavior. Clin Psychology Rev 2(7):904-22, 2007
Fedoroff JP: Sadism, sadomasochism, sex, and violence. Can J Psychiatry 53(10):637-46, 2008

SELF ASSESSMENT QUESTIONS

1. What are the DSM-IV TR criteria for "psychopathy?"
ANSWER: DSM IV TR does not mention "psychopathy," nor are there criteria to meet such a disorder. Recent cultural context supports a psychopathic paradigm that most closely resembles Anti-Social Personality Disorder, based on the use of the word "psychopath" in the popular media.

2. What are the DSM-IV TR criteria for sexual sadism?
ANSWER: a. Over a period of at least 6 months, recurrent, intense, sexually-arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person. These must occur for at least 6 months. b. The person has acted on these urges with a nonconsenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty. (This definition is reprinted from DSM-IV TR, as noted on BehaveNet.com.) Disclaimer: Goldwater Rule will be followed; Josef Fritzl will not be diagnosed by presenters since he has not been a patient directly seen by us.)

T14 PSYCHIATRY TRAINING AND THE PARAPHILIAS: AN UPDATE CONTINUED

Paul Noroian, MD, Worcester, MA
Christopher Myers, MD, Boston, MA
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 the sexual disorders. The treatment of patients with sexual disorders, specifically paraphilic 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 paraphilic 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 paraphilic disorders. The survey and some initial results of this study were presented in poster form at the 2008 AAPL meeting. Early data indicate that few training programs specifically address training residents in the treatment of these disorders. This poster presents an update based on newly collected 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. frotteurism
c. gender identity disorder
d. exhibitionism
ANSWER: c

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

T15 FACT: PARTNERING WITH PROBATION

Alison Deem, MD, Rochester, NY
J. Steven Lamberti, MD, (I) St. Louis, MO
Robert Weisman, DO, (I) St. Louis, MO

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 an adaptation of the assertive community treatment (ACT) model designed to prevent criminal recidivism among high-risk patients through collaboration with criminal justice agencies. A national survey was conducted to examine the extent to which FACT programs utilize collaborations with probation, the perceived effectiveness of such collaborations, and barriers to effective collaboration. Members of the National Association of County Behavioral Health Directors (NACBHD) were surveyed electronically to identify existing FACT programs. Senior program representatives were interviewed by telephone. 29 ACT teams met forensic assertive community treatment study criteria. Of these programs, 62% reported including a probation officer on the treatment team. Probation officers were assigned to programs an average of 20 hours weekly, and nearly two thirds had special training in mental health. The impact of involving probation officers was generally viewed as positive at reducing risk of hospitalization and arrest. The effectiveness of such collaborations may depend, in part, on the ability of team clinicians and probation officers to embrace common values and goals.

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. What was the most commonly reported barrier to effective collaboration between mental health teams and probation officers?
a. Differences in goals and values.
b. Lack of resources (funding, time, etc.).
c. Difficulty maintaining communication.
ANSWER: a

T16 CORPORATE FRAUD: PSYCHIATRIC ANALYSIS AND FORENSIC ISSUES

Gagan Dhaliwal, MD, Huntsville, AL
Margaret Goni, MD, Elmhurst, NY
Kavita Khajuria, MD, Los Angeles, CA
Swachetan Bajwa, MD, MS, (I) Edmond, OK

EDUCATIONAL OBJECTIVE
To define the concept of corporate fraud and its role in recent difficult economic times, to discuss psychological aspects of fraud and ethical and legal pitfalls encountered by forensic psychiatrists in approaching these evaluations, to offer a psychiatric approach termed “FRAUD” that guides understanding this human phenomenon.

SUMMARY
Recently, corporate fraud has hit media headlines, and some consider that it plays a major role in the economic downturn. Fraud is defined as intentional deception made for personal gain or to damage another individual. Fraud is a crime and also a civil law violation. Due to their expertise in mental health and law, forensic psychiatrists are expected to analyze this phenomenon and contribute evidence in the legal proceedings. Using self explanatory photos and graphs, the poster depicts clinical and forensic aspects of corporate fraud along with the review

of available research and literature. It will also address unique ethical and legal issues arising from approaching this type of forensic work. Finally, the poster offers a novel psychiatric approach termed "FRAUD" to enhance the consulting skills of forensic psychiatrists. "FRAUD" (F "Fascination to Power- Narcissism" R "Rationalized Conning" A "Acceptance in Corporate Culture" U "Unlimited Greed" D "Denial of Risk") is based on comprehensive analysis of the clinical constructs considered to explain the motivations and psychological underpinnings of this type of behavior. Comparing "FRAUD" to "Antisocial Personality Disorder (ASPD) in DSM-IV TR" will address psychological similarities and differences between individuals indulging in corporate fraud from other criminals with ASPD.

REFERENCES

Brickey KF: Corporate &White Collar Crime: Cases And Materials, 4th Edition. New York: Aspen Publishers, March 1, 2006
Duffield G, Grabosky P: The Psychology of Fraud. Canberra ACT, Australia: Australian Institute of Criminology, Trends and Issues in Crime and Criminal Justice, March 2001

SELF ASSESSMENT QUESTIONS

1. Why is it important to study corporate fraud?
ANSWER: Because of its possible role in recent economic downturn and role of forensic psychiatrists in its evaluation

2. What does the psychiatric approach termed "FRAUD" include?
ANSWER: It includes clinical constructs associated with explanation of corporate fraud: F "Fascination to Power-Narcissism," R "Rationalized Conning," A "Acceptance in Corporate Culture,", U "Unlimited Greed," D "Denial of Risk"

T17 PSYCHOLOGICAL AUTOPSY OF MARQUIS DE SADE: FORENSIC PERSPECTIVES

Gagan Dhaliwal, MD, Huntsville, AL
Karen Rosenbaum, MD, New York, NY
Swachetan Bajwa, MD, MS, (I) Edmond, OK
Neelam Varshney, MD, Worcester, MA

EDUCATIONAL OBJECTIVE

To define sexual sadism and its original link to Marquis de Sade; to discuss the use of psychological autopsy in sexual sadism; to review aspects of verbal and physical domination through analyzing the Marquis's letters to his wife; and to offer the concept of "sexual domination" in sexual sadism and its significance in the future.

SUMMARY

Sexual sadism is the feeling of sexual excitement resulting from administering pain, suffering, or humiliation to another person. DSM IV TR classifies sexual sadism as a paraphilia, originally derived from Marquis Donatien de Sade (1740-1814), a French aristocrat who became notorious for writing novels around the theme of inflicting pain as a source of sexual pleasure. While imprisoned in 1777, he wrote letters to his wife which have been published in the form of a book entitled "Letters from Prison." Psychological autopsy is a procedure for investigating a person 's death by reconstructing what the person thought, felt, and did preceding his or her death. This reconstruction is based upon information gathered from personal documents, police reports, medical and coroner 's records. Using psychological autopsy techniques, the contents of these letters will be analyzed to better understand the psychology of a human being obsessed with lust and power in intimate relationships. Finally, the concept of "sexual domination" will be discussed to explain the core deficits in sadism and discuss its future use in forensic settings.

REFERENCES

Marquis DeSade: Letters from Prison, 1st Edition. New York: Arcade Publishing, May 27, 1999
Phillips J: The Marquis De Sade: A Very Short Introduction. New York: Oxford University Press, 2005

SELF ASSESSMENT QUESTIONS

1. What is sexual sadism?
ANSWER: Sexual sadism is the feeling of sexual excitement resulting from administering pain, suffering, or humiliation to another person.

2. What is psychological autopsy?
ANSWER: Psychological autopsy is a procedure for investigating a person 's death by reconstructing what the person thought, felt, and did preceding his or her death.

T18 THE CLINICAL UTILITY OF ARRESTING PATIENTS

Elizabeth Feingold, MD, (I) Bronx, NY
Merrill Rotter, MD, Bronx, NY
Ali Khadivi, PhD, (I) Bronx, NY
Ronald Suarez, MD, Bronx, NY

EDUCATIONAL OBJECTIVES
The goals of an arrest are containment, retribution, rehabilitation, and deterrence. Whether or not inpatient arrests accomplish these four endpoints remains unanswered. This study tries to discern the unique demographic and psychiatric profile of the inpatients who were arrested, which will help us to focus on the efficacy.

SUMMARY
This is a retrospective review of 25 inpatients arrested beginning in September 2007. Sources of information: Bronx Psychiatric Center charts and incident reports, and Bronx District Attorney records regarding outcomes. The data points were: age, ethnicity, primary diagnosis, axis II diagnosis, forensic history, psychiatric history, and trauma history. Incident review data from prior to and following the arrest were collected. We focused on data that explain if arresting patients accomplished four goals: (1) In order to assess whether violent patients were contained, we looked at the length of time each patient spent in a more secure setting, or out of the hospital all together. (2) To assess if retribution occurred, the mental status and moral culpability at the time of the violent act were examined as well as the legal outcome. (3) To assess if rehabilitation took place, we studied the clinical status of the patients after the arrest through serial mental status exams and BPRS scores. (4) To assess deterrence, we looked at the incidence of future violence in each patient, as well as the rates of violent incidents in the hospital at large during the one year period. Finally, we compared the cases based on precipitants for arrest.

REFERENCES
Coyne A: Should patients who assault staff be prosecuted? J Psychiatric and Mental Health Nursing 9:139-45, 2002
Applebaum K, Applebaum P: A model hospital policy on prosecuting patients for presumptively criminal acts. Hospital and Community Psychiatry 42:12, 1233-37, 1991

SELF ASSESSMENT QUESTIONS
1. The group most affected by violence in the hospital is:
a. doctors
b. nurses
c. patients
d. family
ANSWER: b

2. Which factor is most likely to influence a victim's decision to prosecute a violent patient?
a. noncompliance with medication
b. patient was provoked
c. belief that it was the patient's choice
d. belief that the patient lacked capacity
ANSWER: c

T19 RACIAL DISPARITY: DIAGNOSIS AND CRIMINAL RESPONSIBILITY

Timothy Allen, MD, Lexington, KY
Tyler Jones, MD, Odenton, MD
Matthew Neltner, MD, (I) Lexington, KY

EDUCATIONAL OBJECTIVE
This presentation will explore racial disparity in arrests and in diagnosis of psychiatric illness. It will also explore our finding that inmates with mental illness were more likely to be found responsible for their crimes if they were white.

SUMMARY
The investigators conducted a review of 194 charts of pre-trial competency evaluees were reviewed from 2006 Kentucky Correctional Psychiatric Center (KCPC) discharges. There was an unexpected finding that white inmates were much more likely than African Americans to be found responsible for their crime. This discrepancy is most likely explained by the disparity in diagnosis of psychotic illness. African Americans are more likely to be diagnosed with psychotic illness. This is a finding which was also observed in our chart review. The authors would also like to explore the racial disparity in arrest in the context of these findings.

REFERENCES
Strakowski SM, Keck PE, Arnold LM, Collins J, Wilson RM, Fleck DE, Corey KB, Amicone J, Adebimpe VR: Ethnicity and diagnosis in patients with affective disorders. J Clin Psychiatry 64:747-54, 2003
Kirk DS: The neighborhood context of racial and ethnic disparities in arrest. Demography 45:55-77, 2008

SELF ASSESSMENT QUESTIONS
1. Considering discrepancies in the diagnosis of psychotic illness, which of the following is accurate?
a. Mentally ill African Americans are less likely to be found responsible for their crimes than their white counterparts.
b. African Americans and whites with mental illness are found responsible for their crimes with equal frequency.
c. African Americans and whites are diagnosed with psychotic illness with equal frequency.
d. White criminals with mental illness are more likely to be diagnosed with psychotic illness than their African American counterparts.
ANSWER: a

2. What are some other factors which are known to be related to racial discrepancies in arrest frequency?
a. Concentrated poverty
b. Immigrant generational status
c. Parental marital status
d. Socioeconomic status
e. All of the above
ANSWER: e

T20 THE MENTAL STATUS EXAMINATION IN THE AGE OF THE INTERNET

Patricia R. Recupero, MD, JD, Providence, RI

EDUCATIONAL OBJECTIVE
At the conclusion of this presentation, participants should be able to explain the relevance of an evaluee's Internet use to conducting a forensic assessment. Participants will learn how an evaluee's Internet use may relate to different dimensions of the mental status examination as well as collateral information and case formulation.

SUMMARY
The Internet has grown increasingly relevant to the practice of forensic psychiatry. In conducting a forensic evaluation, the evaluee's internet use can be relevant to nearly all aspects of the analysis including: specific elements of the mental status examination; the review of collateral information; the assessment of impairment, credibility, and risk; and the process of case formulation. During the psychiatric interview, information about an evaluee's use of the Internet can be a valuable conversational tool to help increase candor and self-disclosure even among less cooperative evaluees. The evaluee's Internet use can yield clues to important aspects of the mental status examination, including attitude, mood, affect, insight, judgment, and impulse control. The Internet is often very useful as a source of collateral information to corroborate, refute, or elaborate upon information gathered during the psychiatric interview, particularly for the purposes of assessing credibility, impairment, and risk. This discussion also addresses the relevance of the internet to case formulation, including predisposing factors, precipitating factors, perpetuating factors, protective factors, and ultimate recommendations and conclusions. The presentation will provide illustrative examples and suggestions for questions and topics the forensic psychiatrist may find helpful in conducting a thorough evaluation in this new age of the internet.

REFERENCES
Recupero PR: Forensic evaluation of problematic Internet use. J Am Acad Psychiatry Law 36:505-14, 2008
Block JJ: Lessons from Columbine: virtual and real rage. Am J Forensic Psychiatry 28:5-34, 2007

SELF ASSESSMENT QUESTIONS
1. Which of the following aspects of computer-mediated communication facilitates impulsive behaviors?
a. deindividuation
b. anonymity
c. sensory input overload
d. altered consciousness
e. all of the above
ANSWER: e

2. Delusions relating to the Internet may emerge in the context of which of the following disorders?
a. schizophrenia
b. schizoaffective disorder
c. bipolar disorder
d. major depressive disorder
e. all of the above
ANSWER: e

T21 **A CRITICAL APPRAISAL OF PROPOSED DSM-V PARAPHILIC DIAGNOSES**

Richard Krueger, MD, New York, NY
Frederick Berlin, MD, PhD, Baltimore, MD
Paul Fedoroff, MD, Ottawa, ON, Canada
Howard Zonana, MD, New Haven, CT
Michael First, MD, New York, NY

EDUCATIONAL OBJECTIVE
To inform participants of the proposed changes to paraphilic diagnosis in DSM-V, and of their forensic implications.

SUMMARY
Dr. Richard Krueger, a member of the American Psychiatric Association's Sexual Disorders Workgroup for DSM-V, and of the Paraphilias Subworkgroup, will present the proposed changes and alternatives for criteria for paraphilic diagnoses. Dr. Michael First, the editor of DSM-IV and DSM-IV-TR, will present his criticism of the process and substance of the DSM-V revisions to the paraphilias. Dr. Paul Fedoroff, Dr. Fred Berlin, and Dr. Howard Zonana will offer their criticisms, with particular attention to the forensic implications of the proposed diagnoses.

REFERENCES
Krueger RB, Kaplan MS: The paraphilic and hypersexual disorders: an overview. J Psychiatric Practice 7:391-403, 2001
Fedoroff JP: Sadism, sadomasochism, sex, and violence. Can J Psychiatry 10:637-46, 2008

SELF ASSESSMENT QUESTIONS
1. The proposed diagnosis of pedophilia in DSM-V:
a. is narrower than in DSM-IV-TR.
b. is broader than in DSM-IV-TR.
c. includes those with an interest in either pubescent or prepubescent children.
d. can be made for those who have used child pornography.
e. requires that an individual has actually abused a child.
f. a, c, and d are correct.
ANSWER: f

2. The proposed diagnosis of sexual sadism
a. has been eliminated from the official list of medical diagnoses in Sweden.
b. requires distress or impairment to be diagnosed.
c. is the same in the DSM as in the ICD (International Classification of Diseases).
d. is the most common diagnosis used in the commitment process for individuals under sexual predator laws in the United States.
e. in the United States has been diagnosed at least once in nonpsychiatric, nonforensic populations.
ANSWER: a

T22 **INDIANA V. EDWARDS: LIMITS ON RIGHTS TO SELF-REPRESENTATION**

Paul S. Appelbaum, MD, New York, NY
Richard Bonnie, LLB, (I) Charlottesville, VA
Erica Hashimoto, JD, (I) Athens, GA
Debra Pinals, MD, Boston, MA

EDUCATIONAL OBJECTIVE
To review the legal underpinnings of the right to self-representation, including the US Supreme Court's decision in Indiana v. Edwards; to present a major empirical study of self-representation; to consider how to assess capacity to act as one's own attorney; and to consider the broader legal implications of Edwards.

SUMMARY
Ahmad Edwards, arrested after wounding a bystander in the course of trying to steal a pair of shoes, made what seemed like a simple request: he wanted to represent himself at trial. But his desires were frustrated when an Indiana judge found Edwards competent to stand trial only if he were represented by an attorney, and not sufficiently competent to be able to represent himself. Edwards' appeal of that ruling, which led to last year's US Supreme Court decision in Indiana v. Edwards, raised profound questions about the dimensions of the right of self-representation for criminal defendants, the extent of which had never been precisely defined by the Court. This panel will consider the origins of the dispute in Indiana v. Edwards in prior decisions of the Court, and the justices' decision that self-representation could be denied to defendants incapable of representing themselves (Dr. Appelbaum); a major empirical study of self-representation, which was cited by the Court in its opinion (Mr. Hashimoto); the practical aspects of performing assessments for the capacity of self-representation, now required by Edwards (Dr. Pinals); and the broader legal implications of the new rule formulated by the Court (Mr. Bonnie).

REFERENCES
Appelbaum PS: "A fool for a client?" Mental illness and the right of self-representation. Psychiatric Services 59:1096-8, 2008
Hashimoto EJ: Defending the right of self-representation: an empirical look at the pro se felony defendant. North Carolina L Rev 85:423-87, 2007

SELF ASSESSMENT QUESTIONS
1. Prior to the ruling in Indiana v. Edwards, existing precedents suggested all of the following except:
a. Criminal defendants have the right to represent themselves at trial.
b. Once found competent to stand trial, defendants are presumed competent for all related tasks.
c. Defendants with severe mental illnesses can be denied the right to self-representation if incapable of exercising it.
d. No basic knowledge of courtroom procedure and relevant law is required before defendants act as their own attorneys.
ANSWER: c

2. Which of the following is correct?
a. Most defendants who want to represent themselves suffer from a mental illness.
b. Defendants' requests for self-representation are uncommon.
c. After Edwards, the standard for self-representation is whether the defendant can communicate coherently with the court or a jury.
d. Defendants who represent themselves are usually found guilty.
ANSWER: b

T23 A COLD SHOULDER: ICE AND DETAINEE PSYCHIATRIC SERVICES

Vasilis Pozios, MD, Ann Arbor, MI
Michael Harlow, MD, JD, Sacramento, CA
Praveen Kambam, MD, Los Angeles, CA
Eric Balaban, JD, (I) Washington, DC
Keenan Keller, JD, (I) Washington, DC

EDUCATIONAL OBJECTIVE
Examine forensic issues relevant to the psychiatric care of ICE detainees, including competency to stand trial, pharmacological treatment, and disposition. Review media reports, landmark legal cases, and legislation relevant to the psychiatric care of ICE detainees. Discuss the role for forensic psychiatrist-law enforcement officer cooperation in implementing mitigating interventions.

SUMMARY
U.S. Immigration and Customs Enforcement (ICE) is the primary law enforcement arm of the United States Department of Homeland Security (DHS). ICE operates detention centers throughout the United States that imprison illegal immigrants who are apprehended and placed into removal proceedings. About 31,000 noncitizens are held in immigration and detention on any given day, in over 200 detention centers, jails, and prisons nationwide. Due process concerns and questions regarding the adequacy of medical services at detention centers have plagued ICE. Thus far, over 80 detainees have died in ICE custody. The American Civil Liberties Union has filed federal lawsuits and called on Congress to investigate ICE's provision of basic medical care, including psychiatric care. The United States House Committee on the Judiciary has held oversight hearings examining issues related to immigration detainee health care. Legislation has been introduced in both the 110th and 111th Congresses to improve the medical care of detainees. A review of issues relevant to forensic psychiatry will be presented, from denial of forensic psychiatric interview in hearings, to prescription of

psychotropic medications. Senior counsel from both the ACLU and the House Committee on the Judiciary will offer their unique perspectives on this controversial issue.

REFERENCES

Lustig SL, Kia-Keating M, Knight WG, et al: Review of child and adolescent refugee mental health. J Am Acad Child Adolesc Psychiatry 43(1):24-36, 2004
Mares S, Jureidini J: Psychiatric status of asylum seeker families in immigration detention: clinical, administrative, and ethical issues. Aust NZ J Public Health 28(6):520-6, 2004

SELF ASSESSMENT QUESTIONS

1. In the U.S. during 2007, approximately how many mental health assessments were performed on alien detainees?
a. 10,000
b. 20,000
c. 30,000
d. 40,000
ANSWER: c

2. In which case did a U.S. Court of Appeals rule that an alien subject to deportation hearings could be deported, even if determined to be mentally incompetent?
a. Jaadan v. Gonzales
b. Mohamed v. TeBrake
c. Lopez v. Gonzales
d. Toledo-Flores v. U.S.
ANSWER: a

T24 **IN THE LION'S DEN: SURVIVING CROSS-EXAMINATION**

Roger Z. Samuel, MD, New York, NY
Henry Conroe, MD, Chicago, IL
Mark DeBofsky, JD, (I) Chicago, IL

EDUCATIONAL OBJECTIVE

This workshop will enhance the skills and competence of expert witnesses in dealing with examinations by attorneys in sworn testimony.

SUMMARY

The workshop will be presented by a disability attorney (Mr. DeBofsky) and two forensic psychiatrists (Drs. Samuel and Conroe). Mr. DeBofsky will provide an overview of direct and cross-examination. Then, vignettes of simulated courtroom testimony will be utilized in which Mr. DeBofsky will first examine one psychiatrist to demonstrate poor cross-examination performance. The audience will be asked to offer criticism and comments on the performance, following which, the vignette will be repeated to demonstrate a better performance by the second psychiatrist. The vignettes are expected to include: examination of the frequently retained expert positive and negative effects; examination of the expert who relies on multiple data points; dealing with being handed a new article on the stand; and testifying about medical certainty. After all the vignettes are done, Mr. DeBofsky will provide an attorney's perspective on expert testimony.

REFERENCES

Babitsky S, Mangraviti JJ: Cross-Examination: The Comprehensive Guide for Experts. Falmouth, MA: SEAK Inc., 2003
Brodsky S: The Expert Expert Witness: More Maxims and Guidelines for Testifying in Court. Washington, DC: American Psychological Association, 2003

SELF ASSESSMENT QUESTIONS

1. To be effective in front of the jury, experts should:
a. make a good first impression
b. maintain eye contact with the jury
c. use analogies
d. speak simply and directly
e. all of the above
ANSWER: e

2. Success during cross-examination is best enhanced by:
a. knowing the 'right' answer to all possible questions
b. depending on opposing attorney to correct errors on direct examination
c. preparation
d. all of the above
e. none of the above
ANSWER: c

T25 **FORENSIC CONSULTATION TO INPATIENT PSYCHIATRIC UNITS**

Rebecca Brendel, MD, JD, Boston, MA
Judith Edersheim, MD, JD, Boston, MA
Fabian Saleh, MD, Boston, MA
Ronald Schouten, MD, JD, Boston, MA

EDUCATIONAL OBJECTIVE
At the end of this workshop participants will be able to describe approaches to risk assessment and management of sexual and nonsexual aggressive inpatients, conceptualize and assess a patient's decision-making capacity and assess capacity and functional impairment in evaluations for guardianship.

SUMMARY
This workshop will provide participants with an informed overview of the essential clinical and legal issues involved in providing forensic consultation to inpatient psychiatric units. Workshop participants will come to appreciate the diverse frameworks through which efforts are made to understand and ultimately manage the risk of patients presenting with both sexual and nonsexual aggression. This includes an exploration of the legal, clinical, etiological, and relevant sub-group contexts within which these patients are frequently viewed, examined, and treated. We will set forth an integrated approach to risk management for these patients with an emphasis on reviewing the use and misuse of psychopharmacological treatments. Workshop participants will also learn how to conceptualize and assess a patient's decision-making capacity specifically as it relates to the patient's ability to consent to or refuse medical and psychiatric treatment. Conditions that may result in impaired medical decision making will be reviewed. Finally, participants will learn how to assess capacity and functional impairment in evaluations for guardianship. In keeping with the current trend in probate law, attention will also be given to how clinicians may fashion guardianship evaluations so that they result in limited, rather than full, guardianships that preserve some rights of incapacitated individuals where possible.

REFERENCES
Saleh FM, Fedoroff P, Ahmed AG, Pinals D: Treatment of violent behavior, in Psychiatry, 3rd Edition. Edited by Tasman A, Kay L, Lieberman J, First M, May M. Hoboken, NJ: John Wiley & Sons, Ltd, 2008, pp 2002-15
Brendel RW, Schouten RA: Legal concerns in psychosomatic medicine. Psychiatr Clin North Am 30(4): 663-76, 2007

SELF ASSESSMENT QUESTIONS
1. The Uniform Probate Code requires which of the following for Guardianship?
a. a psychiatric diagnosis
b. a finding of physical or mental incapacity
c. a finding of functional impairment in one or more domains
d. all of the above
e. b and c
ANSWER: e

2. Valid informed consent to medical treatment requires that the patient be able to:
a. express a choice
b. understand information presented
c. appreciate the significance of alternatives
d. reason logically about treatment options
e. all of the above
ANSWER: e

T26 THE NEUROSCIENTIFIC CHALLENGE TO CRIMINAL RESPONSIBILITY

Stephen J. Morse, JD, PhD, (I) Philadelphia, PA

EDUCATIONAL OBJECTIVE

To acquaint listeners to the challenges the new neuroscience presents to criminal responsibility.

SUMMARY

This address will argue that the new neuroscience presents two challenges to criminal responsibility. The first, the challenge from determinism, is familiar and has persuasive answers. The second, the challenge to the law's concept of the person, is more radical and could overturn traditional responsibility concepts, but this challenge fails at present on both conceptual and scientific grounds.

REFERENCES

Morse S: Brain overclaim syndrome and criminal responsibility: a diagnostic note. 3 Ohio St J Crim Law, 397, 441 (2006)
Morse S: Determinism and the death of folk psychology: two challenges to responsibility from neuroscience. 9 Minn JL Sci & Technology 1, 220 (2008)

SELF ASSESSMENT QUESTIONS

1. Why does neurodeterminism not pose a threat to traditional notions of criminal responsibility?
ANSWER: Neurodeteminism does not pose such a threat because all current conceptions of legal responsibility are consistent with the truth of determinism.

2. Does the new neuroscience pose a successful threat to criminal law's concept of the person and responsibility?
ANSWER: The new neuroscience does pose such a threat, but at present it is entirely unsuccessful on both conceptual and scientific grounds.

T27 SURVEY OF JUDGES – COMPETENCE TO REPRESENT ONESELF

James Knoll, IV, MD, Syracuse, NY
Cecilia Leonard, MD, Syracuse, NY
Bruce Way, MD, (I) Syracuse, NY

EDUCATIONAL OBJECTIVE

To learn about the Supreme Court ruling in Indiana v. Edwards (2008); review a survey of trial judges; discuss factors that would help judges determine the higher standard required for someone already deemed competent to stand trial to act as his own defense attorney.

SUMMARY

Dr. Knoll will speak about the implications of the ruling of the US Supreme Court in Indiana v Edwards (2008). The Court held: "The Constitution does not forbid States from insisting upon representation by counsel for those competent enough to stand trial but who suffer from severe mental illness to the point where they are not competent to conduct trial proceedings by themselves." The Court found that the Constitution permits a trial court to "insist upon representation by counsel for those competent enough to stand under Dusky but who still suffer from severe mental illness to the point where they are not competent to conduct trial procedure for themselves." Dr. Leonard will present the research which proposes to seek the input of trial judges in the development of a screening tool which would assist forensic psychiatrists in evaluating defendants for this higher capacity. The survey contains closed and open-ended questions which seek to clarify what weight a trial judge might give to various criteria that affect the defendant's capacity to conduct his/her own defense proceedings. This study could lead to improved assessment of compence to represent oneself (act as one's own attorney) as well as competence to stand trial.

REFERENCES

CHECK FIRST REFERENCE
Supreme Court of the United States Indiana v. Edwards No. 07–208. Argued March 26, 2008—Decided June 19, 2008 Cite as: 554 U. S. ____ (2008)
Hashimoto E: Defending the right to self representation: an empirical look at the pro se felony defendant. North Carolina L Rev, 85(2):423-87, 2007

SELF ASSESSMENT QUESTIONS

1. Does the US Constitution forbid States from insisting upon representation by counsel for those competent enough to stand trial but who suffer from severe mental illness to the point where they are competent to conduct trial proceedings by themselves?
ANSWER: No

2. Which of the following factors is not addressed in the Dusky standard for competence to stand trial?
a. rational understanding of the proceedings
b. factual understanding of the proceedings
c. ability to act as one's own defense attorney
d. that sufficient ability to consult with one's attorney
ANSWER: c

T28 **THIRD PARTY OBSERVERS OF FORENSIC EXAMINATIONS**

Timothy J. Michals, MD, Philadelphia, PA
Steven Samuel, PhD, (I) Phildelphia, PA

EDUCATIONAL OBJECTIVE
To understand research/clinical literature on the effects of third party observers of forensic psychiatric/neurologic examinations; to learn relevant ethical standards, case law, practice guidelines and professional policy statements regarding the presence of third party observers in psychiatric/neurologic examinations; and to develop a range of responses to requests for the presence of third party observers.

SUMMARY
Today's forensic psychiatrist/neurologist is presented with a complex menu of clinical responsibilities, including conducting independent forensic evaluations in civil and criminal matters. Of the many issues raised in their work, one which stands out for its ethical, legal and clinical complexities is whether, and under what circumstances, a third party observer should be permitted into the examination room. Third party observers could include attorneys, interpreters, family members, treating professionals, and other interested parties. Our presentation discusses results emerging from our ongoing nationwide research of forensic psychiatrist/ neurologists knowledge of, attitudes toward and responses to the presence of third party observers and how their perspectives on these factors forms a signature of their respective forensic practices.

REFERENCES
Michals TJ, Samuel S, Mandel S: Third party observers in neurologic forensic examinations. Practical Neurology 7(9):16-18, 2008
Simon R: "Three's a crowd": the presence of third parties in the forensic psychiatric examination. J Psy Law 27(3): 3-25, 1999

SELF ASSESSMENT QUESTIONS
1. Research consistently demonstrates that admitting a third party observer into a forensic psychiatric/neurologic examination has little, if any, impact on the results of standardized, objective assessment of patients.
ANSWER: false

2. Currently, most states' laws primarily favor excluding third parties into the examination room.
ANSWER: false

T29 **THE ELEPHANT IN COURT: TRANSFERENCE, LAWYERS, AND EXPERTS**

Caren Teitelbaum, MD, (I) New Haven, CT
Madelon Baranoski, PhD (I) New Haven, CT

EDUCATIONAL OBJECTIVE
Attendees will understand the trajectory of transference reactions in the attorney-expert witness relationship across levels of experience; consider the etiologies, content, and meanings of such reactions; and consider the implications of transference reactions on the work of the expert witness.

SUMMARY
Scholars, including Gutheil and Simon, have identified the importance of transference in expert witness testimony. Although forensic fellowship programs educate fellows in principles of evaluation and testimony, transference as a relevant factor in interviewing, consulting, and testifying is often ignored in the training of forensic experts. Yet, the nature of forensic psychiatry includes challenges of public scrutiny and challenges during testimony, particularly cross-examination. The stress of the courtroom for forensic experts and attorneys alike can evoke emotional reactions that affect performance and ultimately the case outcome. Terminology notwithstanding, awareness of transferential reactions can help the forensic psychiatrist improve practice and recognize sources of bias. This qualitative study explores awareness and understanding of transferential reactions for attorneys and forensic psychiatrists at various levels of experience. Through interviews of forensic fellows, law students, and forensic psychiatric experts and practicing attorneys, three areas of transference will be explored: the level of awareness and description of transferential

issues at different degrees of experience; individual reaction to testimony and trial experiences; and (for experts) the psychological and emotional mechanisms used to manage the stress of testimony and courtroom performance. The results of the study will be applied to recommendations for practice, teaching, and further research.

REFERENCES

Gutheil TG, Simon RI: Narcissistic dimensions of expert witness practice. J Am Acad Psychiatry Law 33:55-8, 2005
Sattar SP, Pinals DA, Gutheil TG: Countering countertransference, II: beyond evaluation to cross-examination. J Am Acad Psychiatry Law 32:148-54, 2004

SELF ASSESSMENT QUESTIONS

1. Transference reactions between attorneys and expert witnesses:
a. have been a focus of teaching in forensic psychiatry fellowships.
b. can occur in both the expert witness and the attorney.
c. are irrelevant to expert-witness testimony.
d. have been sufficiently explored in the literature.
ANSWER: b

2. Which of the following statements is false?
a. Transference is relevant to the forensic expert but not to the attorney.
b. Multiple types of transference reactions in the attorney-expert witness relationship exist
c. Transference reactions vary with level of training and experience
d. Understanding transference reactions may have important implications for interactions between the expert and the attorney's client.
ANSWER: a

T30 CHILD SEXUAL ABUSE ALLEGATIONS IN CUSTODY EVALUATIONS

Joseph N. Kenan, MD, Los Angeles, CA
Stephen Billick, MD, New York, NY
Dean De Crisce, MD, Jersey City, NJ
R. Gregg Dwyer, MD, EdD, Columbia, SC
Fabian Saleh, MD, Boston, MA
Christopher Thompson, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE

After attending this presentation, the attendees will understand concepts in the evaluation of sexual abuse allegations in custody evaluations. Attendees will have an understanding of recommendations that can be made in these very difficult cases.

SUMMARY

Different case examples will be presented that will teach how to perform a custody evaluation that involved sexual abuse allegations. All of the elements of the evaluation will be addressed, from document review, to primary and collateral interview. The standards for interviewing children making allegations will be presented. Special attention to controversial subjects will be addressed, such as the use of penile plethysmography; the topic of parental alienation; and the use of audio-taping forensic interviews. Custody recommendations will be outlined, including recommendations for when the sexual abuse occurred, and when a sexual abuse allegation was created by an alienating parent.

REFERENCES

American Academy of Child and Adolescents Psychiatry: Practice parameters for the forensic evaluation of children and adolescents who may have been sexually abused. J Am Acad Child Adolescent Psychiatry 36(3):432-42, 1997
Blanchard R, Klassen P, Dickey R, Kuban ME, Blak T: Sensitivity and specificity of the phallometric test for pedophilia in nonadmitting sex offenders. Psychol Assess 13(1):118-26, 2001

SELF ASSESSMENT QUESTIONS

1. What percentage of sexual abuse allegations, in custody evaluations are false?
a. approximately 10%
b. approximately 20%
c. approximately 30%
d. approximately 40%
e. approximately 50%
ANSWER: e

2. Are custody evaluators required to audio tape forensic examinations?
ANSWER: No, but some evaluators advocate that it should be required.

T31 **RESEARCH ON YOUNG-ONSET DEMENTIA AND FORENSIC IMPLICATIONS**

Brian Appleby, MD, (I) Baltimore, MD
Ryan Hall, MD, Lake Mary, FL

EDUCATIONAL OBJECTIVE
To educate forensic psychiatrists about the current definition, symptoms, treatments, and forensic implications (both criminal and civil) of young-onset dementia.

SUMMARY
The presentation of young-onset dementia (dementia before age 65) is a complicated issue for forensic psychiatrists due to heightened awareness of the condition by the public (see Alzheimer's Association's recent young-onset campaign) resulting in more claims of the condition in legal cases and the multitude of known etiologic mechanisms (e.g., genetics, trauma, frontotemporal lobar degeneration, and prion diseases) causing the condition which can make expertise difficult. The potential causes, prognosis, deficits, and symptom presentations often vary compared to traditional dementia presentations and are frequently more behavioral in nature (e.g., frontotemporal dementia). This workshop will review the differential diagnoses and causes of young-onset dementias, potential early indicators, historical data, risk factors, and prodromal states, and will review recently published research studies regarding young-onset dementias. In addition, challenges of conducting research on and caring for this patient population will also be discussed by Johns Hopkins researcher Brian Appleby MD who is currently engaged in several research studies regarding these conditions. Forensic aspects of these conditions will be discussed and highlighted with a case presentation.

REFERENCES
Appleby BS, Appleby KK, Crain BJ, Onyike CU, Wallin MT, Rabins PV: Characteristics of established and proposed sporadic Creutzfeldt-Jakob disease variants. Arch Neurol 66(2):208-15, 2009
Appleby BS, Appleby KK, Rabins PV: Does the presentation of Creutzfeldt-Jakob disease vary by age or presumed etiology? A meta-analysis of the past 10 years. J Neuropsychiatry Clin Neurosci 19(4):428-35, 2007

SELF ASSESSMENT QUESTIONS
1. What is the most common cause of early onset dementia?
a. Alzheimer's
b. Tertiary syphilis
c. Alcohol related dementia
d. Huntington's Chorea
e. Pugilistic dementia
ANSWER: a

2. What is the average life expectancy for an individual diagnosed with early onset dementia?
a. same as for an individual diagnosed with late onset dementia
b. longer than for an individual with late onset dementia
c. shorter than an individual diagnosed with late onset dementia
d. varies depending on the etiologic cause of the dementia
ANSWER: d

T32 **A REVOLVING DOOR: CRIMINAL BEHAVIOR IN PRISON AND THE STREET**

Michael Champion, MD, Santa Fe, NM
Don Gill, (I) Washington, DC
Sally Johnson, MD, Chapel Hill, NC
Donald Lyddane, BS, (I) Washington, DC

EDUCATIONAL OBJECTIVE
Participants will learn about the spectrum of criminal behavior in prison, its nexus with organized crime in the community, and its impact on correctional psychiatry. Participants will become familiar with the concepts of the gang mentality, anticipated behavior, and radicalization from both a law enforcement and correctional psychiatry perspective.

SUMMARY
A sizable proportion of inmates in today's prisons have been there before. High recidivism rates create a revolving door effect and pose enormous challenges for correctional systems and communities waiting to receive offenders upon effect. Criminal behavior leading to incarceration often does not stop at the prison gate and is frequently

linked with criminal activity in the community. The panel will examine the spectrum of criminal behavior commonly seen in correctional settings, its nexus with organized crime groups in the community, and its collateral impact on the practice of correctional psychiatry. Don Gill, an officer in the gang section of the Federal Bureau of Prison's Intelligence Division, will discuss organized crime activity within correctional facilities and the mentality and behavior of gang members in prison. Don Lyddane, an Intelligence Analyst with the Gang Unit of the FBI and Program Manager of their National Gang Strategy will discuss gang activities in the community and illustrate the continuum from prison to streets with the use of case examples. Sally Johnson, MD will discuss the growing problem of radicalization and recruitment of inmates into extremist groups including terrorist organizations. Michael Champion, MD will discuss the impact of criminal behavior in prisons on correctional psychiatry.

REFERENCES

Lyddane D: Understanding gangs and gang mentality: acquiring evidence of the gang conspiracy. U S Attorneys' Bull 54:1-14, May 2006, http://www.usdoj.gov/usao/eousa/foia_reading_room/usab5403.pdf
Cilluffo F, Cardash S, and Whitehead A: Radicalization: behind bars and beyond borders. Brown J World Affairs 13:113-22, 2007, http://www.gwumc.edu/hspi/pubs/Brown%20Journal.pdf

SELF ASSESSMENT QUESTIONS

1. An effective approach to combat radicalization in prisons includes:
a. denying extremists access to prisons (staff members and volunteers).
b. effectively reintegrating former inmates into society.
c. training prison staff to recognize extremist material.
d. all of the above.
ANSWER: d

2. Which of the following is a motivational factor in joining a gang?
a. to have protection in prison
b. to join an extended family
c. to be associated with a powerful group identity
d. all of the above
ANSWER: d

T33 THE DETECTION OF MALINGERED MENTAL ILLNESS

Phillip J. Resnick, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

Be more skillful in detecting deception and malingering especially in defendants who plead not guilty by reason of insanity and litigants who allege post traumatic stress disorder.

SUMMARY

This course is designed to give psychiatrists practical advice about the detection of malingering and lying. Faculty will summarize recent research and describe approaches to suspected malingering in criminal defendants. Characteristics of true hallucinations will be contrasted with simulated hallucinations. Dr. Resnick will discuss faked amnesia, mental retardation, depression, and the reluctance of psychiatrists to diagnose malingering. The limitations of the clinical interview, psychological testing, hypnosis, and the sodium-amytal interview in detecting malingering will be covered. The course will delineate 12 clues to malingered psychosis, and five signs of malingered insanity defenses. Videotapes of four defendants describing hallucinations will enable participants to assess their skills in distinguishing between true and feigned mental disease. Participants will also have a written exercise to assess a plaintiff alleging PTSD. Handouts will cover the so-called "compensation neurosis," malingered mutism, and feigned post-traumatic stress disorder in combat veterans.

REFERENCES

Resnick PJ, Knoll JL: Malingered psychosis, in Clinical Assessment of Malingering and Deception, 3rd Edition. Edited by Rogers R. New York: Guilford Publications, 2008, pp 51-68
Resnick PJ, West S, Payne JW: Malingering of posttraumatic disorders, in Clinical Assessment of Malingering and Deception, 3rd Edition. Edited by Rogers R. New York: Guilford Publications, 2008, pp 109-27

SELF ASSESSMENT QUESTIONS

1. Choose the incorrect statement:
a. Dilation of pupils is a clue to lying.
b. Extroverts are better liars than introverts.
c. Liars who exaggerate are more likely to be believed.
d. No one can look you in the face and tell a lie.
ANSWER: d

2. Which symptom are malingerers least likely to fake?
a. cognitive deficit
b. delusions
c. hallucinations
d. perseveration
ANSWER: d

T34 FORENSIC DILEMMAS IN INTERNET CHILD PORNOGRAPHY

John R. Lion, MD, Baltimore, MD

EDUCATIONAL OBJECTIVE

To acquaint the clinician with the complexities of evaluating defendants charged with child pornography crimes.

SUMMARY

Child pornography is vigorously prosecuted, and defendants use intense denial in admitting to the various paraphilias suggested by the imagery eventually found on their computers. The extensive number of pictures, and range of sexual deviations can be highly repulsive, and not necessarily indicative of the defendant's sexual preferences. Evidentiary data is often difficult to access as it is protected by laws making it a crime to own one image of child pornography. Mitigating factors are highly limited, and testimony concerning sexual dangerousness must be cautiously made.

REFERENCES

Cooper A: Sex and the Internet. New York: Brunner-Routledge, 2002
Kingston D, Fedoroff P, Firestone P, et al: Pornography use and sexual aggression: the impact of frequency and type of pornography use on recidivism among sexual offenders. Aggressive Behav 34:341-51, 2009

SELF ASSESSMENT QUESTIONS

1. Which of the following statements is true?
a. Child pornograpy defendants admit their crimes.
b. The pathological range of imagery reflects paraphilic interests.
c. Intentional downloading is the rule.
d. Images of very young children can be in a computer collection.
e. a, b, and d
ANSWER: e

2. Assessing defendants is made difficult by which of the following?
a. countertransference sentiments
b. data difficult to access
c. zealous prosecutors
d. the plethora of images found
e. all of the above
ANSWER: e

T35 COVERT EMERGENT MEDICATIONS: EVER ETHICALLY PERMISSIBLE?

Erick Hung, MD, San Francisco, CA
Renée Binder, MD, San Francisco, CA
Dale McNiel, PhD, (I) San Francisco, CA

EDUCATIONAL OBJECTIVE

The learner will be able to describe the standard of care in a psychiatric emergency, discuss the prevalence of covert medication administration, discuss the legal, ethical, and cultural issues with respect to this practice, discuss consumer preferences about involuntary treatment, and describe how psychiatric advance directives may impact this practice.

SUMMARY
Covert administration of medications to patients, defined as the administration of medications to a patient without his knowledge, is a practice surrounded by clinical, legal, ethical, and cultural controversy. Most psychiatrists would advocate that the practice of covert administration of medications in emergency psychiatry is not clinically, ethically, or legally acceptable. This article explores whether or not there may be ethical exceptions to this stance. We first review the standard of emergency psychiatric care. Although we could identify no published empirical studies of covert administration of medications in emergency departments, we review the prevalence of this practice in other clinical settings. While the courts have not ruled with respect to covert medication administration, we discuss the evolving legal landscape of informed consent and the right to refuse treatment. We discuss ethical dilemmas involving this practice including the tensions between autonomy, beneficence, and duty to protect. We explore how differences between cultures regarding the value placed on individual versus family autonomy may affect perspectives with regard to this practice. We investigate how consumers view this practice and their preferences of treatment options during a psychiatric emergency. Lastly, we discuss psychiatric advance directives and explore how these contracts may impact this debate.

REFERENCES
Lewin M, et al: An unusual case of subterfuge in the emergency department: covert administration of antipsychotic and anxiolytic medications to control an agitated patient. Ann Emerg Med 47(1):75-8, 2005
Stroup S, et al: Concealed medicines for people with schizophrenia: a U.S. perspective. Schizophrenia Bull 28(3):537-42, 2002

SELF ASSESSMENT QUESTIONS
1. What country has federal legislation that specifically addresses the administration of covert medications?
a. United States of America
b. United Kingdom
c. France
d. Japan
e. Canada
ANSWER: b

2. What is not an argument for the administration of covert medications in psychiatric emergencies?
a. safety of patients and the emergency staff
b. clinical indications for this practice
c. patient and family preferences for this practice
d. differences between an emergency setting and an outpatient one
e. due process rights are not violated with this practice
ANSWER: e

T36 **WHAT CAN WE LEARN FROM RECENT ANTIPSYCHOTIC DRUG LITIGATION?**

Douglas Mossman, MD, Cincinnati, OH
Jill Steinberg, JD, (I) Cincinnati, OH

EDUCATIONAL OBJECTIVE
Participants will report familiarity with recent scientific findings comparing older antipsychotic drugs to second-generation antipsychotics (SGAs), results of litigation on SGAs, potential claims against drug manufacturers and factors that have contributed to psychiatrists' enthusiastic use of SGAs in treating severe mental illnesses.

SUMMARY
Drug ineffectiveness, hidden drug hazards, and advertising violations have led to drug recalls and lawsuits against pharmaceutical companies in recent years. In early 2009, Eli Lilly & Company agreed to a $1.4 billion settlement — including payment of the largest individual corporate criminal fine in U.S. history — related to improper promotion of olanzapine. But improper promotion is not the sole reason why olanzapine and other "second-generation" antipsychotic (SGA) drugs have become such popular medications. The processes that make certain drugs successful involve medication choices, physicians' judgments, and how drugs are paid for, and litigation will not solve problems with these processes, which contribute to suboptimal use of healthcare dollars. This article reviews the lawsuits brought against Lilly and describes marketing techniques that pharmaceutical companies use to get physicians to prescribe drugs. We also review the special features of SGAs that have made them hugely successful and discuss the ways that drug companies dominate information distribution about their products. Independent comparative effectiveness studies and incentives to generate and disclose more information about flaws in drugs might produce better medications, better medical decisions, and better patient safety.

REFERENCES
Lieberman JA, Stroup TS, McEvoy JP, et al: Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. New Engl J Med 353:1209-23, 2005
U.S. Department of Justice: Eli Lilly and Company agrees to pay $1.415 billion to resolve allegations of off-label promotion of Zyprexa (Jan. 15, 2009) (press release available at http://www.usdoj.gov/opa/pr/2009/January/09-civ-038.html)

SELF ASSESSMENT QUESTIONS
1. State litigation against drug manufacturers has asserted claims for:
a. design defects
b. inadequate warnings
c. fraudulent misrepresentation
d. violations of unfair trade practices
e. all the above
ANSWER: e

2. Recent studies suggest that:
a. Physicians' treatment selections are not influenced by pharmaceutical advertising.
b. Medical students believe they are entitled to gifts from drugs companies.
c. Second-generation antipsychotic drugs are clearly superior to older drugs.
d. High-quality medical journals do not unwittingly promote pharmaceuticals.
e. None of the above.
ANSWER: b

T37 TREATMENT OF METABOLIC SYNDROME AT A FORENSIC HOSPITAL

Nadar Sharifi, MD, (I) Port Coquitlam, BC, Canada

EDUCATIONAL OBJECTIVE
To discuss evidence-based strategies for the prevention and treatment of obesity and metabolic syndrome in a forensic psychiatric population, provide design and implementation details about and present results of ProMotion, an obesity and metabolic syndrome health and wellness initiative in a forensic psychiatric hospital.

SUMMARY
Schizophrenic patients are at elevated risk of becoming obese and of developing metabolic syndrome due in part to side effects of second generation antipsychotics. These patients are also at greater risk of developing CVD and type 2 DM than the general population. At the Forensic Psychiatric Hospital in British Columbia, Canada, a new health and wellness initiative called ProMotion addresses the issue of weight gain in this 190-bed inpatient forensic facility. ProMotion endeavors to prevent and treat weight gain through a combination of diet, exercise, and medical management. One goal is to encourage healthier lifestyle choices for forensic psychiatric inpatients. Facility wide dietary changes include adherence to the Canada Food Guide and the National Cholesterol Education Program. Patients undergo baseline and periodic biomedical assessments and those at risk of metabolic syndrome are referred to a supervised exercise and lifestyle counseling program called LEAP. Medical management includes metabolic rounds, exercise prescriptions, calorie-reduced diets, and pharmacological interventions. Results to date indicate overweight and obesity prevalence of 83.5% and metabolic syndrome at 45%. At the one year mark, HDL increased from 37.6mg/dL to 41.0mg/dL in the LEAP subsample, and triglycerides dropped from 211.7mg/dL to 199.3mg/dL in the general sample. Further results will be presented.

REFERENCES
Lau DC, et al: 2006 Canadian clinical practice guidelines on the management and prevention of obesity in adults and children [summary]. CMAJ 176(8): S1-13, 2007
Usher K, Foster K, Park T: The metabolic syndrome and schizophrenia: the latest evidence and nursing guidelines for management. J Psychiatr Ment Health Nurs 13(6):730-4, 2006

SELF ASSESSMENT QUESTIONS
1. What are the five criteria used to diagnose metabolic syndrome?
ANSWER: Increased waist circumference, elevated triglycerides, reduced HDL cholesterol, elevated blood pressure, and elevated fasting glucose.

2. What are the six steps recommended to prevent metabolic syndrome?
ANSWER: Increase activity level, improve health through better exercise, lose weight, quit smoking, reduce stress levels, take prescribed medications.

T38 **MEDICAL DECISIONAL CAPACITY ASSESSMENT: ARE THERE STANDARDS?**

Ramaswamy Viswanathan, MD, Brooklyn, NY
Paul Appelbaum, MD, New York, NY
Rebecca Brendel, MD, JD, Boston, MA
Carolina Klein, MD, (I) Wahington, DC
Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

To clarify attendees' thinking about some complexities and practical difficulties in decisional capacity assessments in the medical setting, with a view to improving clinical practice and teaching others, and to identify topics that need further study.

SUMMARY

Principles developed for an adversarial legal system can create problems in clinical medicine when conflicts are between a beneficence-oriented physician, who is actually trying to help, and a patient whose thinking processes are influenced by an illness and associated stressors. Setting the bar too high for proving decisional impairment has the potential to harm many patients unintentionally. What are the ethical issues in a consulting psychiatrist going beyond capacity assessment and engaging in interventions to change the patient 's mind? Clinical practices pertaining to capacity assessments vary widely among consulting psychiatrists, and among other physicians. In places with multi-ethnic patient populations, reasonable person standards can vary widely. How much weight should be given to "emotional denial" in capacity assessments? Are phobias or substance dependence grounds for a finding of decisional capacity impairment? If not, why not? What are the implications of clinicians' implementing treatment decisions based on the consulting psychiatrist 's opinion, without going through the judicial system? Through case examples and panel and audience discussions this workshop will attempt to clarify our thinking about these issues, and suggest ideas for future educational, legal and systems improvements and study.

REFERENCES

Ganzini L, Volicer L, Nelson W, Derse A: Pitfalls in assessment of decision-making capacity. Psychosomatics 44:237-43, 2003
Appelbaum PS: Assessment of patients' competence to consent to treatment. N Engl J Med 357:1834-40, 2007

SELF ASSESSMENT QUESTIONS

1. The most common important misconception among physicians regarding mental competence is:
a. The doctor can override the family's wishes.
b. Not appreciating that the assessment of decisional capacity is decision-specific.
c. The doctor can sign as a witness for his/her patient's signature.
d. One should always go to court to assess competency.
ANSWER: b

2. In a majority of decisional capacity assessments in C-L psychiatry:
a. The patient is found to have decisional capacity.
b. The issue is put to court.
c. The family makes the decision.
d. There is a prior history of mental illness.
ANSWER: a

T39 **DISSOCIATIVE IDENTITY DISORDER & THE LAW: DISEASE OR DRAMA?**

Jessica Ferranti, MD, Sacramento, CA
Keelin Garvey, MD, Providence, RI
Andrew Nanton, MD, Mebane, NC
Charles Scott, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

The audience participant will understand the evaluation of Dissociative Identity Disorder (DID) as a diagnosis, theories of causation, relevant tools to evaluate dissociation, key issues related to the forensic assessment of alleged altered states, and the use of DID in criminal litigation with related Daubert challenges.

SUMMARY
Significant controversy remains regarding the validity of DID as a legitimate mental disorder and its use in legal proceedings. Dr. Jessica Ferranti will trace the evolution of DID as a diagnosis from the early work of Pierre Janet up to the most recent proposed continued inclusion in the DSM-V. Dr. Andrew Nanton will review the traumagenic and iatrogenic theories of causation and supportive evidence for each theory. Dr. Nanton will focus particular attention on memories of childhood sexual and ritual satanic abuse reported by adults claiming DID. Dr. Keelin Garvey will outline current criteria for DID. Tools to assess alleged dissociation will be highlighted to include the Dissociative Disorder Interview Schedule (DDIS), the Structured Clinical Interview for DSM-IV Dissociative Disorders, and the Dissociative Experiences Scale (DES). The evaluation of potentially malingered altered states with a discussion of famous criminal cases involving malingered DID will be provided. Dr. Charles Scott will provide a review and updates of the use of DID in criminal law to including three approaches: the Alter Approach; the Unified Approach; and the Host Approach. Daubert concerns and potential challenges to DID will be highlighted. Common cross examination questions for the forensic evaluator testifying regarding DID will be presented.

REFERENCES
Piper A, Merskey H: The persistence of folly: critical examination of dissociative identity disorder, Part II. The defense and decline of multiple personality disorder. Can J Psychiatry 49:678-83, 2004
Saks ER: Does multiple personality disorder exist? The beliefs, the data, and the law. Int J Law and Psychiatry 17:28-43, 1994

SELF ASSESSMENT QUESTIONS
1. The reported prevalence of DID in psychiatric patients ranges from?
a. 0.2-0.5%
b. 1-7%
c. 10-12%
d. 15-20%
ANSWER: b

2. Which of the following is true in regard to the "Unified Approach" analyzing DID in legal proceedings?
a. Acknowledges alternate personalities but does not recognize them as legal entities.
b. Requires a determination if the host personality was aware of the crime, and if so, able to intervene.
c. Requires an identification of the criminal personality and an assessment of his or her state of mind at the time of the offense.
d. None of the above.
ANSWER: a

T40 **PEDOPHILIA: INTRACTABLE AND UNTREATABLE?**

Callum C. Ross, MBChB, Berks, United Kingdom
Kevin Cleary, MB, (I) London, England
Fintan Larkin, MB, (I) Berks, United Kingdom

EDUCATIONAL OBJECTIVE
This debate will feature lively and informed debate from UK speakers on the current treatment opportunities that exist in the UK for pedophilia. Those attending will gain an insight into UK government research data as well as they will learn of the possible limitations of a CBT-based relapse prevention approach.

SUMMARY
Treating pedophilia is complex. Most intervention approaches are cognitive-behavioural in type. Research from the UK has found that 10% of a sample of male offenders who were classified as "benefiting from treatment" (where treatment is psychological) were reconvicted in a six-year, follow-up period, compared with 23% of men who were classified as "not having responded to treatment." However, the question of whether a CBT relapse-prevention approach can ever provide a safe enough treatment model is debatable, and there is RCT evidence that relapse prevention does not assist incarcerated pedophiles. This debate will focus on the effectiveness of CBT and other available treatments. The full motion is: This House believes that pedophilia is an intractable sexual orientation and entirely unresponsive to treatment.

REFERENCES
Marques JK, Day DM, Nelson C, West MA: Effects of cognitive-behavioral treatment on sex offender recidivism. Crim Justice Behav 21:28-53, 1994
Beech A, Erikson M, Friendship C, Ditchfield J: A six-year follow-up of men going through probation-based treatment programmes. Home Office Research Findings #144. London: Home Office, 2001

SELF ASSESSMENT QUESTIONS
1. What percentage of child molesters target children that are known to them?
a. approximately 50%
b. approximately 60%
c. approximately 70%
d. approximately 80%
ANSWER: d

2. Official statistics record that females are much less likely than males to sexually abuse children. In 1986, Finkelhor suggested that the true percentage for females abusing children was five percent for girl victims. What was the figure for boy victims?
a. 5%
b. 10%
c. 15%
d. 20%
e. 25%
ANSWER: d

T41 THE TRIAL OF JOHN W. HINCKLEY JR.: A RETROSPECTIVE

Alan W. Newman, MD, Washington, DC
Park E. Deitz, MD, MPH, PhD, Newport Beach, CA
William T. Carpenter, Jr., MD (I) Baltimore, MD
Roger M. Adelman, Esq., (I) Washington, DC
Robert T.M. Phillips, MD, PhD, Annapolis, MD

EDUCATIONAL OBJECTIVE
To educate the audience about the significance and issues during the trial of John Hinckley and discuss the impact of the verdict of the case on the insanity defense and the disposition of insanity acquittees.

SUMMARY
The shooting of President Ronald Reagan and others by John W. Hinckley, Jr. in 1981 remains one of the most important events in the modern history of forensic psychiatry. The public and political outcry over Hinckley's verdict of not guilty by reason of insanity in 1982 had a major influence on the perception of the justice system and the field of psychiatry. This panel gathers a number of figures from Hinckley's past and present to discuss aspects of the case. Dr. Alan Newman will introduce the audience to the public facts of the case, including Hinckley's background and behavior leading up to the assassination attempt, as well as the effect of the verdict on legal standards related to the insanity defense and the disposition of insanity acquittees. Dr. Park Dietz and Dr. William Carpenter will discuss their respective roles and recollections as prosecution and defense experts during the trial. Roger Adelman will discuss his role and recollections as the senior government prosecutor in the trial. Finally, Dr. Robert Phillips will discuss Hinckley's current legal status and the barriers to discharge facing high-profile insanity acquittees.

REFERENCES
Bonnie R, Jefferies J, Low P: A Case Study in the Insanity Defense: The Trial of John W. Hinckley, Jr. New York: Foundation Press, 2000
Phillips RTM: Assessing presidential stalkers and assassins. J Am Acad Psychiatry Law 34:154-64, 2006

SELF ASSESSMENT QUESTIONS

1. What insanity standard best describes the legal standard that was used during the Hinckley trial?
a. M'Naughten Test
b. ALI Model Penal Code standard
c. Durham Rule (product test)
d. Guilty but mentally ill
ANSWER: b

2. Legislative actions taken by various states concerning the insanity defense following the Hinckley verdict included which of the following?
a. elimination of volitional prong.
b. burden of proof placed clearly on defendant.
c. establishment of Guilty but Mentally Ill verdicts.
d. elimination of the insanity defense.
e. all of the above.
ANSWER: e

FRIDAY, OCTOBER 30, 2009

POSTER SESSION B — 7:15 AM – 8:00 AM/ 9:30 AM – 10:15 AM — **HARBORSIDE FOYER**

F1 ***Implementation and Benefits of Telecourt in Missouri***
Ben W. Holt, MD, Athens GA
James Hoerchler, MA, MBA (I) St. Louis, MO
William Newman, MD, St. Louis, MO
Melissa Swallow Harbit, MD, St. Louis, MO

F2 ***Systematic Review of Interventions for Rape Related PTSD***
Cheryl Regehr, PhD, (I) Toronto, ON, Canada
Ramona Alaggia, PhD, (I) Toronto, ON, Canada
Michael Saini, PhD, (I) Toronto, ON, Canada

F3 ***Womb Raiders: Fetal Abduction by Cesarean Section***
Brett DiGiovanna, MD, Pittsburgh, PA
Muralidhar Kannan, MD, (I) Pittsburgh, PA
Christine Martone, MD, Pittsburgh, PA
Layla Soliman, MD, (I) Pittsburgh, PA
Gayle Strandberg, MD, Pittsburgh, PA

F4 ***Jail Diverted Patients on a Civil City Psychiatric Unit***
Katya Frischer, MD, JD, New York, NY
Ali Khadivi, PhD, (I) Bronx, NY
Karen Rosenbaum, MD, New York, NY
Merrill Rotter, MD, White Plains, NY
Sonia Shah, MD, (I) Bronx, NY
Lizicia Troneci, MD, Floral Park, NY

F5 ***Case Law of Restraint and Seclusion in Psychiatric Hospitals***
Keelin A. Garvey, MD, Providence, RI
Brian Daly, MD, Warwick, RI
Marilyn Price, MD, CM, Boston, MA
Patricia Recupero, JD, MD, Providence, RI
Sarah Xavier, DO, Warwick, RI

F6 ***Criminal Charges and Permanently Incompetent Defendants***
Douglas Morris, MD, Indianapolis, IN

F7 ***Correctional Group-Facilitated Functional Analysis***
Robert Trestman, PhD, MD, Farmington, CT
Edward Keeney, MS, MSW, (I) Farmington, CT
Susan Sampl, PhD, (I) Farmington, CT
Sara Wakai, PhD, (I) Farmington, CT

F8 ***The Life and Crimes of Serial Killer Goyo Cardenas***
J.Arturo Silva, MD, San Jose, CA

F9 ***Risk Assessment in Youth***
Muniza Shah, MD, Vancouver, BC, Canada
Johann Brink, MB,ChB, BA, Vancouver, BC, Canada
Sarah Desmarai, PhD, (I) Vancouver, BC, Canada
Tonia Nicholls, PhD, (I) Vancouver, BC, Canada
Jodi Viljoen, PhD, (I) Burnaby, BC, Canada

F10 ***fMRI of Deception in a Poker Paradigm vs Human and Computer***
Daniel Bowling, JD, (I) Durham, NC
R. McKell Carter, PhD, (I) Durham, NC
Scott Huettel, PhD, (I) Durham, NC
Andrew Nanton, MD, Durham, NC

F11 ***PTSD and Borderline Personality in Incarcerated Offenders***

Sandra K. Antoniak, MD, Sioux Falls SD
Donald Black, MD, (I) Iowa City, IA
Tracy Gunter, MD, St. Louis, MO
Peggy Loveless, PhD, (I) Iowa City, IA
Bruce Sieleni, MD, (I) Coralville, IA

F12 ***Sexual Homicide: A Review of the Literature***

Samuel Leistedt, MD, Boston, MA
Christopher Myers, MD, Boston, MA
Fabian Saleh, MD, Boston, MA

F13 ***Clinical and Forensic Aspects of Pathological Gambling***

Roman Gleyzer, MD, Seattle, WA
Alexander Bukhanovski, MD, PhD, (I) Rostov-on-Don, Russia
Viktor Soldatkin, MD, PhD, (I) Rostov-on-Don, Russia

F14 ***Jackson Then and Now: The Man and the Landmark Case***

George Parker, MD, Indianapolis, IN

F15 ***Legal Implications of Buprenorphine-Naloxone Treatment***

Nalan Ward, MD, (I) Boston, MA
Cally M. Woodard, MSN, (I) Ann Arbor, MI

F16 ***Forensic Sabbatical: Honing Skills***

Carl B. Greiner, MD, Omaha, NE

F17 ***Physicians in Training Referred for Psychiatric Evaluation***

Gabrielle S. Hobday, MD, (I) Malden, MA
Glen Gabbard, MD, (I) Houston, TX

F18 ***HIV/AIDS, Addiction and Ethical and Legal Dilemmas***

Lauren Carter, (I) Boston, MA
Albert Grudzinskas, Jr., PhD, (I) Worcester, MA
Fabian Saleh, MD, Boston, MA

F19 ***CCTV, Surveillance and Offending***

Fin Larkin, MBBCh, (I) Berkshire, United Kingdom

F20 ***Sexual Orientation: Should it Affect Child Custody Rulings?***

Jesse A. Raley, MD, (I) Columbia, SC
Kristin Remke Clary, DO, (I) Columbia, SC

F21 ***Prostitution and Substance Use: Prevalence & Treatment***

Fabian Saleh, MD, Boston, MA
Georgia Stathopoulou, PhD, (I) Boston, MA
Nalan Ward, MD, (I) Boston, MA

F22 ***Sexual Homicide: A Review of the Literature***

Samuel Leistedt, MD, Boston, MA
Christopher Myers, MD, Boston, MA
Fabian Saleh, MD, Boston, MA

PANEL 8:00 AM - 10:00 AM **HARBORSIDE A/B**

F23 ***Subtly Suicidal: Difficult Cases in Suicide Litigation***

Thomas Gutheil, MD, Boston, MA
Jeffrey Janofsky, MD, Baltimore, MD
Phillip Resnick, MD, Cleveland, OH
Robert Simon, MD, Potomac, MD
Skip Simpson, JD, (I) Frisco, TX

PAPER SESSION #2 8:00 AM - 10:00 AM **ESSEX**

F24 ***Current Status of the Duty to Protect***

Matthew Soulier, MD. Sacramento, CA
James C. Beck, MD, PhD, Boston, MA
Andrea Maislen, JD, (I) Summerville, MA

F25 ***The Role of Mental Health Professionals in Political Asylum***

Susan Meffert, MD, MPH, (I) San Francisco, CA
Renée Binder, MD, San Francisco, CA
Dale McNiel, PhD, (I) San Francisco, CA
Karen Musalo, JD, (I) San Francisco, CA

F26 ***Does the Law Recognize a Specific Competence to Divorce?***

Douglas Mossman, MD, Cincinnati, OH
Amanda Shoemaker, JD, (I) Dublin, OH

F27 ***The Evolving Role of Forensic Psychiatrists***

Muniza Shah, MD, Vancouver, BC, Canada

PANEL — 8:00 AM - 10:00 AM — **HARBORSIDE E**

F28 ***Adjudicative Competencies after Edwards and Panetti (Advanced)***

Alan Felthous, MD, St. Louis, MO
Stephen Morse, JD, PhD, (I) Philadelphia, PA
Michael Perlin, JD, (I) New York, NY
Christopher Slobogin, JD, LLM, (I) Nashville, TN

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

F29 ***Comprehensive Risk Assessment of Children and Youth***

Karen Brody, MD, Stamford, CT
Susan Parke, MD, New Haven , CT
Janet Williams, MD, (I) Hartford, CT
Madelon Baranoski, PhD, (I) New Haven , CT

WORKSHOP — 8:00 AM - 10:00 AM — **LAUREL**

F30 ***Ethical Dilemas in Forensic Psychiatry***
Ethics Committee

Philip Candilis, MD, Arlington, MA
Charles Dike, MD, MPH, New Haven, CT
Patricia Recupero, MD, JD, Providence, RI
Howard Zonana, MD, New Haven, CT

COFFEE BREAK — **10:00 AM - 10:15 AM** — **HARBORSIDE FOYER**

WORKSHOP — 10:15 AM - 12:00 PM — **HARBORSIDE E**

F31 ***Technological Innovations in Forensic Education***

Alan Newman, MD, Washington, DC
Debra Pinals, MD, Boston, MA
Charles Scott, MD, Sacramento, CA
Cheryl Wills, MD, Cleveland, OH

RESEARCH IN PROGRESS #2 — 10:15 AM - 12:00 PM — **ESSEX**

F32 ***Assessment of A Dynamic Risk Factor Scale***

Caroline J. Easton, PhD, (I) New Haven CT
Alec Buchanan, MD, PhD, New Haven, CT

F33 ***Functional Risk Assessment: Moving Forward***

Michael Norko, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Michael B. Greenspan, MD, New Haven, CT

WORKSHOP — 10:15 AM - 12:00 PM — **LAUREL**

F34 ***Ask the Experts***
Private Practice Committee

Carla Rodgers, MD, Wynnewood, PA
Brian Crowley, MD, Washington, DC
Linda Francis, MD, Wilmington, NC
Robert Granacher, MD, Lexington, KY
Trent Holmberg, MD, Salt Lake City, UT

PANEL — 10:15 AM - 12:00 PM — **HARBORSIDE D**

F35 Another Road to Perdition: Internet Child Porn Evaluations

Howard Zonana, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Paul Thomas, JD, (I) New Haven , CT
Josephine Buchanan, BA, (I) New Haven , CT

AUDIOVISUAL SESSION — 10:15 AM - 12:00 PM — **HARBORSIDE A/B**

F36 Assessment of Custodial Confessions
Peer Review Committee (For AAPL Members Only)

David Rosmarin, MD, Boston, MA
Bernice Kelly, PsyD, (I) Boston, MA

LUNCH (TICKET REQUIRED) — 12 NOON – 2:00 PM — **HARBORSIDE C**

F37 Mental Health Advocacy, Legislation, and Reform

Congressman Patrick J. Kennedy (I) Washington, DC

PAPER SESSION #3 — 2:15 PM - 4:00 PM — **ESSEX**

F38 Traumatic Brain Injury and Violent Crime: A Chart Review

Matthew J. Neltner, MD, (I) Lexington, KY
Timothy Allen, MD, Lexington, KY
Tyler Jones, MD, Odenton, MD

F39 Assessment of Psychopathy in Juvenile Parricide

Eleanor Justen Vo, MD, (I) Piscataway, NJ
Wade Myers, MD, Tampa, FL

F40 Tobacco, a Major Challenge to Estelle v. Gamble

Sheldon Cohen, MD, Augusta, GA

WORKSHOP — 2:15 PM - 4:00 PM — **HARBORSIDE A/B**

F41 Neuroimaging in Forensic Psychiatry: Uses and Misuses
Forensic Neuropsychiatry Committee

Timothy Allen, MD, Lexington, KY
Manish Fozdar, MD, Wake Forest, NC
Robert Granacher, MD, Lexington, KY
Jacob Holzer, MD, Worcester, MA
Mohan Nair, MD, Seal Beach, CA
Hal Wortzel, MD, Denver, CO

WORKSHOP — 2:15 PM - 4:00 PM — **HARBORSIDE D**

F42 Forensic Evaluation of Teachers Who Violate Boundaries

Marilyn Price, MD, CM, Boston, MA
Donna Norris, MD, Wellesley, MA
Patricia Recupero, MD, JD, Providence, RI
Anne Ryan, EdD, (I) Camas, WA

PANEL — 2:15 PM - 4:00 PM — **LAUREL**

F43 To Sell Or Not To Sell; Here Are The Questions (Core)

Corey A. Beck, MD, Atlanta, GA
The Honorable Stephanie Manis, (I) Atlanta, GA
Douglas Mossman, MD, Cincinnati, OH
Julie Rand, MD, Atlanta, GA

COURSE (TICKET REQUIRED) — 2:15 PM - 6:15 PM — **HARBORSIDE E**

F44 Stalking Risk Assessment and Prevention: Theory to Practice

James L. Knoll, IV, MD, Liverpool, NY
John Femia, BA (I) New York, NY
Graham Glancy, MB, Toronto, ON, Canada
Phillip Resnick, MD, Cleveland, OH
Debra A. Pinals, MD, Boston, MA

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

PANEL — 4:15 PM - 6:15 PM — **HARBORSIDE A/B**

F45 ***Forensic Sampler: Firesetting and Bombing***
Liaison with Forensic Sciences Committee

Alan Felthous, MD, St. Louis, MO
Douglas Carpenter, MS, (I) Columbia, MD
Daniel Martell, PhD, (I) Irvine, CA
Douglas Ubelaker, PhD, (I) Washington, DC
Allan Warnick, DDS, (I) Livonia, MI
Robert Weinstock, MD, Los Angeles, CA

WORKSHOP — 4:15 PM - 6:15 PM — **LAUREL**

F46 ***Functional Assessment of Risk in Forensic Psychiatry***

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

RESEARCH IN PROGRESS #3 — 4:15 PM - 6:15 PM — **ESSEX**

F47 ***Higher Functioning Autism and the Paraphilias***

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

F48 ***Comparison of US Military and Texas Commitment Process***

Gianina Gomez, MD, San Antonio, TX
Matthew Faubion, MD, San Antonio, TX
Leah Frazier, MD, (I) San Antonio, TX

F49 ***Triaging the IST Patient: A Brief Screen to Reduce LOS***

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

F50 ***Juvenile Waivers: Which Factors Influence Decisions***

Ronald Means, MD, Baltimore, MD
Lawrence D. Heller, PhD, (I) Towson, MD
Jeffrey Janofsky, MD, Timonium, MD

WORKSHOP — 4:15 PM - 6:15 PM — **HARBORSIDE D**

F51 ***Computers and Technology in Forensic Psychiatry***
Computers Committee

Mark Hauser, MD, Newton, MA
Alan Newman, MD, Washington, DC
Jason Roof, MD, Sacramento, CA

F1 IMPLEMENTATION AND BENEFITS OF TELECOURT IN MISSOURI

Ben W. Holt, MD, Athens, GA
James Hoerchler, MA, MBA, (I) St. Louis, MO
William Newman, MD, St. Louis, MO
Melissa Swallow Harbit, MD, St. Louis, MO

EDUCATIONAL OBJECTIVE
Demonstrate the use of technology to facilitate probate court hearings in order to better serve patients and medical staff.

SUMMARY
The civil commitment process can be dehumanizing, dangerous, time consuming, and costly. The American Psychiatric Association established guidelines in 1998 for implementing videoconferencing as a tool for psychiatrists and courts to conduct civil commitment hearings. This poster describes steps taken by Barnes-Jewish Hospital to address the logistical obstacles involved in changing the traditional civil commitment process to a telecourt system. Equipment was installed in a dedicated room on the inpatient psychiatry unit staffed by Washington University in St. Louis School of Medicine faculty and also in the probate court to establish a virtual courtroom. Since implementing telecourt, several improvements have been recognized. Patient complaints about the commitment process have decreased dramatically and patient elopement during transport to court is no longer a concern. Barnes-Jewish Hospital and the St. Louis city government have also experienced a considerable cost reduction. Telecourt provides a safe, simple, and cost-effective alternative to the traditional civil commitment process. It has been so successful, in fact, that plans are in place to expand its use to include guardianship and involuntary ECT hearings. Other jurisdictions in Missouri are now considering similar systems, and this system will likely become increasingly utilized around the country in the next several years.

REFERENCES
Telepsychiatry Via Videoconferencing. APA Document Reference No. 980021, July 1998. Available at http://archive.psych.org/edu/other_res/lib_archives/archives/199821.pdf. Accessed February 28, 2009
Miller TW, Burton DC, Hill K, et al: Telepsychiatry: critical dimensions for forensic services. J Am Acad Psychiatry Law 33:4:539-46, 2005

SELF ASSESSMENT QUESTIONS
1. The benefits of telecourt include which of the following?
a. an overall decreased financial burden for the hospital
b. improved patient safety
c. preservation of the patient's dignity
d. reduced hospital liability in the context of decreased elopements
e. all of the above
ANSWER: e

2. What is the APA's policy on the use of telemedicine in forensic psychiatry?
a. The APA prohibits the use of telemedicine in forensic psychiatry as the courts have ruled that it deprives the respondent of constitutional rights.
b. The APA has stated that telemedicine is appropriate for general clinical psychiatry, but that it is inappropriate for forensic uses.
c. The APA has stated that telemedicine is appropriate for a variety of forensic uses, including involuntary commitments and for conducting commitment hearings.
d. The APA has taken no official stance on telemedicine.
ANSWER: c

F2 SYSTEMATIC REVIEW OF INTERVENTIONS FOR RAPE RELATED PTSD

Cheryl Regehr, PhD, (I) Toronto, Ontario, Canada
Romona Alaggia, PhD, (I) Toronto, Ontario, Canada
Michael Saini, PhD, (I) Toronto, Ontario, Canada

EDUCATIONAL OBJECTIVE
To determine reliable and valid psychosocial interventions for reducing post-traumatic stress symptoms in adult victims of sexual violence and rape.

SUMMARY
As the negative effects of sexual assault have become better recognized, there is increasing attention to the possibility that psychosocial interventions may reduce suffering and limit distress. Although a variety of interventions have been used in attempts to reduce distress following sexual assault, Stein, Ipser and Seedat's systematic review of pharmacotherapy for PTSD is the only systematic review to examine the reduction of distress for victims of sexual violence. Within the psychotherapy literature, there have been several nonsystematic reviews of treatment for post-traumatic stress emanating from a number of types of traumatic events. Although these reviews suggest that there may be effective treatments for trauma and PTSD in general, there remains a substantial gap in the empirical evidence related to the effectiveness of various modalities to treat rape and other forms of sexual assault. This poster will present the results of a systematic review of controlled and clinical trials of psychotherapies for victims of rape and sexual assault and a synthesis of effective treatments for addressing distress and trauma.

REFERENCES
Foa E, Keane T, Friedman M: Effective Treatments for PTSD: Practice Guidelines for the International Society for Traumatic Stress. New York: Guilford Press, 2000
Bisson J, Andrew M: Psychological treatment of post-traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews, Issue 3, 2007

SELF ASSESSMENT QUESTIONS
1. Are there effective psychosocial interventions for reducing PTSD symptoms in victims of rape?
ANSWER: Yes

2. What are the most effective psychosocial interventions for reducing PTSD symptoms in victims of rape?
ANSWER: Selected cognitive-behavioral approaches.

F3 WOMB RAIDERS: FETAL ABDUCTION BY CESAREAN SECTION

Brett DiGiovanna, MD, Pittsburgh, PA
Muralidhar Kannan, MD, (I) Pittsburgh, PA
Christine Martone, MD, Pittsburgh, PA
Layla Soliman, MD, (I) Pittsburgh, PA
Gayle Strandberg, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE
To present two cases of fetal abduction by cesarean section in western Pennsylvania and understand these cases in the context of the psychiatric phenomenology of other cases reported in the literature.

SUMMARY
Abduction of newborns by women desperate for a child has been described throughout history. A more extreme scenario, fetal abduction, involves the removal by the perpetrator of an unborn child via forced cesarean section, often resulting in the death of the mother. Two of these rare cases occurred in the Pittsburgh area of western Pennsylvania within a three-year period. We present the psychiatric features and circumstances of these two cases. In one of these cases, the perpetrator had a history of treatment for psychotic symptoms, while in the other case, the perpetrator did not. We examined the international literature to determine whether psychosis was a significant contributing factor in these crimes. We found 16 other cases of fetal abduction by C-section. Perpetrators often had a history of miscarriages or hysterectomy, and displayed predatory behavior in choosing their victims. The perpetrators frequently employed elaborate plans to deceive others into believing they were pregnant, going so far as to show ultrasound pictures of a fetus, augmenting their belly size, and having baby showers. According to these reports, psychotic symptoms were not present as a factor in these crimes. Perpetrators were likely to have been diagnosed with a severe personality disorder.

REFERENCES
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Yutzy SH, Wolfson JK, Resnick PJ: Child stealing by Cesarean section: a psychiatric case report and review of the child stealing literature. J Forensic Sci 38:192-6, 1993

SELF ASSESSMENT QUESTIONS
1. Which of the following is true of perpetrators in the literature who steal infants by C-section?
a. Most have a history of psychosis.
b. Most experience pseudocyesis
c. Most are found not guilty by reason of insanity
d. Most are not psychotic at the time of the crime
ANSWER: d

2. Which behavior(s) or characteristic(s) is/are seen in infant abduction via C-section?
a. Many perpetrators fake pregnancy, going so far as to have baby showers, wear maternity clothes, etc.
b. Most perpetrators later express remorse.
c. Most perpetrators do not seem to know and appreciate the wrongfulness of the act.
d. Most perpetrators work alone.
e. All of the above.
f. a and d
ANSWER: f

F4 **JAIL-DIVERTED PATIENTS ON A CIVIL CITY PSYCHIATRIC UNIT**

Katya Frischer, MD, JD, New York, NY
Ali Khadivi, PhD, (I) Bronx, NY
Karen Rosenbaum, MD, New York, NY

EDUCATIONAL OBJECTIVE
To determine if the course of treatment of jail-diverted patients in a major psychiatric hospital is different from non-jail-diverted patients.

SUMMARY
One result of the increased focus on mentally ill individuals in the criminal justice system, is a complementary increase in the identification of individuals with criminal justice histories in civil treatment settings, with associated concerns about engagement, clinical care and general safety. In this poster we address the question of whether the forensically-referred population is similar to patients referred from traditional civil sources. We compare 30 jail-diverted patients to a random sample of non-jail-diverted patients, both admitted to an acute care general psychiatric unit. Through chart review, data collected include demographic characteristics, diagnosis, substance abuse history, number of past psychiatric hospitalizations, length of stay, number of violent incidents, number of seclusion or restraint episodes, number of episodes requiring stat medications and number of requests for a court hearing regarding discharge and treatment over objection.

REFERENCES
Webster SL, et al: Integrating forensically and civilly committed adult inpatients in a treatment mall program at a state hospital. Psychiatr Serv 60:262-65, 2009
Segal FP, et al: Factors in the use of coercive retention in civil commitment evaluations in psychiatric emergency services. Psychiatr Serv 52:514-20, 2001

SELF ASSESSMENT QUESTIONS
1. Do jail-diverted inpatients have a longer length of stay at a major psychiatric hospital than non jail diverted inpatients?
ANSWER: No

2. Do jail-diverted inpatients have more incidents of violence on an inpatient psychiatric unit than non jail diverted inpatients?
ANSWER: No

F5 **CASE LAW OF RESTRAINT AND SECLUSION IN PSYCHIATRIC HOSPITALS**

Keelin A. Garvey, MD, Providence, RI
Brian Daly, MD, Warwick, RI
Marilyn Price, MD, CM, Boston, MA
Patricia R. Recupero, MD, JD, Providence, RI
Sarah Xavier, DO, Warwick, RI

EDUCATIONAL OBJECTIVE
To review the evolution of regulatory input in the development of modern Restraint and Soclusion procedures and analyze case law highlighting relevant risk management issues, to encourage dialogue regarding legal and ethical aspects of R&S that may assist in development of uniform standards for the use of R&S in inpatient treatment settings.

SUMMARY
Lack of federal regulation governing the use of restraint and seclusion (R&S) in inpatient psychiatric settings renders the use of such measures variable and controversial. These procedures can compromise safety if performed incorrectly or monitored inadequately, evidenced by a number of lawsuits against facilities involved in poorly executed incidents

of R&S. Regulatory agencies have called for stricter regulation of R&S, and case law has established standards for determining appropriate use of R&S in psychiatric treatment settings, going beyond a minimum requirement established in correctional settings to eliminate the use of R&S as measures of punishment and ensure they are used only to maintain safety. Case law has also demonstrated the importance of individualized treatment in R&S, particularly in regard to properly assessing risk of psychological or physical injury. Despite this attention, few jurisdictions have effectively implemented procedures to optimize the use of R&S. Those that have been successful have emphasized leadership, staff training, optimal physical environment, and increased patient involvement in treatment planning. This review aspires to provide a foundation for further research aimed at developing more coherent standards by discussing important legal and ethical developments in R&S.

REFERENCES

Metzner JL, Tardiff K, Lion J, Reid WH, Recupero PR, Schetky DH, Edenfield BM, Mattson M, Janofsky JS: Resource document on the use of restraint and seclusion in correctional mental health care. J Am Acad Psychiatry Law 35(4):417-25, 2007

American Psychiatric Association, American Psychiatric Nurses Association, and the National Association for Psychiatric Health Systems: Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health. Arlington, VA and Washington, DC: author. Available at http://www.psych.org/Departments/QIPS/Downloads/LearningfromEachOther/aspx. Accessed November 5, 2008

SELF ASSESSMENT QUESTIONS

1. In the case of Youngberg v. Romero, the Supreme Court ruled that involuntarily committed patients have a constitutionally-protected right to reasonably safe conditions of confinement, freedom from unnecessary bodily restraints, and training in ways to protect these interests. How is this right protected?

a. under the 2nd Amendment; the right to keep and bear arms
b. under the Due Process Clause of the 14th Amendment
c. under the 8th Amendment; the prohibition of cruel and unusual punishment
d. under the Equal Protection Clause of the 14th Amendment

ANSWER: b

2. Which of the following factors has not been thought to affect outcomes in cases of Restraint and Seclusion?

a. staff countertransference
b. communication and documentation
c. assessment and monitoring
d. high female:male staff ratio

ANSWER: d

F6 CRIMINAL CHARGES AND PERMANENTLY INCOMPETENT DEFENDANTS

Douglas Morris, MD, Indianapolis, IN

EDUCATIONAL OBJECTIVE

This presentation will describe the rationales and implications of contrasting state supreme court decisions regarding due process rights of permanently incompetent criminal defendants and whether due process protections may limit the duration of these defendants' persisting criminal charges.

SUMMARY

In its landmark Jackson v. Indiana decision, the United States Supreme Court ruled that states may not indefinitely confine criminal defendants solely on the basis of incompetency to stand trial. While this decision led to widespread state statutory and procedural changes, the Jackson court left unresolved whether states could indefinitely maintain criminal charges against incompetent defendants. Recently, nearly four decades after the Jackson decision, the Indiana Supreme Court unanimously ruled that holding criminal charges over the head of a permanently incompetent defendant, when her pretrial confinement extended beyond the maximum period of any sentence the trial court could impose, violated the basic notions of fundamental fairness embodied in the Due Process Clause of the Fourteenth Amendment. Other states, however, have reached different conclusions regarding the persistence of incompetent defendants' criminal charges. In this presentation, rationales and implications of state supreme court decisions regarding permanently incompetent defendants' criminal charges are analyzed and contrasted.

REFERENCES

Morris DR, Parker GF: Jackson's Indiana: state hospital competence restoration in Indiana. J Am Acad Psychiatry Law 36:522-34, 2008

Indiana v. Davis (Ind. 2008). Available at http://www.in.gov/judiciary/opinions/pdf/12180801rdr.pdf. Accessed March 31, 2009

SELF ASSESSMENT QUESTIONS

1. Constitutional protections are made applicable to state criminal defendants by which portion of the United States Constitution?

a. First Amendment
b. Fifth Amendment
c. Eighth Amendment
d. Fourteenth Amendment
e. Bill of Rights
ANSWER: d

2. In Jackson v. Indiana, the United States Supreme Court used which Constitutional principle(s) to base its rebuke of indefinite commitment solely on the basis of incompetency to stand trial?

a. Due process protections of the Fourteenth Amendment
b. Equal protection rights of the Fourteenth Amendment
c. Eight Amendment prohibitions against cruel and unusual punishment
d. Both a and b
e. All of the above
ANSWER: d

F7 **CORRECTIONAL GROUP-FACILITATED FUNCTIONAL ANALYSIS**

Robert Trestman, PhD, MD, Farmington, CT
Edward Keeney, MS, MSW, (I) Farmington, CT
Susan Sampl, PhD, (I) Farmington, CT
Sara Wakai, PhD, (I) Farmington, CT

EDUCATIONAL OBJECTIVE

Following this presentation, participants will recognize the elements of functional behavioral analysis, be able to identify the issues relevant to correctional adaptations for functional analysis, and be able to describe the clinical applicability to impulsive, labile offenders.

SUMMARY

Over time, a research-based foundation is growing for supporting behavioral change in the most challenging situations such as correctional settings. One key tool in this process is the adaptation and application of effective functional analysis. Functional analysis is designed to improve the effectiveness of cognitive behavioral treatment. Functional analysis involves identifying the sequence of an antecedent stimulus (A), a behavior (B), and that behavior's consequences (C) Functional analysis has been incorporated as a fundamental skill within a group-based, coping-skills training program for offenders, START NOW. START NOW is an evidence-informed practice in the public domain designed for use in correctional facilities to treat offenders with behavioral disorders and associated behavioral problems. This manual-guided program incorporates aspects of CBT and motivational interviewing, and is trauma sensitive, gender specific, and appropriate for a broad range of inmates. Participating inmates learn to use the ABC system to break down, understand, and manage their behavior. The process of adaptation, repetition, and positive reinforcement as reflected by group-facilitated functional analysis can support corrections-based, skills- training initiatives such as START NOW to help behaviorally disinhibited, affectively labile offenders to build a more successful future.

REFERENCES

Nevin JA, Mace FC: The ABCs of JEAB, September 1993. J Appl Behav Anal 27(3):561-5, 1994
Welches P, Pica M: Functional analysis of behavior: a collaborative-phenomenological approach. The Humanistic Psychologist 33:59-68, 2005

SELF ASSESSMENT QUESTIONS

1. The ABCs of functional analysis stand for:

a. allowance, broadcast, component
b. antecedent, behavior, consequence
c. amplitude, bimodal, component
d. analyze, behave, cope
ANSWER: b

2. Challenges associated with implementing functional analysis in correctional settings include:
a. providing detailed process to participants in an understandable format
b. limiting practice to no more than 2 hours per day
c. preventing generalization to other areas of function
d. giving each inmate participant a laptop for use to record practice sessions
ANSWER: a

F8 **THE LIFE AND CRIMES OF SERIAL KILLER GOYO CARDENAS**

J. Arturo Silva, MD, San Jose, CA

EDUCATIONAL OBJECTIVE
To provide an overview of the life and serial homicides of Gregorio "Goyo" Cardenas. The main objective of this presentation is to discuss the issue of rehabilitation in persons who have been convicted and imprisoned for serial homicides. The case of Cardenas is used to highlight this issue.

SUMMARY
This presentation will provide an overview of the life of serial killer Gregorio "Goyo" Cardenas (1915-1999), who was a 27-year-old man when he killed several adolescent females in Mexico City during the summer of 1942. His serial killings and the associated investigation will be briefly described. Cardenas' early life will be discussed. An overview of Cardenas's life in the black castle of Lecumberri, Mexico's infamous prison, will also be covered. Gregorio Cardenas was pardoned by Mexican president Luis Echeverria in September 8, 1976. Cardenas' post-prison life from the time that he regained his freedom until his death in 1999, will be discussed with special reference to the issue of rehabilitation. Other relevant cases from the United States and other countries will be briefly considered. Cardenas' pardon became the subject of substantial controversy, but the outcome of his case made noteworthy impact on Mexican society. Therefore, adoption of a cultural forensic psychiatric perspective is an important aspect of this presentation.

REFERENCES
Hickey EW: Serial Murderers and Their Victims. Belmont, Thomson: Wadsworth Publishing, 2006
Schlesinger: Sexual Murder: Catathymic and Compulsive Homicides. Boca Raton: CRC Press, 2004

SELF ASSESSMENT QUESTIONS
1. Gregorio Cardenas was:
a. a gifted physics student
b. a serial rapist who became a serial killer
c. a man who was not a malingerer
d. a writer of several books
e. a man without a significant neuropsychiatric history
ANSWER: d

2. All of the following are true about serial killer Gregorio Cardenas except:
a. He killed four adolescent females.
b. His works of art were the subject of a major art exhibit.
c. He worked as a defense criminal attorney.
d. He was a married man who had several children.
e. He never attempted to escape from confinement.
ANSWER: e

F9 **RISK ASSESSMENT IN YOUTH**

Muniza Shah, MD, Vancouver, BC, Canada
Johann Brink, MB, ChB, BA, Vancouver, BC, Canada
Sarah Desmarai, PhD, (I) Vancouver, BC, Canada
Tonia Nicholls, PhD, (I) Vancouver, BC, Canada
Jodi Viljoen, PhD, (I) Burnaby, BC, Canada

EDUCATIONAL OBJECTIVE
This poster will familiarize readers with ongoing research at the University of British Columbia and the Forensic Psychiatric Services Commission, BC, on adapting an existing risk assessment instrument called START for adolescent populations. The poster will also highlight the need for new risk assessment measures for adolescent populations.

SUMMARY
Risk assessment tools are useful when estimating future risk of violence. Most measures are created for adult populations and at times are used with youth populations without proper validation. Research indicates that 50% of adolescent risk assessors do not have training in working with adolescents. The Short-Term Assessment of Risk and Treatability (START) is a risk assessment tool for adults, created by researchers at the University of British Columbia and St. Joseph's Healthcare, Ontario. Clinicians nationally and internationally have used START successfully for the assessment of future risk and management of undesirable patient behaviors. In collaboration with clinicians from the field of child and adolescent psychiatry the START team is creating a youth version of START to be used in adolescent populations. START Jr. will be helpful in effectively assessing and preventing future risk of violence and dangerous behaviors in youth. The emphasis on client strengths as well as vulnerabilities and the use of dynamic variables, reflecting the rapid changes in this client group, as well as its patient centred approach will provide a useful roadmap for the care plan.

REFERENCES
Ann Hubbard: The Future of "The Duty To Protect": Scientific and Legal Perspectives on Tarasoff's Thirtieth Anniversary, Symposium Introduction. Univ Cincinnati L Rev 75:429-45, 2007
Webster C: Risk Assessment: Actuarial Instruments & Structured Clinical Guides,http://www.violence-risk.com, 2004

SELF ASSESSMENT QUESTIONS
1. Can risk assessment tools designed to assess risk in adults be effectively used in youth populations?
ANSWER: No. Assessment tools needs to be properly validated for youth populations.

2. What needs to be done to use available risk assessment tools in youth populations?
ANSWER: Risk assessment tools available for adult population need to be validated and adjusted for youth populations.

F10 FMRI OF DECEPTION IN A POKER PARADIGM VS HUMAN AND COMPUTER

Daniel Bowling, JD, (I) Durham, NC
R. McKell Carter, PhD, (I) Durham, NC
Scott Huettel, PhD, (I) Durham, NC
Andrew Nanton, MD, Durham, NC

EDUCATIONAL OBJECTIVE
To understand the relationship between theory of mind, deception, social cognition, and functional imaging.

SUMMARY
Most fMRI deception experiments are based on a guilty knowledge task. That task does not provide a chance to observe the decision to conceal knowledge, as subjects are explicitly instructed to lie. This experiment is based on a poker bluffing paradigm, which provides an opportunity to observe regional variations in blood flow correlated with the decision to bluff or fold against both a human and a computer opponent. The findings are consistent with previous experiments that show correlation with brain regions that are also seen to be active in theory of mind tasks. As deception is inherently social, we examine the differences in bluffing a human opponent and a computer. Pattern classification models trained on human and computer trials show a subset of anatomic regions with predictive power specific to the opponent, suggesting an inherent social element. A connectivity analysis of these regions is also presented.

REFERENCES
Langleben DD, Loughead JW, Bilker WB, et al: Telling truth from lie in individual subjects with fast event-related fMRI Human Brain Mapping 26:262-72, 2005
Siegal M, Varley R: Neural systems involved in 'theory of mind,' Nature Reviews. Neuroscience 3:463-71, 2002

SELF ASSESSMENT QUESTIONS
1. A mental construct of what another person is thinking is:
a. mindfulness
b. theory of mind
c. logical positivism
d. the homunculus
ANSWER: b

2. In what psychiatric illness is the ability to do theory-of-mind tasks frequently impaired?
a. depression
b. bipolar disorder
c. autism
d. paraphilia
ANSWER: c

F11 **PTSD AND BORDERLINE PERSONALITY IN INCARCERATED OFFENDERS**

Sandra K. Antoniak, MD, (I) Sioux Falls, SD
Donald Black, MD, (I) Iowa City, IA
Tracy Gunter, MD, St. Louis, MO
Peggy Loveless, PhD, (I) Iowa City, IA
Bruce Sieleni, MD, (I) Coralville, IA

EDUCATIONAL OBJECTIVE
This study involves research in correctional psychiatry. It provides perspectives on the association between posttraumatic stress disorder and borderline personality disorder. Psychiatric comorbidity, suicide risk, and functional status are also examined. The goal is to expand the knowledge available to mental health caregivers who work with prison populations.

SUMMARY
Background: A portion of incarcerated persons in the U.S. are mentally ill. This study examined: the prevalence of PTSD and BPD; the overlap of these disorders; and compared psychiatric comorbidity and functional status in inmates with PTSD alone, BPD alone, PTSD and BPD, and inmates with neither. Methods: Tools used to evaluate a sample of 223 inmate volunteers included: MINI PLUS, BPD module of the Structured Interview for DSM IV Personality Disorders, Medical Outcome Survey Short Form 36 Health Survey, and LSI-R. Results: Inmates with PTSD were more likely female. There was overlap between PTSD and BPD. Both disorders were associated with higher suicide risk and higher rates of psychiatric comorbidity. Inmates with PTSD+BPD had the highest rates of mood, anxiety, and psychotic disorders. There was no association between PTSD, BPD, or PTSD+BPD and substance misuse or current offense. Persons with PTSD+BPD had the poorest mental and physical functioning scores. Conclusions: PTSD and BPD are common among incarcerated offenders. The combination of PTSD and BPD was pernicious, and persons with combined illness had high levels of psychiatric comorbidity and impaired functional status. Mental health caregivers who work with prison populations should be aware of both conditions and their consequences.

REFERENCES
Gunter TD, Arndt S, Wenman G, Allen J, Loveless P, Sieleni B, et al: Frequency of mental and addictive disorders among 320 men and women entering the Iowa prison system: use of the MINI-Plus. J Am Acad Psychiatry Law (36):27-34, 2008
Black DW, Gunter TD, Allen J, Blum N, Arndt S, Wenman G, Sieleni B: Borderline personality disorder in male and female offenders newly committed to prison. Comprehensive Psychiatry 5:400-5, 2007. Epub Jul 5, 2007

SELF ASSESSMENT QUESTIONS
1. The findings of this study include?
a. an association between PTSD and BPD in incarcerated persons
b. high psychiatric comorbidities in inmates with PTSD and/or BPD
c. a high suicide risk in the inmates studied
d. all of the above
ANSWER: d

2. Which of the following was not found to be associated with PTSD and BPD?
a. poor mental functioning score
b. suicide risk
c. substance misuse
d. poor physical functioning score
ANSWER: c

F12 SEXUAL HOMICIDE: A REVIEW OF THE LITERATURE

Samuel Leistedt, MD, Boston, MA
Christopher Myers, MD, Boston, MA
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
At the end of this presentation, participants will be able to discuss current evidence related to the etiology, differential diagnosis, and treatment of sexual murderers and describe ways in which this evidence is relevant in forensic settings.

SUMMARY
Sexual homicide is defined as a crime that includes sexual activity before, during, or after the commission of a homicide. This poster will review the available literature on sexual homicide and specifically address the following issues: characteristics of sexual homicides, characteristics of sexual homicide offenders (sexual murderers), theoretical conceptualizations of sexual homicide offenders and implications for future research.

REFERENCES
Heng-Choon C and Heide KM: Sexual homicide: a synthesis of the literature. J Trauma Violence Abuse 10:31-54, 2009
Langevin R: A study of the psychosexual characteristics of sex killers: Can we identify them before it is too late? Int J Offender Therapy and Compar Criminol 47:366-82, 2003

SELF ASSESSMENT QUESTIONS
1. Approximately what percentage of murders in the United States are due to sexual homicide?
a. 1%
b. 4%
c. 8%
d. 10%
ANSWER: a

2. Which of the following developmental factors are thought to be associated with sexual homicide?
a. emotional loneliness
b. abnormal attachment
c. early onset of sexual deviance
d. all of the above
ANSWER: d

F13 CLINICAL AND FORENSIC ASPECTS OF PATHOLOGICAL GAMBLING

Alexander Bukhanovski, MD, PhD, (I) Rostov-on-Don, Russia
Roman Gleyzer, MD, Seattle, WA
Viktor Soldatkin, MD, PhD, (I) Rostov-on-Don, Russia

EDUCATIONAL OBJECTIVE
After reviewing this presentation attendees will be able to discuss clinical features of pathological gambling (PG) and risk factors for criminal and dangerous behavior in individuals diagnosed with this condition.

SUMMARY
The present study demonstrated that pathological gambling (PG) is a disorder associated with high rates of criminal behavior, victimization and suicidal risk. The nature and origins of this association are discussed by the authors. One hundred and fifty people (135 males and 15 females) who fulfilled DSM-IV criteria for PG were included in this study. PG was viewed as an addictive behavioral disorder. The key clinical features included psychological dependence, altered reactivity and progressive personality changes. The course of PG is progressive. The disorder has well defined stages and results in marked but gradual personality changes. Objective assessments of the rates of progression were accomplished by using a rating instrument developed by the authors. It was shown that PG is associated with a high propensity for crimes against both property and individuals. A correlation between the progression rate and criminal behavior was established. It was demonstrated that higher rates of progression were associated with more frequent criminal acts. Subjects were also at increased risk for being victims of crimes. Suicidal ideation was experienced by almost one third of the subjects.

REFERENCES
Blaszczynkki A, Silove D: Pathological gambling: forensic issues. Aust N Z J Psychiatry 30:358-69, 1996
Crockford DN, el-Guebaly N: Psychiatric comorbidity in pathological gambling: a critical review. Can J Psychiatry 43:43-50, 1998

SELF ASSESSMENT QUESTIONS
1. More rapid progression of PG is associated with:
a. decreased risk of criminal behavior and increased suicidality
b. increased risk of criminal behavior and decreased suicidality
c. no change in risk of criminal behavior and suicidality
d. higher risk of becoming a crime victim
ANSWER: d

2. Pathological gambling increases the likelihood of subjects to:
a. commit violent crimes
b. commit property crimes
c. become a victim of a crime
d. commit suicide
e. all of the above
ANSWER: e

F14 JACKSON THEN AND NOW: THE MAN AND THE LANDMARK CASE

George Parker, MD, Indianapolis, IN

EDUCATIONAL OBJECTIVE
Readers will learn about the legal and clinical issues raised by the Landmark Case of Theon Jackson, particularly the challenges of evaluating competence to stand trial in defendants with significant hearing loss.

SUMMARY
Introduction: Theon Jackson 's civil commitment "until sane" after being found incompetent to stand trial led to the Landmark US Supreme Court decision of Jackson v. Indiana in 1972. Little is known of Mr. Jackson beyond what is mentioned in the Court 's decision. Methods: Mr. Jackson 's archived state hospital medical records were reviewed, with written consent of his sister/guardian, and his sister was interviewed. Results: Mr. Jackson was admitted to an Indiana state hospital in December, 1968, with a diagnosis of no mental disorder and was discharged in September 1972 with a diagnosis of "deaf-mutism." Mr. Jackson was never placed on psychiatric medication in the hospital. His primary problems were his poor communication skills and occasional aggressive behavior to women. Although his IQ was estimated to be as low as 50 on admission, he tested as high as 109 by discharge. Mr. Jackson 's sister said her brother had been deaf and mute his entire life but continued to live on his own with her support, and he has always communicated with "homemade" signs. Discussion: Mr. Jackson 's records highlight the challenges of assessing defendants with impaired communication skills and the dilemmas for the courts posed by such defendants.

REFERENCES
Jackson v. Indiana, 406 U.S. 715 (1972)
Vernon M, Steinberg AG, Montoya LA: Deaf murderers: clinical and forensic issues. Behav Sci Law 17:495-516, 1999

SELF ASSESSMENT QUESTIONS
1. Theon Jackson was determined to be incompetent to stand trial due to his:
a. deafness
b. mutism
c. mental retardation
d. illiteracy
e. all of the above
ANSWER: e

2. Defendants with prelingual deafness may have:
a. normal intelligence
b. low educational achievement
c. large discrepancy between verbal and performance IQ
d. difficulty with American sign language
e. all of the above
ANSWER: e

F15 **LEGAL IMPLICATIONS OF BUPRENORPHINE-NALOXONE TREATMENT**

Cally M. Woodard, MSN, (I) Ann Arbor, MI
Nalan Ward, MD, (I) Boston, MA

EDUCATIONAL OBJECTIVE
To inform readers about the positive and negative legal aspects of buprenorphine-naloxone prescribing for opioid dependent clients.

SUMMARY
This poster examines the positive and negative legal aspects of prescribing buprenorphine-naloxone to opioid dependent patients in a clinical outpatient setting. The poster reviews and outlines the available literature on the legal implications of buprenorphine-naloxone prescribing for opioid dependent patients (available since 2000 in outpatient settings). The positive features of buprenorphine-naloxone treatment include the reduction in illicit drug use and associated criminal acts. Research studies have shown that the effects of buprenorphine when compared with methadone have similar outcomes on lowering criminal behavior. The negative legal aspects of prescribing buprenorphine-naloxone include the diversion of the drug itself. In a study by Feroni et al., the researchers describe patients who had consulted multiple physicians in order to obtain a higher quantity of buprenorphine, greater than was therapeutically necessary. The purpose of this excess was then used for personal consumption or dealing to others illicitly. In conclusion, this poster will discuss areas for future research.

REFERENCES
Digiusto E, Shakeshaft A P, Ritter A, Mattick RP, et al: Effects of pharmacotherapies for opioid dependence on participants ' criminal behaviour and expenditure on illicit drugs: An Australian national evaluation (NEPOD). Aust NZ J Criminol 39(2):171-89, 2006
Feroni I, Peretti-Watel P, Paraponaris A, et al: French general practitioners prescribing high-dosage buprenorphine maintenance treatment: Does doctor shopping reflect buprenorphine misuse? J Addictive Diseases 24(3):7-22, 2005

SELF ASSESSMENT QUESTIONS
1. What conditions are most likely to significantly reduce or eliminate the diversion of buprenorphine-naloxone?
a. control of prescriptions to fewer tablets per day, smaller quantity at one time
b. including a comprehensive treatment plan with substance abuse counseling
c. increased training for providers who prescribe buprenorphine-naloxone
d. all of the above
ANSWER: d

2. What are the positive legal implications of buprenorphine-naloxone treatment for opioid dependent clients?
a. increased availability of drug treatment centers
b. increase in illicit drug importation
c. decreased criminal activity
d. decreased in diversion of buprenorphine-naloxone
ANSWER: c

F16 **FORENSIC SABBATICAL: HONING SKILLS**

Carl B. Greiner, MD, Omaha, NE

EDUCATIONAL OBJECTIVE
To encourage taking a forensic sabbatical to learn about other complex legal systems, develop an enhanced forensic curriculum for the home institution, appreciate personal developmental aspects of a sabbatical experience and consider AAPL members as resources for sabbatical training.

SUMMARY
The practice of forensic psychiatry is enhanced for the experienced practitioner by taking a sabbatical. Exposure to forensic services in a larger metropolitan area (New York University) and an international setting (Glasgow, Scotland) expands the practitioner 's frame of reference and challenges basic assumptions about proper practice. Observing the the implementation of the New Mental Health Act in Scotland provided an insight into the application of the European Human Rights guidelines. The Scottish forensic services provided a continuity of care for patients that was impressive in its scope and thoroughness. As an additional benefit, being uprooted for a sabbatical can be a powerful stimulus for personal growth and creativity for a mid-career psychiatrist.

REFERENCES
The New Mental Health Act: An Introduction to the Mental Health Tribunal for Scotland. Edinburgh: Scottish Executive, Crown Copyright, 2006
Thomas RJ: Crucibles of Leadership. Boston: Harvard Business School, 2008

SELF ASSESSMENT QUESTIONS
1. The New Mental Health Act of Scotland states the following, except:
a. where addiction treatment will be provided
b. when you can be treated against your will
c. what your rights are
d. when you can be taken into the hospital against your will
ANSWER: a

2. Thomas defines "crucible of leadership" as what?
a. new territory
b. reversal
c. suspension
d. all of the above
ANSWER: d

F17 PHYSICIANS IN TRAINING REFERRED FOR PSYCHIATRIC EVALUATION

Gabrielle S. Hobday, MD, (I) Malden, MA
Glen Gabbard, MD, (I) Houston, TX

EDUCATIONAL OBJECTIVE
To increase knowledge of what brings physicians in training to evaluation, the prevalent problems and diagnostic picture of these individuals, and proposed recommendations for treatment and rehabilitation.

SUMMARY
Little is known regarding outcomes and effective treatments for physicians in training (PIT) evaluated for professionalism problems or boundary violations. Training programs have increasingly emphasized education about professionalism principles. However, behavior problems encountered with physicians in training are multiply determined by different factors, not simply lack of education. In this retrospective descriptive case series of 24 PIT who underwent a multidisciplinary evaluation, individuals were classified according to the behavior prompting evaluation and according to psychodynamically-informed categories: those who were naive and uneducated about proper behavior, those who were otherwise ethical and well meaning who became vulnerable under stress, and those who were predatory. Basic demographics, history of prior concerns, as well as specialty and level of training, were also included in data collection. The goal of this study is to better understand the factors which contribute to unprofessional and unethical conduct in PIT, and to further educate those involved in their education, licensure and treatment. It is our hypothesis that most PIT who experience professionalism or boundary problems will need to be approached from a multifactorial perspective in terms of understanding and rehabilitative/treatment recommendations to help the physician and to protect the public.

REFERENCES
Myers M, Gabbard GO: Physician as Patient: A Clinical Handbook for Mental Health Professionals. Virginia: American Psychiatric Publishing, 2008
Papadakis MA, Teherani A, Banach MA, et al: Disciplinary action by medical boards and prior behavior in medical school. N Engl J Med 353:2673-82, 2005

SELF ASSESSMENT QUESTIONS

1. Factors responsible for professionalism problems and boundary violations often include all of the following except:
a. naivete and lack of education
b. excessive conscientiousness
c. excessive situational stress
d. predatory tendencies
ANSWER: b

2. The data from this study of physcians in training suggest that most professionalism problems
a. should be treated by education alone
b. will go away without treatment or education
c. require a multifactorial approach to adequately address them
d. are categorically irremediable
ANSWER: c

F18 **HIV/AIDS, ADDICTION AND ETHICAL AND LEGAL DILEMMAS**

Lauren Carter, (I) Boston, MA
Albert Grudzinskas, Jr., PhD, (I) Worcester, MA
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE

To present and explore ethical and legal dilemmas of working with addiction and HIV/AIDS.

SUMMARY

Clinicians working with addiction are faced with a multitude of ethical dilemmas. Much research has been done on the notion of "duty to warn" when working with individuals with mental illness and/or substance disorders. Individuals who are abusing substances have a higher chance of contracting HIV/AIDS or Hepatitis C, and often they are continuing to engage in high-risk behaviors, such as sharing needles and having unprotected sex. It can be extremely challenging to listen and "sit with" information when the patient or another individual is being placed at risk, either knowingly or unknowingly. How can we as clinicians manage our own internal distress and how can we talk with our patients in a respectful way about our concerns? What are the legal obligations, if any, that we have? Are there situations where "duty to warn" comes into play? This poster presentation will review literature on this topic and discuss how clinicians can cope with this dilemma and also be better informed of the laws associated with the potential for mandated reporting.

REFERENCES

Bayer R, Toomey KE: HIV prevention and the two faces of partner notification. Am J Public Health 82:1158-64, 1992
Hansen N D, Goldberg S G: Navigating the nuances: a matrix model of considerations for ethical-legal dilemmas. Profes Psychology 30:495-503, 1999

SELF ASSESSMENT QUESTIONS

1. What was the outcome of the 1974 case Tarasoff v. Regents of California?
a. Clinicians should never in any circumstance break confidentiality in the patient-doctor relationship.
b. If a patient presents a serious danger of violence to another, the clinician has an obligation to use reasonable care to protect the intended victim against such danger.
c. This case determined that the clinician has the duty to warn an identifiable victim.
d. Both b and c.
ANSWER: d

2. Which of the following are potential ethical/legal dilemmas that a clinician may face when working with individuals with HIV/AIDS who are actively using substances?
a. "duty to warn"
b. right to privacy/confidentiality
c. anti-discrimination laws
d. all of the above
ANSWER: d

F19 CCTV, SURVEILLANCE AND OFFENDING

Fin Larkin, MBBCh, (I) Bershire, United Kingdom

EDUCATIONAL OBJECTIVE

To understand the various types of surveillance in institutions and in society. To understand the role they may have, and the available evidence on their effects to inform decision making about the use and impact of surveillance in relation to your practice.

SUMMARY

The aim is to understand the various types of surveillance in institutions and in society, and to inform decision making about the use and impact of surveillance in relation to your practice. Various types of surveillance are explained, as well as counter surveillance and sousveillance. Beliefs about these issues are discussed and the available evidence regarding effects is explored.

REFERENCES

Allare TJ, Wortley RK, Stewart AL: The effect of CCTV on prisoner misbehaviour. The Prison J 88:3, 404-22 2008
Short E, Ditton J: Seen and now heard: talking to the targets of Open Street CCTV. Brit J Criminology 38:404-28, 1998

SELF ASSESSMENT QUESTIONS

1. Name four different methods of surveillance.
ANSWER: There are many different methods of surveillance, four current examples include: closed-circuit television, biometric surveillance, natural surveillance and electronic trails.

2. What is inverse surveillance?
ANSWER: Inverse surveillance is when the target of surveillance (e.g., a citizen), monitors the watcher (e.g. the state's officials). A well-known example is George Holliday's recording of the Rodney King arrest.

F20 SEXUAL ORIENTATION: SHOULD IT AFFECT CHILD CUSTODY RULINGS?

Jesse A. Raley, MD, (I) Columbia, SC
Kristin Remke Clary, DO, (I) Columbia, SC

EDUCATIONAL OBJECTIVE

This poster aims to consolidate and review the pertinent literature impacting child custody evaluations concerning one or more homosexual parent. This is important information to aid forensic psychiatrists in practicing child custody evaluations at the highest level possible given the current body of knowledge.

SUMMARY

The past two decades have been characterized by an increased prevalence of homosexual parenting as well as child custody placement decisions involving homosexual parents. This creates a need for forensic psychiatrists to have increased understanding of the current literature in this area. In the past, many states have equated homosexuality with parental unfitness. Past empirical evidence on homosexual parenting has suggested no significant difference in the psychological development or gender identity of their children when compared to children of heterosexual parents. Nonetheless, custody decisions continue to be handled with great variability among legal jurisdictions across the United States. This poster aims to consolidate and review the pertinent literature impacting custody evaluations concerning one or more homosexual parent. This is important information to aid forensic psychiatrists in practicing child custody evaluations at the highest level possible, given the current body of knowledge.

REFERENCES

Kleber, DJ, Howell, RJ, Tibbits-Kleber, AL: The impact of parental homosexuality in child custody cases: a review of the literature. Bull Am Acad Psychiatry Law 14:81-7, 1986
Allen, M, Burrell, N: Comparing the impact of homosexual and heterosexual parents on children: meta-analysis of existing research. J Homosexuality 32(2):19-35, 1996

SELF ASSESSMENT QUESTIONS

1. A child's sexual identity is impacted by same sex parents in which of the following ways?
a. increased prevalence of homosexuality
b. increased confusion about sexuality as an adolescent
c. delay in establishment of sexual identity
d. no clear impact on sexual identity
ANSWER: d

2. What Utah Supreme Court Case upheld that a mother's lesbian relationship demonstrated her lack of moral example?
a. Tucker v. Tucker
b. A.C. v. B.C.
c. Riggins v. Nevada
d. Jacoby v. Jacoby
ANSWER: a

F21 **PROSTITUTION AND SUBSTANCE USE: PREVALENCE AND TREATMENT**

Fabian Saleh, MD, Boston, MA
Georgia Stathopoulou, PhD, (I) Boston, MA
Nalan Ward, MD, (I) Boston, MA

EDUCATIONAL OBJECTIVE
To review the literature on the association of substance use and prostitution, related issues of physical and mental health, and legal implications. To present recent treatment approaches showing preliminary success in concurrently reducing both substance use and sex work.

SUMMARY
Research has documented the significant association between prostitution and substance use disorders. Among patients with substance use disorders, prostitution is associated with increased risk for physical and mental health issues, higher utilization of treatment services, and increased legal issues. Sharing of drugs between sex workers and their clients is a significant risk marker for increased violence and sexual and drug related issues. Preliminary outcome data from applying motivational outreach to substance abusing female sex workers show that the above clinical intervention significantly reduced participants' frequency of both drug use and sex work. Screening for prostitution among patients with substance dependence is crucial in providing appropriate services and reducing the legal implications involved when these conditions concur.

REFERENCES
Heng-Choon C, Heide KM: Sexual homicide: a synthesis of the literature. J Trauma Violence Abuse 10:31-54, 2009
Langevin R: A study of the psychosexual characteristics of sex killers: Can we identify them before it is too late? Int J Offender Therapy Compar Criminol 47:366-82, 2003

SELF ASSESSMENT QUESTIONS
1. What is the prevalence of reported lifetime history of prostitution among patients in treatment for substance use disorders?
a. 51% of women and 19% of men
b. 35% of women and 10% of men
c. 74% of women and 23% of men
d. 46% of women and 35% of men
ANSWER: a

2. In a pilot study among women who are substance-abusing sex workers, the motivational interviewing had what effect?
a. decreased substance use but did not affect involvement in prostitution
b. had no effect on either substance use or prostitution
c. decreased both substance use and prostitution
d. had no effect on substance use but decreased prostitution
ANSWER: c

F22 **SEXUAL HOMICIDE: A REVIEW OF THE LITERATURE**

Samuel Leistedt, MD, Boston, MA
Christopher Myers, MD, Boston, MA
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
This poster will provide the reader with an understanding of sexual homicide by reviewing the available literature.

SUMMARY
Sexual homicide is defined as a crime that includes sexual activity before, during, or after the commission of a homicide. This poster will review the available literature on sexual homicide and specifically address the following issues: characteristics of sexual homicides, characteristics of sexual homicide offenders (sexual murderers), theoretical conceptualizations of sexual homicide offenders and implications for future research.

REFERENCES
Heng-Choon C, Heide KM: Sexual homicide: a synthesis of the literature. J Trauma Violence Abuse 10:31-54, 2009
Langevin R: A study of the psychosexual characteristics of sex killers: Can we identify them before it is too late? Int J Offender Therapy Compar Criminol 47:366-82, 2003

SELF ASSESSMENT QUESTIONS
1. Approximately what percentage of murders in the United States are due to sexual homicide?
a. 1%
b. 4%
c. 8%
d. 10%
ANSWER: a

2. Which of the following developmental factors are thought to be associated with sexual homicide?
a. emotional loneliness
b. abnormal attachment
c. early onset of hypersexuality
d. all of the above
ANSWER: d

F23 SUBTLY SUICIDAL: DIFFICULT CASES IN SUICIDE LITIGATION

Thomas Gutheil, MD, Boston, MA
Jeffrey Janofsky, MD, Baltimore, MD
Phillip Resnick, MD, Cleveland, OH
Robert Simon, MD, Potomac, MD
Skip Simpson, JD, (I) Frisco, TX

EDUCATIONAL OBJECTIVE
Attendees will learn subtle forms of presentation of suicidal patients and specialized approaches to particularly challenging issues in the most common liability claim topic in litigation.

SUMMARY
This panel will present difficult cases in suicide litigation. Dr. Simon will discuss problematic clinical and management issues in sudden improvement of high-risk suicidal inpatients. Dr. Resnick will discuss how to write a better suicide malpractice report. Dr. Gutheil will review insurance issues that arise in different jurisdictions when a policyholder commits suicide. Dr. Janofsky and Attorney Simpson will serve as discussants for the entire panel.

REFERENCES
Simon RI, Hales RE: Textbook of Suicide Assessment and Management. Arlington, VA: APPI Press, 2006.
Simon RI, Gutheil TG: Sudden improvement in high-risk suicidal patients: should it be trusted? Psychiatric Serv (in press)

SELF ASSESSMENT QUESTIONS
1. Suicide can be an insurance issue because:
a. You would have to be crazy to kill yourself and life insurance isn't for crazy people.
b. Suicide is always considered an intentional act, voiding the policy.
c. The decedent's state of mind at suicide may be determinative.
d. The suicide throws into question the policy holder's competence to take out life insurance.
e. None of the above.
ANSWER: c

2. Sudden improvement in the high risk suicidal patient may:
a. reflect a transitory medication response
b. represent "malingered health" aimed at prompt discharge
c. result from a final internal decision to die
d. represent a positive effect of the milieu treatment setting
e. all of the above
ANSWER: e

F24 CURRENT STATUS OF THE DUTY TO PROTECT

Matthew Soulier, MD, Sacramento, CA
James C. Beck, MD, PhD, Boston, MA
Andrea Maislen, JD, (I) Summerville, MA

EDUCATIONAL OBJECTIVE
To update and add to the scientific research regarding the duty to protect.

SUMMARY
States have responded to the Tarasoff duty to protect by passing statutes in all but 13 states. Such statutes either mandate or permit warning a potential victim. This article analyzes 70 Tarasoff related cases from a Westlaw-based search between 1985 and 2006. The study determines the extent to which clinicians are being held liable for breach of the Tarasoff duty in statutory and nonstatutory states, whether there is an impact in the statutes that permit warning as compared to statutes that mandate warning, and whether recent Tarasoff decisions better reflect the inherent ambiguities in clinical mental health practice. We found 70 appellate cases, and just six were plaintiff verdicts. Statutes that mandate warning a victim appear to be the most protective of clinicians. Seven of the seventeen remanded cases came from the jurisdictions with permission to warn statutes, suggesting that permission rather than a strict mandate to warn may increase the liability for clinicians. Notwithstanding the language of statutes, the protections from Tarasoff are not extended to poor clinical judgment, particularly in the controlled inpatient setting.

REFERENCES
Herbert PB, Young KA: Tarasoff at twenty-five. J Am Acad Psychiatry Law. 30(2):275-81, 2002
Weinstock R, Vari G, Leong GB, Silva JA: Back to the past in California: a temporary retreat to a Tarasoff duty to warn. J Am Acad Psychiatry Law 34(4):523-8, 2006

SELF ASSESSMENT QUESTIONS
1. States have responded to the Tarasoff duty to protect by:
a. passing statutes that permit warning a potential victim
b. passing statutes that mandate warning a potential victim
c. not passing statutes that permit or mandate warning a potential victim
d. all of the above
ANSWER: d

2. In what clinical setting are clinicians most vulnerable to liability related to their duty to protect potential victims?
a. an outpatient VA PTSD clinic
b. an inpatient setting
c. a substance abuse treatment center
d. a correctional setting
ANSWER: b

F25 THE ROLE OF MENTAL HEALTH PROFESSIONALS IN POLITICAL ASYLUM

Susan Meffert, MD, MPH, (I) San Francisco, CA
Renée Binder, MD, Sacramento, CA
Dale McNiel, PhD, (I) Sacramento, CA
Karen Musalo, JD, (I) Sacramento, CA

EDUCATIONAL OBJECTIVE
To understand the legal context of U.S. political asylum application as it pertains to forensic psychiatry evaluations; to learn the special psychiatric needs of asylum seekers; and to recognize the risk of secondary trauma among attorneys working with asylum applicants.

SUMMARY
Applying for asylum in the United States can be a strenuous process for both applicants and immigration attorneys. Mental health professionals with expertise in asylum law and refugee trauma are valuable and often essential to a successful case. Not only can mental health professionals provide diagnostic information that supports applicants' claims, but also they can discuss how culture and mental health symptoms relate to perceived deficits in credibility or delays in asylum application. They can define mental health treatment needs and the likely effects of repatriation on mental health condition. Mental health professionals can also provide supportive functions for clients as they prepare for testimony. Finally, in a consultative role, mental health experts can help immigration attorneys improve their ability to safely and efficiently elicit trauma narratives from asylum applicants and their resilience to vicarious trauma and burnout symptoms arising from asylum work.

REFERENCES
United States Court of Appeals for the First Circuit. (2004, December 1). Allen Mukamusoni, Petitioner, v. John Ashcroft, Attorney General, Respondent. 390 F.3d 110; 2004 U.S. App.
Herlihy J, Scragg P, Turner S: Discrepancies in autobiographical memories--implications for the assessment of asylum seekers: repeated interviews study. BMJ (Clinical Research Ed) 324(7333), 324-7, 2002

SELF ASSESSMENT QUESTIONS
1. What is the "one-year-bar" as it pertains to U.S. asylum applications?
ANSWER: Individuals seeking U.S. asylum must submit their application within one year of arriving in the U.S. Many individuals fail to do so. There are multiple reasons for this, including lack of knowledge of the deadline. Relevant to forensic psychiatry evaluations is the fact that, in some cases, symptoms of PTSD, particularly avoidance symptoms, may interfere with timely application.

2. How much secondary trauma exists among attorneys?
ANSWER: Currently, the literature indicates that attorneys working with traumatized clients have higher symptom scores in all areas of secondary trauma (intrusion, avoidance, and arousal) and burnout compared to mental health providers and social services workers.

F26 DOES THE LAW RECOGNIZE A SPECIFIC COMPETENCE TO DIVORCE?

Douglas Mossman, MD, Cincinnati, OH
Amanda Shoemaker, JD, (I) Dublin, OH

EDUCATIONAL OBJECTIVE
Attendees will report familiarity with cases that recognize a distinct form of competence, competence to maintain a divorce action (CMDA) and report gaps in the law concerning how courts should adjudicate CMDA, whether courts may order expert evaluations of CMDA, and disposition when petitioners lack CMDA.

SUMMARY
If a petitioner brings a divorce action for reasons that sound bizarre or "crazy," what should a court of domestic relations do? If the petitioner appears delusional but still capable of managing most personal affairs, may the court declare him incompetent to maintain a divorce action? Several factors—more effective psychiatric treatment, increasing longevity, and "no-fault" divorce laws—have made it more likely that mentally ill petitioners will seek divorces for delusional reasons. The few published cases addressing this matter and the scant legal literature suggest that some courts recognize a specific legal incompetence to maintain a divorce action even if a petitioner does not qualify for legal guardianship. In this article, we summarize these cases and their criteria for determining whether to bar a mentally ill person from pursuing a divorce action. Left unclear, however, is how courts should respond when a petitioner appears incompetent to divorce—for example, whether courts may hold hearings on competence, order psychiatric examinations, or stay divorce proceedings. Solutions may come from adapting statutes and legal procedures for other forms of incompetence (e.g., incompetence to stand trial) and from case law on divorce actions involving individuals already adjudged incompetent.

REFERENCES
Boyd v. Edwards, 446 N.E.2d 1151 (Ohio App. 1982)
Murray by Murray v. Murray, 426 S.E.2d 781 (S.C. 1993)

SELF ASSESSMENT QUESTIONS
1. Current case law includes which of the following criteria for competence to maintain a divorce action:
a. expressing a wish to divorce
b. testifying competently
c. understanding the meaning and effect of the petition
d. exercising reasonable judgment as to personal decisions
e. all of the above
ANSWER: e

2. Current case law on competence for divorce lacks guidance concerning which of the following matters?
a. what to do if someone is found incompetent to divorce
b. a detailed rationale for requiring competence to divorce
c. provisions for appointing mental health experts to conduct examinations
d. procedures for hearings about competence to divorce
e. all of the above
ANSWER: e

F27 THE EVOLVING ROLE OF FORENSIC PSYCHIATRISTS

Muniza Shah, MD, Vancouver, BC, Canada

EDUCATIONAL OBJECTIVE

To educate attendees about the brief history of medical ethics and the history of forensic psychiatry. Create an understanding about the role and responsibility of forensic psychiatrists as liaisons between the legal community and the field of psychiatry.

SUMMARY

This paper provides an overview of the history of the evolution of medical ethics and practice of forensic psychiatry. The code of medical ethics as it is viewed today has evolved over centuries and has become an organized and authentic document. As history has depicted, the code of medical ethics has changed with time and the future will bring more changes. The code of ethics binds forensic psychiatrists, as they are physicians before they are psychiatrists or forensic psychiatrists. A brief summary of the evolution of the role of psychiatrists practicing in forensics is also presented. It is demonstrated that forensic psychiatrists are working as liaisons between law and psychiatry. Forensic psychiatrists have emerged as experts with the unique ability to follow the practice of medicine and integrate it with that of law. There is an increase in regulations in the criminal justice system and in the awareness of the community at large, and it is becoming important that physicians practicing forensic psychiatry be properly trained and educated.

REFERENCES

Steinberg A: Medical Ethics, JME Book Vol. pp.3-27 (2004) as cited in Jewish Medical Ethics and Halachic (JME) July 2008
AMA.com AMA Code of Ethics 1847 at http://www.ama-assn.org, accessed on Dec 12th 2008

SELF ASSESSMENT QUESTIONS

1. What are the two rules the forensic psychiatrist must work under, besides the AMA code of medical ethics?
ANSWER: Objectivity and respect for the person.

2. What are some of the factors affecting practice of forensic psychiatry?
ANSWER: The evolving legal system, the ever changing medical ethical principals, and raising consumer awareness.

F28 ADJUDICATIVE COMPETENCIES AFTER EDWARDS AND PANETTI

Alan Felthous, MD, St. Louis, MO
Stephen Morse, JD, PhD, (I) Philadelphia, PA
Michael Perlin, JD, (I) New York, NY
Christopher Slobogin, JD, LLM, (I) Nashville, TN

EDUCATIONAL OBJECTIVE

To understand the limitations of neuroimaging for assessments of competence to stand trial, arguments for and against competence to represent oneself determinations and the impact of neuroimaging evidence on competence to be executed.

SUMMARY

The Supreme Court's Edwards and Panetti decisions, together with emerging questions about neuroimaging evidence, raise compelling issues for forensic psychiatry. Christopher Slobogin, JD, LLM, will argue that if a defendant's reason for wanting to proceed pro se are delusional or nonexistent, then the autonomy that gives rise to a right to self-representation does not exist. Otherwise, the defendant who understands the risks of waiving the right to counsel should be allowed to represent himself; no competency-to-represent-oneself test should be required. In Godinez and in Edwards, respectively, the Supreme Court arrived at contrasting conclusions regarding incompetence to represent oneself. Alan R. Felthous, MD, will argue that the approach in Edwards better supports the purposes of adjudicative competency determinations. Stephen J. Morse, JD, PhD, will address the contributions that neuroscience might make to competence adjudications. He will argue that competence criteria are behavioral and functional and that the present scanning and other neuroevaluative technologies can add little to current behavioral methods. Michael L. Perlin, JD, will analyze the potential impact of neuroimaging evidence on determining whether a seriously mentally disabled death row defendant is competent to be executed. He will further explore what impact neuroimaging testimony will have on future Panetti hearings.

REFERENCES

Indiana v. Edwards 128, S.Ct. 2379 (2008)
Panetti v. Quarterman, 127 S.Ct. 2842 (2007)

SELF ASSESSMENT QUESTIONS

1. Edwards is potentially inconsistent with Faretta because it:
a. makes competency to represent oneself a requirement for the right to self- representation.
b. equates incompetency to represent oneself with incompetency to stand trial.
c. forces counsel on those who want to plead guilty without the assistance of counsel.
d. abolishes the right to self-representation for any person with mental illness who wants to go to trial.
ANSWER: a

2. The criteria for competence are largely based on:
a. mental health and insight
b. disorder and causation
c. brain and structure
d. behavior and function
ANSWER: d

F29 COMPREHENSIVE RISK ASSESSMENT OF CHILDREN AND YOUTH

Karen Brody, MD, Stamford, CT
Susan Parke, MD, New Haven, CT
Janet Williams, MD, (I) Hartford, CT
Madelon Baranoski, PhD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will be prepared to formulate a comprehensive risk management plan for children and adolescents, assess developmental and family vulnerabilities and strengths pertaining to risk for violence, and identify effective consultation strategies for work with legislators, school officials, and state policymakers.

SUMMARY

Forensic psychiatrists conduct increasing numbers and kinds of risk assessments of children for courts, school, families, and state departments for the protection of children. They also consult to legislators and policymakers on laws and strategies about children at risk. Assessment and management of violence risk in children and adolescents have all the challenges of adult assessments with the additional complexity of developmental, family, community, and legal issues unique to youth. Although tools have been developed to assess the potential for violence in children, such measures are insufficient for identifying strengths and vulnerabilities of individual children and families, targeting treatment needs and goals, and assessing change in risk status. In this workshop, we will present a comprehensive risk management model that incorporates developmental, family, and systems perspectives to develop risk-intervention trajectories to guide treatment and assess outcomes, We will examine the effect of policies and legislation designed to manage children at risk. The workshop will include a review of assessment tools, state protection and intervention models, and clinical techniques to enhance assessment and management strategies. The audience will participate in formulations and outcome analyses in cases that highlight different strategies across the developmental spectrum within varying family structures and state laws.

REFERENCES

Borum R, Bartel PA, Forth AE: Structured assessment of violence risk in youth, in Mental Health Screening and Assessment in Juvenile Assessment. Edited by Grisso T, Vincent G, Seagrave D. New York: Guilford Press, 2005, pp 311-23
Saner H, Ellickson P: Concurrent risk factors for adolescent violence. J Adolescent Health 19:94-103, 1996

SELF ASSESSMENT QUESTIONS

1. Risk factors for dangerousness in children and adolescents are:
a. identical to risk factors in adults
b. modified from those for adults based solely on age
c. reflect the unique characteristics of children and their families
d. are not affected by environment or available resources
ANSWER: c

2. An effective policy for management of children at risk:
a. identifies child advocacy as its primary but not sole objective.
b. has flexible reporting and monitoring requirements.
c. excludes families and schools from intervention planning to protect the privacy of children.
d. requires an initial out-of-home placement for all children who threatened violence.
ANSWER: a

F30 **ETHICAL DILLEMAS IN FORENSIC PSYCHIATRY**

Phillip Candilis, MD, Arlington, MA
Charles Dike, MD, MPH, New Haven, CT
Patricia Recupero, MD, JD, Providence, RI
Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will have an opportunity to seek answers to vexing ethical questions, and to participate in a discussion with their colleagues across the country on ethical problems they have encountered, and how they were resolved.

SUMMARY

In this workshop, seasoned and experienced forensic psychiatrists will take questions from the audience on ethical dilemmas they have encountered, participated in, or read about. The content of the discussion will be driven largely by the audience members, but the moderator will come prepared with questions to stimulate the discussion. Areas of interest include: competency evaluation prior to execution, participation in hostile interrogations, online communication with patients (email, facebook, twitter, etc.), death penalty issues, confidentiality issues, dual agency issues, outpatient commitment issues, boundary issues, private practice issues, and so on. Audience interaction and participation will be encouraged.

REFERENCES

Opinions of the Ethics Committee on the Principles of Medical Ethics, With Annotations Especially Applicable to Psychiatry. Washington, DC: APA, 1992
Appelbaum, PS: Ethics in evolution: the incompatibility of clinical and forensic functions. Am J Psych 154:4, 1997

SELF ASSESSMENT QUESTIONS

1. Sex with a patient's sibling:
a. is allowed if the sibling lives in another state
b. is allowed if the patient gives consent
c. is allowed after termination of treatment with the patient
d. is allowed if the sibling is a psychiatrist
e. is unethical
ANSWER: e

2. Competency evaluation of a felon prior to execution:
a. is unethical
b. is ethical
c. is the same as active participation in execution
d. has no clear standards governing it
e. should be left to trained non-clinicans
ANSWER: b

F31 **TECHNOLOGICAL INNOVATIONS IN FORENSIC EDUCATION**

Alan Newman, MD, Washington, DC
Debra Pinals, MD, Boston, MA
Charles Scott, MD, Sacramento, CA
Cheryl Wills, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

Participants will be introduced to forensic psychiatrists who use technology to enhance forensic education experiences. Participants will be encouraged to exchange information about their use of 21st century technology to improve the quality of forensic psychiatry education.

SUMMARY

Twenty-first century medical professionals encounter restrictions on how they disseminate clinical and related data for educational and other purposes. Practitioners may be required to complete detailed consent forms and/or obtain IRB approval prior to publishing or presenting case-based reports for educational purposes. Despite these restrictions, forensic psychiatrists increasingly have become acquainted with using technology and other resources that are not subjected to regulatory and legal restrictions to work within parameters required of healthcare professionals. The outcomes of these efforts are technologically innovative educational resources for forensic psychiatry trainees and professionals. Panelists will describe how they use current technology to integrate evidence-based methods of forensic assessment into the learning process, to illuminate and reinforce key forensic concepts, and to provide educational resources for future generations

of forensic psychiatrists and trainees. Examples will include: using digital video recording to produce interactive case-based learning, using digital scanning to expedite record summaries for forensic report writing, developing electronic educational databases that facilitate monitoring the quality of forensic education and meeting core competencies, and technological enhancement of forensic education for general and child psychiatry residents.

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. What should the educator not do when using technology as a teaching tool?
a. be familiar with the limits of that technology
b. have a back up plan
c. depend solely on the technology to carry forth educational points
d. research the educational topic prior to the presentation
ANSWER: c

2. Consent forms for videotaping evaluees for teaching purposes generally must adhere to what?
a. the ethical principle of showing respect for persons
b. HIPAA or state laws related to confidentiality
c. the regulations set forth by one's employer
d. all of the above
ANSWER: d

F32 ASSESSMENT OF A DYNAMIC RISK FACTOR SCALE

Caroline J. Easton, PhD, (I) New Haven, CT
Alec Buchanan, MD, PhD, New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will learn about dynamic risk factors obtained from widely used and standardized assessments and the relationship between these factors and violence across time for substance-abusing violence offenders completing 12 weeks of treatment.

SUMMARY

A large percentage of domestic violence episodes involve alcohol or drug use. Individuals who have dual problems with alcohol and drugs are at high risk for violent offending. Moreover, research has also shown that on days of heavy alcohol and or drug use, an individual is 11 times more likely to partake in severe physical violence. We examine whether scores on dynamic risk factors change when the risk of violence changes. In particular, we seek to relate the scores on a range of dynamic variables known to be associated with violence to violent behavior. The study uses a longitudinal design that allows us to investigate this relationship at an individual level as well as for the group as a whole. The study will describe substance abuse, legal, and psychiatric characteristics among this population, as well as how scores on the dynamic variables relate to treatment outcome. Some of the dynamic variables resemble those used in proprietary instruments such as the HCR-20 and the VRAG. The results have implications for the practice of risk assessment in outpatient psychiatric treatment, and more widely.

REFERENCES

Easton C J, Mandel DM, Hunkele K, Nich C, Rounsaville BJ, Carroll KM: A cognitive behavioral therapy for alcohol dependent domestic violence offenders: an integrated substance abuse-domestic violence treatment approach (SADV). Am J Addictions 16:24-31, 2007
Douglas K: The HCR-20 risk assessment scheme. Crim Justice Behav 26(1):3-19, 1999

SELF ASSESSMENT QUESTIONS

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

2. Which brief instrument has shown to be a useful tool for violence risk assessment among correctional populations and outpatient psychiatric settings?
a. Conflict Tactic Scale
b. State Trait Anger Expression Inventory
c. Sociopathy Checklist
d. HCR-20
ANSWER: d

F33 **FUNCTIONAL RISK ASSESSMENT: MOVING FORWARD**

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

EDUCATIONAL OBJECTIVE
Participants will become familiarized with the Functional Risk Assessment Tool (FRAT), a tool designed to quantify and longitudinally follow psychiatric function; be introduced to the interrater reliability assessment of the FRAT; and understand how the FRAT can assist in identification of treatment targets and mitigation of clinical risk in forensic populations.

SUMMARY
In practice and research, psychiatry has shifted focus from the prediction of violence toward risk assessment and management. Recommendations from current research and literature, coupled with national directives toward a computerized medical chart, encourage development of tools that integrate static and dynamic variables to not only identify risk status but also to identify treatment targets and outcomes relevant to risk mitigation and management in forensic populations. The Functional Risk Assessment Tool (FRAT), introduced at the 2008 AAPL annual meeting, incorporates a dynamic functional risk assessment paradigm in a measure well suited for computerized records. Preliminary trials of the FRAT suggest that the measure provides pertinent data regarding risk level as well as assistance with daily clinical decisions. The current study to determine the FRAT's interrater reliability evaluates clinicians' ratings of vignettes and videotaped interviews of patients with different diagnoses. The data will be analyzed across diagnostic categories and clinical disciplines. The study will be an early step in developing a practical strategy for assessment of risk and function in clinical practice as well as an assessment measure that fits with advances in computerized records. Both of these objectives would bring further insights to education about risk assessment in forensic psychiatry.

REFERENCES
Norko MA, Baranoski MV: The prediction of violence; detection of dangerousness. Brief Treatment & Crisis Intervention 8:73-91, 2008
Buchanan A: Risk of violence by psychiatric patients: beyond the "actuarial versus clinical" assessment debate. Psychiatr Serv 59(2):184-90, 2008

SELF ASSESSMENT QUESTIONS
1. The shift from prediction of violence toward risk assessment and management is supported by which of the following?
a. The low base rate of violence compared to prevalence of risk indicators limits accurate predictions.
b. Violence is a complex phenomenon, likely associated with both psychiatric and nonpsychiatric factors.
c. Risk assessment, compared to prediction, better matches the clinical goal of care provision.
d. Clinical interventions and monitoring may alter outcome, thereby decreasing accuracy in prediction measures.
e. All of the above.
ANSWER: e

2. Dynamic measures aimed at functional risk assessment, such as the FRAT, are designed to:
a. increase the accuracy of the prediction of violence
b. distinguish forensic from nonforensic psychiatric populations
c. identify risk status and provide treatment targets in high-risk populations
d. eliminate the need for clinical input in the assessment of risk
e. create a standard of practice for preventing violence in psychiatric settings
ANSWER: c

F34 ASK THE EXPERTS

Carla Rodgers, MD, Wynnewood, PA
Brian Crowley, MD, Washington, DC
Linda Francis, MD, Wilmington, NC
Robert Granacher, MD, Lexington, KY
Trent Holmberg, MD, Salt Lake City, UT

EDUCATIONAL OBJECTIVE
To learn how to solve problems in private practice forensic psychiatry by using actual case presentations.

SUMMARY
Forensic case vignettes submitted to the Committee will be reviewed by the panel, with audience questions and comments being solicited. Approaches to problem solving will be presented along with specific solutions to various forensic issues. A spectrum of issues will be presented, from more routine to difficult.

REFERENCES
Simon R, Gold L (editors): Textbook of Forensic Psychiatry. Washington, DC: American Psychiatric Publishing Inc., 2004
Appelbaum PS, Gutheil TG: Clinical Handbook of Psychiatry and the Law, 4th Edition. Philadelphia, PA: Lippincott, Williams & Wilkins, 2007

SELF ASSESSMENT QUESTIONS
1. You are contacted by a civil plaintiff 's attorney on a matter. You cannot take the case because you are very busy, but briefly discuss the case with the attorney. Later, when your calendar has opened up, you are contacted by the defense attorney on the same matter. What do you do?

a. Take the case, since you already understand the issues in the matter.
b. Take the case, but tell the defense attorney you were contacted by the plaintiff 's attorney and discussed it.
c. Decline the case, but tell the defense attorney you were contacted by the plaintiff 's attorney and discussed it.
d. Decline the case, but don 't give a reason so you do not offend the defense attorney.
ANSWER: c

2. You have made an assessment for a criminal defense attorney that his client does not meet the jurisdictional criteria for NGRI. The attorney, with your knowledge, contacts another expert, who disagrees with your findings. What do you do?

a. immediately withdraw from the case, too many cooks spoil the soup
b. disucss the pros and cons of each position with the attorney and let the attorney decide which expert to use
c. contact the other expert and see if you cannot persuade him/her to your opinion
d. press the attorney to use your assessment since you saw the defendant closer to the commission of the crime
ANSWER: b

F35 ANOTHER ROAD TO PERDITION: INTERNET CHILD PORN EVALUATIONS

Howard Zonana, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Paul Thomas, JD, (I) New Haven, CT
Josephine Buchanan, BA, (I) New Haven, CT

EDUCATIONAL OBJECTIVE
Participants will understand federal laws prohibiting downloading of child pornography, identify typologies of persons who download child pornography, and appreciate theories of sexual attraction and interest as they apply to internet viewing of pornography, sexual deviance, recidivism, and sexual violence.

SUMMARY
Arrests for internet child pornography have increased 20-fold since 2000. Also increasing is the variation in the histories and personalities of the persons arrested. The public's and law enforcement's image of a perpetrator is of a sexual predator who grooms, seduces, and abuses child victims. Support or refutation of that image is hampered by a paucity of research on outcomes of viewing child pornography, and on general ("normal") patterns of arousal and the effect of pornography exposure in altering arousal patterns. Complicated profiles of persons arrested have resulted in increased requests for forensic evaluations to determine the risk of recidivism and escalation of sexual deviance. We examine the unique psychiatric, psychological, and legal challenges in forensic evaluations of persons accused of internet child pornography. Theoretical constructs of disgust and arousal, assumption of privacy, and attributes of behavior and fantasy will provide a foundation for examining pedophilia within the context of internet child pornography. Using video case presentations, we explore three recurring psychiatric/psychological profiles—casual curiosity, porn addiction, and sexual abuse revisited—and associated legal views and resolutions.

The panel will address recidivism, risk assessment, co-occurring psychiatric disorders, consequences of criminal convictions and limitations of psychiatric assessments across the profiles.

REFERENCES

Webb L, Craissati J, Keen S: Characteristics of internet child pornography offenders: a comparison with child molesters. Sex Abuse 19: 449-65, 2007
Seto MC, Eke AW: The criminal histories and later offending of child pornography offenders. Sexual Abuse: A Journal of Research and Treatment 17:201-10, 2005

SELF ASSESSMENT QUESTIONS

1. Research on child-porn downloading:
a. has established an association with general sexual deviation
b. shows no relationship with psychiatric disorders
c. has identified a three-fold increase in risk of sexual violence
d. is in the earliest stage of development
ANSWER: d

2. Sentencing guidelines for those convicted of downloading child pornography:
a. are usually more lenient than punishment under state statutes
b. do not depend on the number of pictures downloaded or the age of the child
c. allow consideration of psychiatric diagnosis as a downward departure
d. require registration on the federal sex offender registry
ANSWER: c

F36 ASSESSMENT OF CUSTODIAL CONFESSIONS

David Rosmarin, MD, Boston, MA
Bernice Kelly, PsyD, (I) Boston, MA

EDUCATIONAL OBJECTIVE

Attendees will learn the legal context of police-derived confessions; clinical approaches to assess the validity of both recorded and unrecorded confessions; the neuropsychological assessment and the Grisso instrument; and the role of clinical recording of the psychiatric evaluation; and critique the televised testimony of expert witnesses for the prosecution and defense.

SUMMARY

In 1999, an illiterate woman with an IQ of 81, auditory hallucinations, and a long history of violence by and against her was interrogated by police concerning arson at the home of her son's girlfriend, that killed five people. After ten years of legal wrangling and two appellate rulings (there was never a delay for incompetency), the case went to trial. The case garnered national TV coverage, including that of the presenters who were defense experts, and whose focus was on the voluntariness of the confession. With the aid of televised testimony, this audiovisual session will cover the the following topics: video exams by experts and presentation at trial; the literature and approach to assessing confessions and other waivers; the use of the Grisso Miranda competency instrument; the team approach by psychiatry and neuropsychology; testifying under the eyes of the jury and the glare of the camera.

REFERENCES

Drizin S, Leo R: The problem of false confessions in the post-DNA world. North Carolina Law Rev 82:891-1007, 2004
Kassin SM, Norwick R: Why people waive their Miranda rights: the power of innocence. Law Hum Behav 28(2):211-21, 2004

SELF ASSESSMENT QUESTIONS

1. What are the standards required for a confession?
ANSWER: That it be be given voluntarily, knowingly, and intelligently.

2. Which of the following statements are correct?
a. According to the Innocence Project, about 25% of disproved confessions are disproved by DNA evidence.
b. Alaska and Minnesota Supreme Courts mandate electronic recording of custodial confessions.
c. Illinois requires electronic recording of confessions in homicide cases.
d. The Supreme Court invalidated confessions under physical abuse in Brown v. Mississippi in 1936.
e. All of the above.
ANSWER: e

F37 MENTAL HEALTH ADVOCACY, LEGISLATION, AND REFORM

Congressman Patrick J. Kennedy, (I) Washington, DC

EDUCATIONAL OBJECTIVE

At the conclusion of this presentation participants will understand issues relevant to the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and will be able to identify current mental health initiatives and areas in need of reform.

SUMMARY

Congressman Patrick J. Kennedy will discuss his experience with advancing mental health legislation, including the recent passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The new law requires businesses with 50 or more employees and health insurance benefits to provide coverage for mental health treatment that is equal to the coverage offered for other health concerns. Congressman Kennedy, with the support of Congressman Jim Ramstad, was a primary sponsor of this bill as H.R. 1424 in the U.S. House of Representatives. A similar bill was introduced in the Senate, and through negotiations between the House and the Senate, a single final bill was agreed upon. The final version was included as part of the large-scale "bailout" bill, the Emergency Economic Stabilization Act, which became law in October 2008. Congressman Kennedy will describe his work in helping to get the parity law enacted, and he will also describe current mental health initiatives and areas in need of reform.

REFERENCES

Wellstone P, Domenici P: Mental Health Parity and Addiction Equity Act of 2008, H.R.6983, 110th Cong. (2008)
Emergency Economic Stabilization Act of 2008, Pub L No.110-343 (Oct. 3, 2008)

SELF ASSESSMENT QUESTIONS

1. Which of the following statements is true regarding the Wellstone/Domenici Parity Act?
a. It mandates true parity for mental health.
b. It requires all employers to provide mental health insurance coverage.
c. Employers of 50 or more who provide insurance coverage must provide equal coverage for mental health and physical health needs.
d. The bill was not passed.
ANSWER: c

2. Which of the following best describes pre-emption in the Wellstone/Domenici Parity Act?
a. It pre-empts all state laws pertaining to parity.
b. It pre-empts some state laws pertaining to parity.
c. It requires states to have laws protecting parity.
d. It does not pre-empt stronger state laws for mental health parity.
ANSWER: d

F38 TRAUMATIC BRAIN INJURY AND VIOLENT CRIME: A CHART REVIEW

Matthew J. Neltner, MD, (I) Lexington, KY
Timothy Allen, MD, Lexington, KY
Tyler Jones, MD, Odenton, MD

EDUCATIONAL OBJECTIVE

To explore the relationship between mental illness, traumatic brain injury (TBI), and criminal behavior.

SUMMARY

Since the time of Phineas Gage, it has been well known that traumatic brain injury (TBI) can have a dramatic impact on personality. The purpose of this investigation was to determine if having a clinical history of TBI with loss of consciousness predicted the rate of violent crime (murder, attempted murder, assault, wanton endangerment armed robbery, and rape). 194 charts of pre-trial competency evaluees were reviewed from 2006 Kentucky Correctional Psychiatric Center (KCPC) discharges. The investigators found that the number and type of crime (violent and non-violent) was not predicted by TBI history when other confounding variables were controlled.

REFERENCES

Timonen M, Miettunen J, Hakko H, Zitting P, Veijola J, Von Wendt L, Räsänen P: The association of preceding traumatic brain injury with mental disorders, alcoholism and criminality: the Northern Finland 1966 Birth Cohort Study. Psychiatry Research 113:217–26, 2002
Turkstra L, Jones D, Toler H: Brain injury and violent crime. Brain Injury 39-47, 2003

SELF ASSESSMENT QUESTIONS

1. A population-based cohort study in Finland investigated the association between childhood TBI, psychiatric illness, and criminal behavior. Based on this study, how would you describe the occurrence of TBI in childhood for those who later had criminal charges and a psychiatric illness?

a. There is no difference in the rate of childhood TBI between the general population and mentally ill criminals.
b. Mentally ill criminals have a lower rate of childhood TBI than the general population.
c. Mentally ill criminals have a higher rate of childhood TBI than the general population.
d. Mental illness, criminal behavior, and childhood TBI are factors that do not appear to be related.
ANSWER: c

2. Based on the data presented in this poster, and the findings of another study (source 2), which conclusion is most accurate?

a. A clinical history of TBI with loss of consciousness is sufficient to increase the risk of violent crime.
b. More severe forms of TBI (e.g., those with documented neurological consequences) appear to contribute to the risk of subsequent criminal activity.
c. TBI history is never a factor in criminal activity.
d. A TBI history appears to decrease the risk of violent criminal activity.
ANSWER: b

F39 **ASSESSMENT OF PSYCHOPATHY IN JUVENILE PARRICIDE**

Eleanor Justen Vo, MD, (I) Piscataway, NJ
Wade Myers, MD, Tampa, FL

EDUCATIONAL OBJECTIVE

To look at the level of psychopathy in juvenile parricide cases compared to normal youths using Hare's Psychopathy Checklist: Youth Version.

SUMMARY

Parricide is a rare act estimated as only 2% of all homicides in the United States. In this case series, four juvenile parricide offenders were examined for level of psychopathy and its relationship to their acts. Research indicates the majority of juvenile parricides are due to child abuse, with the remainder related to either antisocial conduct or severe mental illness. The Hare PCL:YV, like its adult counterpart, has been shown to have both predictive validity for violent recidivism, rate of recidivism, and problems while incarcerated. The use of the PCL:YV for juvenile populations is growing in usage, but can raise controversy when used in pretrial juvenile homicide defendants. It can provide guidance to the juvenile and adult justice systems for post-adjudication placement and rehabilitation. This present case series compared four adolescent parricide cases, all male, with an average score of 8.0 (S.D. = 7.8; range 0.2-15.8) on the PCL:YV. The wide range in their PCL:YV scores may reflect the varying motivations for their acts. Further study of the concept of psychopathy in juvenile parricide offenders is needed, and such data could prove useful to the development of a better understanding of these offenders.

REFERENCES

Heide KM, Petee TA. Parricide: An empirical analysis of 24 years of U.S. data. J Interpersonal Violence 22(11):1382-99, 2007
Forth A E, Hart S D, Hare R D: Assessment of psychopathy in male young offenders. Psychological Assessment: A Journal of Consulting and Clinical Psychology 2:342-4, 1990

SELF ASSESSMENT QUESTIONS

1. What is a normal PCL score for juveniles?

a. 8
b. 17
c. 3.2
d. 30
ANSWER: c

2. What precentage of homicides are parricides?

a. 2%
b. 10%
c. 25%
d. 0.5%
ANSWER: a

F40 TOBACCO, A MAJOR CHALLENGE TO ESTELLE V. GAMBLE

Sheldon Cohen, MD, Augusta, GA

EDUCATIONAL OBJECTIVE

To understand the importance of environmental tobacco smoke (ETS) to prison staff and inmates.

SUMMARY

Landmark cases are the bedrock of forensic psychiatry. Estelle v. Gamble established the principal that withholding of medical treatment constitutes cruel and unusual punishment under the 8th Amendment. Because environmental tobacco smoke ETS is dangerous, many political entities have legally restricted smoking. Georgia made smoking in any state institution illegal. An op-ed article in the Atlanta Journal Constitution (AJC) noted the discrepancy in Georgia's statute, mandating no smoking policies in all state institutions and numerous observations of smoking in state prisons. Several inmates responded in writing, stating that they had been repeatedly exposed to tobacco smoke. A 43-year-old man, a nonsmoker, developed sinusitis in prison. He states that attempts at relief prompted retaliation. While in prison, his tuberculin skin tests converted to positive. He has agreed to appear in person at the annual American Academy of Psychiatry and the Law (AAPL) Meeting to describe his experiences. It is vital that we psychiatrists realize that those with power in our de facto mental health system do not share our beliefs in the primacy of the Hippocratic Oath, "above all, do no harm".

REFERENCES

Estelle v. Gamble 429 U.S. 97, No. 75-929 (1976)
U.S. Department of Health and Human Services. The Health Consequences of Involuntary Smoking: A Report of the Surgeon General. Rockville, MD: Centers for Disease Control, Center for Health Promotion and Education, Office on Smoking and Health. 1986

SELF ASSESSMENT QUESTIONS

1. What is the only way to ensure inmates are not exposed to ETS?
ANSWER: Complete tobacco free campuses.

2. What established the significance of ETS?
ANSWER: 1986 Surgeon General Report

F41 NEUROIMAGING IN FORENSIC PSYCHIATRY: USES AND MISUSES

Timothy Allen, MD, Lexington, KY
Manish Fozdar, MD, Wake Forest, NC
Robert Granacher, MD, Lexington, KY
Jacob Holzer, MD, Worcester, MA
Mohan Nair, MD, Seal Beach, CA
Hal Wortzel, MD, Denver, CO

EDUCATIONAL OBJECTIVE

The participant will learn the uses and misuses of functional and structural neuroimaging within the practice of forensic psychiatry.

SUMMARY

This workshop will demonstrate exemplars of functional and structural neuroimaging from actual forensic cases. Potential challenges under Daubert will be discussed. In addition, two formal cases will be presented to stimulate audience discussion. No significant knowledge of radiology or nuclear medicine is required.

REFERENCES

Hurley R, Taber K: Windows to the Brain: Insights From Neuroimaging. Washington, DC: American Psychiatric Publishing, 2008
Osborn A: Diagnostic Imaging: Brain. Salt Lake City, Utah: AMIRSYS, 2005

SELF ASSESSMENT QUESTIONS

1. Which one of the following is measured by magnetic resonance spectroscopy?
a. dopamine
b. acetylcholine
c. n-acetylaspartate
d. gamma amino butyric acid
ANSWER: c

2. Which one of the following has no published atlas of pathognomonic lesions?
a. CT
b. PET
c. MRA
d. MRI
ANSWER: b

F42 **FORENSIC EVALUATION OF TEACHERS WHO VIOLATE BOUNDARIES**

Marilyn Price, MD, CM, Boston, MA
Donna Norris, MD, Wellesley, MA
Patricia Recupero, MD, JD, Providence, RI
Anne Ryan, EdD, (I) Camas, WA

EDUCATIONAL OBJECTIVE

To improve knowledge concerning teacher/student boundary violations or crossings and to improve skills in the performance of forensic evaluations of teachers referred for assessment following allegations of sexual misconduct.

SUMMARY

Despite the prominence of articles in the news media exposing the problem of teacher sexual misconduct, the subject of teacher-student boundary violations/crossings in elementary and high schools has received relatively little attention in the forensic literature. There is little published literature to help guide forensic evaluators asked to conduct assessments in cases of alleged teacher misconduct. Following an introduction of the topic, the workshop will provide a brief overview of the applicable law and legal considerations. An educator will discuss the ethical considerations and guidelines governing the teacher/student relationship in public education. She will describe the options available to the school boards and licensing boards when a complaint arises. We will then discuss elements of the evaluation from a forensic perspective, identifying themes to address in the assessment and providing possible recommendations for intervention or treatment. Finally, a case which highlights the difficulty inherent in performing these evaluations will be presented to foster audience analysis and discussion.

REFERENCES

Barrett DE, Headley KN, Stoval B, Witte JC: Teachers' perceptions of the frequency and seriousness of violations of ethical standards. J Psychology 140(5):421-33, 2006
Fitzgerald v. Barnstable School Committee 129 S.Ct.788; 172 L. Ed 2d 582; 20

SELF ASSESSMENT QUESTIONS

1. In a recent survey of school professionals, their perception of the frequency and seriousness of ethical violations was:
a. Student teacher boundary violations were rated as the most serious ethical violation.
b. Student teacher boundary violations were rated as the most common ethical violation.
c. Carelessness in behavior was rated as the least common ethical violation.
d. Carelessness in behavior was rated as the most serious ethical violation.
ANSWER: a

2. Fitzgerald v. Barnstable School Committee:
a. Was decided by the Supreme Court of the United States in 2009.
b. Is a case in which the Court held that § 1983 suits based on the Equal Protection Clause remained available to plaintiffs alleging unconstitutional gender discrimination in schools.
c. Is a case in which the Supreme Court rendered a unanimous decision
d. All of the above
ANSWER: d

F43 TO SELL OR NOT TO SELL; HERE ARE THE QUESTIONS

Corey A. Beck, MD, Atlanta, GA
The Honorable Stephanie Manis, (I) Atlanta, GA
Douglas Mossman, MD, Cincinnati, OH
Julie Rand, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE
To better prepare the forensic psychiatrist who might be called to testify before the court regarding the question of court ordered medication for the sole purpose of restoring competency to stand trial.

SUMMARY
This panel will discuss the pertinent issues of court-ordered involuntary medication for the sole purpose of competency restoration broken down by the criteria laid out in the 2003 Supreme Court case Sell v. U.S. After a brief introduction and overview, including some interesting follow-up on the case of Dr. Sell, presented by Dr. Beck, each speaker will address a critical area of the Sell criteria. Dr. Rand will speak about educating the court about the efficacy and potential side-effects of psychiatric medications. Judge Manis will discuss weighing state's interest. Dr. Mossman will discuss addressing likelihood of restoration. At the end of the discussion the attending forensic psychiatrist should feel better prepared to, if called upon, discuss each of the Sell criteria before the court.

REFERENCES
Mossman D: Predicting restorability of incompetent criminal defendants. J Am Acad Psychiatry Law 35:1:34-43, 2007
Sell v. U.S., 539 U.S. 166 (2003)

SELF ASSESSMENT QUESTIONS
1. Which of the following is not a concern regarding involuntary medication administration outlined by the U.S. Supreme Court in the Sell case?
a. whether the psychiatric medication is necessary to restore the patient to competence
b. whether the psychiatric medication will be so sedating or cognitively impairing as to render the defendant unable to assist counsel
c. whether there are potential viable alternatives to involuntary psychiatric medications that may be used to restore competence such as psychotherapy
d. none of the above
ANSWER: d

2. According to Dr. Mossman's research, which of the following is not significantly associated with a lower probability of restoration to competence to stand trial?
a. mental retardation
b. schizophrenia or Schizoaffective Disorder
c. absence of a substance use disorder
d. misdemeanor charge
ANSWER: c

F44 STALKING RISK ASSESSMENT AND PREVENTION: THEORY TO PRACTICE

James L. Knoll, IV, MD, Liverpool, NY
John Femia, BA, (I) New York, NY
Graham Glancy, MB, Toronto, ON, Canada
Phillip Resnick, MD, Cleveland, OH
Debra A. Pinals, MD, Boston, MA

EDUCATIONAL OBJECTIVE
Participants will learn about the most recent stalking research findings. Participants will be familiar with up to date risk assessment and risk management issues. Participants will be familiar with the stalking victims' most common concerns and emotional reactions, and what is most helpful to them from a risk management standpoint.

SUMMARY
Over the past several decades, stalking research has provided helpful information allowing forensic psychiatrists to more objectively assess stalker typology, evaluate violence risk, and make recommendations to an anti-stalking team. This course will be taught by experienced educators who have published in the area of stalking. It will begin by covering the most recent, or "state of the art," knowledge about stalking behavior and victimization. A comprehensive discussion of risk factors will be followed by the presentation of a newly developed structured clinical guide, the "Stalking HARM," that has been designed to serve as an aide-memoire to qualified experts who are charged

with predicting violence in stalkers. Real life case examples will be used to illustrate how the above evidenced-based data can be used to examine stalkers' threatening communications, and to make helpful recommendations to law enforcement and victims. This portion will involve significant audience participation. A video vignette of a Fox News anchor who was stalked and sought consultation with the presenters will discuss her experience, what steps she took and what she ultimately found helpful. Finally, a veteran police detective and private investigator will discuss the wide-ranging security issues, and how forensic psychiatrists can best assist law enforcement.

REFERENCES

Knoll, J: Risk management of stalking, in Stalking: Psychiatric Perspectives and Practical Approaches. Edited by Pinals D. New York: Oxford University Press, 2007, pp 85-106
Baum K, Catalano S, Rand M: Stalking Victimization in the United States. Bureau of Justice Statistics Special Report, U.S. Dept. of Justice. January, 2009, pp 1-15

SELF ASSESSMENT QUESTIONS

1. In the U.S., the most common threats made against stalking victims consisted of?
a. hit/slap/harm
b. kill the victim
c. harm a pet
d. all of the above
e. a and b only
ANSWER: e

2. In the U.S., approximately how many stalking victims reported some form of cyberstalking (such as e-mail or instant messaging)?
a. 1 in 2
b. 1 in 10
c. 1 in 8
d. 1 in 4
ANSWER: d

F45 **FORENSIC SAMPLER: FIRESETTING AND BOMBING**

Alan Felthous, MD, St. Louis, MO
Douglas Carpenter, MS, (I) Columbia, MD
Daniel Martell, PhD, (I) Washington, DC
Douglas Ubelaker, PhD, (I) Washington, DC
Allan Warnick, DDS, (I) Livonia, MI
Robert Weinstock, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE

Those in attendance will understand how the forensic sciences of engineering, anthropology and odontology contribute to the investigation of fires and bombings and the types of psychological trauma that victims of arson and bombings can experience.

SUMMARY

Destructive fires and explosions must be investigated forensically, and the terror, trauma, and loss to human victims must be addressed. Engineering, physical anthropology and odontology are three forensic disciplines that investigate incendiary and explosive events. Douglas J. Carpenter, MS, from the Engineering Section of the American Academy of Forensic Sciences will explain how forensic engineers investigate fire setting and bombing. Douglas Ubelaker, PhD, from the Physical Anthrolopology Section will review thermal alterations in bone and how they relate to case interpretations in forensic anthropology. Allan Warnick, DDS, from the Odontology Section, will illustrate how new hand-held x-ray units, digital radiographic systems and computer-generated identification programs make it possible to accomplish identification in the comforts of a modern medical examiners office, or in the most isolated rural conditions. Daniel Martell, PhD, from the Psychiatry and Behavioral Science Section will explore the dynamics of the arson victim's experience, with attention paid to issues of loss, survivor guilt, problems involving the perpetrator, and a range of psychiatric sequelae, including depression and post traumatic stress. Additionally, issues involved in the treatment of arson survivors will be discussed.

REFERENCES

Schmidt CW, Symes SA (editors). The Analysis of Burned Human Remains. New York: Academic Press, 2008
Williams D, Clements P: Fire and behavior: exploring intrapsychic trauma in arson survivors, Issues in Mental Health Nursing 26(3):299-310, 2005

SELF ASSESSMENT QUESTIONS

1. For accurate forensic dental identification all of the following antemortem dental information received from the dental office must contain all of the following except:

a. original radiography (with the patient's name, date x-ray taken)
b. complete patient dental chart and record (can be a copy)
c. intra-oral photographs
d. treating dentist's signature (on the radiographs/charts)
ANSWER: c

2. Which bone color corresponds to the extreme thermal changes in bone represented by calcine remains?

a. black
b. brown
c. white
d. gray
ANSWER: c

F46 FUNCTIONAL ASSESSMENT OF RISK IN FORENSIC PSYCHIATRY

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

EDUCATIONAL OBJECTIVE

Participants will understand the fit of functional risk assessment to the goals of clinical forensic practice; be familiar with a tool in development to assess function; experience the application of functional risk assessment to a variety of cases presented; and consider the benefits of various methodologies in assessing risk.

SUMMARY

Risk assessment and management consultations are primary functions of forensic psychiatry. Although some approaches rely on static risk factors and others combine static and dynamic factors, few models relate risk factors to targeted treatment and outcomes. The mechanisms for connecting psychiatric symptoms to risk have not been delineated and are not reflected in measures that include dynamic factors. We have been developing a risk assessment/management paradigm (Functional Assessment and Intervention of Risk (FAIR)) that focuses on function across behavioral, cognitive and emotional domains. Using a function trajectory to determine risk levels and effect of treatment provides a model that is congruent with the multiple roles of the forensic psychiatrist that include reduction of suffering, improved function, and amelioration of risk. Through case examples with audience participation, we will examine the efficacy of the functional assessment strategy in clinical decision making. We will apply the Functional Risk Assessment Tool (FRAT), a tool-in-development based on the functional assessment paradigm. Within the different case scenarios, we will demonstrate the effectiveness of integrating static and dynamic data, including the FRAT, to identify different risk profiles, treatment requirements, and risk management and discharge considerations. We will invite participants to compare and contrast the methodologies.

REFERENCES

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

SELF ASSESSMENT QUESTIONS

1. The Functional Assessment and Intervention Risk Model (FAIR): includes all of the following assumptions except:

a. Psychiatric symptoms impair capacity to reason, make appropriate decisions,
control emotion and direct behavior.
b. Psychiatric diagnosis is the primary indicator of risk.
c. Impaired capacities create measurable changes in function.
d. Restoring functional capacity is an effective risk management strategy.
ANSWER: b

2. Measures of function using the Functional Risk Assessment Tool (FRAT) have thus far been correlated with:

a. long-term risk of violence in the community
b. risk of violence on inpatient psychiatric units
c. success in completing jail diversion programs
d. scores on the Global Assessment of Function Scale
ANSWER: c

F47 HIGHER FUNCTIONING AUTISM AND THE PARAPHILIAS

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

EDUCATIONAL OBJECTIVE
To explore the potential relation between higher functioning autism and paraphilic behavior using data collected from a sample of 20 individuals with higher functioning autism undergoing forensic psychiatric evaluation.

SUMMARY
In recent years, the relationship between autism and criminal behavior has been receiving increased attention in forensic psychiatric settings, especially in the context of violent or aggressive offenses whether by direct physical assault or violence resulting from a proxy such as bombs or poison. However, the relationship between autism and the particular subset of offenses involving criminal sexual behavior appears less clear. To explore the latter relationship, 20 cases of higher functioning autism spectrum disorders (hfASD), i.e., Asperger's Disorder or Pervasive Developmental Disorder, who have been charged with criminal sexual offenses are studied not only in terms of demographic and diagnostic characteristics, but also from the perspective of internal coherence, extreme male theory, and Theory of Mind. The findings from this study point to a potential neuropsychiatric model to explicate the relationship between hfASD and the paraphilias. This neuropsychiatric construct may also have applicability to areas of nonparaphilic sexuality.

REFERENCES
Henault I: Asperger's Syndrome and Sexuality: From Adolescence Through Adulthood. Philadelphia, PA: Jessica Kingsley Publishers, 2006
Aston M: Aspergers in Love: Couple Relationships and Family Affairs. Philadelphia, PA: Jessica Kingsley Publishers, 2003

SELF ASSESSMENT QUESTIONS
1. Which of the following statements about Asperger's Disorder is incorrect?
a. In children, it is frequently associated with aggression.
b. Some cases of Pervasive Developmental Disorder may present with greater disabilities than in some cases of Asperger's Disorder.
c. It may be misdiagnosed as a Social Phobia or as Schizoid Personality Disorder.
d. It may be associated with mild mental retardation or a high level of intelligence.
e. It may co-occur with Necrophilia.
ANSWER: d

2. Forensic psychiatric assessment of individuals with Asperger's Disorder may be optimized by which of the following?
a. assessment of evaluee's family for the presence of autistic symptoms.
b. conceptualization of the evaluee from the perspective of the extreme male theory of autism.
c. using neuropsychological testing designed to explore Theory of Mind abilities and internal coherence.
e. all of the above.
ANSWER: e

F48 COMPARISON OF US MILITARY AND TEXAS COMMITMENT PROCESS

Gianina Gomez, MD, San Antonio, TX
Matthew Faubion, MD, San Antonio, TX
Leah Frazier, MD, (I) San Antonio, TX

EDUCATIONAL OBJECTIVE
To provide an overview and comparison of the involuntary commitment process of the U.S. Military and Texas.

SUMMARY
The United States military has unique security and mission needs as it relates to mental illness. For instance, the involuntary psychiatric hospitalization of military members is based on dangerousness to self, others, or military mission (to include property). One of the fundamental differences between the military and civilian involuntary mental health systems is that the military does not allow for judicial involvement at any stage of the commitment process (either initiation or maintenance of the involuntary psychiatric hospitalization). The U.S. military instead mandates that a second doctoral-level mental health provider conduct reviews for appropriateness of continued involuntary mental health treatment. The purpose of this research is to compare the civil commitment procedures in the U.S. military (specifically Lackland AFB, TX) with the civil commitment process in the Bexar County mental health court (the civilian court encompassing San Antonio---where Lackland AFB is located). This presentation will highlight the differences between the U.S. military system and the Texas statutes governing involuntary psychiatric hospitalization. This

research will discuss the numbers of psychiatric hospitalizations in the civilian sector and at Lackland AFB, and compare release rates between a judicially-driven model and the second-provider reviewer provided for in the U.S. military.

REFERENCES

DoD Directive 6490.1, "Mental Health Evaluations of Members of the Armed Forces," October 1, 1997
Texas Health and Safety Code Chapters 571 through 578

SELF ASSESSMENT QUESTIONS

1. What does the U.S. military's procedure for involuntary psychiatric hospitalization allow for?
a. judicial review and oversight
b. second provider review
c. all of the above
ANSWER: c

2. The judicially-driven review of involuntary psychiatric hospitalizations as compared to the second-provider review system in the U.S. Military results in:
a. more frequent release of civil committees
b. less frequent release of civil committees
ANSWER: a

F49 TRIAGING THE IST PATIENT: A BRIEF SCREEN TO REDUCE LOS

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

EDUCATIONAL OBJECTIVE

The attendee will understand the use of a brief screening process on admission that is intended to reduce the length of stay and improve treatment of patients found incompetent to stand trial.

SUMMARY

Competence for criminal adjudication, more commonly called competence to stand trial, is requisite in the U.S. for criminal defendants. Recent estimates indicate that between 50,000 and 60,000 defendants in the U.S. raise competence as an issue, with approximately 20% found incompetent to stand trial (IST). Jurisdictions vary in regard to how these evaluations are conducted. For example, in Virginia, evaluators are required to attend specialized training. Presumably, such training includes the performance of assessments to rule out the possibility of feigning psychiatric symptoms (when appropriate). In an effort to reduce the length of stay in our IST patients, NSH implemented a triage process to evaluate several aspects relevant to competence: malingering, psychotic symptoms, cognitive deficits and current competence (on admission). These data will be presented with a focus on the assessment of malingering and the validity of the assessments used. Over 300 patients have been evaluated using the M-FAST, the BPRS and aspects of the Georgia Court Competence Test. Data will be presented on the reliability of these assessments and changes in length of stay as a result of this triage process.

REFERENCES

Mossman D: Predicting restorability of incompetent criminal defendants. J Am Acad Psychiatry Law 35:34-43, 2007
Buchanan A: Competency to stand trial and the seriousness of the charge. J Am Acad Psychiatry Law 34:458-65, 2006

SELF ASSESSMENT QUESTIONS

1. Which of the following may be a barrier to speedy restoration to competence?
a. malingering
b. cognitive deficits
c. cultural issues
d. all of the above
ANSWER: d

2. Which of the following assessments does not evaluate the feigning of psychiatric symptoms?
a. TOMM
b. SIMS
c. M-FAST
d. SIRS
ANSWER: a

F50 JUVENILE WAIVERS: WHICH FACTORS INFLUENCE DECISIONS?

Ronald Means, MD, Baltimore, MD
Lawrence D. Heller, PhD, (I) Towson, MD
Jeffrey Janofsky, MD, Timonium, MD

EDUCATIONAL OBJECTIVE
The objective of this study and research-in-progress presentation is to explore which factors are most influential for evaluators when providing opinions on whether the jurisdiction of a juvenile should be transferred. In addition, factors that may influence the decisions of the judges will be examined.

SUMMARY
All states have a means of transferring defendants from juvenile to adult criminal court. Typically, waiver hearings are held to determine the appropriateness of the transfers. Waiver hearings usually involve a mental health evaluation of the juvenile. (In some states this evaluation is required by statute.) Clinicians might be asked to assess the youth's level of maturity, amenability to rehabilitation, and likelihood of future violence and offense in addition to the presence and role of any mental disorder. In the Medical Office for the Circuit Court of Baltimore City, evaluators are charged with completing reverse waiver evaluations. Although each evaluator assesses the same factors, the methods employed in the assessments vary. In addition, it is uncertain what factors influence the opinion of the evaluators when assessing each area. After the evaluator's report is completed, the judge provides the final decision whether the case is transferred back to juvenile court. We investigated how often the judge agreed with the opinion of the evaluators, and which factors are most important to the opinion of the evaluators and the final decision of the judge.

REFERENCES
Kruh IP, Brodsky SL: Clinical evaluations for transfer of juveniles to criminal court: current practices and future research. Behav Sci Law 15:151-65, 1997
Griffin P, Torbert P, Szymanski L: Trying juveniles as adults in criminal court: an analysis of state transfer provisions. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 1998

SELF ASSESSMENT QUESTIONS
1. What factor is most influential to the evaluator's opinion?
ANSWER: amenability to treatment

2. What factor is most influential to the judge's decision?
ANSWER: the evaluator's opinion

F51 COMPUTERS AND TECHNOLOGY IN FORENSIC PSYCHIATRY

Mark Hauser, MD, Newton, MA
Alan Newman, MD, Washington, DC
Jason Roof, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
Participants will learn ways to improve forensic psychiatry practice utilizing the latest technology, will become familiar with many benefits and some detriments of computers, handheld devices, software and connectivity, gain understanding of useful software, heighten awareness of privacy and encryption regulations, and achieve familiarity with selected applications and websites.

SUMMARY
The Computers and Forensic Psychiatry Committee hosts an annual workshop for participants to learn about the use of computer hardware, software, connected gadgets and connectivity, that can enhance training in, and the practice of, forensic psychiatry. Presenters will review a variety of applications, services and gadgets that facilitate and enhance psychiatric practice. More and more people use smart phones, and a vast array of software applications has become available. The presenters will present information about many representative and valuable tools. Presenters will discuss aspects of social networking that are relevant for consideration by the forensic psychiatrist. For the beginner, there will be a review of some computer basics, including the importance of backup strategies and growing concerns about privacy and data security. The presenters will review some of the hazards of the internet and connection to it. HIPAA mandates the use of technology, and data encryption assumes greater prominence. The presenters will demonstrate the use of web-based research to enhance forensic psychiatry practice, and will review selected resources of interest to the forensic psychiatrist. The audience is encouraged to bring questions and share their relevant experience to enable dialogue with the presenters.

REFERENCES

U.S. Department of Health & Human Services website section on Health Information Privacy. http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/index.html accessed 4/13/09

Mossbert W: Walt Mossberg's Column Archive Personal Technology: Some Favorite Apps That Make iPhone Worth the Price. Wall Street Journal. March 25, 2009, accessed 4/13/09 http://online.wsj.com/article/SB123801598971341281.html

SELF ASSESSMENT QUESTIONS

1. The HIPAA Privacy Rule contains many key elements of relevance to psychiatrists. Which of the following are key elements?

a. who is covered
b. what information is protected
c. how protected health information can be used and disclosed
d. allows the unfettered flow of information within the system

ANSWER: d

2. Which of the following strategies can enhance psychiatric practice for the forensic psychiatrist?

a. Familiarity with free tools available online such as medication databases including Epocrates and Medscape, and literature search capabilities including Google Scholar.
b. Developing and using a secure and reliable backup strategy.
c. Using a smart phone enriched with various software applications.
d. Establishing access to online repositories of information using academic affiliations if available and/or paid accounts such as APA online.
e. All of the above.

ANSWER: e

SATURDAY, OCTOBER 31, 2009

POSTER SESSION C — 7:15 AM – 8:00 AM/ 9:30 AM – 10:15 AM — **HARBORSIDE FOYER**

S1 ***Violence Risk Assessment of Children: An Overview***
Sylvester Smarty, MD, Broadview Heights, OH
Christopher Davidson, MD, Sioux Falls, SD
Michael Harlow, MD, JD, Sacramento, CA

S2 ***Sexting: Teen Flirtation or Sex Offense?***
Cheryl Hill, MD, PhD, Morgantown, WV
James Peykanu, MD, Morgantown, WV

S3 ***Suzy Q, Barney, & Red Dragon: A Correctional Addiction Tale***
Michael Harlow, MD, JD, Sacramento, CA
Christoper Davidson, MD, Sioux Falls, SD

S4 ***Self-Injurious Behaviors In Corrections Environments***
Michael Harlow, MD, JD, Sacramento, CA
Elena del Busto, MD, Philadelphia, PA
Oliver Barton, PsyD, (I) Sioux Falls, SD
Christopher Davidson, MD, Sioux Falls, SD

S5 ***State Electroconvulsive Therapy Laws: Psychiatry Issues***
Michael Harlow, MD, JD, Sacramento, CA
Christopher Davidson, MD, Sioux Falls, SD
Joan Prudic, MD, (I) New York, NY
Slyvester Smarty, MD, Broadview Heights, OH

S6 ***Criminality and Dissociative Identity Disorder***
Helen Farrell, MD, Cincinnati, OH

S7 ***Expert Witness Competency - An Anglo-American Law Review***
Tony Adiele, MRCPsych, (I) Manchester, United Kingdom

S8 ***Involuntary Medication and Disciplinary Charges***
Anasuya Salem, MD, MPH, Basking Ridge, NJ
Rusty Reeves, MD, South Orange, NJ

S9 ***The Pit and the Pendulum: Sex Laws and Research***
John Paul Fedoroff, MD, Ottawa, ON, Canada
Albert Grudzinskas, Jr., JD, (I) Worcester, MA
Samuel Leistedt, MD, Boston, MA
Paul Linkowski, MD, PhD, (I) Brussels, Belgium
Fabian Saleh, MD, Boston, MD
Jean-Luc Senninger, MD, (I) Boston, MA
Michael Bunzel, MD, (I) Boston, MA
Peer Briken, MD, (I) Hamburg, Germany

S10 ***Reduction of Prescriptions of Benzodiazepines in Prison***
Rusty Reeves, MD, South Orange, NJ

S11 ***How Coerced Are the Coerced?***
Gary Collins, MD, New York, NY
Haroon Saeed, MD, Woodhaven, NY
Scott Soloway, MD, New York, NY

S12 ***Psychiatric Advance Directives: A State by State Review***
Brian Daly, MD, Providence, RI
Paul Christopher, MD, Providence, RI
Keelin Garvey, MD, Providence, RI
Marilyn Price, MD, CM, Boston, MA
Patricia Recupero, JD, MD, Providence, RI
Sarah Xavier, DO, Providence, RI

S13 ***Social Networking Site Usage by Adolescent Patients***

Smitha Bhandari, MD, Atlanta, GA
Zachary May, BA (I) Atlanta, GA

S14 ***Use of Opioids in Pain Treatment: Ethical and Legal Issues***

Nalan Ward, MD (I) Boston, MA
Joji Suzuki, MD (I) Boston, MA

S15 ***Incorporating Mindfulness into Sex Offender Therapy***

Tammy Benoit, MA (I) Worcester, MA
Fabian Saleh, MD, Boston, MA

S16 ***Cannabis and Forensic Psychiatry***

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

S17 ***The Mara Salvatrucha Gang***

J. Arturo Silva, MD, San Jose, CA

S18 ***The Forensic Psychiatry of the Hikikomori Phenomenon***

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

S19 ***Shoplifting, Kleptomania, and Substance Use***

Fabian Saleh, MD, Boston, MA
Georgia Stathopoulou, PhD, (I) Boston, MA
Nalan Ward, MD, (I) Boston, MA

S20 ***Current Standards of Violence Risk Assessment***

Rebecca Brendel, MD, JD, Boston, MA
Christopher Myers, MD, Wilmington, NC
Fabian Saleh, MD, Boston, MA

COFFEE BREAK **9:45 AM - 10:00 AM** **HARBORSIDE FOYER**

RESEARCH IN PROGRESS #4 10:00 AM - 12:00 PM **ESSEX**

S21 ***Psychiatric Characteristics of Homicide Defendants***

Christine A. Martone, MD, Pittsburgh, PA
Edward Mulvey, PhD, (I) Pittsburgh, PA
Andrei Nemoianu, MD, St. Peter, MN
Ryan Shugarman, MD, Alexandria, VA
Amarpreet Singh, MD, Pittsburgh, PA
Suzanne Yang, MD, Pittsburgh, PA

S22 ***The Ciudad Juarez Female Homicides (1993-2008)***

J. Arturo Silva, MD, San Jose, CA

S23 ***Gender and Delusions in Women Homicide Offenders***

Jessica Ferranti, MD, Sacramento, CA
Barbara McDermott, PhD, (I) Sacramento, CA

S24 ***Involuntary Treatment of Inmates: A Tougher Sell for Jails?***

Gregory Sokolov, MD, Davis, CA

PANEL 10:00 AM - 12:00 PM **HARBORSIDE D**

S25 ***Current Controversy in Juvenile Delinquency***
Child And Adolescent Psychiatry Committee

Peter Ash, MD, Atlanta, GA
Joseph Kenan, MD, Los Angeles, CA
Christopher Thompson, MD, Los Angeles, CA
Robert Weinstock, MD, Los Angeles, CA

PANEL 10:00 AM - 12:00 PM **HARBORSIDE A/B**

S26 ***Forensic Psychiatric Analysis of Dictators-Historical Lessons***

Andrew R. Kaufman, MD, Fayetteville, NC
James Knoll IV, MD, Syracuse, NY
Robert T.M. Phillips, MD, PhD, Annapolis, MD
Jerrold Post, MD, (I) Bethesda, MD
Dan Cotoman, MD, Marcy, NY

WORKSHOP — 10:00 AM - 12:00 PM — **LAUREL**

S27 ***Challenges in Compensation and Pension Examination of Veterans***

Jagannathan Srinivasaraghavan, MD, Carbondale, IL
Antony Fernandez, MD, Richmond, VA
Thomas Martin, MD (I) North Chicago, IL

PANEL — 10:00 AM - 12:00 PM — **HARBORSIDE E**

S28 ***Forensic and Ethical Issues in Developmental Disability Psychiatry***

Developmentally Disabled Committee

John Paul Fedoroff, MD, Ottawa, ON, Canada
Albert Grudzinskas, Jr., JD, (I) Worcester, MA
Mark Hauser, MD, Newton, MA
Deborah Richards, (I) Welland, ON, Canada
Fabian Saleh, MD, Boston, MA

LUNCH (TICKET REQUIRED) — 12 NOON – 2:00 PM — **HARBORSIDE C**

S29 ***Locating Persons and Finding Experts***

Kyle Courtney, Esq., (I) Hanover, MA

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

S30 ***Web-Based Forensic Curriculum for Psychiatry Residents***

Forensic Training of Psychiatry Committee

Michael Harlow, MD, JD, Sacramento, CA
Elizabeth Hogan, MD, Colorado Springs, CO

S31 ***Medical and Mental Health Needs in Community Corrections***

Tracy Gunter, MD, St. Louis, MO

S32 ***General Psychiatry Residents in Correctional Clinics***

Catherine Lewis, MD, Farmington, CT

PANEL — 2:15 PM - 4:00 PM — **LAUREL**

S33 ***To Catch A Conman!***

Charles C. Dike, MD, MPH, New Haven, CT
Babatunde Adetunji, MD, MS, Voorhess, NJ
Akintunde Akinkunmi, MD, Bedfordshire, United Kingdom
Ezra E.H. Griffith, MD, New Haven, CT

PANEL — 2:15 PM - 4:00 PM — **HARBORSIDE A/B**

S34 ***The Capsule Made Me Do It - Psychoactive Drug Defenses***

Psychopharmacology Committee

Gary Chaimowitz, MB, Ancaster, ON, Canada
Graham Glancy, MB, Toronto, ON, Canada
Thomas Gratzer, MD, Edina, MN
Victoria Harris, MD, MPH, Edmonds, WA

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

S35 ***Implementing the COVR as a Screen for Aggression***

Barbara McDermott, PhD, (I) Sacramento, CA
Carmen Caruso, MA, (I) Napa, CA
Anthony Rabin, PhD, (I) Napa, CA
Katherine Warburton, DO, (I) Napa, CA

COURSE (TICKET REQUIRED) — 2:15 PM - 6:15 PM — **HARBORSIDE E**

S36 ***Successful Treatment of Problematic Sexual Behaviors (Advanced)***

Sexual Offenders Committee

John Paul Fedoroff, MD, Ottawa, ON, Canada
John Bradford, MB, Brockville, ON, Canada
William Marshall, PhD, (I) Kingston, ON, Canada
Fabian Saleh, MD, Boston, MA

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

PANEL 4:15 PM - 6:15 PM **HARBORSIDE A/B**

S37 ***The Death Penalty and Mitigating Evidence: Suicide by Court?***

Hal S. Wortzel, MD, Denver, CO
John Blume, JD, (I) Ithaca, NY
Greg Kellermeyer, MD, Denver, CO
Richard Martinez, MD, MH, Denver, CO

PANEL 4:15 PM - 6:15 PM **ESSEX**

S38 ***Evidence-Based Prognosticating PTSD in Civil Litigation (Core)***

Stuart B. Kleinman, MD, New York, NY
The Honorable Robert E. Cadigan, (I) Baltimore, MD
Andrew Levin, MD, Hartsdale, NY
Charles Morgan III, MD, (I) New Haven, CT

WORKSHOP 4:15 PM - 6:15 PM **HARBORSIDE D**

S39 ***Psychiatric Evaluations for Immigration Cases***
Trauma and Stress Committee

Vivian Chern-Shnaidman, MD, Princeton, NJ
Marlyn Quinn, JD, (I) Princeton, NJ

PANEL 4:15 PM - 6:15 PM **LAUREL**

S40 ***Legal and Ethical Aspects of Prisoner Hunger Strikes (Core)***

Michael Greenspan, MD, New Haven, CT
Chinmoy Gulrajani, MD, New Haven, CT
Emily Keram, MD, Santa Rosa, CA
Jeffery Metzner, MD, Denver, CO

S1 VIOLENCE RISK ASSESSMENT OF CHILDREN: AN OVERVIEW

Sylvester Smarty, MD, Broadview Heights, OH
Christopher Davidson, MD, Sioux Falls, SD
Michael Harlow, MD, JD, Sacramento, CA

EDUCATIONAL OBJECTIVE
This activity aims to improve proficiency in the evaluation of violence risk in children. This is achieved by the identification of the most common risk and protective factors for violence in children. In addition, structured instruments to assist in such evaluations are identified.

SUMMARY
The prevalence of fatal violence perpetrated by children is increasing. Even more worrisome is the reality that other children are often the victims of these violent children. This is evident in the growing number of school and gang related shootings. According to the Centers for Disease Control (CDC), homicide is the second most common cause of death among children. In 1999, children accounted for 10% of all individuals arrested for murder. One particularly alarming statistic is that the direct and indirect cost of youth violence exceeds $158 billion yearly. Utilizing an online search of common medical databases, this poster reviews the current literature on the evaluation of violence risk in children. Risk and protective factors for youth violence will be discussed. In addition, a systematic approach for assessing the risk of violence in children will be provided, delineating potential psychometric parameters of youth violence.

REFERENCES
Hahn R, Fuqua-Whitley D, et al: Effectiveness of universal school-based programs to prevent violent and aggressive behavior: a systemic review. Am J Prev Med 33(2): S114-29, 2007
Murakami S, Rappaport N, Penn JV: An overview of juvenile and school violence. Psychiatr Clin North Am 29(3):725-41, 2006

SELF ASSESSMENT QUESTIONS
1. What is the percentage of children arrested for murder that were found to be psychotic at the time they committed their crime?
a. 23%
b. 17%
c. 12%
d. 7%
e. 5%
ANSWER: d

2. Protective factors for youth violence include all of the following except:
a. High IQ/ grade point average
b. Low resting heart rate
c. Intolerant attitude towards deviance
d. Religiosity
e. Resilient temperament
ANSWER: b

S2 SEXTING: TEEN FLIRTATION OR SEX OFFENSE?

Cheryl Hill, MD, PhD, Morgantown, WV
James Peykanu, MD, Morgantown, WV

EDUCATIONAL OBJECTIVE
The purpose of this presentation is to inform the forensic psychiatry community of the growing phenomenon of "sexting" (electronic text message transmission of nude or suggestive photographs) and to stimulate discussion on the topic.

SUMMARY
Sexting is a novel activity involving the electronic distribution, via text message, of nude or suggestive photographs. The prevalence of this behavior is unknown, but it is likely most common among teenagers. It is possible that the most common practice is to send photographs of oneself. The behavior involves the risk of having the image viewed by persons other than the intended recipient; however it is unknown if many who engage in the activity understand the potential legal consequences. Several states have begun prosecuting the activity under child pornography and sex offender statutes. An estimate from the National Center for Missing and Exploited Children is that one-fourth of children identified by the center as victims of online pornography sent the initial image of themselves. When caught exchanging, sending, or viewing sext messages, teenagers, are often charged with possession of child pornography or manufacturing and/or distribution of child pornography, and accorded sex offender status. It appears that girls are often charged with the more severe crimes. The purpose of this presentation is to inform the forensic psychiatry community of this growing issue, and to stimulate discussion on the topic.

REFERENCES
Sex and Tech: Results from a Survey of Teens and Young Adults. The National Campaign to Prevent Teen and Unplanned Pregnancy Survey Conducted from 25 September- 3 October 2008 and involved 653 teenagers (ages 13-19) and 627 young adults (ages 20-26)
Lithwick D: Textual misconduct: what to do about teens and their dumb naked photos of themselves. Slate (online magazine), 14 February 2009

SELF ASSESSMENT QUESTIONS

1. Among teens and young adults who have sent sexually suggestive content, what was the most common reason they gave for doing so? (according to the Sex and Tech survey)

a. to piss off my parents
b. to be fun and flirtatious
c. to win a bet or a dare
d. because I was in love with the recipient
ANSWER: b

2. About what percentage of teens and young adults reported that they had seen explicit images of someone that were not intended for them? (from the Sex and Tech survey)

a. less than 10%
b. between 10 and 20%
c. between 25 and 50%
d. above 50%
ANSWER: c

S3

SUZY Q, BARNEY, AND RED DRAGON: A CORRECTIONAL ADDICTION TALE

Michael Harlow, MD, JD, Sacramento, CA
Christopher Davidson, MD, Sioux Falls, SD

EDUCATIONAL OBJECTIVES
The educational objectives of this poster are to convey to the viewer the current level of knowledge regarding medication misuse in corrections settings and to assist in the development of more effective corrections treatment systems. Extent and aspects of inmate presciption misuse will be discussed, along with system management strategies.

SUMMARY
Substance use disorders among American prison inmates are a national mental health issue, with an estimated 53% of state prisoners and 45% of federal prisoners meeting criteria for substance dependence. Inmate misuse of prescription medications has emerged as an increasing challenge for corrections staff, in part, due to inmates' restricted access to illicit substances. Specifically, psychotropic medications have emerged as currency in the underground prison economy, with inmates misappropriating their prescribed psychotropic medications for monetary gain. Five years of South Dakota State Prison System computerized disciplinary reports were searched for inmate misuse of psychiatric medications. In addition, prison staff were surveyed, over a two-year period, regarding observed inmate economic value of psychotropic medications. In this study, bupropion, "Barney" in inmate slang, was the most commonly reported psychotropic medication of abuse. Bupropion comprised 49% of all disciplinary reports for medication misuse, with an approximate inmate economic value of $5-10 for a single 200 mg tablet. Other substances in high demand included quetiapine (Suzy Q) and venlafaxine (Red Dragon). This poster will discuss the scope and impact of prescription misuse in prison settings, study findings, and management strategies for improved inmate care.

REFERENCES
U.S. Department of Justice Office of Justice Programs. Bureau of Justice Statistics Special Report: Drug Use and Dependence, State and Federal Prisoners. 2004, 2007
Chandler, RK, Fletcher, BW, Volkow, ND: Treating drug abuse and addiction in the criminal justice system: improving public health and safety. JAMA 301(2):183-90, 2009

SELF ASSESSMENT QUESTIONS

1. In the South Dakota State Prison System study, what was the most commonly misused medication?

a. methadone
b. tylenol
c. quetiapine
d. bupropion
ANSWER: d

2. According to the U.S Department of Justice, in 2004, substance dependence in state and federal prisons affected what percentage of prisoners?
a. 10% of state prison inmates and 4% of Federal Inmates
b. 18% of state prison inmates and 29% of Federal Inmates
c. 53% of state prison inmates and 45% of Federal Inmates
d. none of the above
ANSWER: c

S4 **SELF-INJURIOUS BEHAVIORS IN CORRECTIONS ENVIRONMENTS**

Michael Harlow, MD, JD, Sacramento, CA
Elena del Busto, MD, Philadelphia, PA
Oliver Barton, PsyD, (I) Sioux Falls, SD
Christopher Davidson, MD, Sioux Falls, SD

EDUCATIONAL OBJECTIVE
The educational objective of this poster is to assist in the practice of forensic psychiatry at the highest level attainable regarding the issue of inmate self-injurious behaviors. This poster will convey the constellation of symptoms that comprise inmate self-injurious behaviors, inmate motivations, and provider strategies for behavior modification.

SUMMARY
Inmate self-injurious behaviors, a spectrum of harm in correction settings often distinct from suicidality, pose significant challenges for corrections staff world-wide. Self-injurious behaviors (SIB) are prevalent in prisons and jails, with corrections systems reporting inmate SIB rates of up to 50%. These behaviors place significant financial and manpower burdens on corrections systems already straining to meet patient healthcare needs. Inmates expressing SIB display a variety of etiologies and motives, which manifest most commonly in self-cutting and mutilation, insertion of foreign bodies, and harmful object ingestion. These inmates also display distinct and heightened levels of co-morbidity for DSM-IV Axis I and Axis II disorders. This poster will discuss the findings of a web-based search of legal and medical databases regarding inmate SIB. Etiologies, motivations, and manifestations of inmate SIB will be discussed. In addition, the impact of SIB on corrections environments will be examined, along with system management strategies for prevention and treatment.

REFERENCES
Fulweiler C, Forbes C, Santangelo SL, et al: Self-mutilation and suicide attempt: distinguishing features in prisoners. J Am Acad Psychiatry Law 25(1):69-77, 1997
Roe-Sepowitz D: Characteristics and predictors of self-mutilation: a study of incarcerated women. Crim Behav Ment Health 17(5):312-21, 2007

SELF ASSESSMENT QUESTIONS
1. In an American study of incarcerated female inmates, what percentage of inmates reported participating in self-injurious behaviors while incarcerated?
a. 10%
b. 20%
c. 30%
d. 40%
e. 50%
ANSWER: e

2. In a study of inmates admitted to a prison hospital for self-inflicted wounds, what percentage of inmates expressed a primary motivation for self-harm other than suicidality?
a. 0-15%
b. 15-30%
c. 30-45%
d. 45-60%
e. 60-75%
ANSWER: d

S5 STATE ELECTROCONVULSIVE THERAPY LAWS: PSYCHIATRY ISSUES

Michael Harlow, MD, JD, Sacramento, CA
Christopher Davidson, MD, Souix Falls, SD
Joan Prudic, MD, (I) New York, NY
Slyvester Smarty, MD, Broadview Heights, OH

EDUCATIONAL OBJECTIVE

The educational objective of this poster is to assist the viewer in practicing forensic psychiatry, regarding electroconvulsive therapy (ECT) issues, based on current knowledge in the field. The poster will convey to the viewer the current status of state ECT laws, and issues relevant to the practice of forensic psychiatry.

SUMMARY

Electroconvulsive therapy (ECT), a clinically effective treatment for a number of mental illnesses, has emerged as a method of psychiatric care increasingly governed under state law. Efforts by states to regulate the use of ECT have been motivated, in part, in response to negative public perceptions regarding ECT. State legislatures have enacted statutory minimums for valid patient consent to receive ECT, and have established judicial oversight procedures regarding involuntary ECT treatments. Moreover, psychiatrists providing patient care with ECT have been subject to legal action claims of negligence and battery as a result of patient physical injuries, memory loss, and issues of inadequate consent. This poster will discuss the findings of an internet-based search on ECT laws using legal and medical databases. State statutes and administrative codes defining patient voluntary consent, competency, and involuntary treatments with ECT will be reviewed. Landmark cases involving ECT will be discussed. In addition, current ECT standards of practice and tort liability issues will be examined.

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Simon R: Somatic therapies and the law, in Review of Clinical Psychiatry and the Law. Edited by Simon R. Arlington, VA: American Psychiatric Publishing, 1991, pp 3-82

SELF ASSESSMENT QUESTIONS

1. In what case did a court rule that patient consent for ECT was subject to court review under a clear and convincing standard of evidence?
a. Lillian F. v. Santa Clara County Medical Center
b. Price v. Sheppard
c. Pettis v. State
d. Wyatt v. Hardin
e. None of the above
ANSWER: a

2. Which of the following are predominant causes of tort action resulting from ECT treatments?
a. Inadequate pre-ECT medical examinations
b. ECT procedure resulting in patient injury
c. Lack of appropriate post-ECT supervision
d. Inadequate patient consent
e. all of the above
ANSWER: e

S6 CRIMINALITY AND DISSOCIATIVE IDENTITY DISORDER

Helen Farrell, MD, Cincinnati, OH

EDUCATIONAL OBJECTIVE

A forensic case report from a psychiatric resident's PGY-3 experience will be used to highlight the symptoms and presentation of dissociative identity disorder. Forensic psychiatric services will be enhanced through improved knowledge of this disease. Clinicians will acquire improved skills in the evaluation, diagnosis, and treatment of such forensic patients.

SUMMARY

Dissociative identity disorder causes excruciating patient and societal suffering through resultant criminal activity. Some cases of dissociative disorders may present in the criminal justice system rather than in the mental health system. Therefore, thorough evaluation, accurate diagnosis, and effective treatment of dissociative identity disorder are of critical importance. No one is immune to this devastating illness. Victims of the disease range from high school dropouts to Heisman Trophy winners. The case of Ally, a 30-year-old woman with an advanced degree and

esteemed occupation, is presented with the signs and symptoms of dissociative identity disorder. Criminal activities that this patient engaged in were stalking and arson. A case history, formulation, and treatment proposal are offered based on patient interviews and scientific research.

REFERENCES

Bisson JI: Automatism and post-traumatic stress disorder. Brit J Psychiatry 163: 830-32, 1993
Steinberg M, Rounsaville B, *et al*: Detection of dissociative disorder in psychiatric patients by screening instrument and a structured diagnostic interview. Am J Psychiatry 148: 1050-54, 1991

SELF ASSESSMENT QUESTIONS

1. What Heisman Trophy winner recently disclosed he suffers from DID?
ANSWER: Herschel Walker

2. What is the threefold phasic approach to treatment of patients with dissociative identity disorder as delineated by the psychiatrist Dr. Judith Herman?
ANSWER: The approach utilizes empathy, process of traumatic memories, and reintegration with rehabilitation.

S7 EXPERT WITNESS COMPETENCY - AN ANGLO-AMERICAN LAW REVIEW

Tony Adiele, MRCPsych, (I) Manchester, United Kingdom

EDUCATIONAL OBJECTIVE

Forensic psychiatrists are increasingly being required by the courts to give expert evidence both in criminal and civil matters. This research aims to review the requirements for competency in expert evidence provision in England and the United States of America, and to determine whether any similarities or differences exist.

SUMMARY

Expert opinion provision dates back to 14th Century English courts. Opinion evidence was originally deemed inadmissible as it is not for the witnesses, but for the court, to form opinions upon the facts before it. English common law has unclear precedents regarding an expert's competence. In R v Loake (1911), a nonmedical expert was not considered competent to give evidence on a defendant's mental state. Also, in R v Inch (1989), being a medical orderly was not sufficient qualification either. Although section 3(1) of Civil Evidence Act 1972 provides that experts must be "qualified", in R v Stubbs (2003) mere experience in absence of qualifications sufficed. Rule 33.3(1)(a) of Criminal Procedure Rules 2005 requires reports to include an expert's qualifications and experience. Federal Rule of Evidence 702 (USA) permits expert testimony if useful. However, reliability of evidence rather than its bearer appears more crucial. Daubert v. Merrell Dow (1993) provided that evidence admissibility depends on testing, peer review, error rate and wide acceptability. A similarity in England/US jurisdictions is the lack of clarity on an expert's competency. However, the majority of doctors interviewed in both countries suggests that specialized qualification may suffice. Ultimately, acceptance of an expert's testimony is at the mercy of the judge, who may pose voir dire questions to experts.

REFERENCES

Criminal Procedure Rules 2005 (England & Wales)
General Electric v. Joiner, 118 S. Ct. 512 (1997) (USA)

SELF ASSESSMENT QUESTIONS

1. In England and Wales, which of the following statutory instruments currently governs the provision of expert testimony by psychiatrists in criminal courts?
a. The Civil Procedure (Amendment) Rules 2007
b. The Mental Health Act 2007
c. The Civil Evidence Act 1972
d. The Criminal Procedure Rules 2005
ANSWER: d

2. In the United States of America, which of the following cases do not primarily relate to expert testimony?
a. Kumho Tire Co. v. Carmichael, 119 S. Ct. 167 (1999)
b. Daubert v Merrell Dow, 113 S. Ct. 2786 (1993)
c. Kansas v United States, 204 U.S 331 (1907)
d. General Electric v. Joiner, 118 S. Ct. 512 (1997)
ANSWER: c

S8 INVOLUNTARY MEDICATION AND DISCIPLINARY CHARGES

Anasuya Salem, MD, MPH, Basking Ridge, NJ
Rusty Reeves, MD, South Orange, NJ

EDUCATIONAL OBJECTIVE
To analyze medication compliance, incidence and type of disciplinary charges and rate of inpatient hospitalization within the prison.

SUMMARY
Background: Walter Harper, a mentally ill state prisoner, challenged the constitutionality of Washington's prison policy, contending that involuntary administration of antipsychotic drugs without a judicial hearing deprived him of due process. Noting that Harper has a liberty interest in being free from the arbitrary administration of drugs, the U.S. Supreme Court found that the state's policy reasonably related to its legitimate interest in avoiding possible dangers posed by violent, mentally ill inmates.The involuntary medication hearing is presided over by a small committee of nontreating mental health professionals who must render primarily a medical decision regarding the necessity of medication treatment. Objectives: To analyze medication compliance, incidence and type of disciplinary charges, rate of inpatient hospitalization within the prison. Methods: Study population includes data of 208 mentally ill inmates from all NJ prisons, placed on involuntary medication protocol from 2005-2008. These inmates' age, race, gender, legal history, education, marital status, psychiatric diagnosis, location of care in prison and their disciplinary charges will be collected from DOC database. Results Suggest: Placing mentally ill inmates on involuntary medication reduces their violence, and if medication compliance or other factors account for the anticipated reduction in disciplinary charges.

REFERENCES
Wests Supreme Court Report. Washington v. Harper, U.S. Supreme Court, 1990 Feb 27; 110:1028-56
Burns KA: Psychopharmacology in correctional settings, in Handbook of Correctional Mental Health. Edited by Scott CL, Gerbasi JB. Arlington, VA: APPI Press, pp 90-7

SELF ASSESSMENT QUESTIONS
1. What is the lifetime prevalence of violence among people with serious mental illness compared to people without mental illness?
a. 7%
b. 10%
c. 12%
d. 16%
ANSWER: d

2. How many severely mentally ill people are estimated to be crime victims each year in United States?
a. 100,000
b. 500,000
c. 1 million
d. 3 million
ANSWER: d

S9 THE PIT AND THE PENDULUM: SEX LAWS AND RESEARCH

John Paul Fedoroff, MD, Ottawa, ON, Canada
Albert Grudzinskas, Jr., JD, (I) Worcester, MA
Samuel Leistedt, MD, Boston, MA
Paul Linkowski, MD, PhD, (I) Brussels, Belguim
Fabian Saleh, MD, Boston, MA
Jean-Luc Senninger, MD, (I) Boston, MA
Michael Bunzel, MD, (I) Boston, MA
Peer Briken, MD, (I) Hamburg, Germany

EDUCATIONAL OBJECTIVE
At the end of this presentation participants will be able to compare contemporary attempts in the United States, Germany, Israel, Belgium, France, and Canada to address the risk created by sex offenders, describe the rationale for sentencing, and discuss treatment and risk management modalities across these nations.

SUMMARY
For centuries the criminal justice system has struggled to define the methodology and justifications for social control of sexual behaviors that do not conform to community mores. This poster will compare and contrast contemporary attempts in the United States, Germany, Israel, Belgium, France, and Canada to address the risk created by individuals

who engage in behaviors broadly characterized as sexually deviant. It will consider the rationale for sentencing, and attempts to bring treatment into the criminal dispositional formula for sexual based prosecution. It will also consider the impact that the choice of societal response has on risk assessment and evaluation in the various systems. This poster is intended as an overview of the law as it exists, and not as a defense or a critique of any specific model.

REFERENCES

Brakel SJ, Cavanaugh JL: Of psychopaths and pendulums: legal and psychiatric treatment of sex offenders in the United States. New Mex L Rev 30:69-94, 2000

Grudzinskas AJ, Brodsky DJ, Fedoroff JP, Zaitchik M, DiCataldo F, Clayfield JC: Sexual predator laws and their history, in Sex Offenders: Identification, Risk Assessment, Treatment, and Legal Issues. Edited by Saleh FM, Grudzinskas Jr.AJ, Bradford JM, Brodsky D. New York: Oxford University Press, 2009, pp 386-411

SELF ASSESSMENT QUESTIONS

1. How many states in the United States now have laws governing the commitment of sexually dangerous persons?
a. 50
b. 37
c. 10
d. 18
ANSWER: d

2. The laws governing the commitment of sexually dangerous persons in Europe can best be described as:
a. modelled on the U.S. standard as established by Kansas v. Hendricks
b. representing a variety of solutions that seem to have little in common
c. all featuring criminal sanctions as the basis for social control
d. all featuring civil commitment as the basis for social control
ANSWER: b

S10 REDUCTION OF PRESCRIPTIONS OF BENZODIAZEPINES IN PRISON

Rusty Reeves, MD, South Orange, NJ

EDUCATIONAL OBJECTIVE

To identify an effective technique for the reduction of benzodiazepines in a prison.

SUMMARY

Two-thirds to three-quarters of mentally ill inmates abuse drugs. Benzodiazepines are drugs of abuse, and are not the preferred choice for the treatment of anxiety and insomnia in prison. We hypothesized that if we allowed psychiatrists to anonymously compare their prescribing practices of benzodiazepines with their peers, the numbers of prescriptions of benzodiazepines in New Jersey's prisons would decrease. We ranked psychiatrists from highest frequency prescriber to lowest frequency prescriber, and coded the psychiatrists ' names. Each psychiatrist was given his code, but was blinded to his colleagues ' codes. At baseline, the average and median numbers of patients each FTE psychiatrist prescribed a benzodiazepine were 5.6 and 4, respectively. Seven months later, the average and median numbers for these psychiatrists were 3.3 and 2, respectively. These numbers reflect a 39% reduction in the numbers of inmates prescribed a benzodiazepine. Using a signed rank-order test, the difference between the means at baseline and at seven months is statistically significant ($p < 0.0005$.) Allowing psychiatrists to anonymously compare their prescribing practices of benzodiazepines to their colleagues' practices was an effective technique to reduce the prescriptions of benzodiazepines in New Jersey's prisons.

REFERENCES

Burns KA: Commentary: the top ten reason to limit prescription of controlled substances in prisons. J Am Acad Psychiatry Law 37(1):50-2, 2009

Abram KM, Teplin LA: Co-occurring disorders among mentally ill jail detainees: implications for public policy. Am Psychologist 46:1036-45, 1991

SELF ASSESSMENT QUESTIONS

1. What percentage of mentally ill inmates abuse drugs?
ANSWER: two-thirds to three-quarters

2. What is an effective technique for the reduction of the prescription of benzodiazepines in a state prison?
ANSWER: Ranking psychiatrists according to the frequency of their prescription of benzodiazepines, and allowing psychiatrists to anonymously compare their prescribing practices to those of their colleagues.

S11 HOW COERCED ARE THE COERCED?

Gary Collins, MD, New York, NY
Haroon Saeed, MD, Woodhaven, NY
Scott Soloway, MD, New York, NY

EDUCATIONAL OBJECTIVE
To demonstrate an understanding of the perception of coercion in the chronically mentally ill patients mandated to outpatient psychiatric treatment.

SUMMARY
Objective: To evaluate the perceptions of coercion in patients court-mandated by New York State's Kendra's Law (Court-Mandated Outpatient Psychiatric Treatment Program). Method: The authors examined the results of patients' perceived coercion to their court-mandated outpatient psychiatric treatment at 0-, 3-, 6-, 9-, and 12-month intervals into their mandates as assessed by the New York State Office of Mental Health. Results: A substantial reduction in perceived coercion appears to occur in a number of scales occurs during the pendency of the court mandate. Conclusions: These data suggest clinical reduction in perceived coercion during enrollment into court mandated outpatient psychiatric treatment over the course of one year. However, further investigation is warranted to assess what potential impact this finding places on treatment relationships and overall clinical outcomes for those court-mandated to outpatient psychiatric treatment.

REFERENCES
Ridgely MS, Borum R, Petrila J: RAND study on involuntary treatment for people with mental illness: empirical evidence and the experience of eight states. The RAND Institute for Civil Justice. September 2000
New York State Office of Mental Health: Kendra's Law Final Report http:/www.omh.state.ny.us/omhweb/Kendra_web/finalreport

SELF ASSESSMENT QUESTIONS
1. What percentage of those court-mandated by Kendra's Law report "anger and embarrassment" when first enrolled into the program?
a. 0-25%
b. 26-50%
c. 51-75%
d. 76-100%
ANSWER: c

2. At one year into the Kendra's Law mandate, patients reported perceived coercion helps most substantially with which of the following?
a. maintaining medication compliance
b. reducing involuntary hospitalizations
c. improving overall mental health
d. maintaining sobriety
ANSWER: a

S12 PSYCHIATRIC ADVANCE DIRECTIVES: A STATE-BY-STATE REVIEW

Brian Daly, MD, Providence, RI
Paul Christopher, MD, Providence, RI
Keelin Garvey, MD, Providence, RI
Marilyn Price, MD, CM, Boston, MA
Patricia Recupero, MD, JD, Providence, RI
Sarah Xavier, DO, Providence, RI

EDUCATIONAL OBJECTIVE
After reviewing this poster, viewers will be able to identify several different types of statutes on Psychiatric Advance Directives among the 50 states.

SUMMARY
Objective: As background research for a proposed statute Psychiatric Advance Directives (PAD) for the state of Rhode Island, we reviewed the statutes of all fifty states and the District of Columbia to determine which jurisdictions have PAD statutes. This presentation, which summarizes key aspects of these statutes, was created to be an informational resource and to provide an easy way to compare and contrast these statutes. Method: Using various legal databases, including those available on the internet, we collected qualitative data. Each of us examined the several statutes of the aforementioned jurisdictions and summarized key aspects of any extant PAD statutes we found. Information was pooled and is summarized in table form. (i.e. those not part of a general medical advance directive) Results: Twenty-two states and the District of Columbia

have statutes on stand-alone Psychiatric Advance Directives or Mental Health Power of Attorney. The remaining states vary in their handling of psychiatric directives, ranging from no mention of PADs at all to some provisions for PADs embedded within general laws on medical advance directives or other state laws. Conclusion: Laws pertaining to PADs exist in many states. These statutes vary widely and range from being very detailed and informative to being cursory.

REFERENCES

Fleischner RD: Advance directives for mental health care: an analysis of state statutes. Psychology, Public Policy and Law 4:788-804, 1998

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 34(1):43-57, 2006

SELF ASSESSMENT QUESTIONS

1. Statutes on stand-alone psychiatric advance directives exist in the District of Columbia as well as approximately how many other states?

a. 12
b. 22
c. 32
d. 42

ANSWER: b

2. Nearly all states:

a. lack any legal provisions for psychiatric advance directives
b. have official forms for psychiatric advance directives forms in the state laws
c. allow the creation of psychiatric advance directives or mental health powers of attorney
d. require the inclusion of psychiatric advance directives in general healthcare advance directives

ANSWER: c

S13 SOCIAL NETWORKING SITE USAGE BY ADOLESCENT PATIENTS

Smitha Bhandari, MD, Atlanta, GA
Zachary May, BA, (I) Atlanta, GA

EDUCATIONAL OBJECTIVE

To understand the patterns of use of social networking sites of adolescents at high risk for online victimization.

SUMMARY

Background: Eighty-seven percent of youth have online access with many using social networking sites. Prior studies suggest nearly 30% of youth endorse victimization by online bullying. Nine percent of youth (a 50% increase over 5 years) report online harassment, with an association between victimization and perpetration. Hypothesis: If adolescents are displaying an unbiased, uninhibited view of their lives online, then we may expect to see differences in the profiles of adolescents with mild versus severe mental illness, when compared with controls. If we can systematically study these differences, perhaps we can develop and use social networks for early intervention and prevention of psychiatric illness. Methods: The target population consists of 100 adolescents, inpatient and outpatient, ages 14-18, treated at a private psychiatric hospital in Smyrna, Georgia. A questionnaire, including items on relationships and online harassment, was administered to each subject. Psychiatric histories were collected by means of a Child Behavior Checklist and retrospective chart review. Fifty publicly-set adolescent social network profiles served as controls for content evaluation. Results will be presented.

REFERENCES

Wolak J, Mitchell K, Finkelhor D: Online Victimization of Youth: five years later. National Center for Missing and Exploited Children, Washington DC: United States Department of Justice, 2006

Hinduja S, Patchin JW: Personal information of adolescents on the Internet: a quantitative content analysis of MySpace. J Adolesc 31(1):125-46, 2008

SELF ASSESSMENT QUESTIONS

1. Perpetrators of online harassment and/or bullying are:

a. more likely to have been victims of online harassment and/or bullying
b. less likely to have been victims of online harassment and/or bullying
c. have no association with victimization

ANSWER: a

2. What is the percentage of adolescents reporting victimization by online bullying?
a. 5%
b. 10%
c. 20%
d. 30%
ANSWER: d

S14 USE OF OPIOIDS IN PAIN TREATMENT: ETHICAL AND LEGAL ISSUES

Nalan Ward, MD, Boston, MA
Joji Suzuki, MD, (I) Boston, MA

EDUCATIONAL OBJECTIVE

The misuse of prescription opioids such as oxycodone and methadone is associated with adverse health and legal consequences. Physicians often undertreat pain due to legitimate fears of prosecution and fears of enabling an addiction. This poster will explore the ethical and legal implications of using opioids to treat patients with pain.

SUMMARY

Numerous recent studies have documented the rise in prescription-opioid abuse and dependence in the United States, including overdose deaths associated with methadone prescribed for the treatment of pain. For this and other reasons, physicians frequently undertreat pain for fear of creating or "feeding" an addiction, as well as for fear of prosecution by the government. Because of the harms attributed to methadone prescriptions, a recent review by the American Pain Society and the American Academy of Pain Medicine highlighted the need for adequate training of prescribers. Therefore, when patients present with pain, physicians are confronted with competing ethical obligations—reducing the harm caused by opioids and reducing the harm caused by the pain. This poster will provide an ethical analysis of the dilemma using the concepts of autonomy, beneficence, justice, nonmalfeasance, and double effect. In addition, approaches to minimizing the clinical and legal risks of treating opioid-dependent patients with pain will be discussed, including issues physicians face when using methadone to treat patients with chronic noncancer pain.

REFERENCES

Chou R, Ballantyne JC, Fanciullo GJ, Fine PG, Miaskowski: Research gaps on use of opioids for chronic noncancer pain: findings from a review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical practice guideline. C J Pain 10(2):147-59, 2009
Novak SP, Herman-Stahl M, Flannery B, Zimmerman M: Physical pain, common psychiatric and substance use disorders, and the non-medical use of prescription analgesics in the United States. Drug Alcohol Depend 100(1-2):63-70, 2009

SELF ASSESSMENT QUESTIONS

1. What age group has the highest rate of methadone related deaths?
a. 20-29
b. 30-39
c. 40-49
d. more than 50
ANSWER: a

2. Based on the data from the National Epidemiological Survey of Alcohol and Related Conditions (NESARC), which is the presence of significant pain associated with?
a. lower probability of prescription opioid misuse
b. higher probability of prescription opioid misuse
c. not associated with prescription opioid misuse
ANSWER: b

S15 INCORPORATING MINDFULNESS INTO SEX OFFENDER THERAPY

Tammy Benoit, MA, (I) Worcester, MA
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE

At the end of this presentation, participants will be able to discuss current evidence about mindfulness and describe ways in which this evidence could be relevant in sex offender therapy.

SUMMARY

This poster will review data pertaining to mindfulness, which as a mental state is characterized by concentrated awareness of one's thoughts, actions, and/or motivations and could enhance sex offender treatment. We propose that mindfulness

incorporated into a relapse and recovery plan could be beneficial to both the sex offender and the community. Mindfulness emphasizes the importance of being in the present, acceptance of the current situation, self regulation of emotions, self-awareness and being able to separate thoughts from behaviors. Mindfulness helps with improving the ability to cope with stress, the cultivation of empathy and allows the offender to view him/her self as a resilient individual capable of recovery. This improved view could enhance the probability of successful reintegration, foster individual growth, and improve self control thereby increasing social supports and encouraging life satisfaction, thus enhancing The Good Life Model.

REFERENCES

Harvey W: Mindfulness in practice. Healthcare Counseling & Psychotherapy J 9(1):3-7, 2009
Raison CL: Buddhists meet mind scientists in conference on meditation and depression. Psychiatric Times 25(3):12, 2008

SELF ASSESSMENT QUESTIONS

1. Mindfulness in the treatment of sex offenders is intended to address which of the following?
a. ability to cope with stress
b. cultivation of empathy
c. self regulation of emotions
d. all of the above
ANSWER: d

2. A goal with the use of mindfulness is:
a. to find housing
b. to prescribe the correct pharmacological treatment
c. acceptance of the current situation
d. successful reintegration
e. c and d
ANSWER: e

S16 CANNABIS AND FORENSIC PSYCHIATRY

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

EDUCATIONAL OBJECTIVE

The purpose of this poster presentation is to educate forensic psychiatrists about relevant recent developments in cannabis research, including neurobiology, cannabis-induced mental disorders, and sociocultural aspects. An update will be provided on areas of forensic interest, including violence, driving impairment, and criminal responsibility.

SUMMARY

Cannabis is the most widely used illicit substance in the United States, and can cause a number of substance-induced mental disorders which are listed in the DSM-IV-TR. Most notable among these are cannabis-induced psychotic disorder and cannabis intoxication delirium. Cannabis-related cognitive deficits have also been demonstrated in a number of studies. All of these conditions have forensic implications which frequently emerge in civil and criminal cases, including effects on violent behavior, driving impairment, and criminal responsibility. This poster will provide an update on the social and historical aspects of cannabis, recent developments in the neurobiology of the endocannabinoid system, cannabis-induced mental disorders, and the clinical and forensic implications of this information.

REFERENCES

Niveau G: Criminal responsibility and cannabis use: psychiatric review and proposed guidelines. J Forensic Sci 47(3):451-8, 2002
Volavka J: Neurobiology of Violence, 2nd Edition. Washingon DC: American Psychiatric Publishing Inc., 2002

SELF ASSESSMENT QUESTIONS

1. What is the most commonly seen effect of cannabis intoxication on violent behavior in humans and animals?
ANSWER: decreased frequency of violent behavior

2. What endogenous ligands and corresponding receptors have been identified so far in the human endocannabinoid system?

ANSWER: The ligands are anandamide (N-arachidonoyl ethanolamine or AEA) and 2-arachidonoylglycerol (2-AG), and the receptors are CB1 and CB2.)

S17 THE MARA SALVATRUCHA GANG

J. Arturo Silva, MD, San Jose, CA

EDUCATIONAL OBJECTIVE

The purpose of this presentation is to introduce the mental health professional to the forensic psychiatric assessment of the Mara Salvatrucha Gang member. A biopsychosocial and psychohistorical overview of the Mara Salvatrucha Gang will be part of this presentation.

SUMMARY

This presentation will provide a review of the Mara Salvatrucha Gang (also known as the MS gang). The primary objective is to provide the mental health professional with a basic approach for undertaking a forensic psychiatric evaluation of Mara Salvatrucha Gang members. A brief overview of the civil war in El Salvador will be shown, as will the relationship of the civil war to the origins of the Mara Salvatrucha Gang. Subsequent growth of the Mara Salvatrucha in the United States, El Salvador, and elsewhere in the North American hemisphere will be discussed. The transnational impact of Mara Salvatrucha Gangs will also be discussed. Issues involving the national security of several countries will be covered briefly. The presentation encompasses forensic psychiatric, life-span, and psychohistorical perspectives.

REFERENCES

Johnson S, Muhihausen DB: North American transnational youth gangs: breaking the chain of violence. Backgrounder, March 21, 2005. Downloaded on April 5, 2009 from http://www.heritage.org.Research/UrbanIssues/bg1834.cfm
Vigil JD: A Rainbow of Gangs: Street Cultures in the Megacity. Austin: University of Texas, 2002, pp 131-58

SELF ASSESSMENT QUESTIONS

1. All of the following are true of the Mara Salvatrucha Gang except:
a. The civil war in El Salvador was an important causative factor
b. The gang has spread to many states within the United States
c. The gang originated in El Salvador
d. It has collaborated with Mexican drug cartels
e. There is a significant presence of the gang in Mexico
ANSWER: c

2. All of the following are true of the Mara Salvatrucha Gang except:
a. Female members do not present with tattoos
b. Some of its members can present with more extensive tattooing than noted in many other gangs
c. It is also known as the MS-13 gang
d. Social disenfranchisement of the youth has contributed to its growth in El Salvador
e. The gang has spread to Guatemala and Honduras
ANSWER: a

S18 THE FORENSIC PSYCHIATRY OF THE HIKIKOMORI PHENOMENON

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

EDUCATIONAL OBJECTIVE

The objective of this presentation is to present an overview of the hikikomori phenomenon. This presentation will also explore psychiatric-legal aspects associated with the hikikomori phenomenon. The presentation will also consider the potential relevance of the hikikomori phenomenon from a cross-cultural context.

SUMMARY

The hikikomori phenomenon was originally described in Japan, and refers to reclusive persons, usually adolescents or young adults, who become extremely isolative and often confine their daily activities to the parental home. The period of isolation is variable, and may range from several months to years. The term hikikomori may denote a sociocultural phenomenon as well as a culture bound psychiatric condition. A person affected by the hikikomori phenomenon is also referred as a Hikikomori. In recent years individuals identified as hikikomori have also been reported as perpetrators of serious crimes. In this presentation, the psychohistorical origins and psychosociocultural characteristics of the hikikomori are discussed. Potential biopsychosocial causes of the phenomenon are explored. An overview of forensic-psychiatric aspects of the hikikomori phenomenon is provided. Several cases from the literature are summarized in order to highlight potentially important psychiatric-legal aspects of the hikikomori phenomenon. This presentation will briefly consider the potential relevance of the hikikomori phenomenon to cultural settings other than the Japanese culture.

REFERENCES

Zielenziger M: Shutting Out the Sun: How Japan Created its Own Lost Generation. New York: Doubleday, 2006
Greenfield KT: Speed Tribes: Days and Nights With Japan's Next Generation. New York: Harper Collins Publishers, 1994

SELF ASSESSMENT QUESTIONS

1. All of the following are true of the hikikomori phenomenon except:
a. It is considered to be the result of recent sociohistorical changes in Japan.
b. It may be associated with neuropsychiatric deficits.
c. It has no counterpart in countries other than Japan.
d. It is more common in males than females.
e. It is highly associated with the early life cycle.
ANSWER: c

2. All of the following are true of the hikikomori phenomenon except:
a. Some experts conceptualize it as a folk bound syndrome.
b. Its historical development may have some roots in economic factors within Japan.
c. A robust association between the hikikomori phenomenon and violent behavior has been adequately demonstrated.
d. Its psychological development may be associated with the Japanese educational system.
e. It has been hypothesized that the hikikomori phenomenon may be closely associated with posttraumatic stress disorder.
ANSWER: c

S19 SHOPLIFTING, KLEPTOMANIA, AND SUBSTANCE USE

Fabian Saleh, MD, Boston, MA
Georgia Stathopoulou, PhD, (I) Boston, MA
Nalan Ward, MD, (I) Boston, MA

EDUCATIONAL OBJECTIVE

To review the literature on the association of substance use and prostitution, related issues of physical and mental health, and legal implications. Furthermore, to present recent treatment approaches showing preliminary success in concurrently reducing both substance use and sex work.

SUMMARY

Research has documented significant positive associations between substance dependence and both shoplifting and kleptomania. Shoplifting is defined as the behavior of stealing from a store, whereas kleptomania is a clinical disorder included in the impulse control disorder categories of DSM-IV. While kleptomania is considered to be a rather rare condition and prevalence rates are not known, a recent epidemiological study among 43,000 adults in the U.S. found the prevalence of lifetime shoplifting in the U.S. population to be 11.3%. Data from the same study showed that among Axis I disorders, substance use disorders present the strongest association with shoplifting. Extant literature identifies impulse control issues as common underlying conditions in substance dependence, shoplifting and kleptomania. Screening of shoplifting and kleptomania among patients with substance dependence is crucial in providing them with appropriate services, and reducing the above conditions and the implied legal costs. Both pharmacological and psychological treatments of substance dependence by addressing issues of impulse control might successfully address the concurrence of substance use with the above conditions. Further research is needed in clarifying underlying common mechanisms and developing clinical interventions.

REFERENCES

Blanco C, Grant J, Petry NM, Simpson HB, Alegria A, et al: Prevalence and correlates of shoplifting in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). Am J Psychiatry 165:905-13, 2008
Bayle FJ, Caci H, Millet B, Richa S, Olie J-P: Psychopathology and comorbidity of psychiatric disorders in patients with kleptomania. Am J Psychiatry 160:1509-13, 2003

SELF ASSESSMENT QUESTIONS

1. What is the difference between kleptomania and shoplifting?
a. They are different terms referring to the same condition.
b. Kleptomania refers to a clinical disorder from the impulse control disorders spectrum, whereas shoplifting refers to the behavior of stealing from a store.
c. Kleptomania is the legal term for shoplifting.
d. Distinct clinical disorders.
ANSWER: b

2. The association between shoplifting and substance use disorders:
a. has not sufficiently been established in the empirical literature
b. has been shown to be significant but not as strong as the one between shoplifting and anxiety disorders
c. has been shown to be stronger than the association between shoplifting and other AXIS I disorders
d. has been as strong as the association between shoplifting and eating disorders
ANSWER: c

S20 **CURRENT STANDARDS OF VIOLENCE RISK ASSESSMENT**

Rebecca Brendel, MD, JD, Boston, MA
Christopher Myers, MD, Wilmington, NC
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
This poster will review the available actuarial tools for violence risk assessment and review the current literature regarding this topic.

SUMMARY
Authors suggest that clinicians may improve their ability to predict violence if they regularly employ structured risk assessment instruments. However, these screening tools are not regularly used by clinicians in the United States. This poster will provide a background introduction to violence risk assessment and then review the salient features and limitations of available screening tools in predicting general violence, including the Psychopathy Checklist-Revised (PCL-R), the Violence Risk Appraisal Guide (VRAG), the Historical/Clinical/Risk Management 20-item (HCR-20), and the Iterative Classification Tree (ICT). Following this review, the poster will then discuss the current state of knowledge of violence risk assessment and directions for future research.

REFERENCES
Swanson, JW: Preventing the unpredicted: managing violence risk in mental health care. Psychiatr Serv 59:191-3, 2008
Norko MA, Baranoski, MV: The state of contemporary risk assessment research. Can J Psychiatry 50:18-26, 2005

SELF ASSESSMENT QUESTIONS
1. Which of the following actuarial tools have demonstrated better-than-chance accuracy in predicting violence in populations with mental disorders?
a. PCL-R
b. VRAG
c. HCR-20
d. all of the above
ANSWER: d

2. Which of the following variables is most significantly correlated with violence?
a. substance abuse
b. psychosis
c. depression
d. mania
ANSWER: a

S21 **PSYCHIATRIC CHARACTERISTICS OF HOMICIDE DEFENDANTS**

Christine A. Martone, MD, Pittsburgh, PA
Edward Mulvey, PhD, (I) Pittsburgh, PA
Andrei Nemoianu, MD, St. Peter, MN
Ryan Shugarman, MD, Alexandria, VA
Amarpreet Singh, MD, Pittsburgh, PA
Suzanne Yang, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE
To summarize the characteristics and investigate the prevalence of mental illness in homicide defendants. To compare the characteristics of defendants with and without a history of mental illness and assess the correlation between mental illness and legal outcome for homicide defendants.

SUMMARY
Relatively little is known about the psychiatric history and biographical characteristics of individuals charged with homicide in the United States. Studies and case series previously published have either been conducted in Europe,

where social differences may limit generalizability to the United States, or have examined only those homicide defendants referred for psychiatric evaluation, possibly skewing the prevalence of mental illness. In Allegheny County, Pennsylvania, all individuals charged with homicide routinely receive a psychiatric evaluation. We report preliminary results from an ongoing retrospective review of psychiatric evaluations performed on this comprehensive sample of all homicide defendants in one county between 2001 and 2006. Of the 94 subjects whose data have been coded thus far, the median age was 22, 97% were male, 44% were unemployed, and 39% had been previously charged with a violent crime. 48% had a substance use disorder, while the prevalence of other Axis I diagnoses was 29%. 32% of subjects had a personality disorder. The most commonly used murder weapon was a firearm (59%). 94% were found to be competent to stand trial on initial evaluation. We also plan to examine differences in adjudicative competency, verdict, and sentence between those defendants with and without severe mental illness.

REFERENCES

Fazel S, Grann M: Psychiatric morbidity among homicide offenders: a Swedish population study. Am J Psychiatry 161:2129-31, 2004

Matejkowski JC, Cullen SW, Solomon PL: Characteristics of persons with severe mental illness who have been incarcerated for murder. J Am Acad Psychiatry Law 36:74-86, 2008

SELF ASSESSMENT QUESTIONS

1. What factors make the study of individuals who commit homicide challenging?

a. Gang-related homicides are less likely to be solved.

b. Bias in samples of individuals selectively referred for psychiatric evaluation.

c. Potential differences between those individuals initially arrested for homicide and the subgroups who are formally arraigned and/or convicted for homicide.

d. All of the above.

ANSWER: d

2. What can be learned by studying the characteristics of homicide defendants?

a. The potential value of routine psychiatric assessment of all homicide defendants.

b. Whether the diagnosis of a mental illness has an impact on legal disposition.

c. Whether there are differences in weapon choice and relationship to the victim between homicide defendants with severe mental illness and those without severe mental illness.

d. All of the above.

ANSWER: d

S22 THE CIUDAD JUAREZ FEMALE HOMICIDES (1993-2008)

J. Arturo Silva, MD, San Jose, CA

EDUCATIONAL OBJECTIVE

To provide an overview of the homicides of women that occurred in the northern Mexican City of Ciudad Juarez during the period 1993 – 2008; to report on the results of an analysis of a sample of these homicides; and to discuss potential causes of the killings.

SUMMARY

Ciudad Juarez, Chihuahua, is a northern Mexican city which borders the city of El Paso, Texas. In 1993, Ciudad Juarez began to report a significant increase in its rate of homicides involving female victims. Estimates of the number of these homicides for the 1993-2008 period range from approximately 300 to 500. Many of these cases remain unsolved. An overview of this problem will be provided, which takes into account historical, sociodemographic, political and economic factors. The results of an analysis of a sample of those homicides will be presented in order to highlight the more proximal factors potentially responsible for the homicidal activity. Forensic psychiatric aspects of the homicides will also be covered, including an exploration of the possibility that the homicides may be due to sexual homicidal behavior, serial killing behavior and domestic violence. This analysis uses geographical approaches in order to explore the nature of the homicides of females in Ciudad Juarez. Limitations inherent in the study of the Juarez female homicides will also be discussed. This presentation will also consider the significance of these homicides from an international perspective concerning the condition of women.

REFERENCES

Rodriguez T: The Daughters of Juarez: A True Story of Serial Murder South of the Border. New York: Atria Books, 2007

Staudt K: Violence and Activism at the Border: Gender, Fear and Everyday Life in Ciudad Juarez. Austin: University of Texas, 2008

SELF ASSESSMENT QUESTIONS

1. Which one of the following is true of Ciudad Juarez?

a. It is the third largest Mexican city on the United States-Mexican border.

b. In 2008, most homicides involving female victims were likely due to single-sexual, but not serial-sexual, homicide. c. The cotton field, Lote Bravo and Lomas de Poleo homicides are all important subsets of the Ciudad Juarez homicides involving female victims.

d. The illicit drug trade is unrelated to the Ciudad Juarez homicides involving female victims.

ANSWER: c

2. All of the following are true about the Ciudad Juarez homicides involving female victims, except:

a. There is evidence that some of the killings are of a sexual serial nature.

b. An increase of these homicides began in 1993.

c. The pattern of the relevant homicides is similar in 2008 and 1993.

d. Most femicides are not accounted by the trade in illicit drugs.

ANSWER: c

S23 GENDER AND DELUSIONS IN WOMEN HOMICIDE OFFENDERS

Jessica Ferranti, MD, Sacramento, CA
Barbara McDermott, PhD, (I) Sacramento, CA

EDUCATIONAL OBJECTIVE

To review the basic classification of violence with focus on psychotic violence, discuss gender differences in psychosocial and crime variables found in women homicide offenders, review the current literature on psychotic violence and psychotic violence in women and investigate gender differences in psychotic symptoms at time of homicide.

SUMMARY

Until recently, there has been little information regarding female criminality. Women who commit homicide that is motivated by psychosis comprise an even smaller subgroup. There are a small number of studies in the violence-risk- assessment literature investigating gender differences in the risk for violently acting on delusional beliefs. Debate continues regarding whether gender differences exist or are significant. This study includes all women found not guilty by reason of insanity who were hospitalized at Napa State Hospital in California at any time between January, 1991 thru August of 2005 (n= 47). A random sample of 47 men committed during that same time period for the same offenses was selected for comparison. The results reveal no differences in delusion type between men and women. Delusion type is different in women depending on the age of the victim. Among women offenders, religious delusions were most common in infant and child victims. The results showed a difference in delusion type related to amphetamine use in women compared to men. Women using amphetamine at the time of homicide were more likely to have grandiose delusions and ideas of reference delusions. Men were more likely to have persecutory and somatic delusions related to amphetamine.

REFERENCES

Appelbaum PS, Robbins PC, Monahan J: Violence and delusions: data from the MacArthur Violence Risk Assessment Study. Am J Psychiatry 157(4):566-72, 2000

Yourstone J, Lindholm T, Kristiansson M: Women who kill: a comparison of the psychosocial background of female and male perpetrators. Int J Law Psychiatry 31(4):374-83, 2008

SELF ASSESSMENT QUESTIONS

1. What type of delusion seems to be most prevalent in women who kill their children?

ANSWER: Religious delusion

2. Based on current literature, what are three gender differences found in women who commit homicide compared to their male counterparts?

ANSWER: Women are more likely to commit violence and homicide within relationships. More often than men, women have sought help prior to the homicide offense. Women homicide offenders have a more socially ordered lifestyle. Women are more likely to have been sexually abused in their lifetime. Women tend to have more psychosocial aggravation throughout a lifetime. Women homicide offenders exhibited less antisocial and aggressive behaviors in childhood.

S24 INVOLUNTARY TREATMENT OF INMATES: A TOUGHER SELL FOR JAILS?

Gregory Sokolov, MD, Davis, CA

EDUCATIONAL OBJECTIVE

The goal of this research in progress is to survey various jails in California with regard to their practices and policies of involuntary medicating inmates who have been found to be incompetent to stand trial, and determine if there a "standard of care" in this area.

SUMMARY
The Supreme Court in Sell v. United States determined the standards for the involuntary medication of criminal defendants to restore competence to stand trial. In the implementation of these standards in the California Penal Code (section 1369.1), county jails are included as a "treatment facility." The purpose of this investigation is to better understand the trends in various California county jail facilities regarding the process of carrying out judicial orders to involuntarily medicate pre-trial defendants who have been declared incompetent to stand trial. In particular, a survey will be conducted of several different county jail facilities (ranging in size of total inmate population, and the presence or absence of an inpatient psychiatric jail unit). In addition, three specific county jails (Madera, Napa, and Santa Clara County) will be surveyed, as these counties have specific additional criteria outlined in the Penal Code. Factors to be addressed in the survey will include: (a) How do the jail facilities carry out court orders to involuntarily medicate incompetent inmates? and (b) Are there current obstacles, either inherent to the jail facility or court-imposed that make these treatment orders difficult to carry out?

REFERENCES
Appelbaum PS: Law and psychiatry: treating incompetent defendants: the Supreme Court's decision is a tough sell. Psychiatric Serv 54:1335-41, 2003
Leong GB: Sell v. U.S.: involuntary treatment case or catalyst for change? J Amer Acad Psychiatry Law 33:292-4, 2005

SELF ASSESSMENT QUESTIONS
1. According to the California Penal Code, what are county jails considered with regard to administering court-ordered, involuntary antipsychotic medications to defendants found incompetent to stand trial?
ANSWER: treatment facilities

2. What is the maximum time allotted by the California Penal Code for involuntary treatment of an incompetent defendant with an antipsychotic medication while in a jail setting?
a. 1 year
b. 6 months
c. 3 months
d. no maximum time specified
ANSWER: b

S25 **CURRENT CONTROVERSY IN JUVENILE DELINQUENCY**

Peter Ash, MD, Atlanta, GA
Joseph Kenan, MD, Los Angeles, CA
Christopher Thompson, MD, Los Angeles, CA
Robert Weinstock, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE
After attending this presentation, the attendees will understand the controversy of juveniles who have been sentenced to life without parole.

SUMMARY
The U.S. Supreme Court decided in the case of Roper v. Simmons (2005) that it is unconstitutional to impose capital punishment for crimes committed while under the age of 18. The 5-4 decision overruled the Court's prior ruling upholding such sentences on offenders above or at the age of 16, in Stanford v. Kentucky (1989). In Roper v. Simmons (2005), the court decided that under the "evolving standards of decency" test, it was cruel and unusual punishment to execute a person who was under the age of 18 at the time of the murder. The court considered that the execution of juvenile offenders – like that of mentally retarded offenders – is both disproportionate to their personal moral culpability and contrary to national and worldwide consensus. Using the same reasoning, should it be unconstitutional for juveniles to be sentenced to life without parole? This and other controversial issues in juvenile delinquency will be addressed.

REFERENCES
Roper v. Simmons, 543 U.S. 551 (2005)
Cauffman E, Steinberg, L: (Im)maturity of judgment in adolescence: why adolescents may be less culpable than adults. Behav Sci Law 18(6):741-60, 2001

SELF ASSESSMENT QUESTIONS
1. In what case did the Supreme Court find it unconstitutional to impose capital punishment for crimes committed while under the age of 18?
ANSWER: Roper v. Simmons (2005)

2. How did the majority find that it was unconstitutional to impose capital punishment for crimes committed while under the age of 18?
ANSWER: They decided that under the "evolving standards of decency" test, it was cruel and unusual punishment to execute a person who was under the age of 18 at the time of the crime.

S26 FORENSIC PSYCHIATRIC ANALYSIS OF DICTATORS-HISTORICAL LESSONS

Andrew R. Kaufman, MD, Fayetteville, NC
James Knoll, IV, MD, Syracuse, NY
Robert T.M. Phillips, MD, PhD, Annapolis, MD
Jerrold Post, MD, (I) Bethesda, MD
Dan Cotoman, MD, Marcy, NY

EDUCATIONAL OBJECTIVE
To develop and present modern forensic techniques used to analyze political leaders without the ability to interview them directly. Identify psychologic and pathologic variables associated with dictators.

SUMMARY
Throughout recorded history dictators have been uniquely and individually responsible for mass murder and human rights abuses on a tremendous scale of magnitude. For example, Idi Amin Dada Oumee, called by Time magazine "killer and clown, big-hearted buffoon and strutting martinet," leader of the Ugandan regime, was responsible for 100,000 deaths during his 8 years in power. Using the techniques of modern forensic psychiatry, this presentation attempts to uncover the common psychological attributes that modern dictators share. Through forensic profiling of several individual dictators, we will examine their family origins, early adult life, rise to power, and behavior during their reign. We will attempt to accomplish the following goals: (1) adapt the methodology of the psychiatric autopsy to utilize the historical record of these leaders in a forensic analysis; (2) identify and characterize common experiences and attributes that may form a basis for a novel nosology of the dictator persona; (3) identify and characterize common psychological and/or propaganda tactics tied to individual behavior that allow the dictator to gain trust and power over subjects and maintain their position over time; and (4) suggest possible intelligence (risk analysis) strategies to recognize future dictators, thus allowing for public intervention.

REFERENCES
Post JM, George A: Leaders and Their Followers in a Dangerous World: The Psychology of Political Behavior (Psychoanalysis and Social Theory), 1st Edition. Ithaca, NY: Cornell University Press, March 11, 2004
Post JM: The Psychological Assessment of Political Leaders: With Profiles of Saddam Hussein and Bill Clinton, 1st Edition. Ann Arbor: University of Michigan Press, March 23, 2005

SELF ASSESSMENT QUESTIONS
1. How was Idi Amin Dada Oumee, former military dictator of Uganda, referred to in the media?
a. warm-hearted baboon
b. big-hearted buffoon
c. hard-hearted tycoon
d. lion-hearted platoon
ANSWER: b

2. Which of the following statements is/are true?
a. Dictators all suffer from childhood abuse.
b. Dictators are responsible for massive human rights abuses and murders.
c. Dictators are democratically elected leaders.
d. Dictators use financial incentives to stay in power.
ANSWER: b

S27 CHALLENGES IN COMPENSATION AND PENSION EXAMINATION OF VETERANS

Jagannathan Srinivasaraghavan, MD, Carbondale, IL
Anthony Fernandez, MD, Richmond, VA
Thomas Martin, MD, North Chicago, IL

EDUCATIONAL OBJECTIVE
At the conclusion of the workshop, participants will be able to recognize the complexities of Compensation and Pension examinations of veterans, and learn: to maximize the data gathering process; judicious use of psychological testing; the relationship between traumatic brain injury and posttraumatic stress disorder; and the use of templates.

SUMMARY
The Veterans Health Administration is the largest integrated health system in the United States. In addition to clinical care to eligible veterans and education of trainees, Veterans Affairs medical centers and Community Based Outpatient Clinics (CBOC) are also tasked to provide Compensation and Pension examinations of veterans seeking benefit. These examinations can be for physical or mental disorders and can be initial or review. Occasionally veterans may be requested to be seen by the appeals board. Nearly 1.6 million people were deployed to the wars in Iraq (Operation Iraqi Freedom) and Afghanistan (Operation Enduring Freedom) by mid-2007. More than 18,000 medical air evacuations were recorded by August 2007. Better protective gear has decreased mortality but increased morbidity of soldiers and thus those who seek compensation. The examination is for rating purposes and not for treatment purposes and involves reviewing the claims file, an interview, and submission of a report that can be well understood by lay and legal professionals. All the presenters are experienced professionals in the VA, and discuss the process of the examinations, evolving understanding of traumatic brain injury and mental disorders, use of psychological tests, use of templates on the computer, and the significance of unambiguous reports.

REFERENCES
Department of Veterans Affairs VHA DIRECTIVE 2006-013 (Veterans Health Administration): Qualification for Examiners Performing Compensation and Pension (C&P) Mental Disorder Examinations. Washington, DC: Author, March 7, 2006
Schneiderman AI, Braver ER, Kang HK: Understanding sequelae in injury mechanisms and mild traumatic brain injury incurred during the conflicts in Iraq and Afghanistan: persistent post concussive symptoms and posttraumatic stress disorder. Am J Epidemiol 167:1446-52, 2008

SELF ASSESSMENT QUESTIONS
1. What must initial mental disorder examinations of a veteran for Compensation and Pension include?
a. review of claims file
b. a personal interview by a mental health professional meeting the qualification as defined by VHA directive
c. psychological testing
d. physical examination
e. a and b
ANSWER: e

2. All of the following mental health professionals meet the qualification to perform initial mental disorders C&P examinations except:
a. board certified psychiatrists
b. board eligible psychiatrists
c. licensed doctorate level psychologists
d. advanced practice nurses
e. psychiatric residents under close supervision of a psychiatrist
ANSWER: d

S28 FORENSIC AND ETHICAL ISSUES IN DEVELOPMENTAL DISABILITY PSYCHIATRY

John Paul Fedoroff, MD, Ottawa, ON, Canada
Albert Grudzinskas, Jr., JD, (I) Worcester, MA
Mark Hauser, MD, Newton, MA
Deborah Richards, (I) Welland, ON, Canada
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
The audience will become familiar with complex diagnostic considerations and challenges to effective treatment planning in psychiatric care of persons with Intellectual Disability and Developmental Disability (ID and DD); learn about the implications of interface of this unique population with forensic psychiatry; and be able to handle ethical dilemmas effectively, and implement liability prevention strategies.

SUMMARY
In the treatment of individuals with ID and the broader category of DD, there are advantages to conducting a thorough evaluation, followed by a differential diagnosis leading to a diagnostic formulation, a treatment plan, and follow up. There are subsets of difficult challenging patients. Those who interface with the criminal justice system and have ID/DD pose unique challenges. Current practice is at times characterized by pressure to cut corners, leading to predictable patterns, bypassing differential diagnosis and triggering premature treatment planning, and often using psychiatric medication. Many patients exhibit compromised decisional capacity but haven't been adjudicated incompetent yet. The presentation will focus on the risks of the premature diagnostic conclusions that result in overuse or

misuse of psychiatric medication. There are all sorts of risk management hazards, including the possibility of ethical compromise. The presentation will identify strategies for effectively handling such challenges. Whereas a prevailing view recognizes the dramatic influence of the pharmaceutical industry on physician decision making, additional factors less well recognized also provoke the prescribing of medication and imposition of possibly unwarranted treatments. The panelists will explore these issues and provide case examples to elucidate optimal strategies.

REFERENCES

Griffiths D, Richards D, Fedoroff P, Gignac V: Biomedical and psychological considerations for aggressive and destructive behaviour: a case example. J Developmental Disabilities (in press, manuscript currently under revision)
Griffiths D, Fedoroff J P, Richards D, Cox-Lindenbaum D, et al: Sexual and gender identity disorders, in Diagnostic Manual -- Intellectual Disability (DM-ID): A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability. Edited by Fletcher R, Loschen E, Stavrakaki C, First M. Kingston, NY: NADD Press, 2007

SELF ASSESSMENT QUESTIONS

1. Which of the following is not a component of a true informed consent process for persons with ID & DD?
a. voluntariness
b. process for substituted decision-maker
c. the presence of perceived and/or real coercion
d. ability to learn about risks and benefits and weigh them
ANSWER: c

2. People with counterfeit deviance are:
a. a subgroup of malingering
b. a subgroup of dissimulators
c. a subgroup of simulators
d. an example of misdiagnosis
ANSWER: d

S29 LOCATING PERSONS AND FINDING EXPERTS

Kyle Courtney, Esq., (I) Hanover, MA

EDUCATIONAL OBJECTIVE

At the conclusion of this presentation, participants will have learned research strategies to effectively use relevant online sources to find information about individuals and experts. Additionally, the participants will have a basic understanding of related laws affecting access to such information.

SUMMARY

Many research projects involve searching for an individual or an individual's background information. Often the information is required to file a complaint, to subpoena a defendant, or to find an heir to a will or estate. There are hundreds of scenarios that require specific information about an individual. Many Internet companies will provide this information to you for a substantial fee. However, there are still several free tools that can also provide information without the fee. This presentation will review some of the relevant laws affecting this type of information and recommend the best sources and strategies for finding this information on the Internet. Apart from individuals, experts are becoming much easier to find on the Internet. There are many free expert directories, and, additionally, many experts choose to create their own websites. This makes it easier to find contact information, publications, and area of expertise. This presentation will review the best sites for locating an expert in any field.

REFERENCES

Courtney KK, Holmes E, Quinn K: Find It Free and Fast on the Net: Strategies for Legal Research on the Web. Eau Claire, WI: NBI, Inc., 2008
Levitt CA, Rosch ME: The lawyer's guide to fact finding on the Internet. Chicago: American Bar Association, Law Practice Management Section, 2006

SELF ASSESSMENT QUESTIONS

1. The Telephone Records and Privacy Protection Act that was signed into law in 2007:
a. allows private phone companies to share private unpublished phone directories with third party vendors
b. prevents the Government from accessing your phone records without a legally authorized warrant
c. authorizes pre-texting as a legal method of obtaining information about an individual from the phone companies
d. makes the it illegal to procure confidential phone records by "making false or fraudulent statements" to a phone company employee
ANSWER: d

2. Which of the following information sources cannot be used to find phone number and addresses of individuals?
a. Betterwhois.com
b. Federal Elections Commission Campaign Finance Reports Online
c. U.S. InfoSearch.com's Social Security Number ID Verification Search
d. The Ultimates.com
ANSWER: c

S30 **WEB-BASED FORENSIC CURRICULUM FOR PSYCHIATRY RESIDENTS**

Michael Harlow, MD, JD, Sacramento, CA
Elizabeth Hogan, MD, Colorado Springs, CO

EDUCATIONAL OBJECTIVE
The educational objective of this research in progress is to help remedy the gap in knowledge and techniques in the forensic psychiatry education of general psychiatry residents. Presenters will convey the need for a web-based forensic psychiatry curriculum. In addition, presenters will discuss the project's education strategies and goals.

SUMMARY
In 2006, the Accreditation Council for Graduate Medical Education (ACGME) mandated that psychiatry training programs must provide opportunities for forensic psychiatry education to psychiatry residents and that psychiatry training programs should provide psychiatry residents with experience in writing a forensic report. These mandates have posed challenges to psychiatry training programs, particularly under-resourced programs without access to forensic psychiatry lectures or forensic training sites. In 2008, in response to this emerging need, AAPL, in collaboration with the Association for Academic Psychiatry (AAP), created a joint task force to develop a web-based forensic psychiatry curriculum for psychiatry residents. This curriculum will offer online forensic psychiatry lectures relevant to psychiatry residents. Initial written lectures will be converted to online video lectures presented by forensic experts. This curriculum will also include an interactive module that will display videos of a forensic psychiatrist conducting a mock competency interview and discuss core components of a forensic psychiatry competency report, with the resident then completing a mock forensic report. This research in progress will provide an overview of the web-based curriculum, discuss the resident education objectives of this project, and convey technical challenges in project implementation. In addition, strategies for optimum resident web-based learning will be reviewed.

REFERENCES
Lewis C: Teaching forensic psychiatry to forensic psychiatry residents. Acad Psychiatry 23:37-41, 1999
Walter DA, Rosenquist PB, Bawtinhimer G: Distance learning technologies in the training of psychiatry residents, a critical assessment. Acad Psychiatry 28:60-5, 2004

SELF ASSESSMENT QUESTIONS
1. Which of the following are common technical problems for effective web-based education curricula?
a. insufficient system band-width signal
b. lack of high speed real-time connections
c. lectures failing to use sufficient graphics to maintain viewer interest
d. inadequate remote site computer equipment
e. all of the above
ANSWER: e

2. Which of the following are common challenges for psychiatry residents mastering principles of forensic psychiatry?
a. unfamiliarity with the roles of a forensic psychiatrist that are different from those of a treating psychiatrist
b. lack of knowledge of the legal system
c. anxiety over prospect of testifying in court
d. lack of understanding of legal terminology
e. all of the above
ANSWER: e

S31 **MEDICAL AND MENTAL HEALTH NEEDS IN COMMUNITY CORRECTIONS**

Tracy Gunter, MD, St. Louis, MO

EDUCATIONAL OBJECTIVE
To fill a current void in the literature by presenting new data on the magnitude of medical and mental health care needs among those supervised by community corrections, and to examine the impact of treatment of these needs on recidivism in a sample followed over the course of one year.

SUMMARY
Correctional populations have complex health needs that too often remain unaddressed during correctional supervision. Although identification and treatment of physical and mental illness is costly, chronic illnesses exact substantial public health costs and may contribute to recidivism. While work is progressing in understanding these needs in incarcerated offenders, relatively little work has been done in community corrections settings. The current study investigates the frequency of medical and mental health concerns in a sample of 336 individuals followed over the course of one year while being supervised by the community corrections office of Iowa's Sixth Judicial District. This presentation will focus on providing the audience with an overview of the medical and mental health needs of this special population, the impact of these needs on recidivism, and ideas for addressing the needs identified in this rapidly growing population.

REFERENCES
Glaze LE, Bonczar TP: Probation and parole in the United States, 2007 (NCJ 224707). Washington, DC: Department of Justice, Bureau of Justice Statistics, December 2008
Osher F, Steadman HE, Barr H: A best practice approach to community reentry from jails for inmates with co-occurring disorders: the apic model. Crime Delinquency 49(1):79-96, 2003

SELF ASSESSMENT QUESTIONS
1. Who does community corrections serve?
a. more than 5 million offenders or 2.2% of the U.S. population
b. a homogenous group of individual with similar needs
c. relatively young and healthy people with few specialized needs
ANSWER: a

2. Health needs of offenders in the community are:
a. easily identified and met within existing community resources
b. covered by traditional third party payor arrangments
c. well understood and articulated by the offender
d. none of the above.
ANSWER: d

S32 GENERAL PSYCHIATRY RESIDENTS IN CORRECTIONAL CLINICS

Catherine Lewis, MD, Farmington, CT

EDUCATIONAL OBJECTIVE
To identify variables associated with later career choice in the public sector in a group of general psychiatry residents who did a rotation in a correctional facility. To describe resident review regarding strengths and weaknesses of correctional rotations during the residency.

SUMMARY
Objective: To describe a five-year experience placing general psychiatry residents in correctional clinics. Introduction: The University of Connecticut places general psychiatry residents in faculty-run correctional clinics . While such placements are becoming common, there are little data about resident perception of the experience or its potential impact on later career path. Methods: Data were drawn from residents who had rotations at correctional facilities from 2002-2008. Residents were asked to complete evaluations in which Likert scales (1-5) were used to rate experiences. Residents were contacted after graduation to review their career choice and to assess the impact of their correctional experience on that choice. Results: 23 residents were included in the sample. The majority rated their experience highly; there was a trend for higher ratings than general clinics. Residents identified the ability to see patients over time, free from the burden of insurance issues, and with unique pathology as assets of the rotation. Residents who completed correctional rotations were more likely to practice public sector psychiatry.

REFERENCES
Rotter M, Preven D: Commentary: gernal forensic psychiatry training--the first forensic stage. J Am Acad Psychiatry Law 33(3):324-323, 2005
Lewis CF: Teaching forensic psychiatry to general psychiatry residents. Academic Psychiatry 28(1):40-46, 2004

SELF ASSESSMENT QUESTIONS
1. In comparison to residents who did not rotate in correctional settings, residents who rotated in correctional clinics were:
a. more likely to pursue public sector psychiatry after graduation
b. less likely to pursue public sector psychiatry after graduation
c. as likely to pursue public sector psychiatry after graduation
ANSWER: a

2. Residents who rotated in correctional clinics identified which of the following as negatives for the rotation:
a. distance to site
b. patient population
c. work load
d. quality of supervision
ANSWER: a

S33 **TO CATCH A CONMAN!**

Charles C. Dike, MD, MPH, New Haven, CT
Babatunde Adetunji, MD, MS, Voorhees, NJ
Akintunde Akinkunmi, MD, Bedfordshire, United Kingdom
Ezra E.H. Griffith, MD, New Haven, CT

EDUCATIONAL OBJECTIVE
To understand the psychological factors that drive behaviors of perpetrators and victims of advance fee fraud, a special type of scam with origins in Nigeria.

SUMMARY
Late last year, many Americans were riveted by the NBC program with the above caption. Finally, some of the faces behind the numerous emails tantalizing us with unbelievable wealth without hard work were exposed. Also revealed, however, were bright and intelligent victims, some of whom had not only lost their life savings and irreparably tarnished their images, but had also lost public funds entrusted to them. These raised many questions: Why did such respectable individuals succumb to the evil manipulations of the conmen? What was the role of greed on victims and conmen? What makes one vulnerable to such manipulations? To further complicate matters, a 72-year-old Czech man, a victim of advance fee fraud, was arrested in 2003 for shooting and killing Nigeria's Consul to the Czech Republic. Using introductory clips, we will review advance fee fraud, a.k.a. 419 of the Nigerian Criminal Code, including the historical development of the phenomenon – is it a culture bound scheme? We will also review the different types of introductory (fishing) letters that hook the victims, discuss the psychological mechanisms that drive the behaviors of both perpetrators and victims, and review the various responses of victims. Finally, we will discuss forensic psychiatric implications.

REFERENCES
Providing Services to the Victims of Fraud: Resource for Victims/Witness Coordinators. Available at www.ojp.usdoj.gov/publications/infores/fraud/psvf/chap3.htm (assessed on 3/11/08)
Duffield G, Grabosky P: The Psychology of Fraud. Australian Institute of Criminology. Available at www.aic.gov.au/publications/tandi/ti199.pdf (assessed on 3/11/09)

SELF ASSESSMENT QUESTIONS
1. In advance fee fraud:
a. the victims are always non-Nigerians
b. altruism may explain the victim's behavior
c. greed may explain the victim's behavior
d. a and b
e. b and c
f. a, b, and c
ANSWER: e

1. What does 419 mean?
a. number of people who were successfully conned in 2008
b. number of people jailed in relation to advance fee fraud in 2008
c. number of Nigerians who form the nucleus of advance fee fraud
d. the Nigerian Criminal Code that describes advance fee fraud
e. none of the above
ANSWER: d

S34 THE CAPSULE MADE ME DO IT - PSYCHOACTIVE DRUG DEFENSES

Gary Chaimowitz, MB, Ancaster, ON, Canada
Graham Glancy, MB, Toronto, ON, Canada
Thomas Gratzer, MD, Edina, MN
Victoria Harris, MD, MPH, Edmonds, WA

EDUCATIONAL OBJECTIVE
The panel will inform the participants about psychiatric defenses associated with adverse reactions to four different classes of psychoactive drugs. Relevant literature will be reviewed. The panel will discuss cases of potentially criminal behaviors that resulted from intentional and unintentional, licit and illicit use of pharmacologic agents.

SUMMARY
Psychiatric defenses have been employed by attorneys whose clients, on trial on charges of violent criminal behaviors, alleged that they had experienced a wide variety of adverse behavioral reactions to different psychoactive drugs. Some of these defenses have involved the use of medications well known for producing aberrant behavioral reactions, such as triazolam (Halcion). Dr. Gratzer will discuss "Halcion defenses." Commonly used medications employed therapeutically, such as selective serotonin reuptake inhibitors (SSRIs) and bupropion, have also been alleged in court to have produced violent behaviors. Such reactions are less widely known. Dr. Glancy will discuss "SSRI defenses," and Dr. Harris will discuss an unusual and successful "bupropion defense." Recreational use of CNS depressants such as gamma hydroxy butyrate (GHB) and flunitrazepam (Rohypnol) has been used as a defense by persons accused of raping other individuals while both persons were allegedly intoxicated by those same substances! Dr. Chaimowitz will provide examples of "date rape drug defenses." Panelists will review literature on cognitive, emotional, and behavioral adverse effects of these drugs. They will weigh the scientific evidence supporting and discounting the potential for these substances to cause loss of control leading to murder, rape, and other types of violence.

REFERENCES
Du Mont J, MacDonald S, Rodbart N, Asilani E, Bainbridge D, Cohen MM: Factors associated with suspected drug facilitated sexual assault. CMAJ 180(5):513-9, 2009
Daderman AM, Fredriksson B, Kristiansson M, Nilsson LH, Lidbeg L: Violent behavior, impulsive decision-making, and anterograde amnesia while intoxicated with flunitrazepam and alcohol or other drugs: a case study in forensic psychiatric patients. J Am Acad Psychiatry Law 30:238-51, 2002

SELF ASSESSMENT QUESTIONS
1. Which of the following is/are true about Rohypnol?
a. It is tasteless.
b. It is prescription benzodiazepine.
c. It is used recreationally.
d. Victims sometimes appear drunk with slurred speech.
e. All of the above.
ANSWER: e

2. Bupropion has been associated with which of the following neuropsychiatric symptoms in patients with depression?
a. delusions
b. hallucinations
c. psychosis
d. paranoia
e. all of the above
ANSWER: e

S35 IMPLEMENTING THE COVR AS A SCREEN FOR AGGRESSION

Barbara McDermott, PhD, (I) Sacramento, CA
Carmen Caruso, MA, (I) Napa, CA
Anthony Rabin, PhD, (I) Napa, CA
Katherine Warburton, DO, Napa, CA

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

SUMMARY
The prediction of violent behavior has long been considered one of the primary tasks in forensic psychiatry. A substantial amount of research has been conducted in past decades indicating that actuarial assessments are more accurate in identify-

ing 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. Recent research has indicated that the COVR is also applicable in the identification of aggressive forensic patients. This panel will discuss the process by which the COVR was implemented at a large forensic hospital, including barriers to implementation, logistic issues and follow-up. Dr. Warburton will discuss the institutional needs related to violence risk assessment, Dr. Rabin will discuss the psychological perspectives associated with the use of the COVR in a novel population. Dr. McDermott will discuss the outcomes associated with this screening and Ms. Caruso will discuss the integration of violence risk assessment results into treatment planning.

REFERENCES

Monahan J, Steadman HJ, Appelbaum PS, et al: The classification of violence risk. Behav Sci Law 24:721-30, 2006
Gray NS, Fitzgerald S, Taylor J, Snowden RJ: Assessing risk of future violence in inpatients using the Classification of Violence Risk (COVR). Psychiatric Services, In Press

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 is not included in the COVR software?

a. threat control override symptoms
b. the PCL-R
c. violent thoughts and fantasies
d. anger
ANSWER: b

S36 **SUCCESSFUL TREATMENT OF PROBLEMATIC SEXUAL BEHAVIORS**

John Paul Fedoroff, MD, Ottawa, ON, Canada
John Bradford, MB, Brockville, ON, Canada
William Marshall, PhD, (I) Kingston, ON, Canada
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE

To be familiar with state-of-the art techniques for successful assessment and treatment of people with problematic sexual behaviors.

SUMMARY

This course is an update of a course presented at the AAPL Annual Meeting in Miami, 2007: Nuts and Bolts: How To Run A Sex Offender Program. Dr. Fedoroff will provide an overview of how the Sexual Behaviors Clinic works. Dr. Bradford will provide an update on pharmacologic treatments for problematic sexual behaviors; Dr. Marshall will describe recent innovations in psychotherapeutic interventions; Dr. Saleh will describe treatment interventions for juvenile sex offenders.

REFERENCES

Fedoroff JP: Treatment of paraphilic sexual disorders, in The Handbook of Sexual and Gender Identity Disorders, Chapter 18. Edited by Rowland DL, Luca Iacocci L. Hoboken, NJ: John Wiley & Sons, 2008, pp. 563-86
Saleh F, Grudzinskas Jr. A, Bradford J, Brodsky D (editors): Sex Offenders: Identification, Risk Assessment, Treatment and legal Issues. Oxford, Oxford University Press, 2009

SELF ASSESSMENT QUESTIONS

1. In the treatment of sex offenders:

a. psychotherapy is useful
b. pharmacotherapy is useful
c. enhancement of self esteem is crucial
d. couples therapy is useful
e. all of the above
ANSWER: e

2. Most outpatient sex offenders are likely to:
a. eventually reoffend sexually
b. know their victims prior to the offense
c. be untreatable
ANSWER: b

S37 **THE DEATH PENALTY AND MITIGATING EVIDENCE: SUICIDE BY COURT?**

Hal S. Wortzel, MD, Denver, CO
John Blume, JD, (I) Ithaca, NY
Greg Kellermeyer, MD, Denver, CO
Richard Martinez, MD, MH, Denver, CO

EDUCATIONAL OBJECTIVE
The evolution of capital punishment in the United States and the vital role delineated for mitigating evidence will be reviewed, as will recent case law that seemingly neglects this crucial role for mitigating evidence. The forensic psychiatrist's part in optimizing both defendants' rights and state's interests will be explored.

SUMMARY
The death penalty remains the most severe and controversial form of punishment in the United States. The forensic psychiatrist is frequently asked to address issues surrounding competency and mitigating evidence in such cases. To perform optimally in the challenging context of a capital case, the psychiatric expert must be familiar with pertinent case law, and would benefit from awareness of contemporaneous medicolegal issues raised by a potential execution. The panel opens with review of Supreme Court death penalty cases, focusing on Furman v. Georgia and Gregg v. Georgia, and the critical role for mitigating evidence created with the reintroduction of capital punishment. Next comes a discussion of recent developments in case law (Chapman v. Kentucky and Schriro v. Landrigan) which appear to neglect the crucial role previously delineated for mitigating evidence, and raise concern for potential "suicides by court." Law Professor John H. Blume then discusses his work with defendants who volunteer for the death penalty, revealing troubling demographic similarities this population shares with those who complete suicide. The panel concludes with discussion on how the forensic psychiatrist may engage issues of competency and mitigating evidence to optimize defendants' rights and state's interests, and minimize the potential for "suicide by court."

REFERENCES
Blume JH: Killing the Willing: "Volunteers," Suicide and Competency. Michigan L Rev, March 2005. Available at SSRN: http://ssrn.com/abstract=591263. Accessed March 2, 2009
Gregg v. Georgia, 428 U.S.153, 190 (1976); Furman v. Georgia, 408 U.S. 238, 388 (1972)

SELF ASSESSMENT QUESTIONS
1. What do characteristics linking the population of completed suicides to death penalty "volunteers" include?
a. male gender
b. white race
c. history of substance abuse
d. history of mental illness
e. all of the above
ANSWER: e

2. All of the following statements regarding mitigating evidence in capital cases are true, except:
a. encourages consideration of the specific crime and the criminal prior to recommending a sentence
b. helps prevent implementation of the death penalty in an arbitrary and capricious manner
c. may be viewed as more than the defendant 's optional right, but a vital safeguard in protecting the state 's interests
d. potentially facilitates suicide by court
ANSWER: d

S38 **EVIDENCE-BASED PROGNOSTICATING PTSD IN CIVIL LITIGATION**

Stuart B. Kleinman, MD, New York, NY
The Honorable Robert E. Cadigan, (I) Baltimore, MD
Andrew Levin, MD, Hartsdale, NY
Charles Morgan III, MD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE
To better understand the current state of science regarding the course of PTSD and the role of evidence-based treatments and resilience in impacting such. Appreciation of the psychobiological underpinnings of resilience, and how litigators regard and employ prognostic data will be particularly emphasized.

SUMMARY
In addition to assessing current symptoms and functioning in claimants asserting posttraumatic stress disorder (PTSD) in civil actions, the examiner must formulate prognosis and recommendations for future treatment. In our experience few expert reports accurately reflect current understanding of risk factors, resiliency, and evidence-based treatment as required under Daubert. This presentation will address: 1) current efficacy data for psychopharmacologic and psychotherapeutic treatments of PTSD; 2) a review of demographic, historical, event-related, and biological factors that predict risk and resiliency; 3) application of this data to forensic evaluation including proper assessment of the claimant, evaluation of the adequacy of treatments, and formulation of prognosis; and 4) case vignettes that illustrate application of these principles. Time will be set aside for discussion between the panelists and the audience.

REFERENCES
Bradley R, Greene J, Russ E, et al: A multidimensional meta-analysis of psychotherapy for PTSD. Am J Psychiatry 162:214-27, 2005
Ballenger JC, Davidson JRT, Lecrubier Y, Nut D, Marshall RD, Nemeroff CB, Shalev AY, Yehuda R: Consensus statement update on posttraumatic stress disorder from the International Consensus Group on Depression and Anxiety. J Clin Psychiatry 65 (suppl 1), 2004

SELF ASSESSMENT QUESTIONS
1. Which of the following treatments for PTSD has the smallest "effect size"?
a. SSRIs
b. EMDR
c. cognitive processing
d. exposure plus cognitive therapy
e. skills training plus exposure
ANSWER: a

2. Which has been the most important predictor of chronicity of PTSD?
a. the post trauma environment
b. the history of trauma exposure
c. a family history of PTSD
d. low baseline cortisol
ANSWER: a

S39 PSYCHIATRIC EVALUATIONS FOR IMMIGRATION CASES

Vivian Chern-Shnaidman, MD, Princeton, NJ
Marlyn Quinn, JD, (I) Princeton, NJ

EDUCATIONAL OBJECTIVE
Participants will learn about the types of immigration cases in which psychiatric opinion and testimony are utilized, how to apply their knowledge of psychiatry and forensic psychiatry in this growing niche field.

SUMMARY
Marlyn E. Quinn, Esq., will present the legal basis for utilizing psychiatric expert testimony in the immigration courts. The various legal applications will be discussed, in addition to relevant case law. We will cover the topics of removal and cancellation of removal, and the various situations which can lead to removal. We will then explain how the laws are actually written to protect American citizens or permanent residents, and not the alien subject to removal. Vivian Shnaidman, M.D. will then present the form and content of the psychiatric evaluation and report and how to tailor the report to the specific case. Both presenters will discuss how to formulate the psychiatric-legal question, as the statutes are not specific in this regard. Then the participants will be broken up into small groups and given case vignettes (a different one for each group). The participants will have approximately half an hour to discuss the case and formulate a presentation to the "court." Each group will present its case to the entire audience and then the audience and presenters will discuss the case.

REFERENCES
http://uscis.gov (US immigration website - full of information for applicants and attorneys)
Bray I, Evans J, Lieberman R: U.S. Immigration Made Easy, 14th Edition. Berkeley, California: NOLO, 2009

SELF ASSESSMENT QUESTIONS

1. Extreme hardship is not defined by federal statute. Instead, case law is utilized to interpret this definition. Which of the following best defines extreme hardship in immigration cases?

a. exceptional and extremely unusual hardship
b. the alien will face death or severe punishment if returned to his original country
c. hardship substantially beyond that which would ordinarily be expected to result from the alien's deportation
d. deportation (removal) of the alien must result in death or severe punishment for the American citizen or permanent resident.

ANSWER: c

2. Some people can be subject to removal if they have committed a felony or a crime involving moral turpitude. Moral turpitude is defined as:

a. any crime involving nudity
b. any crime committed for financial gain
c. a crime involving fraud, larceny, and the intent to harm persons or things
d. a crime resulting in the degradation or humiliation of another person

ANSWER: c

S40 LEGAL AND ETHICAL ASPECTS OF PRISONER HUNGER STRIKES

Michael Greenspan, MD, New Haven, CT
Chinmoy Gulrajani, MD, New Haven, CT
Emily Keram, MD, Santa Rosa, CA
Jeffrey Metzner, MD, Denver, CO

EDUCATIONAL OBJECTIVE

Participants will be introduced to an historical perspective of hunger strikes; become familiar with the international and ethical concerns surrounding force-feeding; receive an overview of the state and federal case law dealing with force-feeding; be able to formulate a practical approach consistent with these considerations.

SUMMARY

Prisoner hunger strikes raise complex issues of constitutional and privacy rights, as well as medical ethics. United States federal and state laws provide conflicting guidance on the management of prisoner hunger strikers. Ethical guidelines of American and international medical groups conflict as well. Forensic psychiatrists may be involved in the evaluation and treatment of those on hunger strikes in detention. Panel members will compare and contrast cases including a recent Connecticut Superior Court ruling permitting force feeding of a prisoner on hunger strike, the management of the Guantanamo hunger strikers, and the past and current international experience with terrorist and dissident prisoner hunger strikes in England and Turkey. Through this case analysis the panel will explore issues including whether force-feeding constitutes cruel and unusual punishment and violates privacy rights, and whether competent prisoners have the right to refuse such intervention in the face of clear and imminent risk to their lives. Case law, national and international medical and ethical guidelines, as well as policies advocated by the International Committee of the Red Cross will be discussed.

REFERENCES

Lantz v. Coleman, Unreported; Superior Court of Hartford, Connecticut; May 21, 2008
World Medical Association (WMA): Declaration on Hunger Strikers. Adopted by the 43rd World Medical Assembly, Malta, November 1991, revised by the WMA General Assembly, Pilanesburg, South Africa, October 2006

SELF ASSESSMENT QUESTIONS

1. Which of the following country's policy on the treatment of politically dissident hunger strikers offers alternative approaches to force feeding?

a. China
b. France
c. England
d. South Africa

ANSWER: c

2. Legal questions raised by the practice of forced feeding include:

a. the constitutional ban of cruel and unusual punishment
b. individual privacy rights
c. the right of competent individuals to refuse bodily intervention
d. all of the above

ANSWER: d

SUNDAY, NOVEMBER 1, 2009

AUDIOVISUAL SESSION — 8:00 AM - 10:00 AM — **GRAND 1/2**

Z1 ***Rediscovering Forensic Psychiatry: Historical Origins***
Liza H. Gold, MD, Arlington, VA

PANEL — 8:00 AM - 10:00 AM — **GRAND 3/4**

Z2 ***The Release of Dangerous People: International Perspectives***
International Relations Committee
Kenneth Busch, MD, Chicago, IL
John Baird, MD, Glasgow, Scotland
Ian Cumming, MBBS, (I) London, United Kingdom
Adrian Grounds, FRCP, Cambridge, United Kingdom
Patricia Recupero, MD, JD, Providence, RI

PANEL — 8:00 AM - 10:00 AM — **GRAND 9/10**

Z3 ***Adolescent Substance Abuse: Corrections and College***
Addiction Psychiatry Committee
Mace Beckson, MD, Los Angeles, CA
Christopher Thompson, MD, Los Angeles, CA
Robert Weinstock, MD, Los Angeles, CA

RESEARCH IN PROGRESS #6 — 8:00 AM - 10:00 AM — **WATERVIEW A/B**

Z4 ***Psychiatric Traits of Severely Violent Substance Abusing Men***
Lauren Lussier, PsyD, (I) New Haven, CT
Caroline Easton, PhD, (I) New Haven, CT
Laurie Edwards, PsyD, (I) New Haven, CT
Melanie Scott, PsyD, (I) New Haven, CT

Z5 ***Using Virtual Reality Tasks Among Substance Abusing Men***
Caroline Easton, PhD, (I) New Haven CT
Susan Devine, MSN, RN (I) New Haven, CT
Laurie Edwards, PsyD, (I) New Haven, CT

Z6 ***The Drug War and Mexico's Great Social Disorder***
J. Arturo Silva, MD, San Jose, CA

Z7 ***Communicating Treatability and Violence Risk Level***
Research Committee
Todd Tomita, MD, Vancouver, BC, Canada
Eugene Wang, MD, Vancouver, BC, Canada

PANEL — 8:00 AM - 10:00 AM — **WATERVIEW C/D**

Z8 ***Uncovering the Taboo: A Review of the Female Sex Offender***
Elena T. del Busto, MD, Philadelpia, PA
Michael Harlow, MD, JD, Sacramento, CA
Solange Margery-Bertoglia, MD, Philadelphia, PA
Douglas Smith, MD, (I) Bronx, NY

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

RESEARCH IN PROGRESS #7 — 10:15 AM - 12:00 PM — **WATERVIEW A/B**

Z9 ***Attitudes of Correctional Officers Toward the Mentally Ill***
Jamae Campbell, MD, Columbia, SC,
Richard Frierson, MD, Columbia, SC

Z10 ***Racial Differences in Incarceration and Substance Dependence***
Melanie Scott, PsyD, (I) New Haven, CT
Susan Devine, MSN, RN, (I) New Haven, CT
Caroline Easton, PhD, (I) New Haven, CT
Laurie Edwards, PsyD, (I) New Haven, CT
Lauren Lussier, PsyD, (I) New Haven, CT

Z11 ***A Process Evaluation of the Implementation of START NOW Research Committee***

Robert Trestman, MD, PhD, Farmington, CT
Deborah Shelton, PhD, (I) Farmington, CT
Sara Wakai, PhD, (I) Farmington, CT

WORKSHOP 10:15 AM - 12:15 PM **GRAND 3/4**

Z12 ***Assaults on an Inpatient Service: Legal and Ethical Concerns***

Patricia Recupero, MD, JD, Providence, RI
Paul Christopher, MD, Providence, RI
Brian Daly, MD, Providence, RI
Keelin Garvey, MD, Providence, RI
Marilyn Price, MD, CM, Malden, MA

PANEL 10:15 AM - 12:15 PM **GRAND 9/10**

Z13 ***Forensic Aspects of Factitious Disorders***

Michael Harlow, MD, JD, Sacramento, CA
Henry Conroe, MD, Evanston, IL
Susan Pearlson, MD, Chicago, IL
Christopher Davidson, MD, Sioux Falls, SD

PANEL 10:15 AM - 12:15 PM **GRAND 1/2**

Z14 ***Management of Insanity Acquittees: Multi-State Perspectives***

Li-Wen G. Lee, MD, New York, NY
Larry Fitch, JD, (I) Jessup, MD
Michael Norko, MD, New Haven, CT
Debra Pinals, MD, Boston, MA

WORKSHOP 10:15 AM - 12:15 PM **WATERVIEW C/D**

Z15 ***Assessment for Reverse Transfer from Adult to Juvenile Court***

Stephen Zerby, MD, Pittsburgh, PA
Shabneet Hira-Brar, MD, Levittown, PA
Barbara Beadles, MD, Pittsburgh, PA
Amarpreet Singh, MD, Pittsburgh, PA
Gayle Strandberg, MD, Pittsburgh, PA

Z1 REDISCOVERING FORENSIC PSYCHIATRY: HISTORICAL ORIGINS

Liza H. Gold, MD, Arlington, VA

EDUCATIONAL OBJECTIVE

To explore the development of the subspecialty of forensic psychiatry in context with the development of the profession of psychiatry in the nineteenth century and to demonstrate that forensic psychiatry was in fact a key component in the establishment of the profession of psychiatry.

SUMMARY

This powerpoint slide presentation will use numerous visual images to supplement a lecture that reviews the historical development of forensic psychiatry, and forensic psychiatry's role in the establishment of the profession of psychiatry in the nineteenth century. Clinical psychiatry developed as a recognizable medical subspecialty in the first decades of the nineteenth century. Prior to the late nineteenth century, forensic psychiatric practice played an important and underrecognized role in the history of the development of the field of psychiatry. The clinical and forensic roles of psychiatrists separated in the hundred or so years between the Civil War and the organization of AAPL in 1969. However, early psychiatrists and founders of the American Psychiatric Association, men such as Benjamin Rush and Isaac Ray, considered forensic practice an integral part of their professional role and utilized forensic practice as a means of establishing the professional identity of psychiatry. These early and prominent specialists in psychiatry considered the provision of forensic services a social and professional obligation. Thus, psychiatrists rediscovering forensic practices are in fact only rediscovering their professional origins, which are closely allied with those of clinical psychiatric practice.

REFERENCES

Gold LH: Rediscovering forensic psychiatry, in American Psychiatric Publishing Textbook of Forensic Psychiatry. Edited by Simon RI, Gold LH. Washington, DC: American Psychiatric Publishing, Inc., 2004, pp 3-36
Robinson DN: Wild Beasts and Idle Humours: The Insanity Defense from Antiquity to the Present. Cambridge, MA: Harvard University Press, 1996

SELF ASSESSMENT QUESTIONS

1. The historical record of cases involving expert psychiatric testimony in the early nineteenth century consists primarily of what kinds of cases?

a. testamentary capacity
b. the insanity defense
c. a and b
ANSWER: c

2. The earliest expert psychiatric witnesses were acknowledged to have specialized knowledge beyond that of the lay witness or even the general medical practitioner. How was the basis of this knowledge derived?

a. from academic medicine
b. from evaluation of large numbers of patients in asylums
c. from familiarity with the literature of insanity
d. all of the above
ANSWER: b

Z2 THE RELEASE OF DANGEROUS PEOPLE:INTERNATIONAL PERSPECTIVES

Kenneth Busch, MD, Chicago, IL
John Baird, MD, Glasgow, Scotland
Ian Cumming, MBBS, (I) London, United Kingdom
Adrian Grounds, FRCP, Cambridge, United Kingdom
Patricia Recupero, MD, JD, Providence, RI

EDUCATIONAL OBJECTIVE

This session will provide a detailed examination of the decision making process that leads to the discretionary release of a prisoner or a patient from a secure hospital.

SUMMARY

The European Convention on Human Rights had a profound impact upon the mechanisms by which prisoners eligible for discretionary release and patients detained indefinitely in secure psychiatric hospitals can have their status reviewed and gain release. Successive speakers will outline the key elements of human rights legislation and draw such parallels as can be drawn between them and elements of the American Constitution. There will be a description of procedures for release from prison and secure hospitals highlighting the independent nature of the tribunals

that consider release, the emphasis on risk and public safety, and the aspects of the release process that include ongoing risk management in the community. There will be a discussion on ethics issues for clinicians involved in discretionary release processes of this kind, limitations of the risk assessment reports that can be required, and the need to balance the protection of the public and the rights of the individual who, if in prison, will have already served what is termed the "punishment" part of the sentence. There will be a discussion of American perspectives on this process and the ways in which the same conflicting objectives are balanced.

REFERENCES

Niveau G, Materi J: Psychiatric commitment: over 50 years of case law from the European Court of Human Rights. European Psychiatry 21:427-35, 2006

Londono P: The executive, the parole board and article 5 ECHR: progress within "an unhappy state of affairs"? Cambridge L Rev 67:230-33, 2008

SELF ASSESSMENT QUESTIONS

1. Which of the following statements is/are correct?

a. The European Convention on Human Rights is incorporated into domestic law in the United Kingdom.

b. Public authorities in the UK have a statutory obligation not to act in a way that is incompatible with European Convention rights.

c. a and b

d. none of the above

ANSWER: c

2. When do patients indefinitely detained under hospital and restriction orders in the UK have a statutory right to apply for an independent review of their detention?

a. every six months

b. every year

c. every three years

e. none of the above

ANSWER: b

Z3 ADOLESCENT SUBSTANCE ABUSE: CORRECTIONS AND COLLEGE

Mace Beckson, MD, Los Angeles, CA
Christopher Thomspon, MD, Los Angeles, CA
Robert Weinstock, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE

To understand the adolescent substance abuse issues encountered in juvenile correctional settings and in the college environment.

SUMMARY

Disruptive behavior and substance use disorders (SUDs) increase the risk of adolescent antisocial behavior. Treatment of SUDs reduces antisocial behavior and subsequent legal entanglements of juveniles. More recent data have shown that treating disruptive behavior disorders can also lead to a reduction in SUDs, particularly in adolescence. In a juvenile justice population, special challenges include diversion and abuse of medications and illicit substance use. Organizational treatment philosophies for adolescent SUDs often vary from detention setting to the community, giving rise to problems with consistency and continuity of care. This talk will focus on "mental health demographics" of the juvenile justice population and ways to minimize diversion and abuse of psychotropic medications, and explore the efficacy of different treatment interventions in treating adolescent SUDs. On college campuses, stimulants for attention deficit disorder present especially thorny problems in addition to the difficulties in making the diagnosis of attention deficit disorder itself. There are incentives to malinger, e.g., stimulants can be sold or used to cram for exams. It can be a problem to rely blindly on another clinician's diagnosis. The LSATs for law school now require psychological test evidence in addition to a clinician's assessment. Abuse of stimulants on campus can lead to suicide.

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, pp 672-84

SELF ASSESSMENT QUESTIONS

1. What is the rate of SUDs (i.e., formal criteria for Abuse or Dependence) in detained juveniles?
a. 10%
b. 30%
c. 50%
d. 70%
e. 90%
ANSWER: c

2. Which of the following medications is most likely to be diverted or abused in juvenile detention settings?
a. lisdexamfetamine (Vyvanse)
b. mixed amphetamine salts-extended release (Adderall XR)
c. atomoxetine (Strattera)
d. methylphenidate (Ritalin)
e. methylphenidate-OROS (Concerta)
ANSWER: d

Z4 PSYCHIATRIC TRAITS OF SEVERELY VIOLENT SUBSTANCE-ABUSING MEN

Lauren Lussier, PsyD, (I) New Haven, CT
Caroline Easton, PhD, (I) New Haven, CT
Laurie Edwards, PsyD, (I) New Haven, CT
Melanie Scott, PsyD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will learn about precipitants to severe physical violence, such as substance abuse, and the impact of these factors on treatment outcomes for substance abuse and domestic violence.

SUMMARY

Intimate partner violence (IPV) is prevalent in the United States, and it is estimated that one in four women will be a victim of domestic violence. There are many different behaviors that constitute IPV, and these behaviors can fall on a continuum of severity, from pushing or shoving to homicide. Many clinical treatment trials exclude offenders who report or demonstrate severe violence at baseline evaluations. The current study included any endorsements of violence, including more severe offenses, such as using weapons, choking and sexual assault. The purpose of the present study is to examine baseline characteristics of male offenders who endorse engaging in severely violent acts with intimate partners as compared to those male offenders who do not endorse severe violent acts with intimate partners. The present study will examine a total sample of 85 men, 10 of whom endorsed severely violent behaviors. The study will present legal, substance abuse, and psychiatric characteristics and treatment outcome among this high risk population.

REFERENCES

Easton CJ, Mandel D, Babuscio T, Rounsaville BJ, Carroll KM: Differences in treatment outcome between male alcohol dependent offenders of domestic violence with and without positive drug screens. J Addictive Behav 32(10): 2151-63, 2007

Fals-Stewart W, Stappenbeck C A: Intimate partner violence and alcohol use: the role of drinking in partner violence and implications for intervention. Fam Law Psych Briefs 4:4, 2003. Retrieved from http://www.jmcraig.com/subscribers/archives.htm

SELF ASSESSMENT QUESTIONS

1. What is most likely to lead to severe physical violence?
a. alcohol and/or drugs
b. violence
c. previous arrests
d. none of the above
ANSWER: a

2. What is related to poorer responses to treatment including violence, drug use, and poorer anger management styles?
a. lack of attendance
b. alcohol use at pretreatment
c. drug use at pretreatment
d. any positive drug screening throughout treatment
ANSWER: d

Z5 USING VIRTUAL REALITY TASKS AMONG SUBSTANCE ABUSING MEN

Caroline Easton, PhD, (I) New Haven, CT
Susan Devine, MSN, RN, (I) New Haven, CT
Laurie Edwards, PsyD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will learn about anger management styles among substance-dependent, domestic-violence offenders, and will observe a video demonstration of a client who partakes in a virtual reality task designed to increase ways of coping with anger to decrease aggression and improve treatment response.

SUMMARY

A large number of domestic violence episodes involve alcohol or drug use. Furthermore, research has shown that individuals who have problems with trait anger are likely to partake in violence when provoked. Additionally, research has shown that individuals who are high in trait anger and using alcohol and/or drugs have even higher rates of violence than individuals with high trait anger without co-occurring substance abuse. The purpose of this study is to demonstrate several anger management styles present among substance-dependent men arrested for violence, and to illustrate how an evidenced-based treatment approach that targets and utilizes anger management coping skills over the course of 12 weeks of treatment is related to positive treatment response. Moreover, state-of-the-art, virtual-reality tasks and facial morphing tasks and tools are being used to improve treatment outcomes among this high risk population. A video demonstration will be used to illustrate a virtual reality task designed to elicit anger management styles as targeted behaviors for treatment among substance using domestic violence offenders.

REFERENCES

Easton C J, Mandel DM, Hunkele K, Nich C, Rounsaville BJ, Carroll KM: A cognitive behavioral therapy for alcohol dependent domestic violence offenders: an integrated substance abuse-domestic violence treatment approach (SADV). Am J Addictions 16:24-31, 2007
Parrott DJ, Giancola PR: A Further Examination of the Relation Between Trait Anger and Alcohol-Related Aggression: The Role of Anger Control. Alcoholism Clinical 28(6):855-64, 2004

SELF ASSESSMENT QUESTIONS

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

2. Only among men who were intoxicated, what significantly predicted aggression?
a. angry temperament
b. state anger
c. trait anger
d. none of the above
ANSWER: c

Z6 THE DRUG WAR AND MEXICO'S GREAT SOCIAL DISORDER

J. Arturo Silva, MD, San Jose, CA

EDUCATIONAL OBJECTIVE

To provide an overview and exploration of the current level of social disorder in Mexico as a result of the illicit drug trade and other factors. To consider the potential relevance of forensic psychiatry and other behavioral sciences in aiding our understanding of Mexico's current social upheaval.

SUMMARY
During 2008 and 2009, Mexico experienced substantial social upheaval associated with the illicit drug trade. The first part of this presentation will provide an overview of the Mexican drug cartels. Other factors thought to contribute to Mexico's current social disorder, such as government and law enforcement corruption, the nature of globalization, illicit weapon trade, the emergence of various technologies, an economic world recession and the demand for drug consumption from the United States, will also be considered. Although Mexico's social problems are most dramatically highlighted by an upsurge of homicides, other relevant criminal activities such as abductions and extortions will also be discussed. The impact of the drug war on Mexico's education, economy, and political stability will be discussed briefly. This presentation is partially based on a preliminary study derived from numerous sources of both a qualitative and quantitative nature, and is complemented by a large array of visual media. The possibility that Mexico's current crisis may affect the United States will be considered. Potential roles that forensic psychiatry and other behavioral and forensic sciences may play in assessing problems associated with Mexico's drug war, will be discussed.

REFERENCES
News Report. Justice in Mexico Project. February, 2009. Downloaded on April 5, 2009 from http://www.justiceinmexico.org/from
Helman C, Vardi N: Mexican Meltdown. Forbes 182:73-6, 78, 80, 2008

SELF ASSESSMENT QUESTIONS
1. All of the following statements are true, except:
a. Forensic psychiatrists may have a role in the evaluation of drug cartel members in the United States.
b. Amado Carillo was closely associated with the Tijuana cartel.
c. Mexican drug cartel members obtain most of their weapons from the United States.
d. Knowledge concerning the nature of gangs may be an important area of forensic psychiatric expertise in the assessment of members of Mexican drug cartels.
e. Religious components can be part of the narcotraficant subculture.
ANSWER: b

2. Which one of the following statements is true?
a. It is well established that emerging debate concerning the drug cartels and the current social disorder in Mexico is not relevant to forensic psychiatry or to other forensic behavioral sciences in the United States.
b. Mexican drug cartel activity in the United States is not likely to be limited to the United States-Mexico border.
c. The current social disruption in Mexico associated with illicit drug trade is not likely to affect the United States.
d. The current social disorder in Mexico presents with issues of a forensic scientific nature which are relevant for Mexico but not for other countries.
e. Government corruption and the illicit arm trade are positively, though only modestly, associated with the current social upheaval in Mexico.
ANSWER: b

Z7 COMMUNICATING TREATABILITY AND VIOLENCE RISK LEVEL

Todd Tomita, MD, Vancouver, BC, Canada
Eugene Wang, MD, Vancouver, BC, Canada

EDUCATIONAL OBJECTIVE
Following the presentation, participants will understand four different psychiatric perspectives that clinicians use in addressing treatability, be aware of three general research themes emerging from a review of the treatability literature and gain increased awareness of assumptions that underlie opinions of treatability and violence risk in written reports.

SUMMARY
Forensic clinicians routinely make predictions about treatability when making decisions about violence risk management. Forensic decision making involves balancing the degree of freedom granted to an offender/patient, with the potential risk those liberties may pose to others. As the stakes rise on both sides of this equation, greater demands are placed on clinicians to accurately apply the available treatability research in making predictions about an individual's violence risk level. This is a complex task, and opinions often have many qualifiers and caveats that can be difficult to communicate to consumers of forensic evaluations. This presentation begins with a selected review of the perspectives-of-psychiatry approach, treatment motivation, and treatment responsivity literature. This is followed by a heuristic framework flowing from the available types of treatment literature. Although we are at the preliminary stages of examining in a structured way the relationship between treatability and violence risk level, it is hoped that further work in this area will help improve communication to consumers about the strengths and limitations of assessments of level of treatability and the impact on violence risk level.

REFERENCES
Fagan PJ: Sexual Disorders: Perspectives on Diagnosis and Treatment. Baltimore: Johns Hopkins University Press, 2003
Drieschner KH, Lammers SMM, van der Staak CPF: Treatment motivation: an attempt for clarification of an ambiguous concept. Clin Psychology Rev 23:1115-37, 2004

SELF ASSESSMENT QUESTIONS
1. Which of the following is not one of the perspectives of psychiatry in the framework proposed by McHugh, Slavney, and Fagan?
a. disease perspective
b. dimensional perspective
c. cognitive perspective
d. behavioral perspective
e. life story perspective
ANSWER: c

2. Which of the following risk assessment tools is not an example of the structured professional judgment tools?
a. HCR-20
b. SVR-20
c. RSVP
d. VRAG
ANSWER: d

Z8 UNCOVERING THE TABOO: A REVIEW OF THE FEMALE SEX OFFENDER

Elena T. del Busto, MD, Philadelphia, PA
Michael Harlow, MD, JD, Sacramento, CA
Solange Margery-Bertoglia, MD, Philadelphia, PA
Douglas Smith, MD, (I) Bronx, NY

EDUCATIONAL OBJECTIVE
To educate participants regarding the characteristics of female sex offenders that set them apart from male sex offenders. Participants will learn about the various issues that states face in the treatment of this unique subset of sex offenders.

SUMMARY
The phenomenon of male sex offenders has been widely researched in the literature and discussed in the forensic arena. Female sex offenders, on the other hand, have been historically overlooked. The belief that female sex offenders are a rare phenomenon seems to be supported by statistical data. Still, research suggests that this is an under-recognized occurrence due to the uncertainty in diagnosing, societal attitudes and underreporting. According to the U.S. Department of Justice (2006) 1% of perpetrators charged with forcible rape were females, and females comprised 6% of criminals charged with sex offenses. This presentation will cover the definitions of sex offender and violent sexual predator in the female population. It will also cover the epidemiological data available for this problem. The presenters will include a description of the historical and legal background on how our society has dealt with female sex offenders. Topics discussed will include characteristics and proposed typologies of these offenders. High profile cases will be discussed to illustrate the different female sex-offender typologies and the outcomes of their legal cases. Additionally, differences and similarities between male and female sex offenders, their recidivism rates, treatment options and reintegration into communities will be addressed.

REFERENCES
Denov M: Perspectives on Female Sex Offending: A Culture of Denial. Surrey: Ashgate Publishing, Ltd, 2004
Female Sex Offenders. Center for Sex Offender Management. A project of the Office of the Justice Programs, U.S Department of Justice, March 2007

SELF ASSESSMENT QUESTIONS
1. According to Vandiver's and Kercher's female sex offender typology, the most common group of female sex offenders are?
a. aggressive homosexual offenders
b. female sexual predators
c. young adult child exploiters
d. heterosexual nurturers
ANSWER: d

2. Female sex offenders, when compared with male sex offenders, are:
a. more likely to be incarcerated
b. more likely to have a prior history of drug offenses
c. less likely to have prior history of mental health treatment
d. more likely to have committed violent offenses
ANSWER: b

Z9 **ATTITUDES OF CORRECTIONAL OFFICERS TOWARD THE MENTALLY ILL**

Jamae Campbell, MD, Columbia, SC
Richard Frierson, MD, Columbia, SC

EDUCATIONAL OBJECTIVE
The purpose of this research is to understand how correctional officers perceive mental illness in the inmate population and how their attitudes impact the mental health care of this population.

SUMMARY
The population of mentally-ill individuals in the United States prison system has increased significantly over the last decade. As the number of mentally-ill inmates rises, correctional officers play an increasingly important role in dealing with mental illness within correctional facilities. It is therefore important to understand correctional officers' knowledge and attitudes toward mentally-ill inmates and how these attitudes impact the need for further training in this area. However, little research has been done regarding how officers perceive mental illness and the inmates who suffer from these disorders. This investigation involves a survey of correctional officers' knowledge about and attitudes toward mental illness in general and specifically within the prison population of the South Carolina Department of Corrections. Results are correlated with officer experience working with this population and other demographic factors.

REFERENCES
Callahan L: Correctional officer attitudes toward inmates with mental disorders. Int J Forensic Mental Health 3(1):37-54, 2004
Cotton D: The attitudes of Canadian police officers toward the mentally ill. Int J Law Psychiatry 27(2):135-46, 2004

SELF ASSESSMENT QUESTIONS
1. Can correctional officers' attitudes regarding inmates with mental illness affect the mental health treatment of such inmates?
ANSWER: How inmates with mental illness are regarded by staff may affect inmates' decisions to get mental health treatment if they are worried about being stigmatized due to having a mental illness.

2. Why do correctional officers play an important role in the treatment of inmates with mental illness?
ANSWER: Because correctional officers spend more time with inmates than other staff, they are in a unique position to observe an inmate's behavior and possibly their mental health symptoms.

Z10 **RACIAL DIFFERENCES IN INCARCERATION AND SUBSTANCE DEPENDENCE**

Melanie Scott, PsyD, (I) New Haven, CT
Susan Devine, MSN, RN, (I) New Haven, CT
Caroline Easton, PhD, (I) New Haven, CT
Laurie Edwards, PsyD, (I) New Haven, CT
Lauren Lussier, PsyD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE
Participants will learn about findings from current research examining differences in legal characteristics and substance dependence between Caucasian and African-American female offenders.

SUMMARY
As of 2005, the US Department of Justice, Bureau of Justice Statistics indicated that African-American females were more than three times as likely as Caucasian females to have been incarcerated. Although research has examined racial inequalities of imprisonment for men, little attention has been given to understanding the same factors for women. It is important to highlight racial inequalities in legal characteristics for women if such inequalities are to be rectified. The purpose of this study is to assess the differences in legal characteristics between Caucasian and African-American women being diverted into substance abuse treatment. Results showed no significant difference in the total number of arrests between Caucasian and African-American female offenders. However, length of longest incarceration showed a significant difference, with Caucasian women averaging 4 months and African-American women averaging 13 months. Implications of these findings are discussed.

REFERENCES
Freudenberg N: Jails, prisons, and the health of urban populations: a review of the impact of correctional system on community health. J Urban Health 78(2):214-35, 2001
Alleyne V: Locked up means locked out: women, addiction, and incarceration. Women and Therapy 29(3):181-94, 2006

SELF ASSESSMENT QUESTIONS
1. African-American women are incarcerated how many times more than Caucasian women?
a. 0
b. 2
c. 3
d. 4
ANSWER: d

2. Why is incarceration a significant issue for women from urban areas?
a. women's role's as caregivers/mothers
b. women have many complex social issues prior to incarceration
c. women often have more complex re-entry issues
d. all of the above
ANSWER: d

Z11 A PROCESS EVALUATION OF THE IMPLEMENTATION OF START NOW

Robert Trestman, MD, PhD, Farmington, CT
Deborah Shelton, PhD, (I) Farmington, CT
Sara Wakai, PhD, (I) Farmington, CT

EDUCATIONAL OBJECTIVE
Following this presentation, participants will be able to identify the elements of evidence-informed treatment, to recognize the components of process evaluation, and to identify the challenges of translating research into practice in correctional settings.

SUMMARY
A process evaluation was conducted to evaluate START NOW (Sampl, Trestman, & Harrison, 2007), an evidence-informed, skills-training program designed to assist inmates in modifying their maladaptive cognitions and behaviors while incarcerated (Berzins & Trestman, 2004). The intervention was piloted in one men's and one women's correctional facility with a total of 20 facilitators and 60 inmates. The objective of the process evaluation was to identify systematic procedures in the program design or implementation, to provide information for program decision-making, and to maintain a record of procedural events and activities. Data was collected via the Facilitator/Inmate Demographic Form, the Facilitator/Inmate Satisfaction Survey, Facilitator/Inmate Individual Interviews, Facilitator/Inmate attendance, Quality Assurance Forms, and DOC electronic databases. Preliminary findings suggest that modifications to program design included reducing the number of minutes per session, rescheduling groups, and rotating facilitators. Modifications were due to shift schedules, lock downs, and other logistics inherent in a correctional environment. Facilitators and inmates reported high satisfaction with START NOW. Inmates tended to leave the program because of being released or transferred and facilitators discontinued program involvement because of schedule changes or promotions. Further data collection and analyses of DOC electronic databases and health services utilization are pending.

REFERENCES
Berzins L, Trestman RL: The development and implementation of dialectical behavior therapy in forensic settings. Int J Forensic Mental Health 3(1):93-103, 2004
Sampl S, Trestman RL, Harrison J: START NOW skills training facilitator manual. Unpublished treatment manuscript. Farmington, CT: University of CT Health Center, 2007

SELF ASSESSMENT QUESTIONS
1. What is the major reason for inmates dropping out of START NOW?
a. didn't like program
b. conflicted with recreation time
c. placed in restrictive housing
d. transferred to different facility
ANSWER: d

2. Adherence to the START NOW program design (fidelity) is most influenced by which of the following?
a. Correctional Social Workers are more likely to adhere to program design.
b. Correctional Treatment Officers are more likely to adhere to program design.
c. Facilitators with less than 5 years of work experience in DOC are more likely to adhere to program design.
d. Facilitator characteristics do not make a difference.
ANSWER: a

Z12 **ASSAULTS ON AN INPATIENT SERVICE: LEGAL AND ETHICAL CONCERNS**

Patricia Recupero, MD, JD, Providence, RI
Paul Christopher, MD, Providence, RI
Brian Daly, MD, Providence, RI
Keelin Garvey, MD, Providence, RI
Marilyn Price, MD, CM, Boston, MA

EDUCATIONAL OBJECTIVE
At the conclusion of this workshop participants will know and be able to apply the legal and ethics principles of managing assaultive patients on an inpatient service.

SUMMARY
This workshop will address potential legal responses to patient-perpetrated assaults on inpatient units. Brief 15-minute presentations will introduce: typology of patient-perpetrated assaults; legal and ethical considerations; perspective of law enforcement and prosecution; and hospital and staff response to assaults by patients. Throughout the presentations, speakers will discuss differing considerations for patient-to-patient assaults, patient-to-visitor assaults, and patient-to-staff assaults. Afterwards, the workshop chair and presenters will guide audience participation in a discussion about the relevant issues and questions. Discussions will explore possible legal responses and management dilemmas such as: criminal prosecution, tort liability, confidentiality, workers compensation, licensing, duty to protect, risk management, administrative/supervisory concerns, and ethical implications. Illustrative examples will be drawn from real-life scenarios and first-hand experience as well as from relevant case law and forensic scholarship in the area of patient-perpetrated assaults.

REEFERENCES
Norko MA, Zonana HV, Phillips RTM: Prosecuting assaultive psychiatric patients. J Forensic Sci 37(3):923-31, 1992
Quanbeck C: Forensic psychiatric aspects of inpatient violence. Psychiatr Clin N Am 29:743-60, 2006

SELF ASSESSMENT QUESTIONS
1. Which of the types of violence described by Quanbeck, et al. (2006) is the least common type of assault?
a. organized
b. Impulsive
c. psychotic
d. affective
ANSWER: c

2. John Doe, who suffers from schizoaffective disorder, has recently assaulted a fellow patient, Jason Roe, whom he describes as having "invaded my personal space." Mr. Roe has suffered only minor bruising on his arm from the assault, but he is visibly shaken and upset by the incident. Mr. Doe has apologized and is calm, but Mr. Roe tells staff that he is afraid of Mr. Doe and asks staff to "keep him away from me." Which of the following actions would be an appropriate response to the incident?
a. keeping John Doe in restraints or seclusion indefinitely to prevent further violence
b. assisting Mr. Roe in filing a criminal complaint against Mr. Doe
c. discharging Mr. Doe for violating hospital policies
d. instructing Mr. Roe to remain in his room to avoid further injury
ANSWER: b

Z13 **FORENSIC ASPECTS OF FACTITIOUS DISORDERS**

Michael Harlow, MD, JD, Sacramento, CA
Henry Conroe, MD, Evanston, IL
Susan Pearlson, MD, Chicago, IL
Christopher Davidson, MD, Sioux Falls, SD

EDUCATIONAL OBJECTIVE
The educational objective of this panel presentation is to assist forensic psychiatrists in practicing forensic psychiatry, regarding factitious disorders, at the highest level attainable based on current knowledge. Panel members will convey to the audience how the issue of factitious disorders pertains to the practice of forensic psychiatry.

SUMMARY

Factitious disorders, characterized by physical or psychological symptoms that an individual intentionally produces or feigns in order to assume the sick role, offer a myriad of clinical issues for medical treatment teams. Moreover, factitious disorders pose a variety of forensic psychiatry questions. In addition to directly affecting the criminal justice process, physical and mental factitious disorders impact criminal cases, even when the disorder is not primarily related to the instant offense. This panel will discuss various aspects of factitious disorders and how they are expressed in forensic settings. Hank Conroe, MD will review the diagnosis of Munchausen's Syndrome. Dr. Conroe will provide case vignettes to demonstrate how a defendant's need to assume the sick role affects fitness to stand trial, as distinct from malingering. Michael Harlow, MD, JD will discuss Munchausen-Syndrome By Proxy and this disorder's impact on criminal justice issues of child abuse. Christopher Davidson, MD will review Ganser Syndrome, providing a clinical report on this disorder, as experienced in a corrections setting. Susan Pearlson, MD will discuss forensic psychiatry issues of factitious disorders that are encountered by a consult-liaison psychiatry service, including capacity for medical decision making, capacity for a transplant, and evaluation for involuntary commitment.

REFERENCES

Adshead G: Evidence-based medicine and medicine based evidence: the expert witness in cases of factitious disorder by proxy. J Am Acad Psychiatry Law 33:99-105, Mar 2005

Meadow R: Munchausen syndrome by proxy: the hinterland of child abuse. Lancet 2(8033):343-45, 1977

SELF ASSESSMENT QUESTIONS

1. What is the estimated prevalence of death secondary to abuse in children previously abused by a Munchausen-By-Proxy Parent?

a. 0-5%
b. 5-10%
c. 10-15%
d. 15-20%
ANSWER: b

2. What is the prevalence of factitious disorder diagnoses for tertiary medical center consult-liasion services?

a. 0.5-1.0%
b. 1.0%-1.5%
c. 1.5-2.0%
d. 2.0-2.5%
ANSWER: a

Z14 MANAGEMENT OF INSANITY ACQUITTEES: MULTI-STATE PERSPECTIVES

Li-Wen G. Lee, MD, New York, NY
Larry Fitch, JD, (I) Jessup, MD
Michael Norko, MD, New Haven, CT
Debra Pinals, MD, Boston, MA

EDUCATIONAL OBJECTIVE

Insanity acquittees are a key group of forensic patients. This panel will educate the audience regarding the varied approaches of four states for the management of insanity acquittees, with a discussion of statutory requirements, state systems for risk management and clinical care, and the sociolegal implications.

SUMMARY

The insanity defense remains a controversial topic in the public forum. Less publicly visible is what happens after a successful insanity plea. State management of insanity acquittees involves different legal standards and levels of oversight, with resulting variations in psychiatry's adaptations to providing care in these systems. The respective systems of Connecticut, Maryland, Massachusetts, and New York represent different approaches to balancing clinical needs, civil liberties, and public safety. Dr. Lee will describe the New York system, in which post-acquittal determination of dangerousness distinguishes future management routes, with the potential for indefinite state monitoring. Dr. Pinals will describe the Massachusetts system, in which acquittees may be sent to either a correctional or mental health facility, and when released face no further distinction from other mental health clients. Dr. Norko will describe the Connecticut system, in which a quasi-judicial board maintains control over movement and commitment decisions, with protection of the public as its first priority. Prof. Fitch will describe the Maryland system, in which inpatient or outpatient commitment are options for those found guilty but not criminally responsible, with central monitoring during conditional release. The panel will discuss the socio-legal dimensions of these approaches, comparing their advantages and disadvantages.

REFERENCES
Pinals DA, Packer I, Fisher B, Roy K: Relationship between race and ethnicity and forensic clinical triage dispositions. Psychiatric Services 55:873-8, 2004
McGreevy MA, et al: New York State's system of managing insanity acquittees in the community. Hospital and Community Psychiatry 42:512-17, 1991

SELF ASSESSMENT QUESTIONS
1. Following the finding of not guilty by reason of insanity, defendants are?
a. never sent to correctional facilities
b. sometimes sent to correctional facilities
c. released from court jurisdiction
d. none of the above
ANSWER: d

2. What does management of insanity acquittees require attention to?
a. psychiatric treatment
b. public safety
c. statutory requirements
d. all of the above
ANSWER: d

Z15 ASSESSMENT FOR REVERSE TRANSFER FROM ADULT TO JUVENILE COURT

Stephen Zerby, MD, Pittsburgh, PA
Shabneet Hira-Brar, MD, Levittown, PA
Barbara Beadles, MD, Pittsburgh, PA
Amarpreet Singh, MD, Pittsburgh, PA
Gayle Strandberg, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE
Participants will receive recommendations for the assessment of factors influencing the decision to transfer the cases of juveniles from adult court to juvenile court.

SUMMARY
In Pennsylvania, persons 15 years of age and over accused of a felony are automatically transferred to adult court. This began with PA Act 33, which took effect in March 2009 and automatically excluded certain offenders from the juvenile court system based on age and offense. This process is called certification, juvenile waiver, or transfer depending on region and literature. Adult courts may hear petitions for the transfer of the juvenile from adult court to juvenile court, which is termed reverse transfer or decertification. Multiple factors are considered and in some cases a mental health assessment is ordered to assist the court in determining whether the juvenile is appropriate for transfer to juvenile court. This workshop reviews the history of juvenile transfer and reverse transfer law, the role of the mental health professional in such judicial decisions, the basic elements of an evaluation, suggestions for writing an effective report, and reviews elements of effective testimony. Panel presentations will be focused to allow time for audience participation. A handout of a sample mock juvenile report will be provided. This workshop will provide a forum for audience discussion focusing on practical issues involved in this class of forensic evaluation.

REFERENCES
Jordan K: Violent Youth in Adult Court: A Comprehensive Examination of Legislative Waiver and Decertification. LFB Scholarly Publishing LLC, 2006
Marczyk GR, Heilbrun K, Lander T, DeMatteo D: Juvenile Decertification. Crim Justice Behav 32(3):278-301, 2005

SELF ASSESSMENT QUESTIONS
1. Which of the following is not a factor considered in a juvenile decertification hearing?
a. the degree of criminal sophistication exhibited by the child
b. whether the child can be rehabilitated prior to the expiration of the juvenile court jurisdiction
c. the wishes of the youth's family
d. the youth's amenability to treatment
ANSWER: c

2. Which of the following factors are considered to have the strongest affect on the decision to transfer to juvenile court?
a. the youth's level of maturity
b. offense seriousness and prior criminal record
c. age at time of offense
d. diagnosis of a mental disorder
ANSWER: b

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