American Academy of Psychiatry and the Law

41st Annual Meeting

October 21-24, 2010
Tucson, Arizona

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

Forty-first Annual Meeting
American Academy of Psychiatry and the Law
October 21-24, 2010
Tucson, Arizona

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PAST PRESIDENTS

Name	Years
Patricia R. Recupero, MD, JD	2008-09
Jeffrey S. Janofsky, MD	2007-08
Alan R. Felthous, MD	2006-07
Robert I. Simon, MD	2005-06
Robert T.M. Phillips, MD, PhD	2004-05
Robert Wettstein, MD	2003-04
Roy J. O'Shaughnessy, MD	2002-03
Larry H. Strasburger, MD	2001-02
Jefrey L. Metzner, MD	2000-01
Thomas G. Gutheil, MD	1999-00
Larry R. Faulkner, M.D	1998-99
Renée L. Binder, MD	1997-98
Ezra E. H. Griffith, MD	1996-97
Paul S. Appelbaum, MD	1995-96
Park E. Dietz, MD, PhD, MPH	1994-95
John M. Bradford, MB	1993-94
Howard V. Zonana, MD	1992-93
Kathleen M. Quinn, MD	1991-92
Richard T. Rada, MD	1990-91
Joseph D. Bloom, MD	1989-90
William H. Reid, MD, MPH	1988-89
Richard Rosner, MD	1987-88
J. Richard Ciccone, MD	1986-87
Selwyn M. Smith, MD	1985-86
Phillip J. Resnick, MD	1984-85
Loren H. Roth, MD	1983-84
Abraham L. Halpern, MD	1982-83
Stanley L. Portnow, MD	1981-82
Herbert E. Thomas, MD	1980-81
Nathan T. Sidley, MD	1979-80
Irwin N. Perr, MD	1977-79
G. Sarwer-Foner, MD	1975-77
Seymour Pollack, MD	1973-75
Robert L. Sadoff, MD	1971-73
Jonas R. Rappeport, MD	1969-71

2010 ANNUAL MEETING CO-CHAIRS

Peter Ash, MD, and Eraka Bath, MD

EXECUTIVE OFFICES OF THE ACADEMY

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

Howard V. Zonana, MD
Medical Director

Jacquelyn T. Coleman, CAE
Executive Director

CALL FOR PAPERS 2011

The 42nd Annual Meeting of the
American Academy of Psychiatry and the Law will be held in
Boston, Massachusetts October 27-30, 2011

Inquiries may be directed to,
Charles Scott, MD or Christopher Thompson, 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, 2011

FUTURE ANNUAL MEETING DATES and LOCATIONS

43rd Annual Meeting

October 26-29, 2012
Le Centre Sheraton, Montreal, PQ, 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

(Arizona Foyer, 2nd Floor)

Hours of Operation

Day	Hours
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

Arizona Foyer, 2nd Floor

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Arizona Foyer, 2nd Floor

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. Questions on the evaluation form 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.

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.

FINANCIAL DISCLOSURES

All those in control of content for this meeting returned signed statements regarding financial relationships.

SPEAKERS/PRESENTERS

The following speakers/presenters have indicated that they have no financial relationship pertaining to the content of their presentation:

Abbate, E.; Adshead, G.; Allen, T.; Alonso-Katzowitz, J.; Anfang, S.; Antoniak, S.; Aramburu, P.; Arndt, S.; Ash, P.; Ayoub, C.; Baranoski, M.; Bartlett, P.; Barzman, D.; Bath, E.; Beers, S.; Bender, E.; Bettencourt, J.; Billick, S.; Binder, R.; Black, D.; Blum, B.; Bodkin, C.; Bradford, J.; Brendel, R.; Brink, J.; Brower, M.; Buchanan, J.; Bursch, B.; Burton, P.; Busch, K.; Campbell, W.; Candilis, P.; Catingub, E.; Cerny, C.; Champagne, D.; Chism, L.; Christopher, P.; Cohen, B.; Cohen, F.; Coleman, J.; Collins, N.; Cooke, B.; Coomer, N.; Corcoran, J.; Crecelius, G; Curry, S.; Daley, C.; Daly, B.; Davidson, C.; Desmarais, S.; Dike, C.; Dinwiddie, S.; Dualan, I.; Dvoskin, J.; Dwyer, R.; Fabian, J.; Faigman, D.; Farnham, F.; Farrell, H.; Faulkner, L.; Fedoroff, P.; Fell, H.; Fellner, J.; Felthous, A.; Fergueson, J.; Fettman, M.; Fischer, E.; Fisher, W.; Fox, P.; Fozdar, M.;Franklin, K.; Frazier, L.; Frierson, R.; Fulwiler, C.; Galatzer-Levy, R.; Gannon, N.; Garrett, T.; Glancy, G.; Gold, L.; Goldberg, C.; Granacher, R.; Gray, J.; Greenspan, M.; Greenwood, P.; Greiner, C.; Griffith, E.; Gunter, T.; Gutheil, T.; Hall, R.; Hanson, A.; Harlow, M.; Hartwell, S.; Hasan, R.; Hatters Friedman, S.; Hanson, H.; Haun, J..; Herman, S.; Hicks, K.; Hillberg, T.; Hira-Brar, S.; Holzer, J.; Humphrey, M.; Hung, E.; James, D.; Johnson, R.; Joshi, K.; Juliano-Bult, D.; Kaempf, A.; Kalantarzadeh, S.; Kaplan, J.; Kapoor, R.; Kaufman, A.; Kaye, N.; Keating, J.; Kenan, J.; Kenney-Herbert, J.; Khadivi, A.; Khan, M.; Kiehl, K.; Kingston, D.; Klein, C.; Kleinman, S.; Knight, S.; Knoll, J.; Kolsrud, R.; Krueger, R.; LaCroix, C.; Lamberti, J.; Landron, E.; Lee, L.; Leonard, C.; Levin, A.; Levine, H.; Lilly, S.; Lopez-Leon, M.; LoPiccolo, C.; Lyons, C.; Maden, A.; Martin, E.; Martinez, R.; Maskel, L.; Massaro, J.; Mayberg, H.; Mayes, T.; McDermott, B.; McGavin, C.; McKinnon, N.; McNamara, S.; McNiel, D.; McReynolds, L.; Meyer, D.; Metzner, J.; Miklave, M.; Miller, G.; Moffit, C.; Moholkar, R.; Moran, J.; Morenz, B.; Mossman, D.; Mulbry, L.; Mulvey, E.; Murphy, L.; Musabegovic, H.; Myers, C.; Myers, W.; Nair, M.; Napoli, J.; Newman, W.; Nicholls, T.; Norko, M.; Noroian, P.; Obi, M.; O'Leary, P.; Olfson, M.; Olson, E.; O'Shaughnessy, R.; Pan, P.; Pandya, A.; Parker, G.; Phillips, R.; Pinals, D.; Pitt, S.; Plowman, D.; Post, J.; Price, M.; Punwani, M.; Rabin, T.; Rackliffe, D.; Reba-Harrelson, L.; Recupero, P.; Reeves, D.; Regehr, C.; Resnick, P.; Rivera, P.; Rogers, M.; Roof, J.; Rosenfeld, B.; Rotter, M.; Ryan, A.; Ryan, E.; Saleh, F.; Salem, A.; Sanders, M.; Sawyer, D.; Schlanger, J.; Schmidt, T.; Schultz, S.; Schwartz, A.; Scott, C.; Shreier, H.; Siegel, D.; Silva, J.; Simon, R.; Simpson, S.; Smelson, D.; Smith, D.; Smith, J.; Soderquist, C.; Sokolov, G.; Soliman, L.; Soliman, S.; Sonkiss, J.; Sonnier, L.; Soulier, M.; Spanggaard, M.; Sparr, L.; Stahl, P.; Stark-Riemer, S.; Steadman, H.; Stejeskal, W.; Stevenson, B.; Strandberg, G.; Temporini, H.; Thatcher, B.; Thomas, P.; Thompson, C.; Thornton, D.; Tippins, T.; Trestman, R.; Tucker, D.; Vanderpool, D.; Wadsworth, C.; Wall, B.; Wasserman, G.; Way, B.; Weinstock, R.; Weintraub, P.; Weiss, K.; Wernsing, S.; West, S.; Williamson, J.; Wills, C.; Wittman, J.; Woofter, C.; Wortzel, H.; Yang, S.; Young, J.; Zander, T.; Zawadzki, E.; Zerby, S.; Zonana, H.

The following speaker made a declaration of a financial relationship. A potential financial conflict of interest was resolved by review of the content of the presentation.

Edward P. Mulvey, PhD	Shareholder	COVR, Inc.

PROGRAM AND EDUCATION COMMITTEE MEMBERS DISCLOSURE

The following meeting planners in control of content for this meeting have indicated that they have no relevant financial relationships with any commercial interests. No meeting planners disclosed relevant financial relationships.

Alizai-Cowan, S.; Anfang, S.; Ash, P.; Bath, E.; Benedek, E.; Billick, S.; Campbell, W.; Christopher, P.; Coleman, J.; Decker, K.; Fozdar, M.; Frierson, R.; Gold, L.; Greiner, C.; Halavonich, R.; Henry, S.; Holzer, J.; Hung, E.; Kaye, N.; Kenan, J.; Keram, E.; Krueger, R.; LeBourgeois, H.; Newman, A.; Noffsinger, S.; Ostermeyer, B.; Parker, G.; Pearlson, S.; Pinals, D.; Pozios, V.; Preven, D.; Price, M.; Reid Johnson, N.; Resnick, P.; Rosmarin, D.; Schiffman, E.; Scott, C.; Sokolov, G.; Srinivasaraghavan, J.; Stolar, A.; Thompson, CR.; Wall, B.; Wills, C.

SPECIAL EVENTS

THURSDAY, OCTOBER 21

Event	Time	Location
Past Presidents' Breakfast	7:00 a.m. - 8:00 a.m.	San Pedro 1 3rd Floor
Opening Ceremony - President's Address (open to all attendees)	8:00 a.m. - 10:00 a.m.	Salon 6 2nd Floor
Association of Directors of Forensic Psychiatry Fellowships Reception (for fellowship program faculty, fellows, and potential applicants)	6:00 p.m. - 7:00 p.m. .	Tash Lawn

FRIDAY, OCTOBER 22

Event	Time	Location
Rappeport Fellows Breakfast (Rappeport Fellows and Committee)	7:00 a.m. - 8:00 a.m.	San Pedro 1 3rd Floor
Reception (for all meeting attendees)	6:00 p.m. - 7:30 p.m.	Ania Terrace

SATURDAY, OCTOBER 23

Event	Time	Location
Early Career Development and Fellows Breakfast (Those in the first seven years after training and current fellows)	7:00 a.m. - 8:00 a.m.	San Pedro 1 3rd Floor
AAPL Business Meeting (members only)	8:00 a.m. - 9:30 a.m.	Salon 6 2nd Floor

COFFEE BREAKS WILL BE HELD IN THE ARIZONA 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
Forty-first Annual Meeting

OPENING CEREMONY

Thursday, October 21, 2010
8:00 a.m. - 10:00 a.m.

WELCOME, INTRODUCTIONS
Stephen B. Billick, MD
President

PRESENTATION OF RAPPEPORT FELLOWS
Victoria L. Harris, MD, MPH
Chair, Rappeport Fellows Committee

David Bobb, MD
University of Texas Southwestern Medical Center

Susan Buratto, MD
University of Chicago Hospitals

Tarita Collins, DO
Albert Einstein Medical Center

Ergi Gumusaneli, MD
University of Colorado

Jennifer Piel, MD, JD
University of Washington

Loretta Sonnier, MD
Cincinnati Children's Hospital Medical Center

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

Golden Apple Award
Joseph D. Bloom, MD

Seymour Pollack Award
Park E. Dietz, PhD, MD

Red Apple Award
David Rosmarin, MD

Award for Outstanding Teaching in a Forensic Fellowship Program
Susan Hatters Friedman, MD

Young Investigator Award
Camilla L. Lyons, MD, MPH

Robert Trestman, PhD, MD
Chair, Research Committee

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

OVERVIEW OF THE PROGRAM
Peter Ash, MD
Eraka Bath, MD
Program Co-Chairs

INTRODUCTION OF THE PRESIDENT
Robert Sadoff, MD

PRESIDENT'S ADDRESS
Stephen B. Billick, MD

ADJOURNMENT
Peter Ash, MD
Eraka Bath, MD

AWARD RECIPIENTS

RED AAPL OUTSTANDING SERVICE AWARD

The Red AAPL is presented for service to the American Academy of Psychiatry and the Law.

DAVID ROSMARIN, MD

Dr. David Rosmarin graduated from Boston University School of Medicine, interned at Boston City Hospital, spent a year as an emergency room physician, and did his psychiatric residency at the University of Massachusetts Medical Center. During his chief residency year in forensic psychiatry, he was a special student at Harvard Law School. In the 1980s, when there were proposals to tattoo sero-positive HIV patients, Dr. Rosmarin wrote chapters and articles concerning HIV and Tarasoff, and initiated the Committee on AIDS at AAPL.

Dr. Rosmarin was a charter member of the Law and Psychiatry Service at Massachusetts General Hospital, moving to McLean Hospital in 2001, where he is the senior psychiatrist on the Forensic Service. Dr. Rosmarin's primary forensic focus has been in insanity and diminished capacity cases, and he has evaluated over 150 murder defendants. Since 1999, Dr. Rosmarin has consulted to the US government on forensic matters in the United States and abroad.

Dr. Rosmarin has provided much service to the American Academy of Psychiatry and the Law. He has served on the Executive Council, the Program Committee, and helped rewrite the AAPL ethics guidelines. Most significantly, he has chaired the Committee on Peer Review since 2001. At last year's annual meeting, he presented his own nationally televised testimony.

In recognition of his years of service, especially in terms of his outstanding chairmanship of the Committee on Peer Review, the American Academy of Psychiatry and the Law presents the 2010 Red AAPL Outstanding Service Award to Dr. David Rosmarin.

GOLDEN AAPL AWARD

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

JOSEPH D. BLOOM, MD

Dr. Joe Bloom received his medical degree from Albert Einstein College of Medicine. He did his internship at Mt. Zion Hospital and Medical Center in San Francisco and his residency at Massachusetts Mental Health Center. He was Chief of the Mental Health Unit for the Alaska Native Health Service and was in private practice in Anchorage, Alaska from 1969-1977. He is currently a Dean Emeritus and Professor Emeritus at Oregon Health Sciences University where he served as Chair of Psychiatry and then Dean.

Dr. Bloom has made significant contributions to forensic psychiatry. He was on the Board of Directors of the American Board of Forensic Psychiatry for six years and also served as its President. He was a member of the Committee on Added Qualifications in Forensic Psychiatry for four years and served as President of AAPL. Internationally, he has worked for the U.S. State Department to review Forensic Psychiatric Practices in the Soviet Union and consulted on Taiwan's Mental Health Law. He has published widely on mental health programs in Alaska focusing on the Eskimo population and homicide offenders. He also has written widely about Oregon's Psychiatric Security Review Board, the insanity defense, and civil commitment. He has authored or co-authored 129 papers and 23 book chapters or books.

Dr. Bloom has also been an outstanding teacher and mentor to medical students, residents, general and forensic psychiatrists.

In recognition of his significant contributions to the field of forensic psychiatry, the American Academy of Psychiatry and the Law presents the 2010 Golden AAPL award to Dr. Joe Bloom.

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.

SUSAN HATTERS FRIEDMAN, MD

Dr. Susan Hatters Friedman received her medical degree, did her psychiatric residency, and completed her forensic fellowship at Case Western Reserve University School of Medicine. She is currently a Senior Instructor in Psychiatry and Pediatrics at Case Western University, a forensic psychiatrist at Northcoast Behavioral Healthcare, a perinatal and forensic psychiatrist at North East Ohio Health Services and has a private forensic psychiatry practice. From 2003-2004, she was an AAPL Rappeport fellow.

Dr. Hatters Friedman's outstanding teaching abilities are described in her nomination letters in the following way: "Susan has been a role model for fellows both at Case Western Reserve University and in New Zealand… Her lectures are clear, well organized and creatively presented…Susan's teaching skills have enriched the educational and personal lives of many forensic fellows… She showed her skills for teaching by being able to give constructive criticism in a way that allowed fellows to develop their thoughts, critical thinking skills, and reach maximum potential without feeling unduly criticized… I never felt afraid to ask even the most naïve of forensic questions while at the same time feeling driven to learn to impress her and live up to her high expectations and impressive personal knowledge. In supervising reports, she emphasized the basic principles of good report writing from style to crisp logic…Dr. Friedman is an inspiring, intelligent and innovative teacher."

In recognition of her outstanding teaching and mentorship in a fellowship program, the American Academy of Psychiatry and the Law presents this award to Dr. Susan Hatters-Friedman.

SEYMOUR POLLACK AWARD

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

PARK DIETZ, MD, MPH, PhD

Dr. Park Dietz earned his medical degree, a masters degree in public health, and a Ph.D. in sociology at Johns Hopkins University. He did his psychiatric residency at Johns Hopkins Hospital and at the University of Pennsylvania. He served as an Assistant Professor of Psychiatry at the Harvard Medical School and as Professor of Psychiatry and Professor of Law at the University of Virginia. He is now Clinical Professor of Psychiatry at the UCLA School of Medicine.

Dr. Dietz has testified in such notable cases as those involving John Hinckley, Jeffrey Dahmer, Susan Smith, Polly Klaas, John DuPont, the Unabomber, the shootings at the U.S. Capital, the DC sniper cases, and the school shootings at Columbine.

Dr. Dietz is a Past President of AAPL and consults to the FBI's Profiling and Behavioral Assessment Unit and the New York State Police Forensic Sciences Unit. He has authored more than 100 publications. He was a member of the National Academy of Sciences Committee on Trauma Research, has conducted numerous studies of sex offenders and violent criminals, directed a five-year study for the National Institute of Justice on mentally disordered offenders who threaten and stalk public figures, and headed a two-year privately funded study of risks to the children and families of executives and other public figures.

In recognition of his distinguished contributions to the teaching and educational functions of forensic psychiatry, the American Academy of Psychiatry and the Law presents the 2010 Seymour Pollack Award to Dr. Park Dietz.

DISTINGUISHED LECTURERS

Thursday, October 21

HELEN MAYBERG, MD

The Brain on Trial

Dr. Mayberg is Professor of Neurology and Psychiatry and the Dorothy Fuqua Chair in Psychiatric Imaging and Therapeutics at the Emory University School of Medicine, where she heads an integrative depression research program. Current projects focus on development of imaging biomarkers predictive of treatment response and optimal treatment selection for individual depressed patients at all stages of illness. Dr. Mayberg, a Board Certified Neurologist, trained at Columbia's Neurological Institute in New York, with fellowship training in nuclear medicine at Johns Hopkins. She received a BA in Psychobiology from UCLA and an MD from University of Southern California. She is active in the Society for Neuroscience, the American Neurological Association, the Organization for Human Brain Mapping, and the Society of Biological Psychiatry where she is this year's President. Among various honors, she is the recipient of the Falcone Prize in Mood Disorders Research from NARSAD and the Roche Award for Translational Neuroscience, and was elected to the Institute of Medicine in 2008. Dr. Mayberg has served as an expert witness in a variety of criminal and civil cases where brain-imaging evidence has been introduced for purposes of causation or mitigation.

Friday, October 22

CAROLE GOLDBERG, ESQ.
DUANE CHAMPAGNE, PhD

Indigenous Ways of Justice: Healing Individuals and Communities

Carole Goldberg is the Jonathan D. Varat Distinguished Professor of Law and Director of the Joint Degree Program in Law and American Indian Studies at UCLA, where she teaches Federal Indian Law, Tribal Legal Systems, the Tribal Legal Development Clinic, the Tribal Appellate Court Clinic, and Civil Procedure. She also serves as a Justice of the Court of Appeals of the Hualapai Tribe, and as a hearing officer for the Morongo Band of Mission Indians. Professor Goldberg is co-author of a casebook in the field of federal Indian law, *American Indian Law: Native Nations and the Federal System* (6th ed. 2010) (with Rebecca Tsosie, Elizabeth Rodke Washburn, and Kevin Washburn) and co-editor and co-author of both the 1982 and 2005 editions of the leading treatise in the field, *Cohen's Handbook of Federal Indian Law*. She has published articles and books on a wide range of subjects in federal Indian law and tribal law, including state jurisdiction on reservations under Public Law 280, individual rights issues in Indian country, and the constitutionality of federal and state classifications favoring Indians. Her most recent book is *Defying the Odds: The Tule River Tribe's Struggle for Sovereignty in Three Centuries* (Yale University Press, 2010, with Gelya Frank). She and Professor Duane Champagne are co-authors of a major report, *Law Enforcement and Criminal Justice under Public Law 280* (2008), and recently received a $1.5 million grant from the National Institute of Justice to conduct a nationwide study of the administration of criminal justice in Indian country. Through her work with UCLA's Tribal Legal Development Clinic, she has assisted Indian nations in drafting their constitutions, legal codes, and intergovernmental agreements.

Duane Champagne is a member of the Turtle Mountain Band of Chippewa from North Dakota. He is Professor of Sociology and American Indian Studies, a member of the Faculty Advisory Committee for the UCLA Native Nations Law and Policy Center, Senior Editor for *Indian Country Today*, and a member of the TLCEE (Tribal Learning Community and Educational Exchange) Working Group, and contributor of the education chapter to the United Nations Permanent Forum on Indigenous Issues' (UNPFII) *State of the World's Indigenous Peoples Report*. Professor Champagne was Director of the UCLA American Indian Studies Center from 1991 to 2002 and editor of the *American Indian Culture and Research Journal* from 1986 to 2003. He has written or edited over 125 publications including *Social Change and Cultural Continuity Among Native Nations; Native America: Portraits of the Peoples; The Native North American Almanac; Social Order and Political Change: Constitutional Governments Among the Cherokee, Choctaw, Chickasaw and Creek, and Social Change* and *Cultural Continuity Among Native Nations*. Champagne's research and writings focus on issues of social and cultural change in both historical and contemporary Native American communities, the study of justice institutions in contemporary American Indian reservations, including policing, courts, and incarceration, and policy analysis of cultural, economic and political issues in contemporary Indian country. He has written about social and cultural change in a variety Indian communities including: Cherokee, Tlingit, Iroquois, Delaware, Choctaw, Northern Cheyenne, Creek, California Indians, and others. He is currently co-principal investigator on a $1.5 million grant from the National Institute of Justice to conduct a nationwide study of the administration of criminal justice in Indian country.

BRYAN STEVENSON, ESQ.

Reevaluating Juvenile Culpability and Evolving Standards of Decency

Bryan Stevenson is the Executive Director of the Equal Justice Initiative in Montgomery, Alabama and also a Professor of Law at the New York University School of Law. His representation of poor people and death row prisoners in the deep south has won him national recognition. He and his staff have been successful in overturning dozens of capital murder cases and death sentences where poor people have been unconstitutionally convicted or sentenced. Mr. Stevenson has been recognized as one of the top public interest lawyers in the country. His efforts to confront bias against the poor and people of color in the criminal justice system have earned him dozens of national awards including the National Public Interest Lawyer of the Year, the ABA Wisdom Award for Public Service, the ACLU National Medal of Liberty, the Reebok Human Rights Award, the Olaf Palme Prize for International Human Rights, the Gruber Foundation International Justice Prize and the prestigious MacArthur Foundation Fellowship Award Prize. He is a graduate of Harvard Law School and the Harvard School of Government. He has published articles on race and poverty and the criminal justice system, and manuals on capital litigation and habeas corpus.

THURSDAY, OCTOBER 21, 2010

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

T1 ***The Efficacy of Judicial Psychotropic Orders in NYS Prisons***

Stephanie Lilly, MA, (I) Marcy, NY
Jonathan Kaplan, MD, Marcy, NY
Bruce Way, MD, (I) Syracuse, NY
Catherine Moffitt, PhD, (I) Marcy, NY
Donald Sawyer, PhD, (I) Marcy, NY
Steve Stark-Riemer, Esq., (I) Albany, NY

T2 ***From the Hinterland to Factitious Disorder on Another***

Loretta Sonnier, MD, Cincinnati, OH

T3 ***PTSD in DSM-5: A Better Fit For Stockholm Syndrome?***

Christopher Davidson, MD, Sioux Falls, SD
Hillary Hanson, MD, Sioux Falls, SD
Melissa Spanggaard, DO, Sioux Falls, SD

T4 ***MISSION: Court-based Jail Diversion for Veterans***

Paul Christopher, MD, Worcester, MA
William Fisher, PhD, (I) Worcester, MA
Carl Fulwiler, MD, PhD, (I) Worcester, MA
Stephanie Hartwell, PhD, (I) Boston, MA
Debra Pinals, MD, Worcester, MA
David Smelson, PsyD, (I) Worcester, MA

T5 ***Traumatic Brain Injury Versus Malingering***

Helen Farrell, MD, Cincinnati, OH

T6 ***Verbal-Performance IQ Disparity in Adolescent Sex Offenders***

Cameron McGavin, MD, Pittsburgh, PA
Sue Beers, PhD, (I) Pittsburgh, PA
Gayle Strandberg, MD, Pittsburgh, PA
Stephen Zerby, MD, Pittsburgh, PA

T7 ***Completed Suicide in New York State Jails vs Prisons***

Manfred Obi, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY

T8 ***Sex Hormones and Aggression***
Sexual Offender Committee

Paul Fedoroff, MD, Ottawa, ON, Canada
John Bradford, MB, Ottawa, ON, Canada
Susan Curry, BA, (I) Ottawa, ON, Canada
Drew Kingston, PhD (I) Ottawa, ON, Canada

T9 ***The Neuroanatomy of Lying***

Charles LoPiccolo, MD, Fort Lauderdale, FL
Edward Zawadzki, DO, (I) Indiantown, FL

T10 ***Impact of Circles of Support and Accountability on Members***

Paul Fedoroff, MD, Ottawa, ON, Canada
Lisa Murphy, MCA, (I) Ottawa, ON, Canada
Jonathan Gray, MD, LLB, (I) Ottawa, ON, Canada

T11 ***Honor Killings and Mental Illness: A Medico-Legal Review***

Rabiya Hasan, MD, (I) Charleston, SC
Susan Knight, PhD, (I) Charleston, SC
Eva Landron, MD, (I) Charleston, SC
L. William Mulbry, MD, (I) Charleston, SC

T12 ***Religious/Political Extremism and the Insanity Defense***

Jacob Holzer, MD, Pocasset, MA

T13 Patient Threats Against the President: Clinician Obligations
Kristin Hicks, MD, Columbus, OH
Delaney Smith, MD, Columbus, OH

T14 My Sleep Disorder Made Me Do It: Parasomnias and Violent Behavior
George Parker, MD, Indianapolis, IN
Cynthia Bodkin, MD, (I) Indianapolis, IN

T15 Child Murder and Blood Drinking in Early 20th Century Spain
J. Arturo Silva, MD, San Jose, CA

T16 Involuntary Medication and Disciplinary Charges
Anasuya Salem, MD, Newark, NJ
Donald Reeves, MD, Newark, NJ

OPENING CEREMONY — 8:00AM - 10:00AM — **SALON 6**
T17 Being True to Psychiatry
Stephen Billick, MD, New York NY

COFFEE BREAK — 10:00AM - 10:15AM — ARIZONA FOYER

PANEL — 10:15AM - 12:00PM — **SALON 6**
T18 High Risk Suicidal Patients: Assessing the Unpredictable (CORE)
Robert Simon, MD, Washington, DC
Thomas Gutheil, MD, Boston, MA
James Knoll IV, MD, Syracuse, NY
Skip Simpson, JD, (I) Frisco, TX

WORKSHOP — 10:15AM - 12:00PM — **SALON 8-10**
T19 Preparing for Maintenance of Certification
Education Committee
Debra Pinals, MD, Worcester, MA
Richard Frierson, MD, Columbia, SC
Larry Faulkner, MD, Buffalo Grove, IL

WORKSHOP — 10:15AM - 12:00PM — **SALON 11-12**
T20 Anatomy of Forensic Cases: Dissecting Risk and Dangerousness
Brian Cooke, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Reena Kapoor, MD, New Haven, CT
Michael Norko, MD, New Haven, CT

WORKSHOP — 10:15AM - 12:00PM — **SALON 1-3**
T21 Empirical Limitations in Child Custody Recommendations
Glenn Miller, MD, Bethesda, MD
Robert Galatzer-Levy, MD, Chicago, IL
Philip Stahl, PhD, (I) Queen Creek, AZ
Timothy Tippins, Esq., (I) Albany, NY
Jeffrey Wittmann, PhD, (I) Albany, NY

RESEARCH IN PROGRESS #1 — 10:15AM - 12:00PM — **SALON 4/5**
T22 A Comparative Study of Long-Term Insanity Acquitees
Michael Greenspan, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY
Li-Wen Lee, MD, New York, NY

T23 Beta Blockers for Violence Prophylaxis
William Newman, MD, Sacramento, CA
Barbara McDermott, PhD, (I) Sacramento, CA

LUNCH (TICKET REQUIRED) — 12 NOON - 2:00PM — **SALON 7**
T24 The Brain on Trial
Helen Mayberg, MD, (I) Atlanta, GA

PANEL 2:15PM - 4:00PM **SALON 6**
T25 ***Do Practice Guidelines Belong In Court? Where Do They Belong?***
Psychopharmacology Committee
Henry Levine, MD, Bellingham, WA
John Bradford, MB, Ottawa, ON, Canada
Ryan Hall, MD, Lake Mary, FL
Neil Kaye, MD, Hockessin, DE
Andrew Levin, MD, Hartsdale, NY

COURSE (TICKET REQUIRED) 2:15PM - 6:15PM **SALON 1-3**
T26 ***Report Writing: Restraints, Reasoning and Refinement***
Phillip Resnick, MD, Cleveland, OH
Nancy Coomer, JD, (I) Tucson, AZ
Honorable Howard Fell, (I) Tucson, AZ
Ezra Griffith, MD, New Haven, CT
Richard Martinez, MD, Denver, CO
Ted Schmidt, JD, (I) Tucson, AZ

PANEL 2:15PM - 4:00PM **SALON 4/5**
T27 ***Munchausen by Proxy: Forensic Issues***
(Not Recorded)
Herbert Schreier, MD, (I) Oakland, CA
Catherine Ayoub, EdD, (I) Boston, MA
Mary Sanders, PhD, (I) Stanford, CA
Brenda Bursch, PhD, (I) Los Angeles, CA

PANEL 2:15PM - 4:00PM **SALON 8-10**
T28 ***Criminal Behavior and Blackouts: Madness, Malingering, or Memory Loss?***
Charles Scott, MD, Sacramento, CA
Barbara McDermott, PhD, (I) Sacramento, CA
Jason Roof, MD, Sacramento, CA
Humberto Temporini, MD, Sacramento, CA

WORKSHOP 2:15PM - 4:00PM **SALON 11-12**
T29 ***Practical Skills in Conducting and Assessing Correctional Psychiatry Research***
ARS
Tracy Gunter, MD, St. Louis, MO
Donald Black, MD, (I) Iowa City, IA
Robert Trestman, PhD, MD, Farmington, CT

COFFEE BREAK **4:000PM - 4:15PM** **ARIZONA FOYER**

DEBATE 4:15PM - 6:15PM **SALON 6**
T30 ***Enforcing AAPL's Ethics***
Ethics Committee
ARS
Philip Candilis, MD, Arlington, MA
Charles Dike, MD, MRCPsy, New Haven, CT
Donald Meyer, MD, Cambridge, MA
Wade Myers, MD, Providence, RI

PANEL 4:15PM - 6:15PM **SALON 4/5**
T31 ***Child and Adolescent Forensic Mental Health Professionals in Juvenile Specialty Courts***
Child and Adolescent Psychiatry Committee
Christopher Thompson, MD, Los Angeles, CA
Eraka Bath, MD, Los Angeles, CA
Gia Crecelius, MD, (I) Los Angeles, CA
Joseph Kenan, MD, Los Angeles, CA
Lauren Reba-Harrelson, MA, (I) Los Angeles, CA

PANEL 4:15PM - 6:15PM **SALON 8-10**
T32 ***You Got Personality: Diagnostic Challenges in Forensics***
Howard Zonana, MD, New Haven, CT
Josephine Buchanan, BA, (I) New Haven, CT
Patrick Fox, MD, New Haven , CT
Madelon Baranoski, PhD, (I) New Haven, CT

SCIENTIFIC PAPER SESSION #1 4:15PM - 6:15PM **SALON 11-12**

T33 Prevalence and Predictors of Diagnostic Changes in Forensic Psychiatry

Rajesh Moholkar, MRCPsych, Birmingham, United Kingdom
Tanya Garrett, MsC, PhD, (I) Birmingham, United Kingdom
Jeremy Kenney-Herbert, MRCPsych, (I) Birmingham, United Kingdom
Tanja Hillberg, MSCPsych, (I) Birmingham, United Kingdom

T34 From Schadenfreude to Contemplation: Lessons for Forensic Experts

Graham Glancy, MB, ChB, Toronto, ON, Canada
Cheryl Regehr, PhD, (I) Toronto, ON, Canada

T35 Forensic Applications of Diffusion Tensor Imaging in Mild Traumatic Brain Injury: Current Status

Hal Wortzel, MD, Denver, CO

T36 Automatism: A 15-Year Analysis of Criminal Appellate Case Law

Susan Knight, PhD, (I) Charleston, SC
Leonard Mulbry, Jr., MD, Charleston , SC

MOCK TRIAL 7:00PM - 9:00PM **SALON 6**

T37 Foreseeability, Lethal Violence and Risk Assessment: You Be The Judge

Stephen Pitt, DO, Scottsdale, AZ
Natalie Collins, Esq., (I) Scottsdale, AZ
Marshall Humphrey, Esq., (I) Tucson, AZ
Jeffrey Metzner, MD, Denver, CO
Joel Dvoskin, PhD, (I) Tucson, AZ
Russell Kolsrud, Esq., (I) Scottsdale, AZ

T1 THE EFFICACY OF JUDICIAL PSYCHOTROPIC ORDERS IN NYS PRISONS

Stephanie Lilly, MA, (I) Marcy, NY
Jonathan Kaplan, MD, Marcy, NY
Bruce Way, MD, (I) Syracuse, NY
Catherine Moffitt, PhD, (I) Marcy, NY
Donald Sawyer, PhD, (I) Marcy, NY
Steve Stark-Riemer, Esq., (I) Albany, NY

EDUCATIONAL OBJECTIVE:
To provide an overview on the efficacy of court orders in New York State that permit the administration of psychotropic medications over objection of State prisoners.

SUMMARY
Non compliance with psychiatric medication by outpatients is a primary cause of psychiatric emergencies, including inpatient hospitalization. The objective of this study is to examine the effectiveness of court orders that permit the administration of psychiatric medication over patient objection in corrections-based mental health services in New York State. Data were collected for 6 months before and after the court order was granted. Follow-up data were collected for the 12 months after the court order expired. Eighty-three patients are included in this analysis. Medication compliance and mental health functioning were significantly improved during the period of the court order. Additionally, there were significant reductions in disciplinary sanctions, inpatient admissions, and transfers to prison-based crisis observation cells. Reductions in disciplinary sanctions and observation cell transfers were maintained 12 months after the court order expired. Judicial process in psychiatry is becoming common; one example is court ordered psychiatric medication in the correctional setting. The study results indicate that the existence of a court order was successful in improving overall functioning. The relative effectiveness of judicial compared with administrative implementation of treatment over objection in correctional settings needs examination.

REFERENCES
Zygmunt A, Olfson M, Boyer CA: Interventions to improve medication adherence in schizophrenia. Am J Psychiatry 159:1653-1664, 2002
Swartz MS, Swanson JW, Hiday VA, et al: A randomized controlled trial of outpatient commitment in North Carolina. Psych Serv 52:325-329, 2001

SELF ASSESSMENT QUESTIONS
1. In New York State, judicial orders for the administration of psychotropic medications are valid for how many months after discharge from inpatient services?
a. 6
b. 12
c. 18
d. 24
ANSWER: b

2. In New York State, the judicial process for medication over objection was based upon which court ruling?
a. Washington v. Harper
b. Dusky v. U.S.
c. Rivers v. Katz
d. Matter of Wilson G.
ANSWER: c

T2 FROM THE HINTERLAND TO FACTITIOUS DISORDER ON ANOTHER

Loretta Sonnier, MD, Cincinnati, OH

EDUCATIONAL OBJECTIVE
The term "Munchausen Syndrome By Proxy" was coined in 1977. Since then, many terms have been used for this type of abuse. "Factitious Disorder on Another" is being proposed for the DSM-V. This poster presentation will guide the reader through pertinent terminology and surrounding controversies from 1977 to present.

SUMMARY
Sir Roy Meadow introduced the term "Munchausen Syndrome by Proxy" in 1977 in his article in the Lancet entitled, "MSBP: The Hinterland of Child Abuse." He described two patients who were presented as ill with such periodicity, planning and degree of fabrication that he had felt their abuse should be set apart from other forms of nonaccidental trauma. Since that time, the entity of a caretaker abusing another through the use of the medical system has taken

on many different names. Munchausen by Proxy Syndrome, Munchausen by Proxy, Munchausen by Proxy Abuse, Munchausen by Proxy Maltreatment, Polle Syndrome, the Dauphin of Munchausen, Factitious Disorder by Proxy, Pediatric Condition Falsification, Factitious or Induced Illness and Medical Child Abuse, are just some of the examples. This poster presentation will serve as a guide through the different terminologies from 1977 to today with an explanation of controversies and disagreements among experts in the fields of pediatrics, child abuse and psychiatry.

REFERENCES

Meadow, R: Munchausen Syndrome by Proxy: The Hinterland of Child Abuse. Lancet, 1977. Aug 13; 2 (8033): 343-5
Roelser T, Jenny C: Medical child abuse: beyond Munchausen Syndrome by Proxy. Am Acad Pediatric Publishing. Oct 2008.

SELF ASSESSMENT QUESTIONS

1. In using the term, "Factitious Disorder on Another," the writers of the DSM-V hope to:
a. Emphasize objective identification of behavior
b. Ignore underlying motivation or intentionality
c. Make it clear that the perpetrator gets a diagnosis
d. All of the above
ANSWER: d

2. To describe abuse that occurs through unecessary, harmful medical care at the instigation of a caretaker, the American Academy of Pediatrics currently endorses the following term:
a. Factitious Disorder by Proxy
b. Factitious or Induced Illness
c. Medical Child Abuse
d. Munchausen By Proxy
ANSWER: c

T3 PTSD IN DSM-5: A BETTER FIT FOR STOCKHOLM SYNDROME?

Christopher Davidson, MD, Sioux Falls, SD
Hillary Hanson, MD, Sioux Falls, SD
Melissa Spanggaard, DO, Sioux Falls, SD

EDUCATIONAL OBJECTIVE

To improve the reader's knowledge of Stockholm Syndrome and ability to assess it in the framework of current psychiatric diagnostic guidelines.

SUMMARY

Stockholm Syndrome (StS) has been described as a specific type of traumatic experience where kidnap victims develop positive bonds with their captors. First described by Nils Bejerot in 1973, StS exists in literature primarily as case reports, although it may be readily recognized from highly publicized media coverage. Common features of StS have been identified. However, there exists ambiguity and a lack of validated diagnostic criteria. It may be best represented in modern versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as PTSD (Post Traumatic Stress Disorder). Controversy surrounds this issue as authors disagree on the association between PTSD and StS. The relationship of the victim to the captor may be somewhat different from that associated with other types of trauma perpetrated on victims. A 49 item Stockholm Syndrome Scale (SSS) was created in 1995 to identify Stockholm Syndrome in dating women. This poster discusses a case study of StS and compares the DSM-IV TR and DSM-5 draft criteria for PTSD to the SSS in an attempt to recognize current diagnostic criteria most likely to align with published StS features. Additionally, this poster addresses the issue of identifying Stockholm Syndrome as a possible subcategorical type of PTSD.

REFERENCES

Namnyak N, Tufton N, Szekely R, Toal M, Worboys S, Sampson, EL: Stockholm syndrome: psychiatric diagnosis or urban myth? Acta Psychiatrica Scandinavica 117(1):4-11, 2008
Maiuro RD, O'Leary, KD: Psychological Abuse in Violent Domestic Relations, 1st Edition. New York: Springer, 2001

SELF ASSESSMENT QUESTIONS

1. Stockholm Syndrome has been described as specific type of traumatic experience where kidnap victims develop positive bonds with which of the following?

a. Feral children
b. Virtual avatars
c. Psychiatric clinicians
d. Their captors
e. Random strangers
ANSWER: d

2. Which answer is true?

a. Stockholm Syndrome is a well defined diagnostic entity in the DSM-IV.
b. The Stockholm Syndrome Scale is a widely used research tool often mentioned in current psychiatric literature.
c. Criteria for Stockholm Syndrome are clearly defined and validated in psychiatric literature.
d. The ICD-9 and DSM III criteria for Stockholm Syndrome are very similar.
e. The Syndrome Scale was created to identify Stockholm Syndrome in dating women.
ANSWER: e

T4 MISSION: COURT-BASED JAIL DIVERSION FOR VETERANS

Paul Christopher, MD, Worcester, MA
William Fisher, PhD, (I) Worcester, MA
Carl Fulwiler, MD, PhD, (I) Worcester, MA
Stephanie Hartwell, PhD, (I) Boston, MA
Debra Pinals, MD, Worcester, MA
David Smelson, PsyD, (I) Worcester, MA

EDUCATIONAL OBJECTIVE

Participants will become familiar with a court-based jail diversion program for veterans; will be able to identify important components in early program development and planning; and will understand strategies used to address barriers to program implementation.

SUMMARY

High rates of post-deployment mental health and substance use problems among U.S. military service members raise concerns regarding a growing risk for involvement of veterans in the criminal justice system post deployment. Developing interventions to prevent or decrease criminal justice involvement among new combat veterans has become a national priority. MISSION – Diversion and Recovery for Traumatized Veterans (MISSION DIRECT VET) is a post-adjudication, presentencing, court-based, jail-diversion program that was developed for veterans returning from Iraq/Afghanistan with trauma-related symptoms and problematic substance use. Over a five-year period, the program will recruit 250 participants; each will receive one year of veteran-focused wraparound services including mental health and substance abuse treatment, case management, trauma-informed care, and peer support. This poster addresses several key elements in the early planning stages of MISSION DIRECT VET (applicable for anyone interested in developing a jail-diversion program) and discusses the strategies used to engage various state criminal justice, mental health and public health agencies; develop successful collaborative relationships; and remove a number of identified barriers to program implementation.

REFERENCES

CMHS National GAINS Center: Responding to the needs of justice-involved combat veterans with service-related trauma and mental health conditions: A consensus report to the CMHS National GAINS Center's Forum on Combat Veterans, Trauma, and the Justice System. Delmar, NY: Author, 2008
Milliken CS, Auchterlonie JL, Hoge CW: Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. JAMA 298(18):2141-8, 2007

SELF ASSESSMENT QUESTIONS

1. Which of the following is the aim of the MISSION DIRECT VET program?

a. To identify criminal defendants who are veterans with mental illness and substance use disorders prior to the sentencing of their criminal case.
b. To propose services and treatment options as alternatives to incarceration.
c. To coordinate services between treatment providers and the courts, attorneys, jails, probation officers, and houses of correction.
d. All of the above.

ANSWER: d

2. Which of the following concerns for service members in the Iraq War increased the most over the first year following their return from deployment?

a. Depression
b. Post Traumatic Stress Disorder
c. Interpersonal conflict
d. Suicidal Ideation

ANSWER: c

T5 TRAUMATIC BRAIN INJURY VERSUS MALINGERING

Helen Farrell, MD, Cincinnati, OH

EDUCATIONAL OBJECTIVE

To understand the potential deficits imposed by traumatic brain injury to individuals, define the M'Naughten rule's criterion for an insanity defense, define malingering and understand which psychological tests are applicable to the determination of whether a defendant is malingering.

SUMMARY

While defendants may legitimately suffer from TBI and resultant complications, many individuals capitalize upon any history of minor head injury to assist in their NGRI defense. Forensic psychiatrists must retain a healthy degree of clinical suspicion for malingering in defendants who claim NGRI due to complications from brain injury especially when not documented and simply reported by the patient. This poster will illustrate the neurological complications of TBI, along with its controversial relationship to impulse dyscontrol and criminality. Malingering will also be defined, and various strategies to detect malingering in patients with a history of TBI will be reviewed.

REFERENCES

Barzman D, Kennedy J: Does traumatic brain injury cause violence? Current Psychiatry 1(4): 2002

Resnick PJ: Malingered Psychosis, Clinical Assessment of Malingering, 2nd Edition. Edited by Rogers R. New York: Guilford Press, 1997, pp 47-67

SELF ASSESSMENT QUESTIONS

1. What is the definition of malingering?

ANSWER: A condition, rather than a diagnosis, malingering is characterized by the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives.

2. What is the M’Naughten Rule of 1843?

ANSWER: The rule requires that for an insanity defense, the defendant must have a mental illness or defect, and consequently not know the nature/quality of the wrongfulness of the offense.

T6 VERBAL-PERFORMANCE IQ DISPARITY IN ADOLESCENT SEX OFFENDERS

Cameron McGavin, MD, Pittsburgh, PA
Sue Beers, PhD, (I) Pittsburgh, PA
Gayle Strandberg, MD, Pittsburgh, PA
Stephen Zerby, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE

The use of existing screening measures to assess for underlying neurocognitive deficits may lead to improved treatment of adjudicated adolescent sex offenders. This would allow better identification of those with cognitive deficits and pave the way for more effective approaches to treatment in these impaired offenders.

SUMMARY
Adolescent sexual offenders undergo sex-offender specific treatment. In the presence of significant neurocognitive deficits, treatment benefit may be quite limited. The goal of this study was to assess whether markers found in a commonly applied IQ assessment could detect significant deficits and identify for whom more extensive testing would be warranted. Wechsler IQ scores gathered from sequential admissions to an inpatient sex offender program were retrospectively evaluated for three markers of neurocognitive deficits: significant discrepancy in verbal/performance IQ scores (VIQ-PIQ); Digit Span (DS) or Digit Symbol Coding (DSC) as the lowest subtest score; and significant subtest scatter (SS) as defined by the test manual. Of the 138 subjects, 33% showed significant disparity in VIQ-PIQ scores; 37% met criteria for either DS or DSC as the lowest subtest score; and 22% met criteria for clinically significant subtest scatter. Of all subjects 43% met one criterion for neurocognitive impairment, 13.5% met two criteria, and 4.5% met all three. Nearly half of those in an adolescent sex offender treatment program demonstrated at least one neurocognitive deficit. Subsequent research may support screening to estimate amenability to current treatment and assess the need for further testing. Adjustments in treatment based on these deficits may lead to improved outcomes.

REFERENCES
Cornell DG, Wilson LA: The PIQ greater than VIQ discrepancy in violent and nonviolent delinquents. J Clin Psychol 48:256-261, 1992
Veneziano C, Veneziano L, LeGrand S, Richards L: Neuropsychological executive functions of adolescent sex offenders and nonsex offenders. Percept Mot Skills 98:661-674, 2004

SELF ASSESSMENT QUESTIONS
1. Which of the following Wechsler IQ test results can be considered markers for neurocognitive deficits?
a. Verbal IQ - Performance IQ disparity
b. Digit Span or Digit Symbol Coding as lowest score
c. Subtest Scatter
d. All of the above
ANSWER: d

2. Neuropsychological testing may be beneficial in treating adolescent sex offenders for which of the following reasons?
a. Administering neuropsychological testing is enjoyable
b. Sex offender treatment is complex and often language-based
c. Neuropsychological testing can explain why the offense was committed
d. Neuropsychological testing is expensive
ANSWER: b

T7 **COMPLETED SUICIDE IN NEW YORK STATE JAILS VS. PRISONS**

Manfred Obi, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE
To educate clinicians and correctional staff of suicide risk factors peculiar to jails and prisons in New York State, and to improve services at critical times to reduce suicide in the facilities.

SUMMARY
Suicide is the leading cause of death in jails and the third leading cause of death in prisons. Suicide is also the leading cause of litigation in both correctional settings. While they have similar features, jail and prison are unique environments and the pressures faced by inmates differ. This study is aimed at comparing and contrasting suicides in prison and in jail. Suicides during 2008 and 2009 in New York State (NYS) jails (n=20) and New York State prisons (n=20) will be reviewed utilizing sources of information including NYS Office of Mental Health psychological autopsies, suicide reviews conducted by NYS Department of Corrections, NYS Commission on Correction (NYSCOC) Review Board reports regarding inmate suicides, Central New York Psychiatric Center data on inmate suicides, and NYSCOC data on inmate suicides. Data collected will include age, ethnicity, offense, length of incarceration, method used, isolation, psychiatric diagnosis, precipitating events/ emotional stressors, previous suicide attempts while incarcerated or in the community, previous psychiatric hospitalization while incarcerated and in the community, and psychiatric symptoms at the time of the suicide. The data for each cohort will be aggregated and compared to ascertain what unique characteristics are associated with successful suicide in jail versus prison.

REFERENCES
Hayes LM: National study of jail suicides: seven years later. Psychiatric Quarterly 60(1): 1989, pp 729
State of New York Department of Correctional Services, Inmate Suicide Report 1998-2007

SELF ASSESSMENT QUESTIONS
1. The most common means of suicide in jails and prison is:
a. Medication overdose
b. Sharp objects
c. Gunshot
d. Hanging
e. Street drug overdose
ANSWER: d

2. Sixty percent suicides in jail occur within how many days of incarceration?
a. Five days
b. Seven days
c. Three days
d. One day
e. Fourteen days
ANSWER: c

T8 SEX HORMONES AND AGGRESSION

Paul Fedoroff, MD, Ottawa, ON, Canada
John Bradford, MB, Ottawa, ON, Canada
Susan Curry, BA, (I) Ottawa, ON, Canada
Drew Kingston, PhD, (I) Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE
To become familiar with hypotheses concerning androgenic hormones and sexual aggression.

SUMMARY
Testosterone has been implicated in problematic sexual behavior, such as sexual aggression. However, results are not consistent and the direction of the effect is unclear: whether elevated testosterone levels precede or follow aggressive behavior. In fact, questions have been raised about whether there is any relationship at all between testosterone and sex offending. This study examined the relationship between androgenic hormone levels [total serum testosterone, free testosterone, luteinizing hormone (LH), and follicle-stimulating hormone (FSH)], self-reported hostility, the violence of the offense, and subsequent aggression in a consecutive sample of 847 sexual offenders. Recidivism data were collected up to 20 years post-release. Results showed a positive association between testosterone, self-reported hostility level, and aggression. FSH was significantly associated with recidivism, although the size of the effect was small (ROC = .59); LH was moderately associated with sexual, violent, and criminal recidivism (ROC's = .63). Our results suggest that sex hormones may be modestly associated with violent and sexual aggression in sexual offenders. This study also indicates that hypothalamic hormones may be more sensitive proxies of problematic sexual behaviors than testosterone.

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Book AS, Starzyk KB, Quinsey VL: The relationship between testosterone and aggression: a meta-analysis. Aggression Violent Behav 6:579-599, 2001

SELF ASSESSMENT QUESTIONS
1. The proven relationship between androgenic hormones and sexual aggression is:
a. unequivocal
b. additive
c. reciprocal
d. a and c
e. none of the above
ANSWER: e

2. Hormones associated with sexual aggression include:
a. testosterone
b. LH
c. FSH
d. a and c
e. all of the above
ANSWER: e

T9 THE NEUROANATOMY OF LYING

Charles LoPiccolo, MD, Fort Lauderdale, FL
Edward Zawadski, DO, (I) Indiantown, FL

EDUCATIONAL OBJECTIVE
The purpose of this paper is to demonstrate the neuroanatomical structures that have been implicated in the process of lying. It will delineate the difference between neural pathways involved in truth telling and lying. It will provide background into the neural structures cited.

SUMMARY
Lying is a uniquely human and universal experience. The universality of this experience is a key to a biological component. The detection of lying has become the holy grail of jurisprudence and related forensic sciences. Functional magnetic resonance imaging has identified differences in brain activity in "truth only" conditions versus "lie-only"conditions. In the "lie-only"conditions, left medial and left inferior frontal lobes, right hippocampus, left lingual gyrus, anterior cingulate, right fusiform gyrus, and the right sublobar insula are especially active. During "truth only" conditions, the left subcallosal gyrus and left inferior temporal gyrus are more active. This poster will illustrate these differences. The poster will further explain the normal functions of these neural structures. The poster will also describe the limitations and practicality of this neuroradiological technique which prevent its introduction into the legal system from the perspective of the Frye and Daubert criteria.

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Simpson J: Functional MRI Lie Detection: Too Good to be True? J Am Acad Psychiatry Law 36 :4:491-498 (2008)

SELF ASSESSMENT QUESTIONS
1. Is there a presumed difference between neural tracks involved in "lie-only"conditions and "truth-only" conditions?
ANSWER: Yes. Seven additional areas are activated in lie-only conditions.

2. Which are the neural structures thought to be involved with lying?
ANSWER: Left Medial Frontal Cortex, Right Hippocampus, Right Infereior Parietal, Left Lingual Cortex, Right Fusiform Gyrus, Right Sublobar Insula, Thalamus

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T10 IMPACT OF CIRCLES OF SUPPORT AND ACCOUNTABILITY ON MEMBERS

Paul Fedoroff, MD, Ottawa, ON, Canada
Lisa Murphy, MCA, (I) Ottawa, ON, Canada
Jonathan Gray, MD, LLB, (I) Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE
To measure the effect of participation in CoSA on the self-reported psychological well-being of CoSA members; to identify components of the program that contribute to changes in well being; and to find ways to enhance the positive impact of the program.

SUMMARY
Background: Circles of Support and Accountability (CoSA) is a nonprofit community-based program. CoSA aims to substantially reduce the risk of future sexual victimization by introducing offenders to trained volunteers who support the reintegration of sex offenders released into the community. CoSA has emerged from the "what works" literature on successful reintegration of sex offenders into the community. However, questions remain about the impact of participation in CoSA on the wellbeing of core members and volunteers. Methods: Core members (n= 10) and volunteers (n=29) completed the General Health Questionnaire (GHQ) and a survey soliciting demographic information and subjective experiences. Results and Conclusions: Results from the GHQ indicated 50% (n=5) of all

core member respondents showed signs of diminished wellbeing and psychological distress. Conversely, about 20% (n= 6) of volunteers met the GHQ significance threshold. Overall, results indicated that most core members and volunteers found the program a rewarding and fulfilling experience that led to feelings of belonging and self growth. Themes pertaining to areas of concern and recommendations for program improvement were also noted and will be presented in the poster presentation.

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Cesaroni C: Releasing sex offenders into the community through "Circles of Support"–a means of reintegrating the "Worst of the Worst." J Offender Rehab 34(2):85-98, 2001

SELF ASSESSMENT QUESTIONS

1. What is Circles of Support and Accountability (CoSA)?

a. A court mandated program for high risk sex offenders to participate in while reintegrating back into the community after serving a sentence for a sexual offense.

b. A voluntary community based program designed to assist in the successful reintegration of high risk sexual offenders.

c. A prison-based treatment program that aims to make sex offenders accountable for their actions.

d. A housing program for low and high risk sex offenders after release from prison.

ANSWER: b

2. Which of the following were NOT noted as an experience that negatively impacted volunteer member's involvement with CoSA?

a. Periods of increased tension when the core member [former sex offender] is not being honest or is 'shutting out' other volunteer members.

b. Feel that they are not being sufficiently supported by other volunteer members.

c. When volunteers attempt to address issues that they are not trained to handle (such as taking on the role of the treatment provider).

d. None of the above answers were reported by volunteer members.

ANSWER: d

T11 HONOR KILLINGS AND MENTAL ILLNESS: A MEDICO-LEGAL REVIEW

Rabiya Hasan, MD, (I) Charleston, SC
Susan Knight, PhD, (I) Charleston, SC
Eva Landron, MD, (I) Charleston, SC
L. William Mulbry, MD, (I) Charleston, SC

EDUCATIONAL OBJECTIVE

To promote understanding of cultural, psychological, and legal factors associated with honor killings.

SUMMARY

Background: Honor killings are homicides committed most commonly by males against female family members believed to have dishonored the family name. 5,000 female victims are estimated annually worldwide. Legal and moral acceptance of this practice varies widely across nations. Minimal data are available on the psychiatric status of perpetrators and victims. Objective: To review the available literature for information on honor killings from a medico-legal perspective. Method: Medical and legal databases and internet search engines were searched from 1980 to 2010 for published studies and newspaper articles regarding honor killings. Results: Honor killings remain legal in many nations. In nations that have outlawed the practice recently, reported homicide rates have declined but may have been offset by a rise in the rate of reported suicide. Honor killings are committed most commonly by husbands of the victims. No studies have systematically assessed the prevalence of psychiatric illness in victims or perpetrators. Obstacles to research progress include social stigma associated with mental illness and limited recognition of honor killings as homicides in cultures that sanction the practice. Conclusion: Systematic studies are needed to assess social, cultural and psychological factors associated with honor killings to aid in the development of prevention strategies.

REFERENCES

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Douki S, Nacef F, Belhadj A, Bousaker A, Ghacem R: Violence against women in Arab and Islamic countries. Arch Women's Mental Health 6:165-171, 2003

SELF ASSESSMENT QUESTIONS

1. Are there countries where honor killings are legal?
a. yes
b. no
ANSWER: a

2. Who is most likely to be the perpetrator of an honor killing?
a. brother
b. father
c. male cousin
d. husband
ANSWER: d

T12 RELIGIOUS/POLITICAL EXTREMISM AND THE INSANITY DEFENSE

Jacob Holzer, MD, Pocasset, MA

EDUCATIONAL OBJECTIVE

This poster provides a review of legal cases involving extremism and terrorism where mental illness and use of the insanity defense were, or may be, factors, highlighting in particular the case of Major Nidal Hasan; and examines various complexities associated with these types of cases.

SUMMARY

Religious and political extremism and violence are not usually associated with mental illness. However, in individual cases, mental illness may play a role in the extremist's belief system and resulting behavior. Prominent cases of extremism and terrorism where mental illness or psychological factors were raised have included the "Shoe Bomber" Richard Reid, the "20th hijacker" Zacarias Moussaoui, and Major Nidal Hasan. Major Hasan is accused of the mass shooting on 11/5/09 at Fort Hood, Texas, in which 13 people were killed and 28 wounded, and his mental state at the time of the shootings has been raised as a possible defense. Mounting an insanity defense in extremism cases may be very difficult, however, due to a number of factors, including potential lack of a formal psychiatric history, lack of collateral information, religious/political motivation and the expression of beliefs predating the violent event, and association with a group or cause. This poster reviews the case of Major Hasan as a model for the complexities of developing an insanity defense in extremism cases.

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http://www.nytimes.com/2009/11/09/us/09reconstruct.html?_r=1: McKinley JC, Dao J. Fort Hood Gunman Gave Signals Before His Rampage. NY Times, Pub. 11/8/09. Accessed November 22, 2009

SELF ASSESSMENT QUESTIONS

1. Which of the following concepts may be important in the evaluation of a terrorism suspect/defendant for the insanity defense?
a. Theories about the psychology of terrorism
b. A culturally-informed evaluation, including language translation if needed
c. If the terrorism/violent event results in a large amount of media coverage and popular opinion.
d. Whether there is a history of formal psychiatric evaluations, diagnoses, treatment
e. If the terrorism/violent act is aimed at a specific political goal
f. b, d, and e
ANSWER: f

2. Which of the following factors is relevant in Major Hasan's background in relation to his mental state at the time of the alleged shooting?
a. Early attempts to get a discharge from the Army over feeling disgruntled
b. Increasingly vocal opposition to the wars during training
c. Potential interactions with Anwar Al-Awlaki
d. On the morning of the shootings, saying goodbye to friends at a Mosque and asking for forgiveness for past offenses
e. All of the above
ANSWER: e

T13 PATIENT THREATS AGAINST THE PRESIDENT: CLINICIAN OBLIGATIONS

Kristin Hicks, MD, Columbus, OH
Delaney Smith, MD, Columbus, OH

EDUCATIONAL OBJECTIVE

To gain a better understanding of how to fulfill national obligations to aid the Secret Service in protecting the President, while considering issues of confidentiality and freedom from self-incrimination.

SUMMARY

In considering how to manage psychiatric patients who threaten the life of the President, clinicians confront both the dictates of the Presidential threat statute and the general duty-to-protect laws specific to their state. These often conflict with ethics principles that guide clinical decision making, namely confidentiality and nonmaleficence. The liability of clinicians for both warning and not warning must also be considered. A literature review was performed in pub med using terms "President and threats," "President and assassination," and "President and Secret Service." Eight articles were found to be relevant. There seems to be divergence in interests between the Secret Service and clinicians. For example, in 1996 Coggins, et al., studied clinician attitudes about reporting threats against the President and found that 89.9% would report only if they thought the threat was real, despite knowledge that the position of the Secret Service is to report all threats. In this review we will discuss existing proposed guidelines and their applicability to various clinical settings. We will then consider ways to develop guidelines that accommodate the interests of both the Secret Service and mental health care providers, while taking into account the reality of practice standards and resource limitations.

REFERENCES

Brakel SJ, Topelsohn L: Threats to Secret Service protectees: guidelines on the mental health services provider's duty to report. J Contemporary Health Law Policy 7:47-72, 1991
Coggins MH, Steadman HJ, Veysey, BM: Mental health clinicians' attitudes about reporting threats against the president. Psychiatr Serv 47(8):832-836, 1996

SELF ASSESSMENT QUESTIONS

1. The following is/are the only state/states that have a statute specifically enabling therapists to report threats against the President to the Secret Service for investigative purposes:

a. Ohio
b. Pennsylvania
c. Illinois
d. b and c
e. All of the above
ANSWER: c

2. All of the following are functions of the Secret Service, except:

a. Investigation of certain financial crimes
b. Protection of the President of the United States and selected other government officials
c. National Security
d. Protective Intelligence Activities
e. Physical Security Operations
ANSWER: c

T14 MY SLEEP DISORDER MADE ME DO IT: PARASOMNIAS AND VIOLENT BEHAVIOR

George Parker, MD, Indianapolis, IN
Cynthia Bodkin, MD, (I) Columbus, OH

EDUCATIONAL OBJECTIVE

To describe typical behavioral patterns seen in people with parasomnias, in the context of a case of aggravated battery while asleep.

SUMMARY

Introduction: Violent behavior during sleep may result in criminal charges but the legal system has difficulty assessing responsibility for such violence. Methods: A 49-year-old woman was charged with aggravated battery after stabbing her husband multiple times, apparently while asleep. She had no memory of the attack; she had a history of sleepwalking and no history of violence. Her attorney argued she was not responsible due to a parasomnia and requested dismissal

of the charges. The prosecutor requested a review of the defendant 's medical records and the police report to assess the validity of the defense claim. Results: The defendant was evaluated by a neurologist after release from jail and was diagnosed with REM behavior disorder. She had a history of use of medications and alcohol to induce sleep. A sleep expert was consulted and found inconsistencies with the aggressive behavior occasionally seen in parasomnias. Discussion: Analysis of this case required an understanding of the typical behavior patterns in the parasomnias and an understanding of the complex interaction of medications, alcohol and parasomnias.

REFERENCES

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Avidan AY: Parasomnias and movement disorders of sleep. Semin Neurol 29(4):372-92, 2009. Epub 2009 Sep 9, 2009

SELF ASSESSMENT QUESTIONS

1. Violent behavior while sleepwalking is characterized by:
a. Appearing to act out a dream
b. Suddenly attempting to jump out of a window
c. An aggressive response when approached by the victim
d. Seeking out a weapon
ANSWER: c

2. Violent behavior during REM behavior disorder is characterized by:
a. Walking with a blank look on one's face
b. An awareness of one's surroundings
c. Injury to an immediate bed partner in a sudden outburst
d. Searching for the victim
ANSWER: c

T15 **CHILD MURDER AND BLOOD DRINKING IN EARLY 20TH CENTURY SPAIN**

J. Arturo Silva, MD, San Jose, CA

EDUCATIONAL OBJECTIVE

To introduce the phenomenon of medicinal vampirism; to illustrate the phenomenon with three historical cases; and to discuss it from historical, forensic-psychiatric and general medical perspectives.

SUMMARY

Medicinal vampirism is a phenomenon that dates to earliest recorded history. Although medical causes of vampirism have been addressed by forensic psychiatry, the phenomenon of medicinal vampirism has received little psychiatric attention. This presentation discusses a study of three cases of medicinal vampirism that occurred in Spain from 1910 to 1917. All three cases involved a child who was bled and killed in order to use his blood to treat tuberculosis. In one of the cases, the fat of the child was also used as a medicinal agent. Psychiatric-legal issues will be discussed. This presentation will provide an overview of the use of blood and related body components from both animals and human beings to treat tuberculosis and other diseases. Potentially important factors in the genesis of the crimes will be discussed. Although the excessive reliance of folk medicine in early 20th-century Spain has been advanced as an important cause of the crimes, medical advances from scientifically oriented medicine will also be proposed as a potential factor in the development of the crimes. The relevance of medicinal vampirism for 21st-century society will also be addressed from a medical and more specifically a psychiatric-legal perspective.

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Calmet A: The Phantom World: Or, the Philosophy of Spirits, Apparitions, Etc. (Vol. II). London, England: Richard Bentley, 1850

SELF ASSESSMENT QUESTIONS

1. All of the following statements are not true of medicinal vampirism except:
a. Currently, it is most common in Brazil.
b. During the early 20th century over 80 cases were documented in Spain.
c. It was probably practiced in the United States during the 19th century.
d. It was frequently associated with paraphilic disorders.
e. It probably has a modest association with schizophrenia.
ANSWER: c

2. All are true of medicinal vampirism except:
a. It is a different problem than medical vampirism.
b. Sometimes it is subsumed under medicinal cannibalism.
c. Blood was used to cure leprosy and rheumatism.
d. Some forensic-psychiatric cases of medicinal vampirism have been recorded in the last few decades.
e. It has little relevance to modern medicine other than forensic psychiatry.
ANSWER: e

T16 INVOLUNTARY MEDICATION AND DISCIPLINARY CHARGES

Anasuya Salem, MD, Newark, NJ
Donald Reeves, MD, Newark, NJ

EDUCATIONAL OBJECTIVE

To analyze medication compliance, incidence and type of disciplinary charges and rate of inpatient hospitalization within the prison.

SUMMARY

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 non-treating mental health professionals who must render primarily a medical decision regarding the necessity of medication treatment. Objective: To analyze medication compliance, incidence and type of disciplinary charges and rate of inpatient hospitalization within the prison. Methods: The 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: Whether or not placing mentally ill inmates on involuntary medication reduces their violence, and whether or not medication compliance or other factors account for the anticipated reduction in disciplinary charges.

REFERENCES

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Burns KA: Psychopharmacology in correctional settings, in Handbook of Correctional Mental Health. Edited by Scott CL, Gerbasi JB. Chapter 5. Arlington, VA: American Psychiatric Publishing, pp 90-97

SELF ASSESSMENT QUESTIONS

1. How many severely mentally ill people are estimated to be crime victims each year in the U.S.?
a. 100, 000
b. 500,000
c. 1 million
d. 4.3 million
ANSWER: d

2. 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

T17 BEING TRUE TO PSYCHIATRY

Stephen Billick, MD, New York, NY

EDUCATIONAL OBJECTIVE
To help the forensic psychiatrist navigate the competing interests in legal contests where psychiatric evaluation and testimony are needed.

SUMMARY
Psychiatry is the scientific understanding of the brain and its thought processing. Starting with the Diagnostic Statistical Manual (DSM), 1st Edition, the American Psychiatric Association has tried to standardize psychiatric nomenclature and with DSM-III and DSM-IV, standardized making a diagnosis by using criteria that are reliable and valid. Scientific research is the foundation of the diagnoses which also have scientific treatments specific to them. Obviously, psychiatry in 1945 was not as advanced as it is in 2010, nor advanced as it will be in 2050. We are only able to establish psychiatric understanding of patients with the updated current knowledge. In our forensic evaluations we do not advocate per se for the legal side which may have hired us, but rather for the scientific understanding of the psychiatric issues involved. The courts have sometimes found that when the forensic expert has also treated the patient, then the courts may give greater weight to the psychiatric opinion because it is based on more extensive knowledge. Some forensic experts believe this puts the forensic psychiatrist into a competing or dual relationship. In child psychiatry, the child psychiatrist has often been in complex and dual relationships. In mandated child abuse reporting, the child psychiatrist helps the family understand that the goal is to correct the problems and hopefully to restore the family to health and harmony. Indeed, in child psychiatry it is quite rare for the actual patient to pay for treatment. Being paid by the parent does not change the central understanding that the child is the patient. Likewise, recommending to a patient in an emergency room that they be hospitalized, or more seriously, having them committed involuntarily, does not mean that the psychiatrist is acting other than in a scientific and therapeutic manner. Involuntary psychiatric inpatient treatment is not punitive as being jailed might be. Psychiatric recommendations are made based on the current understanding of psychiatric science. The forensic psychiatrist, like the clinical psychiatrist, needs to be true to psychiatry and work within the scientific parameters established by psychiatric research. Being true to psychiatry will help the forensic psychiatrist keep their medical perspective within the legal environment with its quite different culture.

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Simon, RI & Shuman, DW: Clinical-legal issues in psychiatry, in Sadock, BJ, Sadock, VA, Ruiz, P, eds. Comprehensive Textbook of Psychiatry, 9th Edition, Lippincott Williams & Wilkins, Philadelphia, 2009
Pizarro, R & Billick, SB: Forensic evaluation of physically and sexually abused children, in Rosner, R ed, Principles and Practice of Forensic Psychiatry, 2nd edition, Arnold, London, 2003

SELF ASSESSMENT QUESTIONS
1. A psychiatrist hired by a prosecutor and another psychiatrist hired by a defense attorney, will generally:
a. have similar opinions
b. have opposite opinions
c. have some overlapping aspects of their opinions
d. any of the three previous answers
e. a, b, and c
ANSWER: d

2. Therapeutic alliances and relationship may occur in which of the following:
a. mandated child abuse reporting
b. involuntary psychiatric hospitalization
c. clinically treating a patient while performing a forensic evaluation
d. all of the above
ANSWER: d

T18 HIGH RISK SUICIDAL PATIENTS: ASSESSING THE UNPREDICTABLE

Robert Simon, MD, Washington, DC
Thomas Gutheil, MD, Boston, MA
James Knoll IV, MD, Syracuse, NY
Skip Simpson, JD, (I) Frisco, TX

EDUCATIONAL OBJECTIVE
To reduce liability exposure in the treatment of high risk suicidal patients.

SUMMARY
Although the acute and chronic high risk suicidal patient is a categorical paradigm, the severity of suicide risk is dimensional and dynamic, affected by constantly changing risk and protective factors. No bright line separates the chronic from acute high risk suicidal patient. The transition from chronic to acute can be gradual and nuanced or alarmingly rapid. In the gradual transition from chronic to acute high risk, early identification may allow for aggressive management treatment. Knowing the patient's evolving symptoms, the prodromal "signature" suicide risk factor profile leading up to a prior attempt(s), can alert the clinician to take quick action.

REFERENCES
Simon RI: Preventing Patient Suicide: Clinical Assessment and Management. Arlington, VA: American Psychiatric Publishing, 2010
Fawcett J: Depressive Disorders in Textbook of Suicide Assessment and Management. Edited by Simon RI, Hales RE. Arlington, VA: American Psychiatric Publishing, 2006

SELF ASSESSMENT QUESTIONS
1. Therapeutic risk management of the high risk suicidal patient requires the clinician to:
a. Know the patient
b. Perform formal suicide risk assessments
c. Appropriately manage clinical-legal dilemmas
d. Never worry alone (consider consultation)
e. All of the above
ANSWER: e

2. In the gradual transition from chronic to acute high suicide risk, the clinician should focus on:
a. Early identification
b. Spending sufficient time with the patient
c. Knowing the patient's prodromal risk factor profile
d. Sequential suicide risk assessments
e. All of the above
ANSWER: e

T19 **PREPARING FOR MAINTENANCE OF CERTIFICATION**

Debra Pinals, MD, Worcester, MA
Richard Frierson, MD, Columbia, SC
Larry Faulkner, MD, Buffalo Grove, IL

EDUCATIONAL OBJECTIVE
At the end of this presentation, participants will be able to: describe the requirements for maintenance of certification (MOC) of forensic boards; learn about AAPL activities related to MOC; and identify strategies to plan for ongoing certification for themselves.

SUMMARY
Maintenance of Certification (MOC) is now an officially recognized requirement of the American Board of Psychiatry and Neurology. To the general and forensic psychiatrist, however, some of the related requirements remain a mystery while generating trepidation and anxiety. Because forensic psychiatry is a recognized subspecialty of psychiatry, MOC is required for those practitioners who wish to keep their board certification current. Many of the requirements are being phased in over time, but all aspects of the requirements are fast-approaching. Information about the MOC requirements is available on the ABPN website, but this information is geared toward general practitioners and does not always answer the questions professionals are raising. This workshop is specifically designed to provide AAPL members and meeting participants with an update on the development of MOC requirements and strategies to utilize to ensure ongoing certification. The discussion will focus on individuals who desire ongoing certification in forensic psychiatry, although the themes will also cover general psychiatry MOC. Information regarding AAPL activities to assist members with MOC requirements will also be reviewed. Opportunities for questions and answers with experts on MOC will be provided.

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Faulkner LR, Tivnan PW, Winstead DK, Reus VI, Andrade NN, Brooks BA, Colenda CC, Mrazek DA, Reifler BV, Schneidman B: The ABPN Maintenance of Certification Program for psychiatrists: past history, current status, and future directions. Acad Psychiatry 32:241-248, 2008

SELF ASSESSMENT QUESTIONS

1. The main components of maintenance of certification consist of the following except:
a. professional standing
b. self-assessment and lifelong learning
c. performance in practice
d. cognitive expertise
e. academic affiliation
ANSWER: e

2. According to the American Board of Psychiatry and Neurology Website, the first requirement for a self assessment activity as a component of Maintenance of Certification (MOC) to be phased in by which year of a MOC examination?
a. 2009
b. 2010
c. 2011
d. 2012
e. 2013
ANSWER: c

T20 **ANATOMY OF FORENSIC CASES: DISSECTING RISK AND DANGEROUSNESS**

Brian Cooke, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Reena Kapoor, MD, New Haven, CT
Michael Norko, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

At the conclusion of the workshop, participants will understand different risk trajectories that have resulted in violent events and will be prepared to incorporate information about these trajectories into future risk assessments and consultations.

SUMMARY

Forensic psychiatrists frequently conduct risk assessments and consultations that are informed by research on risk factors and assessment measures. However, less frequently incorporated into such assessments are the patterns of disruptive behaviors and the interactions of social, psychiatric, and developmental factors that have been identified in other forensic assessments conducted after a significant event has occurred. This workshop will present a framework for risk consultation based on a critical evaluation of three prototypical forensic cases that demonstrate principles of risk consultation focused on trajectories of disorders and function, effectiveness of treatment, and factors that limit interventions. Methods of enhancing the relevance and usefulness of consultation will incorporate developmental, functional, and social variables into the traditional psychiatric and diagnostic assessment that remains the cornerstone of risk assessments. Legal, clinical, social, and economic barriers will be explored through recent notable cases. The audience will participate in a risk consultation exercise applying the framework and will explore its limitations and advantages. Audience members will also discuss methods to identify the missed opportunities, red flags, and subtle evolutions of risk.

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Scott CL, Resnick PJ: Violence risk assessment in persons with mental illness. Aggress Violent Behav 11:598-611, 2006

SELF ASSESSMENT QUESTIONS

1. The most effective and reasonable approach to an individual risk assessment:
a. Relies only on clinical judgment and psychiatric history.
b. Relies only on actuarial tools that have acceptable psychometric properties.
c. Requires a multidisciplinary team to utilize all the appropriate methodologies/tool.
d. Selects measures and methods of evaluation based on the characteristics of the individual case.
ANSWER: d

2. Analysis of individual cases of violence as a means of improving risk assessment:
a. Is an anecdotal exercise, with little research or practical utility.
b. Excludes actuarial data and standardized assessments as population-based.
c. Uses qualitative research methods and can uncover patterns and variables for further investigation.
d. Confounds an assessment by emphasizing unusual and misleading information.
ANSWER: c

T21 **EMPIRICAL LIMITATIONS IN CHILD CUSTODY RECOMMENDATIONS**

Glenn Miller, MD, Bethesda, MD
Robert Galatzer-Levy, MD, Chicago, IL
Philip Stahl, PhD, (I) Queen Creek, AZ
Timothy Tippins, Esq., (I) Albany, NY
Jeffrey Wittman, PhD, (I) Albany, NY

EDUCATIONAL OBJECTIVE
To explore the scientific basis of making child custody recommendations in the face of limited empirical data.

SUMMARY
Custody evaluations are plagued by an absence of evidence. This workshop will address the scientific evidence available for use in custody recommendations. Empirical limitations and the reliability of determinations in custody decisions will be addressed by all panelists. Miller will outline the problem. Galatzer-Levy will discuss the problems associated with applying findings about populations to particular cases, how they arise from a misunderstanding of statistical concepts, and the meaning of research findings for individual situations. Wittmann will deconstruct forensic opinions using a model employing four levels of clinical inference. He will present a risk-analysis model as a preferred alternative to traditional custody opinions. Tippins will focus on the evidentiary requirements for expert opinion testimony. He will emphasize the reliability standards and criteria applicable to expert testimony under the Frye, Daubert and related decisions. Stahl will discuss situations where the data allow for different opinions, especially in cases with allegations of domestic violence, alienation, or involving relocation. He will comment on judicial weighting in such instances.

REFERENCES
Galatzer-Levy R, Kraus, L, Galatzer-Levy J: The Scientific Basis of Child Custody Decisions, 2nd Edition. Hoboken: John Wiley & Son, 2009
Tippins, TM, Wittmann, JP: Empirical and Ethical Problems with Custody Recommendations. Family Court Review, 43:193–222, 2005 (Response: Stahl, P: The Benefits and Risks of Child Custody Evaluators Making Recommendations to the Court. Family Court Review. 43:260-265, 2005)

SELF ASSESSMENT QUESTIONS
1. Which of the following has the most evidence based support for custody decisions:
a. parenting plans
b. placement with a parent with mental illness
c. placement with gay or lesbian parents
d. diagnosis of the child
e. none of the above
ANSWER: c

2. Psychological testing:
a. is never needed in custody evaluations
b. is necessary for parents, but not for the child
c. includes scientifically valid instruments designed for custody assessment
d. b and c
e. none of the above
ANSWER: e

T22 A COMPARATIVE STUDY OF LONG TERM INSANITY ACQUITEES

Michael Greenspan, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY
Li-Wen Lee, MD, New York, NY

EDUCATIONAL OBJECTIVE

To inform the audience of historical and clinical characteristics unique to those patients detained for long periods of time pursuant to an insanity acquittal. To discuss the possible implications of issues including insight, resistant psychiatric symptoms and severity of instant offense in level of care considerations for insanity acquitees.

SUMMARY

In New York State, persons adjudicated as criminally not responsible due to a mental disease or defect (CPL 330.20) are transferred to a forensic psychiatric hospital upon a judicial finding of a dangerous mental disorder. Thereafter, they are detained and receive treatment until such time as they are deemed to no longer suffer from a dangerous mental disorder. Given the open-ended nature of such detention, certain patients remain hospitalized for decades. This inquiry aims to characterize the differences between a long stay and a short stay cohort. The study group (N=26) consisted of 330.20 patients at a forensic psychiatric hospital in New York State (Mid Hudson Forensic Psychiatric Center [MHFPC]) who had been hospitalized for at least 10 years. In addition to the collection of demographic, historical, and clinical variables, an HCR-20 was performed for all study group patients. The control group for this study consisted of CPL 330.20 patients recently transferred from MHFPC to a civil facility after having spent less than five years in the maximum security setting. We anticipate a higher severity instant offense, greater symptomatology, and lower level of insight among the long stay cohort.

REFERENCES

NY Crim Proc Law § 330.20 (McKinney, 2002)
Webster CD, Douglas KS, Eaves D, Hart SD: HCR-20: Assessing risk of violence (version 2). Vancouver: Mental Health Law and Policy Institute, Simon Fraser University, 1997

SELF ASSESSMENT QUESTIONS

1. In New York State, which of the following determinations is most specifically required for an insanity acquitee to be admitted to a maximum security forensic hospital following a 330.20 finding?

a. Lack of appreciation of wrongfulness regarding instant offense
b. Inability to conform behavior regarding instant offense
c. A dangerous mental disorder
d. Resistant psychiatric symptoms
e. Co-morbid substance abuse or dependence
ANSWER: c

2. Which of the following factors is least important in discharge considerations for insanity acquitees?

a. Current medication regimen
b. Severity of instant offense
c. Insight regarding instant offense and future risk
d. Behavioral stability
e. History of violence aside from instant offense
ANSWER: a

T23 BETA BLOCKERS FOR VIOLENCE PROPHYLAXIS

William Newman, MD, Sacramento, CA
Barbara McDermott, PhD, (I) Sacramento, CA

EDUCATIONAL OBJECTIVE

To educate participants about research supporting the use of beta blockers for violence prophylaxis; and to introduce an ongoing research project involving this topic.

SUMMARY

Beta blockers have been used for decades by psychiatrists for violence prophylaxis. The literature includes some case reports and small studies which have shown this practice to be both beneficial and safe in varying populations. Identifying an effective and safe treatment for patients prone to violence would benefit practitioners in correctional settings, forensic hospitals, and virtually any situation with violent patients. Pindolol is an ideal agent for violence prophylaxis for a variety of reasons. It exhibits intrinsic sympathomimetic activity, which provides

low-level agonism at the beta adrenergic receptor. The low-level agonism helps prevent problematic drops in a patient's pulse and blood pressure, which can occur with other beta blockers. Pindolol can be safely titrated to an effective dose within a matter of days. It is nonsedating, unlike many antipsychotic medications used with violent patients. It also comes in a generic formulation and is therefore cost-effective. This presentation discusses a review of the existing literature, provides personal experiences with this treatment approach, and introduces a large-scale, controlled study using pindolol with violent patients at Napa State Hospital, a California state forensic hospital with over 1300 beds.

REFERENCES

Greendyke RM, Kanter DR: Therapeutic effects of pindolol on behavioral disturbances associated with organic brain disease: a double-blind study. J Clin Psychiatry 47:423-26, 1986

Weiler PG, Mungas D, Bernick C: Propranolol for the control of disruptive behavior in senile dementia. J Geriatr Psychiatry Neurol 1:226-30, 1988

SELF ASSESSMENT QUESTIONS

1. Which of the following beta blockers displays intrinsic sympathomimetic activity?
a. atenolol
b. labetalol
c. metoprolol
d. pindolol
e. propranolol
ANSWER: d

2. Beta blockers are most useful for preventing which type of violence?
a. organized (predatory) assaults
b. psychotic assaults
c. impulsive assaults
d. school violence
e. workplace violence
ANSWER: c

T24 THE BRAIN ON TRIAL

Helen Mayberg, MD, (I) Atlanta, GA

EDUCATIONAL OBJECTIVE

To develop critical perspective on the current forensic uses function and structural neuroimaging methods, including the examination of the potential probative as well as prejudicial value of such data when introduced as mitigating or exculpatory evidence in the courtroom.

SUMMARY

Advances in neuroimaging have facilitated novel research investigations of normal human brain functioning and have provided important new insights into mechanisms of many neurological and psychiatric disorders with implications for diagnosis, treatment and risk assessment. Despite such progress, scan findings in individuals are proving quite variable, and except in certain limited clinical circumstances, are not sufficiently sensitive or specific to be used for diagnostic or prognostic purposes in most cases. It is therefore surprising that despite the absence of published consistent and reliable imaging patterns, such scans are being increasingly introduced in forensic circumstances to provide objective evidence of 'brain damage' most generally, or specific behavioral abnormalities including poor judgment, impaired impulse control, aberrant sexual drive, psychopathic and sociopathic traits. Unambiguous results from empirical experimental studies designed to specifically examine the causative relationships between regional brain dysfunction using any imaging modality and these types of complex behaviors are needed before any introduction of functional or structural scans into the courts as either exculpatory or mitigating evidence can be considered scientifically justified.

REFERENCES

Mayberg, HS: Functional brain scans as evidence in criminal court: An argument for caution. J Nucl Med 33(6):18N-25N, 1992

Patel P, Meltzer CC, Mayberg HS, Levine K. The role of imaging in United States courtrooms. Neuroimaging Clin N Am. 17(4):557-67, 2007

SELF ASSESSMENT QUESTIONS

1. What types of imaging modalities have been successfully introduced in court?
a. FDG PET scans
b. SPECT blood flow scans
c. structural MRI scans
d. functional MRI scans
e. a, b and c
f. all of the above
ANSWER: e

2. Which of the following assertions would likely meet criteria for admissibility under Daubert?
a. MAO-A deficiency is a risk factor for violent behavior.
b. Orbital frontal atrophy is a predictor of poor impulsive control
c. Both
d. Neither
ANSWER: a

T25 DO PRACTICE GUIDELINES BELONG IN COURT? WHERE DO THEY BELONG?

Henry Levine, MD, Bellingham, WA
John Bradford, MB, Ottawa, ON, Canada
Ryan Hall, MD, Lake Mary, FL
Neil Kaye, MD, Hockessin, DE
Andrew Levin, MD, Hartsdale, NY

EDUCATIONAL OBJECTIVE

To enhance audience knowledge about treatment guidelines, algorithms and protocols; their development, their problems, and their uses in court and by domestic and foreign government agencies and payers.

SUMMARY

The development and publication of practice guidelines, protocols and algorithms present unique challenges for clinicians and forensic psychiatrists. Practice guidelines have been promoted as best practice, evidence-based medicine. They also have been lambasted as overly formulaic, as restrictive, as promoting laziness, and as out of touch with current practice. Despite their original intent to directly influence the behavior of clinician-patient dyads, they have had indirect but significant effects via third parties on reimbursement for tests and treatments. Further, government agencies draw on guidelines to dictate access to and use of medical procedures. The panel will review present and anticipated uses of treatment guidelines in court and by third-party payers and government agencies here and abroad. We will review methodologies for developing guidelines, using as illustration a new guideline from the World Federation of Biological Psychiatry on the treatment of sexual offenders. We will highlight recurring problems in existing guidelines and in their uses. The panel will describe attempts to use guidelines in the courtroom, with particular focus on the effects of Daubert v. Merrell Dow Pharmaceuticals on the admissibility of treatment guidelines as evidence.

REFERENCES

Davies J: Clinical guidelines as a tool for legal liability; an international perspective. Med Law 28(4):603-13, 2009
Tibballs J: Clinical practice guidelines in the witness box: can they replace the medical expert?: J Law Med 14(4):479-500, 2007

SELF ASSESSMENT QUESTIONS

1. All treatment protocols, guidelines and algorithms provide for patient preference as one of their criteria for choice by clinician.
a. true
b. false
ANSWER: b

2. A major 2001 study published in JAMA estimated that 50% of treatment guidelines in medicine were out of date within:
a. one year of publication
b. two years of publication
c. six years of publication
d. ten years of publication
ANSWER: c

T26 REPORT WRITING: RESTRAINTS, REASONING AND REFINEMENT

Phillip Resnick, MD, Cleveland, OH
Nancy Coomer, JD, (I) Tucson, AZ
Honorable Howard Fell, (I) Tucson, AZ
Ezra Griffith, MD, New Haven, CT
Richard Martinez, MD, Denver, CO
Ted Schmidt, JD, (I) Tucson, AZ

EDUCATIONAL OBJECTIVE
To improve draftsmanship of reports; to understand the ethical implications of omissions and narrative style; and to understand what attorneys value most in reports.

SUMMARY
This course will be useful to both novice and experienced forensic psychiatrists because it will emphasize what our employers (judges and attorneys) value most in our reports. Although faculty will discuss the body of the report, special emphasis will be given to writing the opinion section in a clear, persuasive ethical manner. Tips on report writing style will include the separation of fact from opinion, avoidance of jargon, "pregnant negatives," and length of sentences and paragraphs. Participants will learn the importance of narrative story telling and ethical issues involving interactions with attorneys about report content. Legalists will tell participants their preferences in civil and criminal reports regarding length, degree of detail, and how they like to see opinions supported. Participants will see a nine-minute videotape and write insanity opinions, which will be critiqued in small groups.

REFERENCES
Babitsky S, Mangraviti JJ: Writing and Defending Your Expert Report: The Step-by-Step Guide with Models. MA: Seak, Inc., Falmouth, MA, 2002
Goldyne AJ: Minimizing the influence of unconscious bias in evaluations: a practical guide. J Amer Acad Psychiatry Law 35(1):60-6, 2007

SELF ASSESSMENT QUESTIONS
1. The ideal sentence length is about:
a. 10-15 words
b. 15-20 words
c. 20-25 words
d. 25-30 words
e. 30-35 words
ANSWER: c

2. Which one of the following words is most neutral?
a. denies
b. admits
c. reports
d. alleges
e. claims
ANSWER: c

T27 MUNCHAUSEN BY PROXY: FORENSIC ISSUES

Herbert Schreier, MD, (I) Oakland, CA
Catherine Ayoub, EdD, (I) Boston, MA
Mary Sanders, PhD, (I) Stanford, CA
Brenda Bursch, PhD, (I) Los Angeles, CA

EDUCATIONAL OBJECTIVE

Attendees will learn: the historical context of Munchausen by Proxy and Factitious Disorder by Proxy; most recent findings related to the psychopathology; available treatment options; and common strategies employed by attorneys to challenge the expert.

SUMMARY

This panel will discuss the impact of the psychopathology in the medical setting and the courtroom; describe the complex psychopathology of 35 women identified with a diagnosis of factitious disorder by proxy; review available treatment options and evidence to support their use with those who falsify illness in others; and review a number of strategies frequently used by attorneys to challenge the expert and make recommendations about how to address them.

REFERENCES

Schreier HA, Ayoub CA, Bursch B: Forensic issues in Munchausen by Proxy, in Principles and Practices of Child and Adolescent Forensic Mental Health. Edited by Benedek E, Ash P, Scott C. Washington DC: American Psychiatric Publishing, Inc., 2010
Sanders MJ, Bursch B: Forensic assessment of illness falsification, Munchausen by proxy, and factitious disorder, NOS. Child Maltreatment 7(2):112-124, 2002

SELF ASSESSMENT QUESTIONS

1. Which of the following is the most common psychiatric co-morbidity of Factitious Disorder by Proxy?
a. personality disorder
b. learning disorder
c. psychotic disorder
d. substance abuse
ANSWER: a

2. Which of the following is correlated with cessation of illness falsification?
a. confrontation
b. videotape of being caught
c. being arrested
d. being in the hospital
e. none of the above
ANSWER: e

T28 CRIMINAL BEHAVIOR AND BLACKOUTS: MADNESS, MALINGERING, OR MEMORY LOSS?

Charles Scott, MD, Sacramento, CA
Barbara McDermott, PhD, (I) Sacramento, CA
Jason Roof, MD, Sacramento, CA
Humberto Temporini, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

This presentation will improve the knowledge of forensic psychiatrists who consult to the court regarding alleged blackouts of defendants and accusing victims. New scientific data on the relationship of various substances to blackouts will be presented along with state of the art assessment tools to evaluate alleged memory loss.

SUMMARY

A defendant's or victim's loss of memory for events involved in an alleged crime presents significant problems for both the prosecution and defense. Dr. Temporini will provide definitions of key terms important for assessing discrete memory loss to include blackouts, fragmentary and en bloc blackouts, and grayouts. Dr. Temporini will review distinguishing features of various psychiatric disorders that incorporate reported memory loss as a diagnostic symptom. Dr. Roof will discuss specific substances related to reported periods of memory loss to include alcohol and various "date rape" drugs. Dr. Roof will review assessment issues related to complete or fragmentary memory loss in allegations of rape. Dr. McDermott will highlight important testing strategies in assessing reported memory loss to include the use of the MMPI-2, TOMM, WMT, and other symptom validity tests. Dr. Scott will highlight impor-

tant legal principles and landmark cases that address the relationship of consciousness to confessions, competency, and criminal culpability. Admissibility of expert testimony regarding memory recovery techniques and resulting information obtained will also be reviewed.

REFERENCES

Hartzler B, Fromme K: Fragmentary and en bloc blackouts: similarity and distinction among episodes of alcohol-inducted memory loss. J Studies on Alcohol 64:547-550, 2003

Lee H, Roh S, Kim DJ: Alcohol-induced blackout. Int J Environ Res Public Health 6:2783-2792, 2009

SELF ASSESSMENT QUESTIONS

1. Which of the following is most commonly associated with an alcoholic blackout?
a. First ever use of alcohol
b. Rapid rise in alcohol blood level
c. Blood alcohol level greater than 0.12%
d. Family history of alcoholism in first degree relative
ANSWER: b

2. All of the following are true regarding grayout, except:
a. Person has a fragmentary memory loss for a discrete period of time.
b. Grayouts are the most common type of blackouts.
c. Cueing has been reported to assist those with grayouts in memory recall for lost memory.
d. The person has a complete loss of memory for a distinct period of time.
ANSWER: d

T29 PRACTICAL SKILLS IN CONDUCTING AND ASSESSING CORRECTIONAL PSYCHIATRY RESEARCH

Tracy Gunter, MD, St. Louis, MO
Donald Black, MD, Iowa City, IA
Robert Trestman, PhD, MD, Farmington, CT

EDUCATIONAL OBJECTIVE

Participants will understand how to design, implement, and interpret human subjects research in correctional psychiatry settings.

SUMMARY

This workshop will provide the participant with an introduction to conducting human subjects research in correctional settings. The presenters have extensive experience in conceptualizing, securing funding for, and conducting studies in prisons, jails, and a variety of community corrections settings. Dr. Trestman will begin the workshop by discussing the development of a testable hypothesis and identification of agencies interested in funding research conducted in correctional settings. Dr. Gunter will then focus on study site development and institutional review board applications. Dr. Donald Black will conclude with an overview of methodological considerations and regulatory limitations placed on study design in correctional settings. Complex issues that arise in multiple stages of the investigation process such as informed consent, confidentiality, longitudinal follow-up, and data interpretation will be touched on throughout the presentations. The panel anticipates active participant discussions regarding study design, implementation, and interpretation for at least one half of the total work shop time.

REFERENCES

Chwang, E: Against risk-benefit review of prisoner research. Bioethics 24(1):14-22, 2010

Wakai S, Shelton D, Trestman RL, Kesten K: Conducting research in corrections: challenges and solutions. Behav Sci Law 27:743-752, 2009

SELF ASSESSMENT QUESTIONS

1. Federal regulations mandate supplementary safeguards for prisoners who participate in research. Which of the following is allowed?
a. Placebos
b. More than minimal compensation
c. Certificates of completion
d. Control groups with limited benefit
e. All of the above
ANSWER: c

2. Challenges to meaningful hypothesis generation and translation to the real world of correctional settings include:
a. Randomization of subjects and conditions
b. Avoiding coercive conditions
c. Availability of contextually valid assessments
d. Generalizability to other correctional settings
e. All of the above
ANSWER: c

T30 **ENFORCING AAPL'S ETHICS**

Philips Candilis, MD, Arlington, MA
Charles Dike, MD, MRCPsy, New Haven, CT
Donald Meyer, MD, Cambridge, MA
Wade Myers, MD, Providence, RI

EDUCATIONAL OBJECTIVE
At the conclusion of this presentation, participants will be able to: identify challenges in the adjudication of ethics complaints in forensic psychiatry; recent procedural changes in the filing of ethics complaints; strengths and weaknesses of two approaches to applying ethics guidelines: aspirational and regulatory.

SUMMARY
At the time of the 2005 AAPL ethics revision, the APA, which adjudicates complaints in forensic psychiatry, was undergoing changes in its own procedures that would affect AAPL. Charles Dike, MD, Chair of the AAPL Ethics Committee, will present current procedures for handling ethics complaints; Wade Myers, MD, Immediate Past Chair of the APA Ethics Committee, will present changes in the APA's handling of complaints. Philip Candilis, MD, Chair of the AAPL Ethics Committee's Guidelines Revision, and Donald Meyer, MD, AAPL Ethics Committee member, and former MA District Branch Ethics Committee Co-Chair, will debate two approaches to applying the ethics guidelines: one aspirational and one regulatory. The resources, institutional frameworks, policies, and standards necessary for these approaches will be debated.

REFERENCES
Kassirer JP: Pseudoaccountability. Ann Intern Med 134(7):587-90, Apr 3, 2001
Babb RR: Comment on Pseudoaccountability. Ann Intern Med 136(8):631, Apr 16, 2002

SELF ASSESSMENT QUESTIONS
1. Resources for adjudicating ethics complaints in forensic psychiatry can include:
a. APA procedures
b. APA ethics guidelines
c. AAPL ethics guidelines
d. Expert testimony
e. All of the above
ANSWER: e

2. Requirements for the adjudication of ethics complaints include all of the following, except:
a. Resources for investigations and hearings
b. Due process
c. Established interpretations of ethics standards
d. Consultation with the AAPL ethics committee
e. A standard of practice for the behavior in question
ANSWER: d

T31 **CHILD AND ADOLESCENT FORENSIC MENTAL HEALTH PROFESSIONALS IN JUVENILE SPECIALTY COURTS**

Christopher Thompson, MD, Los Angeles, CA
Eraka Bath, MD, Los Angeles, CA
Gia Crecelius, MD, (I) Los Angeles, CA
Joseph Kenan, MD, Los Angeles, CA
Lauren Reba-Harrelson, MA, (I) Los Angeles, CA

EDUCATIONAL OBJECTIVE
To inform and educate attendees about the role child forensic psychiatrists assume in different juvenile specialty court settings, the legal issues that are frequently addressed, and the potential pitfalls of working in these settings.

SUMMARY
Over the past twenty years, specialty courts for children and adolescents have proliferated, acknowledging the special issues involved when adjudicating youth or when deciding which treatments or placements may be in youth's best interests. Accordingly, courts have turned to child-and-adolescent forensic psychiatrists to serve as liaisons/consultants in helping them make determinations about a variety of issues. For example, in Los Angeles County, the Juvenile Court Mental Health Services' (JCMHS) attending child-and-adolescent psychiatrist attempts to optimize mental health care for children who are under the jurisdiction of the Juvenile Court. This psychiatrist accomplishes this goal through facilitation of effective court decision-making by helping all court personnel obtain and interpret relevant mental health information and promoting collaboration between the various agencies in making and implementing plans to meet children's mental health needs. Similarly, the Los Angeles County Juvenile Mental Health Court's consulting child-and-adolescent forensic psychiatrist and psychologists attempt to help the court determine wards' trial-related capabilities, their most appropriate placements, and a variety of other issues. Finally, child-and-adolescent forensic psychiatrists consult with family court judges with regard to child custody determinations, parental aptitude, and a variety of other matters.

REFERENCES
Ash P: Commentary: Risk markers for incompetence in juvenile defendants. J Am Acad Psychiatry Law 31:310-13, 2003
Bernet W: Parental alienation disorder and DSM-V. Am J Family Therapy 36(5):349–366, 2009

SELF ASSESSMENT QUESTIONS
1. A new psychotropic medication authorization must be submitted when:
a. a medication is being discontinued
b. a new medication is requested
c. an increase in the maximum approved dosage is requested
d. the period of consent has expired
e. b, c and d
ANSWER: e

2. Generally speaking, family court judges use which standard in determining child custody issues?
a. The "tender years" doctrine
b. The "most attached parent" (i.e., the parent to which the child is most attached)
c. The "least detrimental alternative"
d. The "best interests of the child"
e. c and d
ANSWER: e

T32 YOU GOT PERSONALITY: DIAGNOSTIC CHALLENGES IN FORENSICS

Howard Zonana, MD, New Haven, CT
Josephine Buchanan, BA, (I) New Haven, CT
Patrick Fox, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE
Attendees at this panel will be prepared to use a framework for personality assessment that combines clinical assessment, standard measures, and narrative presentation and will be prepared to use strategies for explaining and formulating the effects of personality disorders in forensic cases.

SUMMARY
Personality disorders challenge forensic experts in criminal and civil cases. The capacity of persons with Axis II disorders to manage life affairs, the repetition of disruptive patterns of behavior, and the often ineffective resolution through medication lead to an assumption that the problem behaviors are always controlled and willful. The DSM formulations categorize separate disorders and focus on symptoms and patterns of behavior but any forensic formulation must also include the social and temporal context. Through case presentations, personality theory, and examination of structured tests, the panel will present personality disorders within a framework of central common dimensions (e.g., attachment, dependency, social conscience, intimacy, and function) that offer effective strategies for forensic formulations and persuasive explanations. Thorough analysis of the trajectories of treatment for NGRI acquittees who have personality disorders, their response to treatment, and the risk that they present will allow us to describe the essential dysfunctions common to Axis II diagnoses. In the adversarial and often rigid context of legal cases, most effective are the formulations that go beyond diagnosis and translate the psychiatric complexity into familiar patterns that can integrate the disorder, life activities, and the behavior of legal interest.

REFERENCES
Hart SD: Commentary: The forensic relevance of personality disorders. J. Am Acad Psychiatry Law, 30:510-12, 2002
Oguntoye A, Bursztajn HJ: Commentary: Inadequacy of the categorical approach of the DSM for diagnosing female inmates with borderline personality disorders and/or PTSD. J Am Acad Psychiatry Law 37:3306-309, 2009

SELF ASSESSMENT QUESTIONS

1. In forensic cases, Axis II disorders:
a. are not recognized as a basis for mitigation or exculpation.
b. are by law excluded as the basis for a mental illness and defect defense.
c. require complex formulation strategies in report writing and testimony.
d. are easier to explain to a jury because of the absence of psychosis.
ANSWER: c

2. Dysfunctions in personality disorders:
a. include those that are common across all Axis II diagnoses.
b. are less severe than those in Axis I disorders in terms of effects on daily life.
c. do not respond to psychotropic medication.
d. cannot be assessed on structured measures.
ANSWER: a

T33 **PREVALENCE AND PREDICTORS OF DIAGNOSTIC CHANGES IN FORENSIC PSYCHIATRY**

Rajesh Moholkar, MRCPsych, Birmingham, United Kingdom
Tayna Garrett, MsC, PhD, (I) Birmingham, United Kingdom
Jeremy Kenney-Herbert, MRCPsych, (I) Birmingham, United Kingdom
Tanja Hillberg, MSCPsych, (I) Birmingham, United Kingdom

EDUCATIONAL OBJECTIVE

To study the prevalence of changes in psychiatric diagnoses in forensic psychiatric hospitals and compare it with prevalence of diagnostic change in general psychiatric patients; assess whether forensic patients with unstable diagnoses are significantly different from forensic patients with stable diagnoses when compared on relevant demographic, clinical and criminological variables.

SUMMARY

Research suggests delay in diagnosis and treatment increases comorbidity including substance misuse and violence. The prevalence of diagnostic changes in forensic patients studied (n=100) was higher (41.7%) than the prevalence in General Psychiatric patients (8-33%) reported in literature. Two thirds of patients with diagnostic change had multiple diagnoses in the past. Ten percent of patients were told at some point that they do not have a mental disorder and were lost to follow up. Block entry Logistic Regression was used. Age, number of previous violent offenses, age when symptoms first started, and current diagnosis and history of substance misuse, as a group of covariates significantly predicted diagnostic change (chi-square= 14.36, df =5, p=0.013). Overall, 70.3% of cases with diagnostic change were correctly predicted on the basis of combination of these co-variables. Patients with a higher number of previous violent offenses were more likely and those with current diagnosis of schizophrenia were less likely to undergo diagnostic changes. Mean time gap between first different diagnosis and current diagnosis was six years. Sixty percent had a diagnostic change soon after the index offense. The study highlights the need for a closer liaison between forensic and general psychiatrists and closer scrutiny of diagnosis in violent patients.

REFERENCES
Chen Y, Swan A, Burt D: Stability of diagnosis in schizophrenia. Am J Psychiatry 153:682-686, 1996
Schwartz J, Fenning S, Tanenberg-Karant M, et al: Congruence of diagnoses 2 years after a first- admission diagnosis of psychosis. Arch Gen Psychiatry 57:593-600, 2000

SELF ASSESSMENT QUESTIONS

1. What is the prevalence of diagnostic change in forensic patients and how does it compare with prevalence in general psychiatric patients?

ANSWER: 41.7%. It is higher than the reported prevalence in general psychiatry (8-33%)

2. What are the variables that differentiate forensic patients with unstable diagnoses from forensic patients with stable diagnoses?

ANSWER: Age, number of previous violent offenses, age when symptoms first started, current diagnosis and history of substance misuse.

T34 FROM SCHADENFREUDE TO CONTEMPLATION: LESSONS FOR FORENSIC EXPERTS

Graham Glancy, MB, ChB, Toronto, ON, Canada
Cheryl Regehr, PhD, (I) Toronto, ON, Canada

EDUCATIONAL OBJECTIVE

Participants will learn ways to improve their ability to provide expert opinion evidence in forensic psychiatry. Discussions will include the evidentiary basis of expert opinion, elements of report writing and expert testimony, and adherence to ethics guidelines.

SUMMARY

In 2005, the Chief Coroner of Ontario instituted a review of 45 cases of criminally suspicious child deaths about which a prominent pediatric forensic pathologist, Dr. Charles Smith, expressed an opinion that the death was homicide. Subsequent to the findings of the review, a provincial inquiry was called into the professional practice of Dr. Smith. The inquiry concluded that Dr. Smith actively misled his superiors, made false and misleading statements to the court, and misrepresented the nature of his expertise. Recommendations from the inquiry cover issues of medical subspecialization, the evidentiary basis for expert opinion, oversight of the profession, and the development of best forensic practices. Although the inquiry initially addressed pathologists, it becomes clear that these recommendations have significant implications for all forensic professions including forensic psychiatry. This paper summarizes the inquiry report and considers the potentially important implications for forensic psychiatry.

REFERENCES

Glancy G, Bradford J: The admissibility of expert evidence in Canada. J Am Acad Psychiatry Law 35:350-356, 2007
Goudge S: (2008) Inquiry into Pediatric Forensic Pathology in Ontario Report. Toronto: Ministry of the Attorney General, 2008. http://www.attorneygeneral.just.gov.on.ca/inquiries/goudgest/report/index.html.

SELF ASSESSMENT QUESTIONS

1. Forensic experts should:
a. advocate for their clients in court
b. disclose controversies in the field
c. hide any doubts about their opinion
d. either not take notes or destroy notes before giving testimony

ANSWER: b

2. Forensic experts should:
a. go beyond the limits of their expertise if called upon to do so.
b. delay their report until the last minute so the other side cannot see it.
c. clearly state the reasoning behind their opinions.
d. use legal language in their reports.

ANSWER: c

T35 FORENSIC APPLICATIONS OF DIFFUSION TENSOR IMAGING IN MILD TRAUMATIC BRAIN INJURY: CURRENT STATUS

Hal Wortzel, MD, Denver, CO

EDUCATIONAL OBJECTIVE

Diffusion Tensor Imaging is a relatively new imaging technique. Like many other forms of neuroimaging, it is beginning to show up in medicolegal contexts. Those in attendance will be introduced to this technology, its strengths and limitations, and how to evaluate its appropriateness as evidence in litigation.

SUMMARY
Traumatic brain injury (TBI) remains a substantial source of mortality and morbidity worldwide. Although most such injuries are relatively mild, accurate diagnosis and prognostication after mild TBI (mTBI) remains challenging. These problems are frequently exacerbated in medicolegal contexts, particularly civil litigation, where plaintiffs continue to seek a means for objective demonstration of brain injury. Diffusion Tensor Imaging (DTI) has garnered much attention as a potential technique for the diagnosis of TBI. Because DTI is a powerful research tool for investigating white matter integrity, and because TBI frequently results in white matter injury, DTI represents a conceptually appealing means for detecting white matter pathology in the wake of mild TBI. However, alterations in white matter integrity are not specific to TBI, and their presence on DTI imaging does not confirm a diagnosis of mild TBI. Using the rules of evidence shaped by Daubert v. Merrell Dow Pharmaceuticals, Inc. and its progeny to analyze the suitability of DTI for forensic purposes, we suggest that expert testimony regarding DTI findings will seldom be appropriate. If and when such testimony is admitted, it should be carefully monitored by courts to ensure proper deference to ethics requirements and scientific realities.

REFERENCES
Taber KH, Pierpaoli C, Rose SE, et al: The future for diffusion tensor imaging in neuropsychiatry. J Neuropsychiatry Clin Neurosci 14:1-5, 2002
Wortzel HS, Filley CM, Anderson CA, Oster T, Arciniegas DB: Forensic applications of cerebral single photon emission computed tomography in mild traumatic brain injury. J Am Acad Psychiatry Law 36:310-22, 2008

SELF ASSESSMENT QUESTIONS
1. DTI 's theoretical appeal for detecting mTBI is based upon:
a. its ability to measure glucose utilization in injured frontotemporal regions
b. the sensitive and specific nature of lesions identified
c. its ability to characterize white matter intergrity
d. all of the above
e. none of the above
ANSWER: c

2. In considering DTI 's readiness for court, pertinent factors include:
a. well established standards and uniform techniques
b. unknown error rates
c. an abundance of well designed studies and publications with converging results
d. minimal risk of subjective interpretations being offered as objective data
ANSWER: b

T36 **AUTOMATISM: A 15-YEAR ANALYSIS OF CRIMINAL APPELLATE CASE LAW**

Susan Knight, PhD, (I) Charleston, SC
Leonard Mulbry, Jr., MD, Charleston, SC

EDUCATIONAL OBJECTIVE
To educate on the evolving legal precedent regarding the defense of automatism by analyzing the past fifteen years of criminal appellate case law from state and federal jurisdictions; and to review a history of the defense and conditions commonly implicated in the defense.

SUMMARY
In raising the defense of automatism, the defendant argues a state of unconsciousness or semiconsciousness during commission of a criminal offense, or claims his actions were the result of involuntary bodily movement. Conditions implicated in the use of this defense include epilepsy, parasomnias, hypoglycemia, dissociative disorders, hypnotic states and intoxication. Courts have approached automatism through various legal channels, including incorporation of automatistic states under the insanity defense, through recognition of an unconsciousness defense or by recognition of a specific defense of automatism. However, due to the infrequency of the defense, case law and legal precedent are relatively limited in scope. This paper will analyze and discuss recent appellate case law concerning the defense of automatism. Using legal search engines, criminal appellate case law from state and federal jurisdictions was reviewed for the past fifteen years. Cases were analyzed for significant variables and patterns as related to the practice and study of law and psychiatry. Results yielded a substantial number of cases implicating intoxication and parasomnias, with several jurisdictions clarifying the relationship between automatism, intoxication, and insanity.

REFERENCES
Horn, M: A rude awakening: what to do with the sleepwalking defense? Boston College L Rev 46:149-182, 2004
Schopp R: Automatism, Insanity and the Psychology of Criminal Responsibility: A Philosophical Inquiry. New York: Cambridge University Press, 2008

SELF ASSESSMENT QUESTIONS
1. Courts have systematically overruled the use of which condition in relation to automatism?
a. Hypoglycemia
b. Psychosis
c. Voluntary Intoxication
d. Somnambulism
ANSWER: c

2. Which state or jurisdiction(s) listed below have specifically recognized a defense of automatism?
a. U.S. Military Courts
b. North Carolina
c. South Carolina
d. Minnesota
ANSWER: b

T37 FORESEEABILITY, LETHAL VIOLENCE AND RISK ASSESSMENT: YOU BE THE JUDGE

Stephen Pitt, DO, Scottsdale, AZ
Natalie Collins, Esq., (I) Scottsdale, AZ
Marshall Humphrey, Esq., (I) Tucson, AZ
Jeffrey Metzner MD, Denver, CO
Joel Dvoskin, PhD, (I) Tucson, AZ
Russell Kolsrud, Esq., (I) Scottsdale, AZ

EDUCATIONAL OBJECTIVE
To educate participants about common pitfalls in serving as an expert witness in cases involving foreseeability, lethal violence and risk assessment.

SUMMARY
This is a wrongful death case. Jane and John Doe were brutally stabbed to death in their home by their 19 year old grandson, Zachary Bradford. Zachary was severely mentally ill. At the time of the homicides, Zachary was receiving outpatient behavioral health services from Defendant HELP Services. The Plaintiffs are the Does' adult children, Elizabeth Bradford and Stephanie Arlington. Plaintiffs allege that Defendants were negligent in the provision of services to Zachary Bradford and his family, and that this negligence contributed to their parents' deaths. Plaintiffs claim that HELP knew or should have known that Zachary Bradford posed a serious risk of violence to others, that the Does were foreseeable victims of that violence, and that residential treatment or additional outpatient services were indicated. The Defendants deny that they were negligent and deny that anything they did or failed to do was a cause of the deaths of Mr. and Mrs. Doe. The Defendants claim that Zachary Bradford was solely at fault for the deaths of the Does, and that the killings were not foreseeable. In the alternative, Defendants claim that the treating psychiatrist, a subcontractor of HELP, is at fault. (The psychiatrist settled with Plaintiffs prior to trial.)

REFERENCES
Hart SD, Michie C, Cooke, DJ: Precision of actuarial risk assessment instruments: Evaluating the "margins of error" of group v. individual predictions of violence. British Journal of Psychiatry, 190, s60-s65, 2007
Dvoskin JA, Heilbrun K: Risk assessment and release decision-making: Toward resolving the great debate. Journal of the American Academy of Psychiatry and the Law Vol. 29:6-10, 2001

SELF ASSESSMENT QUESTIONS
1. Name four aspects of violence that should be assessed as part of a violence risk assessment.
ANSWER: Likelihood, Severity, Imminence, Duration

2. Name two risk factors that are commonly found in studies of violence risk.
ANSWER: Prior history of violence, Substance abuse, Anger

FRIDAY, OCTOBER 22, 2010

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

F1 ***Madness of Two and Passage to the Act:Analysis of a Matricide***
Paula Aramburu, (I) Rosario, Santa Fe, Argentina

F2 ***First You Must Engage: RAP - A New Reentry Focused Treatment***
Merrill Rotter, MD, Bronx, NY
Jackie Massaro, LMSW, (I) Freehold, NY

F3 ***American Firearm Restriction Laws for the Mentally Ill***
Michael Harlow, MD, JD, St. Peter, MN
Christopher Davidson, MD, Sioux Falls, SD
Jeffrey Haun, PhD, (I) St. Peter, MN
Shane Wernsing, MD, St. Peter, MN

F4 ***Threats of Violence, Duty to Protect, and Confidentiality***
Tara Mayes, MD, Columbus, OH
Mark Fettman, MD, Columbus, OH
Delaney Smith, MD, Columbus, OH

F5 ***Domestic Violence: Tracking a Killer Through Love Letters***
Helen Farrell, MD, Cincinatti, OH

F6 ***Clemency for Clemmons – Correctional Risk Assessment***
Cecilia Leonard, MD, Basking Ridge, NY
Anasuya Salem, MD, MPH, Syracuse, NY

F7 ***Doctors and Psychotropics Without Borders***
Carolina Klein, MD, Washington, DC

F8 ***Survey of Forensic Psychiatry Fellows: Treatment of Deliberate Self-Harm***
Paul O 'Leary, MD, Birmingham, AL
Joshua Sonkiss, MD, Salt Lake City, UT
Camille LaCroix, MD, (I) Boise, ID

F9 ***The Recovery Model in the Forensic Setting***
Charles LoPiccolo, MD, Fort Lauderdale, FL
Enza Abbate, MPA, (I) Indiantown, FL
Patricia Rivera, MSCP, (I) Indiantown, FL

F10 ***Is Methamphetamine Use Associated with Female Offending? An Analysis of the 2007 National Survey on Drug Use and Health***
Sandra Antoniak, MD, (I) Iowa City, IA
Stephan Arndt, PhD, (I) Iowa City, IA
Susan Schultz, MD, (I) Iowa City, IA

F11 ***Charged with a Misdemeanor, but Unfit for Trial... Now What?***
Mohammad Khan, MD, Bronx, NY
Li-Wen Lee, MD, New York, NY
Merrill Rotter, MD, Bronx, NY

F12 ***Inpatient Violence and History of Sexual Abuse of Female Adults***
Sanaz Kalantarzadeh, MD, (I) Bronx, NY
Merrill Rotter, MD, Bronx, NY

F13 ***Aging in Prison: A Problem on the Rise***
Elaine Martin, MD, (I) Philadelphia, PA
Kenneth Weiss, MD, Philadelphia, PA

F14 ***Medical Students Behind Bars: Psychiatric Training in a Jail Setting***
Jason Roof, MD, Sacramento, CA
Edgar Catingub, MD, Sacramento, CA

F15 ***Examining Two Cases of Medical Child Abuse: Risk Assessment and the Role of the Forensic Psychiatrist***
Julie Alonso-Katzowitz, MD, (I) Atlanta, GA

F16 Noah's Ark: A Review of ADA and the Presence of Service Animals in a Pysychiatric Setting
Carl Greiner, MD, Omaha, NE

F17 Lavrentii Beria: Alleged Sexual Predator in Role as Chief of Soviet Secret Police
Stephen Zerby, MD, Pittsburgh, PA

WORKSHOP 8:00AM - 10:00AM **SALON 8-10**
F18 Marines Court-Martialed for Murder in Iraq: PTSD Redux
Landy Sparr, MD, Beaverton, OR
Rev. John Fergueson, (I) Kenmore, WA
Nicholas Gannon, JD, (I) Camp Pendleton, CA
Donald Plowman, JD, (I) Camp Pendleton, CA

COURSE (TICKET REQUIRED) 8:00AM - 12:00PM **SALON 1-3**
F19 Review of Clinical Neuroscience for Forensic Psychiatry
Forensic Neuropsychiatry Committee
Jacob Holzer, MD, Pocasset, MA
Montgomery Brower, MD, Belmont, MA
Hal Wortzel, MD, Denver, CO
Manish Fozdar, MD, Wake Forest, NC
Robert Granacher, MD, Lexington, KY

PANEL 8:00AM - 10:00AM **SALON 11-12**
F20 Parental Alienation - An Addition to the DSM-V?
Stephen Herman, MD, New York, NY
Honorable Bruce Cohen, (I) Mesa, AZ
John Moran, PhD, (I) Phoenix, AZ
Carol Soderquist, Esq., (I) Tempe, AZ
Philip Stahl, PhD, (I) Queen Creek, AZ

WORKSHOP 8:00AM - 10:00AM **SALON 6**
F21 Ethics in Forensic Psychiatry Publishing
Reena Kapoor, MD, New Haven, CT
Jacquelyn Coleman, MA, (I) Bloomfield, CT
Ezra Griffith, MD, New Haven, CT
Michael Norko, MD, New Haven, CT
John Young, MD, MTh, New Haven, CT

SCIENTIFIC PAPER SESSION #2 8:00AM - 9:00AM **SALON 4/5**
F22 Psychotropic Medication Patterns Among Youth in Juvenile Justice
Camilla Lyons, MD, MPH, New York, NY
Gail Wasserman, PhD, (I) New York, NY
Mark Olfson, MD, MPH, (I) New York, NY
Larkin McReynolds, PhD, (I) New York, NY
Hana Musabegovic, MA, (I) New York, NY
Joseph Keating, (I) New York, NY

F23 Brief Rating of Aggression by Children and Adolescents
Drew Barzman, MD, Wyoming, OH
Douglas Mossman, MD, Cincinnati, OH
Loretta Sonnier, MD, Cincinnati, OH

RESEARCH IN PROGRESS #2 9:00AM - 10:00AM **SALON 4/5**
F24 Psychiatry Training and the Paraphilic Disorders
Paul Noroian, MD, Worcester, MA
Christopher Myers, MD, Bridgewater, MA
Fabian Saleh, MD, Boston, MA

F25 How Do Symptom Levels Relate to Alcohol in Patient Violence?
Suzanne Yang, MD, Pittsburgh, PA
Edward Mulvey, PhD, (I) Pittsburgh, PA

COFFEE BREAK 10:00AM - 10:15AM ARIZONA FOYER

WORKSHOP 10:15AM - 12:00PM **SALON 6**

F26 What's New in AAPL Advocacy at the AMA and APA

Barry Wall, MD, Providence, RI
Stuart Anfang, MD, Worcester, MA
Robert Phillips, MD, PhD, Annapolis, MD
Howard Zonana, MD, New Haven, CT

PANEL 10:15AM - 12:00PM **SALON 4/5**

F27 Juvenile Malingering: How Do We Assess Children and Adolescents Who Falsify Information?

Matthew Soulier, MD, Sacramento, CA
Barbara McDermott, PhD, (I) Sacramento, CA
Charles Scott, MD, Sacramento, CA

WORKSHOP 10:15AM - 12:00PM **SALON 8-10**

F28 Criminal Responsibility Case Conference Using a DVD Format

Debra Pinals, MD, Worcester, MA
Aimee Kaempf, MD, Tucson, AZ
David Siegel, JD, (I) Boston, MA

WORKSHOP 10:15AM - 12:00PM **SALON 11-12**

F29 Beyond Suicide Prevention: A Multifaceted Exploration of Risk Management
Education Committee

Cheryl Wills, MD, Cleveland, OH
Marilyn Price, MD, CM, Cambridge, MA
Anne Ryan, EdD, (I) Vancouver, WA

LUNCH (TICKET REQUIRED) 12 NOON - 2:00PM **SALON 7**

F30 Indigenous Ways of Justice: Healing Individuals and Communities

Carole Goldberg, Esq., (I) Los Angeles, CA
Duane Champagne, PhD, (I) Los Angeles, CA

COURSE (TICKET REQUIRED) 2:15PM - 6:15PM **SALON 1-3**

F31 Can't Work or Won't Work? Psychiatric Disability Evaluations

Liza Gold, MD, Arlington, VA
Donna Vanderpool, JD, (I) Arlington, VA
William Stejskal, PhD, (I) Charlottesville, VA

PANEL 2:15PM - 4:00PM **SALON 8-10**

F32 Mass Violence: Mass Liabilities
Trauma and Stress Committee

Stuart Kleinman, MD, New York, NY
Matthew Miklave, JD, (I) New York, NY
Joseph Napoli, MD, (I) New York, NY
Anand Pandya, MD, Los Angeles, CA
Jeffrey Schlanger, Esq., (I) New York, NY

PANEL 2:15PM-4:00PM **SALON 4/5**

F33 Punitive Segregation and SMI: Human Rights, Litigation and New York's Multi-Million Dollar Solution (CORE)

Andrew Kaufman, MD, Fayetteville, NY
Jamie Fellner, JD, (I) New York, NY
James Knoll IV, MD, Syracuse, NY
Fred Cohen, LLB, LLM, (I) Tucson, AZ

PANEL 2:15PM - 4:00PM **SALON 11-12**

F34 Forensic Sampler: Computer Crime
Liaison with Forensic Sciences Committee

ARS

Alan Felthous, MD, St. Louis, MO
Marcus Rogers, PhD, (I) West Lafayette, IN
Robert Weinstock, MD, Los Angeles, CA
Edward Fischer, PhD, (I) Long Beach, CA

ISAAC RAY LECTURE — 2:15PM - 4:00PM — **SALON 6**

F35 Isaac Ray: Lessons Learned, Lessons Forgotten

John Bradford, MB, Ottawa, ON, Canada
Discussant: Thomas Gutheil, MD, Brookline, MA
Discussant: Howard Zonana, MD, New Haven, CT

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

DEBATE — 4:15PM - 6:15PM — **SALON 6**

F36 Should Videotaping be Required for Child Forensic Evaluation?
Child and Adolescent Psychiatry Committee

Eileen Ryan, DO, Fishersville, VA
R. Gregg Dwyer, MD, EdD, Columbia, SC
Joseph Kenan, MD, Los Angeles , CA
Manuel Lopez-Leon, MD, New York, NY
Christopher Thompson, MD, Los Angeles, CA

WORKSHOP — 4:15PM - 6:15PM — **SALON 11-12**

F37 The AAPL/APLS Forensic Research Collaborative

Robert Trestman, PhD, MD, Farmington, CT
Edward Mulvey, PhD, (I) Pittsburgh, PA
Denise Juliano-Bult, MSW (I) Bethedsa, MD
John Bradford, MB, Ottawa, ON, Canada

PANEL — 4:15PM - 6:15PM — **SALON 8-10**

F38 PTSD Gone Wild: Nightmare Cases in Court

Charles Scott, MD, Sacramento, CA
H. Eric Bender, MD, Sacramento, CA
William Newman, MD, Sacramento, CA
Christopher Wadsworth, MD, Sacramento, CA

SCIENTIFIC PAPER SESSION #3 — 4:15PM - 6:15PM — **SALON 4/5**

F39 I Did What? Zolpidem and the Courts

Christopher Daley, MD, San Francisco, CA
Dale McNiel, PhD, (I) San Francisco, CA
Renée Binder, MD, San Francisco, CA

F40 Tasing - A Rare Event that Can Provide Psychiatric Clues in Forensic Cases

B. Todd Thatcher, DO, Salt Lake City, UT

F41 The Mentally Ill Defendant and Mental Illness Verdicts: Perceptions of the Criminal Bar

Richard Frierson, MD, Columbia, SC

F42 Burning Issues: Fire Setting, Arson, Pyromania, and the Forensic Mental Health Expert

Paul Burton, MD, San Francisco, CA
Renée Binder, MD, San Francisco, CA
Dale McNiel, PhD, ABPP, (I) San Francisco, CA

RECEPTION FOR MEETING ATTENDEES — 6:00PM - 7:30PM — **ANIA TERRACE**

F1 **MADNESS OF TWO AND PASSAGE TO THE ACT: ANALYSIS OF A MATRICIDE**

Paula Aramburu, (I) Rosario, Santa Fe, Argentina

EDUCATIONAL OBJECTIVE

To provide concepts applicable to the research of matricide, and to the therapeutic effects of penalty in some particular cases; and to convey the experience in evaluation of severe clinical-forensic cases as a member of an interdisciplinary team, which could be applied to mental health centers in other countries.

SUMMARY

Matricide is a highly unusual domestic homicide and virtually no theoretical analysis has been made on this field. The qualitative study of a case which occurred in 2004 in Santa Fe, Argentina led us to research the connection between the "madness of two" and the passage to the homicidal act as the fatal releasing of shared mother-daughter delusion. Based on this case, we analyze the peculiarities of the mother-daughter constitutive tie which exceeds and differs from mental mechanisms involved with father-daughter relationships. We will examine the characteristics of delusion in the "madness of two" and the definition of passage to the homicidal act. Likewise, we will delineate the relation between Forensic Psychology/ Psychiatry and Law, an interdisciplinary praxis which seems to create a gap that cannot be easily filled, causing great difficulties and important challenges in our practice. Last, we will examine what is known as the "therapeutic effect of law," reflecting upon concepts such as "subjective responsibility," "legal responsibility," "insanity," and the therapeutic effect that penalty could have in some particular cases.

REFERENCES

Allouch J, Porge E, Mallete V: El doble crimen de las hermanas Papin. Mexico: Editorial Colección Libros de Artefacto, 1995

Bespali Y: El matricidio y la destrucción del cuerpo materno, Revista Asociación Escuela de Psicoterapia para Graduados. No. 25, Buenos Aires, 2000

SELF ASSESSMENT QUESTIONS

1. The fact that a person who suffers from psychosis at the time of committing a homicide is found "guilty" or "legally responsible" could have a therapeutic effect:

a. In all cases
b. Only in some cases
c. In no case at all
ANSWER: b

2. In clinical psychology, "madness of two" or "folie a deux" refers to a mental illness shared by two or more people who usually belong to the same family group with very close emotional ties to each other. This phenomenon is also known as:

a. Borderline Personality Disorder
b. Histrionic Personality Disorder
c. Induced Delusional Disorder
ANSWER: c

F2 **FIRST YOU MUST ENGAGE: RAP - A NEW REENTRY FOCUSED TREATMENT**

Merrill Rotter, MD, Bronx, NY
Jackie Massaro, LMSW, (I) Freehold, NY

EDUCATIONAL OBJECTIVE

Participants will have increased appreciation of the challenges to engagement of the mentally ill offender in the community and will be introduced to a new structured group intervention developed to address the lingering impact of incarceration upon mentally ill offenders even after their release from prison or jail.

SUMMARY

Among the thorniest challenges in providing community services for forensic patients is engaging them in treatment. The barriers to engagement include the influence of substance abuse, unstable housing, lack of financial resources and employment, active symptoms of mental illness, and character pathology. The experience of incarceration itself reinforces attitudes and behaviors that delay or preclude the alliance needed between provider and patient for therapeutic improvement. In this poster we present a pilot manualized group treatment intervention,

FRIDAY

RAP (Re-entry After Prison/Jail), based on the published findings of the the SPECTRM Project, which has focused on the culture of incarceration and its lingering effects on forensic patients even after re-entry. RAP applies trauma treatment principles, psycho-educational techniques and cognitive behavioral theory to help people with successful transition back to the community and to utilize therapeutic services. RAP promotes cultural re-adaptation by challenging prison and jail attitudes and beliefs and by introducing new skills. The presentation will cover the principles underlying the intervention, specific examples of active group process, as well as staff and patient feedback.

REFERENCES

Massaro J: Working with People with Mental Illness Involved in the Criminal Justice System: What Mental Health Service Providers Need to Know, 2nd edition. Delmar, NY: Technical Assistance and Policy Analysis Center for Jail Diversion, 2004
Rotter M, Mcquistion H, Broner N, Steinbacher M: The impact of the incarceration culture on re-entry for adults with mental illness: a training and group treatment model. Psychiatr Serv 56(3):265-267

SELF ASSESSMENT QUESTIONS

1. Which of the following are RAP reentry themes?
a. respect
b. trust
c. stonewalling
d. suicidality
e. a, b and c
f. all of the above
ANSWER: e

2. All of the following are RAP interventions, except:
a. connecting
b. exploring
c. changing
d. dissolving
ANSWER: d

F3 **AMERICAN FIREARM RESTRICTION LAWS FOR THE MENTALLY ILL**

Michael Harlow, MD, JD, St. Peter, MN
Christopher Davidson, MD, Sioux Falls, SD
Jeffrey Haun, PhD, (I) St. Peter, MN
Shane Wernsing, MD, St. Peter, MN

EDUCATIONAL OBJECTIVE

To educate the viewer regarding the diversity of state and federal firearm restriction laws that restrict firearm purchase and possession for mentally ill Americans. To convey to the viewer the issues involving the efficacy of these laws in preventing firearm violence among the mentally ill.

SUMMARY

The right to bear arms, a fundamental precept of the American Constitution, offers an issue of controversy regarding Americans with a history of mental illness. Given the prevalence of more than 200 million firearms in the U.S. and high-profile incidents of firearm killings by mentally ill Americans, state and federal legislatures have enacted laws restricting gun ownership for mentally ill persons. These laws reflect a diverse spectrum of firearm ownership restriction for the mentally ill. To date, 46 states have enacted statutes restricting firearm possession and purchase by individuals diagnosed with mental illness. As of 2010, only four states, Alaska, Colorado, New Hampshire, and Vermont, have not enacted firearm restriction laws for the mentally ill. The objective of this poster is to provide the viewer with an understanding of American firearm restriction laws for the mentally ill and the impact of these laws on firearm related violence. Utilizing a review of internet databases, including Westlaw and Lexis-Nexis, this poster will compare and discuss federal and state statutes and case law regulating firearm ownership for the mentally ill. In addition, this poster will analyze evidence of the violence reduction efficacy of the laws among the mentally ill.

REFERENCES

Norris DM, Price M: Firearms and mental illness. Psychiatric Times 26(11): 109-114
Simpson JR: Bad risk? An overview of laws prohibiting possession of firearms by individuals with a history of treatment of mental Illness. J Am Acad Psychiatry Law 35:3, 2007

SELF ASSESSMENT QUESTIONS

1. How many states have enacted laws restricting firearm ownership for the mentally ill?
a. 34
b. 38
c. 40
d. 42
e. 46
ANSWER: e

2. Which states have not passed firearm restiction laws for mentally ill individuals?
a. Alaska
b. Colorado
c. New Hampshire
d. Vermont
e. All of the Above
ANSWER: e

F4 THREATS OF VIOLENCE, DUTY TO PROTECT, AND CONFIDENTIALITY

Tara Mayes, MD, Columbus, OH
Mark Fettman, MD, Columbus, OH
Delaney Smith, MD, Columbus, OH

EDUCATIONAL OBJECTIVE

By reviewing a state psychiatric hospital's duty to protect data, psychiatrists will gain a better appreciation of the frequency with which third parties are informed of threats as well as the characteristics of those who make threats and those whose threats are judged to meet the duty-to-protect threshold.

SUMMARY

Like many states, Ohio has enacted a "Tarasoff limiting statute" to clarify under what circumstances a therapist or hospital can be held liable for harm to a third party at the hands of a patient. The most controversial of the ways in which a clinician can discharge this potential duty to a third party is by notifying law enforcement and attempting to notify the potential victim, thereby breaching confidentiality. In this study we reviewed one year of quality assurance data of threats of violence made within a large state psychiatric facility. One hundred and forty-eight separate threats were identified during that time period. Only 32 (21.6%) were deemed to be credible by the patient's treatment team. Consultation was then undertaken, and 20 (13.5% of the total threats made and 64.5% of those deemed credible) were believed to meet the duty-to-protect threshold, prompting notification of law enforcement and, if feasible, the potential victim. More than half (55%) of the patients in the group which had third parties notified had a diagnosis or traits of a personality disorder. Thirteen (65%) had a substance use disorder, 9 had a psychotic disorder (45%), and 13 had a mood disorder (65%).

REFERENCES

Anfang SA, Appelbaum PS: Twenty years after Tarasoff: reviewing the duty to protect. Harv Rev Psychiatry 4(2):67-76, 1996
Binder RL, McNiel DE: Application of the Tarasoff ruling and its effect on the victim and the therapeutic relationship. Psychiatr Serv 47(11):1212-5, 1996

SELF ASSESSMENT QUESTIONS

1. All of the following are ways in which psychiatrists can discharge the duty to protect a potential victim under Ohio's Tarasoff limiting statute, except:
a. voluntarily hospitalize the individual making the threat.
b. involuntarily hospitalize the individual making the threat.
c. notify law enforcement and if feasible, the identified victim.
d. notify the local news agency.
e. order a consultation, perform a risk assessment and establish and undertake a documented treatment plan to eliminate the threat.
ANSWER: d

2. What conditions must a threat meet in order to establish a duty to protect a third party under Ohio's Tarasoff limiting statute?
a. The threat must be toward an identifiable person or structure.
b. The threat must be of serious physical harm.
c. The threat must be imminent.
d. The patient must have the intent and ability to carry out the threat.
e. All of the above.
ANSWER: e

F5 DOMESTIC VIOLENCE: TRACKING A KILLER THROUGH LOVE LETTERS

Helen Farrell, MD, Cincinnati, OH

EDUCATIONAL OBJECTIVE

To recognize domestic violence as a major World Health Organization concern through literature review; to understand the details of an Ohio murder case; to review a forensic analysis of love letters written from a murderer to his victim; and to know what tools are used to identify perpetrators of abuse.

SUMMARY

Domestic violence, otherwise known as Intimate Partner Violence is a major World Health Organization concern. Women are more often beaten, raped and murdered by partners than strangers. Such abuses impose health consequences to women, including potential death, and a great burden to healthcare system costs as women present to the ER and clinics rather than the criminal justice system or social service agencies. In an Ohio murder case, John Broe was sentenced to two life sentences for the aggravated murder of his wife and unborn child. Forensic analysts have reviewed love letters that track the development of this violent murderer through the courtship of his victim, which spanned adolescence to adulthood. Forensic psychiatrists may be called upon in the clinical or legal systems to evaluate potential for abuse. The two best instruments for determining potential abusive perpetrators are the SARA and ODARA.

REFERENCES

Meuer T, Seymour A, Wallace H: Domestic Violence. National Victim Assistance Academy Textbook. Washington, DC: U.S. Dept of Justice, June 2002
MacMillon H, et al: Intimate partner violence in health care settings. JAMA 296:5, 2006

SELF ASSESSMENT QUESTIONS

1. What tools are used to identify perpetrators of abuse?
ANSWER: SARA and ODARA

2. What are the nine stages that occur in an abusive relationship according to the U.S. Department of Justice?
ANSWER: Wonderful and intense, control, commitment, psychological and emotional abuse, physical abuse, psychological and physical abuse, isolation, emotional conflict and confusion, and dominance.

F6 CLEMENCY FOR CLEMMONS – CORRECTIONAL RISK ASSESSMENT

Cecilia Leonard, MD, Basking Ridge, NJ
Anasuya Salem, MD, MPH, Syracuse, NY

EDUCATIONAL OBJECTIVE

Participants will learn about the factors that contributed to the pardon of Mr. Clemmons, such as age at the time of crime, letters and political interests. Participants will have the opportunity to discuss psychiatric responsibility in risk assessment and to what extent they should assist governors who are contemplating executive pardons.

SUMMARY

Mr. Clemmons was a felon and prime suspect in the November 29, 2009, murder of four police officers in Parkland, Washington. After evading police for two days following the shooting, Clemmons was shot and killed by a police officer in Seattle. Information about this case will be obtained from the internet and media (television) for the analysis. Obtaining informed consent and IRB approval process was exempted due to the subject being deceased and also this information is freely available to the public through media and online. A posthumous violence risk assessment will be done using the HCR-20 instrument scale. The results indicate that: (1) Mr. Clemmons was a high risk for dangerousness to self and others at the time of his release; and (2) Giving clemency to Mr. Clemmons without taking the following into consideration contributed to his reoffending criminal behavior: his psychiatric assessment in the prison, past legal history, history of violence, institutional progress and violations, and his history of substance abuse. Mr. Clemmons' persuasive writing style and his age at first crime provided a sentimental distraction from his actual violent propensities.

REFERENCES
Morison ST: The Politics of Grace: On the Moral Justification of Executive Clemency. Buffalo Crim L Rev, 2005, 9 Buff Crim L R 1
A path to murder: The story of Maurice Clemmons. The Seattle Times. December 6, 2009 http://seattletimes.nwsource.com/html/localnews/2010436039_clemmonsprofile06m.html. Retrieved January 31, 2010.

SELF ASSESSMENT QUESTIONS
1. What is the rate of violence among mentally ill patients who suffer from substance dependence?
a. 11%
b. 21.4%
c. 9.4%
ANSWER: c

2. What is the best predictor of future violence?
a. Past violence
b. No violence
c. Mental Illness
d. Incarceration
ANSWER: a

F7 DOCTORS AND PSYCHOTROPICS WITHOUT BORDERS

Carolina Klein, MD, Washington, DC

EDUCATIONAL OBJECTIVE
To understand the ethics and legal implications of internet-based access to psychiatric medications. To promote discussion of this complex matter through data compiled from the literature, and through hypothetical case scenarios.

SUMMARY
The poster will present some background and statistical data pertaining to medications bought without a prescription over the internet, clinical considerations regarding the required pharmacological fund of knowledge, the effects on the doctor-patient relationship, and the legal implications surrounding this issue. Finally, the poster will present some hypothetical scenarios to promote discussion and debate among attendees who see the poster.

REFERENCES
Liang BA, Mackey T: Searching for safety: addressing search engine, website, and provider accountability for illicit online drug sales. Am J Law Medicine 35(1):125-84, 2009
Weiss A: Buying prescription drugs over the internet: promises and pitfalls. Cleveland Clinic J Medicine 73(3):282-8, 2006

SELF ASSESSMENT QUESTIONS
1. What are some of the agencies that govern this issue and provide guidelines for physician conduct?
ANSWER: FDA, DEA, EA, AMA.

2. What are some of the dangers that must be considered when encountering a patient who is purchasing prescription medication over the internet?
ANSWER: poor monitoring, false or misleading advertisement, suboptimal consideration of clinical risk factors or comorbidities, toxicity, drug-drug interactions, potential for abuse.

F8 SURVEY OF FORENSIC PSYCHIATRY FELLOWSHIP PROGRAMS: HOW THEY TREAT DELIBERATE SELF HARM IN THE FORENSIC SETTING

Paul O'Leary, MD, Birmingham, AL
Joshua Sonkiss, MD, Salt Lake City, UT
Camille LaCroix, MD, (I) Boise, ID

EDUCATIONAL OBJECTIVE
To survey North American forensic psychiatry fellows about Deliberate Self Harm (DSH) in the forensic setting; and to discuss the results of the survey, specifically, how much teaching fellows receive in identifying risk factors, treatment options, and how to prevent DSH, and how well prepared the fellows feel they are to address DSH.

SUMMARY
The rate of Deliberate Self Harm (DSH) in inmates is two to four times higher than in the general population. The rate of DSH among inmates who were identified as having a mental disorder has been reported as 50 times higher than that of the general population. As DSH is so prevalent, we are interested in how much exposure to DSH forensic fellows receive and how much specific training they receive on identifying risk factors, treatment options, and prevention of DSH. By surveying North American forensic fellows we can identify the most prevalent training methods, the amount of time devoted to them, and if any methods are associated with improved feelings of competence in addressing DSH in the forensic setting.

REFERENCES
Hayes L, Rowan J: National Study of Jail Suicides: Seven Years Later. Alexandria, VA: National Center for Institutions and Alternatives, 1988
Hillbrand M, Krystal JH, Sharpe KS, Foster HG: Clinical proctors of self- mutilation in hospitalized forensic patients. J Nerv Ment Dis 182:9-13, 1994

SELF ASSESSMENT QUESTIONS
1. Individual inmates have engaged in Deliberate Self Harm for what reason(s)?
a. Suicidal intent and depression
b. To manipulate their environment
c. For emotion regulation
d. Due to psychotic delusions or hallucinations
e. All of the above
ANSWER: e

2. Inmates with an identified psychiatric disorder are how many times more likely to engage in Deliberate Self Harm than the general population?
a. 2 times
b. 4 times
c. 25 times
d. 50 times
e. 70 times
ANSWER: d

F9 **THE RECOVERY MODEL IN THE FORENSIC SETTING**

Charles LoPiccolo, MD, Fort Lauderdale, FL
Enza Abbate, MPA, (I) Indiantown, FL
Patricia Rivera, MSCP, (I) Indiantown, FL

EDUCATIONAL OBJECTIVE
The purpose of this poster is to demonstrate how the Recovery Model is valid in the treatment of forensic patients. However, it must be adapted to the realities of their situations.

SUMMARY
The Recovery Model of Mental Health has its early origins in the Social Service models that developed after the deinstitutionalization of the 1960s. It became more formalized in the 1980s as an outgrowth of the Alcoholics Anonymous and patient advocacy groups. Its foundational ideas are patient empowerment, peer support, whole life approach, nonlinearity, strength focus, respect, responsibility, and hope. This poster shall delineate these foundational principles and how they pertain to the experience of the forensic patient. It will demonstrate that the Recovery Model must be adapted to the various types of forensic settings or it will not be suited for this patient population. Examples of forensic settings will include maximum security, minimum security, forensic community and correctional. It will show that while the location may change, the principles form a healthy lifestyle which will remain constant and relevant in the lives of our patients.

REFERENCES
U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Center for Mental Health Services: National Consensus Statement on Mental Health Recovery. Washington, DC: U.S. Department of Health and Human Services, 2004
Frese F, Stanley J, Kress K, Vogel-Scibilia S: Integrating evidence-based practices and the Recovery Model. Psychiatr Serv 52:1462-1468, 2001

SELF ASSESSMENT QUESTIONS

1. How must the Recovery Model be adapted to enable its application in the forensic setting?
ANSWER: By recognizing the limitations of choices the patient/inmate is able to make.

2. What are the principles of the Recovery Model?
ANSWER: Self Direction, Empowerment, Holistic approach, Non-Linearity of illness, Strength-based approach, Peer Support, Respect, Responsibility, and Hope.

F10 **IS METHAMPHETAMINE USE ASSOCIATED WITH FEMALE OFFENDING? AN ANALYSIS OF THE 2007 NATIONAL SURVEY ON DRUG USE AND HEALTH**

Sandra Antoniak, MD, (I) Iowa City, IA
Stephen Arndt, PhD, (I) Iowa City, IA
Susan Schultz, MD, (I) Iowa City, IA

EDUCATIONAL OBJECTIVE

To identify patterns of substance use in women that may be associated with increased rates of arrest and incarceration for multiple offense types including violent crime.

SUMMARY

Introduction: Methamphetamine use has been associated with mental illness as well as an increased risk of illegal behaviors and incarceration. Among male users, methamphetamine has been associated with crimes across multiple offense types and severity, but it is relatively unknown whether the same association exists for women. Methods: The National Household Survey on Drug Use and Health is a yearly face-to-face survey of 70,000 U.S. civilian, noninstitutionalized persons over age twelve. The survey addresses the incidence and prevalence of illicit drug, alcohol, and tobacco use. The 2007 results regarding sex, methamphetamine use, and offense type were examined to determine the relationship between self-reported legal involvement, mental health service use, and methamphetamine use in women. Results: An association between methamphetamine use and legal offenses is reported here, as well as an interaction between mental health service use and legal offenses in women. Methamphetamine use was significantly associated with mental health treatment. Conclusions: Methamphetamine use in women may be a risk factor for legal offenses. Additional analyses are necessary to determine the prevalence of violent offending in female users. Identification and treatment of those women at risk for legal involvement may decrease the rate of female incarceration and/or recidivism.

REFERENCES

Magura S: Validating self-reports of illegal drug use to evaluate National Drug Control Policy: a reanalysis and critique. Evaluation and Program Planning, 2009, in press. doi:10.1016/j.evalprogplan.2009.08.004 (in press)
Stretesky PB: Methamphetamine use: national case-control study of homicide offending. J Interpers Violence 24, 2009 (Originally published online http://jiv.sagepub.com/cgi/content/abstract/24/6/911).

SELF ASSESSMENT QUESTIONS

1. Methamphetamine use in women is associated with increased utilization of which types of mental health care services?
a. Inpatient substance abuse treatment
b. Outpatient substance abuse treatment
c. Inpatient psychiatric treatment
d. Outpatient psychiatric treatment
ANSWER: c

2. Methamphetamine use in women is associated with what broad categories of offenses?
a. Property crime (theft, burglary)
b. Assault
c. Possession of a controlled substance, drug manufacturing or sale
d. All of the above
ANSWER: d

F11 CHARGED WITH A MISDEMEANOR, BUT UNFIT FOR TRIAL... NOW WHAT?

Mohammad Khan, MD, Bronx, NY
Li-Wen Lee, MD, New York, NY
Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE

Participants will learn the spectrum of how individual states manage misdemeanor defendants who are found incompetent to stand trial. The specific areas of interest will be their treatment, confinement, and what happens to the charges against them.

SUMMARY

Each day, individuals are brought into the criminal justice system on misdemeanor or felony charges. The majority of these individuals have the capacity to proceed and reach a resolution on their case. The decision on Dusky v. United States specifies the basic standards for the determination of competency, but states are left to decide how to manage those defendants who are found incompetent to stand trial. In the State of New York, different guidelines are used for defendants charged with misdemeanors and felonies. Misdemeanor defendants found incompetent to stand trial are civilly committed to a state hospital for treatment and the charges against them are dropped, thus providing judicial efficiency and the necessary treatment for these individuals. In this study, we aim to investigate how these cases are handled nationally. This will be accomplished by a review of individual state statutes regarding competence to stand trial, as well as a survey of state forensic directors questioning what happens to these defendants in terms of treatment, commitment, and disposition of charges.

REFERENCES

Rosenfeld B, Ritchie K: Competence to stand trial: clinician reliability and the role of offense severity. J Forensic Sci 43(1):151-7, 1998
Mossman D: Predicting restorability of incompetent criminal defendants. J Am Acad Psychiatry Law 35(1):34-43, 2007

SELF ASSESSMENT QUESTIONS

1. When compared to felony defendants, misdemeanor defendants are:
a. Less likely to be found incompetent to stand trial
b. Equally likely to be found incompetent to stand trial
c. More likely to be found incompetent to stand trial
ANSWER: c

2. In New York State, once a misdemeanor defendant is found unfit to stand trial, he/she is then:
a. Transferred to a local public hospital for treatment and restoration of fitness
b. Transferred to a civil state hospital for treatment with charges dropped
c. Transferred to a forensic hospital for treatment with charges dropped
d. Transferred to outpatient treatment for restoration of fitness
ANSWER: b

F12 INPATIENT VIOLENCE AND HISTORY OF SEXUAL ABUSE OF FEMALE ADULTS

Sanaz Kalantarzadeh, MD (I) Bronx, NY
Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE

Participants will gain an understanding of the impact of childhood sexual abuse and later inpatient violent behavior in female adults.

SUMMARY

Current evidence suggests that sexual abuse is an important problem with serious long-term sequelae, but the specific effects of sexual abuse as opposed to physical abuse on future violent behavior remains unclear. Adult women with a history of childhood sexual abuse show greater evidence of sexual disturbance or dysfunction, homosexual experiences in adolescence or adulthood, and depression, and are more likely than nonabused women to be revictimized. Anxiety, fear, and suicidal ideas and behavior have also been associated with a history of childhood sexual abuse. We will examine whether a history of childhood sexual abuse is associated with inpatient violence in adult female state hospital. Data is to be collected from state hospital patient records (n=50). Medical charts will be reviewed to extract the patients who have a history of sexual abuse from those who do not have such a history. Variables include demographic factors, diagnosis, type and frequency of violent incidents in the hospital, as well as a past legal/criminal history.

REFERENCES
Jacobson A, Herald C: The relevance of childhood sexual abuse to adult psychiatric inpatient care. Hosp Community Psychiatry 41:154-158, February 1990 © 1990 American Psychiatric Association, Psychiatric Services
Margo GM, McLees EM: Further evidence for the significance of a childhood abuse history in psychiatric inpatients. Compr Psychiatry 32(4):362-6, Jul-Aug, 1991

SELF ASSESSMENT QUESTIONS
1. What type of crime is more likely seen in people with history of sexual abuse?
a. Rape
b. Sodomy
c. Prostitution
ANSWER: c

2. What type of childhood maltreatment is most associated with later arrest?
a. Physical abuse
b. Sexual abuse
c. Emotional abuse
ANSWER: a

F13 **AGING IN PRISON: A PROBLEM ON THE RISE**

Elaine Martin, MD, (I) Philadelphia, PA
Kenneth Weiss, MD, Philadelphia, PA

EDUCATIONAL OBJECTIVE
Participants will increase their knowledge in forensic psychiatry in the following areas: characteristics/demographics of elderly offenders and inmates; problems faced by prisons/jails housing elderly inmates; and solutions to improving the care of elderly inmates while decreasing the overall costs.

SUMMARY
Elderly offenders are an important sector of the population that will become increasingly important in the field of forensic psychiatry. Although only a small percentage of crimes are attributable to the elderly, they constitute the fastest growing sector of the inmate population. Factors contributing to the increased number of aging prisoners include felony sentencing laws such as three-strikes laws and truth-in-sentencing. As inmates age, there is an increased risk of medical problems such as heart disease and cancer. It is also estimated that 15-25% of elderly inmates suffer from mental illness. Therefore, there is a need for specialized care for elderly inmates, which has led to increased spending on health care. Additionally, in order to comply with the Americans with Disabilities Act, prisons must allocate funds to construct facilities equipped to house geriatric inmates. It is estimated that the cost of housing a typical inmate is $33 per day while an elderly inmate costs up to $100 per day. To solve the problem of increased spending, several solutions such as telemedicine, transfer to minimum security facilities, early release, and lenient sentencing have been proposed in order to provide elderly inmates with more cost effective and humane treatment.

REFERENCES
Lewis, CF, Fields C, Rainey E: A study of geriatric forensic evaluees: Who are the violent elderly? J Am Acad Psychiatry Law 34:324-32, 2006
Curtin T: The continuing problem of America's aging prison population and the search for a cost-effective and socially acceptable means of addressing it. Elder Law J 15:2, 2007

SELF ASSESSMENT QUESTIONS
1. Common medical conditions found in elderly prisoners include:
a. heart disease
b. cancer
c. liver disease
d. all of the above
ANSWER: d

2. Proposed solutions to decrease spending on elderly inmates include:
a. early release
b. transfer to minimum security facilities
c. increased use of the death penalty
d. a and b
ANSWER: d

F14 MEDICAL STUDENTS BEHIND BARS: PSYCHIATRIC TRAINING IN A JAIL SETTING

Jason Roof, MD, Sacramento, CA
Edgar Catingub, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

To understand the experience of training medical students in a correctional setting and to review performance and satisfaction data from medical students at the University of California, Davis on their inpatient psychiatric clerkship at the Sacramento County Jail.

SUMMARY

As incarcerated populations increase and community mental health resources decrease, psychiatry in correctional environments becomes ever more significant. This poster will detail the University of California, Davis's medical student psychiatric clerkship on the inpatient psychiatric unit at the Sacramento County Jail. Additionally, it will detail student satisfaction data and reasons why this clerkship rotation has become the top rated psychiatric clerkship for third year medical students. Training techniques, rotation structure and expectations for medical students on the clerkship will be reviewed.

REFERENCES

Leamon MH, Fields L, Cox PD, Scott C, Mirassou M: Medical students in jail: the psychiatric clerkship in an outpatient correctional setting. Acad Psychiatry 25:167-172, 2001
Bender SL, Hays DS, Klug R, et al: The teaching of psychiatry in the correctional institution at the third year level: a new dimension in the medical school curriculum at New York medical college. Psychiatr J Univ Ott 10:139-145, 1985

SELF ASSESSMENT QUESTIONS

1. Students who had psychiatric clerkships at the jail site performed as well as students from other sites in which area(s)?
a. National board examination
b. Clinical performance
c. All of the above
ANSWER: c

2. Aspects of the jail psychiatry inpatient psychiatric clerkship rotation which have been prominently commented on by students in their reviews include:
a. A sense of autonomy
b. “High yield" targeted teaching
c. Education during rounds
d. Wide range of seriously mentally ill patients
e. All of the above
ANSWER: e

F15 EXAMINING TWO CASES OF MEDICAL CHILD ABUSE: RISK ASSESSMENT AND THE ROLE OF THE FORENSIC PSYCHIATRIST

Julie Alonso-Katz, MD, (I) Cincinnati, OH

EDUCATIONAL OBJECTIVE

To discuss two cases of medical child abuse - simulation of a complicated medical history, and production of life-threatening symptoms. The forensic psychiatrist’s role, risk assessment and examining the medical record will be explored. Primary concerns are the health and safety of child victims and consideration of psychopathology in the perpetrator.

SUMMARY

Medical Child Abuse (Munchausen Syndrome by Proxy, Factitious Disorder by Proxy) is a complicated and under-reported form of child abuse in which the forensic psychiatrist plays a unique role. Its delineation as a syndrome or diagnosis is controversial. By definition, the abuse involves an adult perpetrator, the mother in 85% of cases, and the child victim, (median age 20 months and >65% under age 5). The DSM-IV TR criteria include “intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care. The motivation for the perpetrator's behavior is to assume the sick role by proxy.” The spectrum of abuse is wide, ranging from being over-anxious about the child’s symptoms, exaggerating symptoms, inventing symptoms, and producing or feigning symptoms. Two specific categories of medical child abuse have been differentiated. The

more rare form is simulation – where the abuser feigns illness in the child by presenting inaccurate medical history verbally. The more severe and common form is production – where the perpetrator actively produces or procures symptoms. The short and long-term effects of the abuse may differ depending on the type and extent of the harm done, whether psychological or physical.

REFERENCES

Bartsch, et al: Munchausen syndrome by proxy (MSBP): an extreme form of child abuse with a special forensic challenge. Foren Sci Int 137:147-151, 2003

Sanders M, Bursch B: Forensic assessment of illness falsification, Munchausen by Proxy, and Factitious Disorder, NOS. Child Maltreatment 7:112, 2002

SELF ASSESSMENT QUESTIONS

1. What does the DSM-IV definition of Munchausen Syndrome by Proxy (Medical Child Abuse) include?

a. "Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care."
b. "The motivation for the perpetrator's behavior is to assume the sick role by proxy."
c. "External incentives for the behavior, such as economic gain, avoiding legal responsibility, or improving physical well-being, are absent."
d. All of the above

ANSWER: d

2. What are two broad types of medical child abuse?

a. Procurement and Neglect
b. Simulation and Neglect
c. Simulation and Production
d. None of the above

ANSWER: c

F16 NOAH'S ARK: A REVIEW OF ADA AND THE PRESENCE OF SERVICE ANIMALS IN A PSYCHIATRIC SETTING

Carl Greiner, MD, Omaha, NE

EDUCATIONAL OBJECTIVE

To provide a current review of ADA requirements for the access of patients with disabilities who have service animals; to identify typical institutional concerns about the presence of service animals in a clinic or hospital setting; and to encourage forensic psychiatrists to increase familiarity with an important area of relevant law.

SUMMARY

The Americans with Disabilities Act (ADA, 1990) is a civil federal civil rights law that defines disability and service animals. The ADA defines a service animal as any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability. The service animals function to enhance the freedom and scope of those with disabilities. However, an increased range of service animals has included monkeys, chimpanzees, miniature horses, and parrots, among others. The psychiatric clinic or hospital will need to find appropriate ways to accommodate the service animal of a disabled patient. Distinguishing service animals from therapy animals or pets is important. Specific challenges include: 1) appreciating the specific guidelines of ADA regarding relevant questions about the service animal and the disability; 2) understanding that general concerns about infection control are not a basis for excluding the service animal; 3) appreciating that a service animal could be excluded if the presence of the service animal would fundamentally alter the business or produce a safety hazard; and 4) understanding that there cannot be an extensive review of the training of the service animal.

REFERENCES

U.S. Department of Justice, Civil Rights Division, Disability Rights section. Commonly asked questions about service animals in places of business. Washington, DC: U.S. Department of Justice. www.ada/gov/qasrvc.htm

U.S. Department of Justice, Civil Rights Division, Disability Rights Section. ADA Business Brief: Service Animals. Washington, DC: U.S. Department of Justice. www.ada.gov/svcanimb.htm

SELF ASSESSMENT QUESTIONS

1. Which of the following is most correct?
a. All service animals have a special collar.
b. Service animals are companions for those with disabilities.
c. Service animals may assist in mobility and balance.
d. Service animals have licensed training.
ANSWER: c

2. Which of the following is correct?
a. Violators of ADA can be required to pay money damages and penalties.
b. Businesses may ask if an animal is a service animal.
c. Patients with disabilities cannot be charged extra fees to have the service animals with them.
d. A business can ask for a service animal to be removed if it is a direct threat.
e. All of the above.
ANSWER: e

F17 LAVRENTII BERIA: ALLEGED SEXUAL PREDATOR IN ROLE AS CHIEF OF SOVIET SECRET POLICE

Stephen Zerby, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE

To provide an overview of the life and career of former Soviet secret police (NKVD) chief Beria, who is widely reported to have used his official capacity as NKVD chief to procure victims for the commission of rapes.

SUMMARY

This presentation provides an examination of the life and career of former NKVD chief Lavrentii Beria (1899-1953). Beria is considered responsible for the deaths of millions of Soviet citizens in the gulags. For many years Beria has been widely reported to have used his position as NKVD chief in the commission of multiple sadistic sexual crimes. His strategies are believed to have ranged from the arrest of male relatives to lure and blackmail women into submission to rape, to the use of bodyguards and agents in armored cars patrolling city streets to abduct schoolgirls and young women to be brought to Beria's residence where he would rape them. The discovery of human bones in the grounds of Beria's former residence raised the question of homicide. While Beria's prosecution and execution was largely political in nature, recently opened Soviet evidence files and archives have supported the reports of serial rape and the Russian Supreme Court refused to overturn his conviction. A striking aspect of the case of Beria is the report of serial sexual assaults committed through the use of state resources. The cautionary tale of Beria illustrates the danger of manipulation of political power for the commission of serial offenses.

REFERENCES

Knight A: Beria: Stalin's First Lieutenant. Princeton, NJ: Princeton University Press, 1993
Montefiore SS: Stalin: The Court of the Red Tsar. New York: Alfred A. Knopf, 2003

SELF ASSESSMENT QUESTIONS

1. Lavrentii Beria was:
a. a famous Soviet psychiatrist
b. a former Soviet NKVD chief believed to have committed serial rapes
c. a star hockey player on the Red Army Team
d. the last premier of the Soviet Union
ANSWER: b

2. The following statements about Lavrentii Beria are FALSE except:
a. he was best known for his poetry
b. he married Josef Stalin's daughter
c. he was instrumental in expanding the gulag system
d. he initiated glasnost
ANSWER: c

F18 MARINES COURT-MARTIALED FOR MURDER IN IRAQ: PTSD REDUX

Landy Sparr, MD, Beaverton, OR
Rev. John Fergueson, (I) Kenmore, WA
Nicholas Gannon, JD, (I) Camp Pendleton, CA
Donald Plowman, JD, (I) Camp Pendleton, CA

EDUCATIONAL OBJECTIVE

To discuss the use of mental incapacity defenses under the Uniform Code of Military Justice; and to recognize that while PTSD continues to be popular in forensic venues its application may be misapplied.

SUMMARY

In the past year, four separate trials have made their way through court-martial proceedings as the result of U.S. marines being charged with killing unarmed Iraqis in Fallujah, Haditha, and Hamdania. All told, 19 marines have been charged and a trial of a discharged marine recently took place in Federal District Court. A central issue at several trials has been the putative influence of PTSD on defendants' criminal responsibility and/or intent. This question which has surfaced after previous armed conflicts (e.g., Vietnam) has not been put to rest. Most U.S. courts have been loath to excuse criminal behavior unless the defendant has a psychotic disorder. The Uniform Code of Military Justice allows for the affirmative defense of lack of mental responsibility using a cognitive standard. Partial mental responsibility is also allowed but not as an affirmative defense. The court-martials have once again tested the limits of PTSD as a mental incapacity defense and have even raised the question of whether or not repetitive stress can lead to the perception of the need to kill proactively. Majors Plowman and Gannon are Marine lawyers with extensive working knowledge of the trials. Rev. Fergueson is a highly decorated Vietnam Marine combat veteran.

REFERENCES

Sparr LF, Pitman RK: PTSD and the law, in Handbook of PTSD: Science and Practice. Edited by Friedman MJ, Keane TM, Resick PA. New York: Guilford Publications, 2007, pp 449-468
Simon, RI (editor): Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment. Washington, DC/ London: American Psychiatric Publishing Inc., 2003

SELF ASSESSMENT QUESTIONS

1. According to the Uniform Code of Military Justice "partial mental responsibility" is:
a. An affirmative defense
b. A "Failure of Proof" defense
c. A justification defense
d. An excuse defense
ANSWER: b

2. Under the Uniform Code of Military Justice "lack of mental responsibility" is a modified version of the:
a. American Law Institute standard
b. Durham standard
c. Irresistible Impulse standard
d. M' Naughten standard
ANSWER: d

F19 REVIEW OF CLINICAL NEUROSCIENCE FOR FORENSIC PSYCHIATRY

Jacob Holzer, MD, Pocasset, MA
Montgomery Brower, MD, Belmont, MA
Hal Wortzel, MD, Denver, CO
Manish Fozdar, MD, Wake Forest, NC
Robert Granacher, MD, Lexington, KY

EDUCATIONAL OBJECTIVE

Participants will gain an understanding of key aspects of clinical neuroscience and neuropsychiatry relevant to forensic psychiatric practice, including functional neuroanatomy, mental state, and neurodiagnostic assessment. A review of a brain injury case with audience participation will provide participants with practical information for forensic assessment and reporting/testimony.

SUMMARY
This course will provide a review and update relevant to forensic psychiatric practice, including: a) functional neuroanatomy, including the limbic system, memory systems, language areas, and frontal/subcortical networks; b) neurobehavioral, psychiatric mental state, and cognitive examinations, with attention to areas affecting thought, mood, perception and orientation, important to forensic psychiatric evaluation; and c) relevant neurodiagnostic assessment, with a focus on uses and misuses of neuroimaging. Following this review, a forensic psychiatric civil or criminal case involving brain injury will be presented and discussed, with audience participation, covering aspects of assessment, working with an attorney and the courts, reporting, and testimony, from the viewpoints of both opposing sides in the case.

REFERENCES
Mesulam MM: Neural substrates of behavior: the effects of focal brain lesions upon mental state, in The Harvard Guide to Psychiatry. Edited by Nicholi, AM. Cambridge: Belknap Press of Harvard University Press, 1999, Chapter 6, pp 101-133
Granacher, RP: Traumatic Brain Injury: Methods for Clinical and Forensic Neuropsychiatric Assessment. Boca Raton: CRC Press, 2008

SELF ASSESSMENT QUESTIONS
1. How is evaluation of language functioning in a case involving brain injury relevant to assessment of competency abilities (as in making informed decisions for treatment or competence to stand trial)?
ANSWER: Language functions include output, comprehension, repetition, naming, writing, and reading. These functions can be differentially affected in brain injury, and depending on the area and deficits, may or may not result in impaired competency abilities.

2. Is there a role for functional imaging in forensic psychiatric assessment involving mild traumatic brain injury?
ANSWER: Not as stand-alone data, although functional imaging may support other data obtained from history and neuropsychological testing. Functional imaging findings can be specific to certain disease states, however, such as Alzheimer's Disease.

F20 PARENTAL ALIENATION - AN ADDITION TO THE DSM-V?

Stephen Herman, MD, New York, NY
Honorable Bruce Cohen, (I) Mesa, AZ
John Moran, PhD, (I) Phoenix, AZ
Carol Soderquist, Esq., (I) Tempe, AZ
Philip Stahl, PhD, (I) Queen Creek, AZ

EDUCATIONAL OBJECTIVE
The purpose of this panel is to present arguments in favor of and against the concept of parental alienation and the parental alienation "syndrome." The audience should gain perspective on this construct and decide whether or not it applies to divorcing families—especially those in a custody dispute.

SUMMARY
Dr. Herman will serve as moderator and present the history of the concept of parental alienation. He will discuss the ramifications of consideration for inclusion in the DSM-V. Attorney Soderquist will discuss the legal history of this concept and the use and relevance in a legal context. Dr. Stahl will present common arguments of proponents of the legitimacy of parental alienation syndrome. Dr. Moran will discuss why parental alienation—and the concept of it as a "syndrome"—is a false construct and better approached as children rejecting parents, and the implications for therapy and forensic evaluations. Judge Cohen will discuss the view from the bench.

REFERENCES
JR Johnston: Parental alignments and rejection: an empirical study of alienation in children of divorce. J Am Acad Psychiatry Law 31(2):171-2, 2003
Warshak R. Bringing sense to parental alienation: a look at the disputes and the evidence. Fam Law Quart 37(2):273-301, 2003

SELF ASSESSMENT QUESTIONS
1. Why is "parental alienation syndrome" not a helpful construct?
a. It is a conclusory concept.
b. It presupposes the presence of specific family dynamics.
c. It truncates the legal and mental health analysis without examining causality.
d. All of the above.
ANSWER: d

2. Empirical research indicates in what percentage of family dissolution will a child reject a parent?
a. 1-2%
b. 5-7%
c. 13-22%
d. 62-84%
ANSWER: c

F21 **ETHICS IN FORENSIC PSYCHIATRY PUBLISHING**

Reena Kapoor, MD, New Haven, CT
Jacquelyn Coleman, MA, (I) Bloomfield, CT
Ezra Griffith, MD, New Haven, CT
Michael Norko, MD, New Haven, CT
John Young, MD, MTh, New Haven, CT

EDUCATIONAL OBJECTIVE
Participants will understand the history of medical publishing ethics and the underlying ethics principles involved in forensic psychiatry publishing, discuss the ethics dilemmas that have arisen in the past ten years of publishing the JAAPL, and explore possible resolutions to these dilemmas and others that they bring to the workshop.

SUMMARY
Publication in medical journals conveys many benefits to authors. The number of papers published in medical journals has risen almost fivefold since 1966. Cases of fraud and misconduct have been identified in increasing numbers as well. A number of organizations have developed guidelines to help authors and editors of medical journals to negotiate ethics dilemmas, but very little is known about how these guidelines translate to the context of forensic psychiatry. In this workshop, we begin to explore the important topic of ethics in forensic psychiatry publishing. First, we review the historical development of ethics principles in medical and psychiatric publishing and identify the underlying ethics principles that guide forensic psychiatry publishing. Then we review ethics dilemmas that have arisen in the publication of the JAAPL from 2000-2009, including disputes about authorship, conflict of interest, redundant publication, bias in editors and peer reviewers, and confidentiality in case reports, and others. We will discuss how each of these dilemmas was resolved by the editors of JAAPL, and explore other possible resolutions with the participants. Participants are encouraged to bring their own dilemmas about publishing ethics and suggestions for resolving ethics conflicts to the workshop for panelists and other participants to consider.

REFERENCES
Walter G and Bloch S: Publishing ethics in psychiatry. Aust NZ J Psychiatry 35:28-35, 2001
International Committee of Medical Journal Editors: Uniform requirements for manuscripts submitted to biomedical journals. Available at http://www.icmje.org/urm_full.pdf

SELF ASSESSMENT QUESTIONS
1. The Ingelfinger Rule refers to a prohibition against:
a. publishing case reports without the informed consent of the human subject
b. submitting an article for publication in a medical journal that has already been published or submitted elsewhere
c. publishing an article without disclosing financial conflicts of interest
d. attributing authorship of an article to a person who did not make a substantial contribution to the work
ANSWER: b

2. According to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, authorship of an article must include which of the following?
a. a substantial contribution to conception of design, acquisition of data, or analysis or interpretation of data
b. drafting the article or revising it critically for important intellectual content
c. final approval of the version to be published
d. all of the above
ANSWER: d

FRIDAY

F22 PSYCHOTROPIC MEDICATION PATTERNS AMONG YOUTH IN JUVENILE JUSTICE

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Gail Wasserman, PhD, (I) New York, NY
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Hana Musabegovic, MA, (I) New York, NY
Joseph Keating, (I) New York, NY

EDUCATIONAL OBJECTIVE

At the end of this presentation, participants will be able to identify: at least three diagnoses present in a sample of youth incarcerated in a secure facility; the most commonly prescribed psychotropic drug classes in this sample; and demographic variables that predict receiving a psychotropic medication.

SUMMARY

This paper aims to determine the prevalence, patterns and demographic and diagnostic correlates of psychotropic medication use in a sample of youth in one state's postadjudicatory secure facilities. The health records database of the secure facilities was the source of linked demographic, diagnostic and pharmacy information for the one-year period ending June 30, 1999. Age, gender, race, offense, prior petitions and diagnoses were examined across groups, and concomitant psychotropic pharmacotherapy patterns were identified. Period prevalence was 10.2 percent for youth ranging in age from 12 through 22 years who had any psychotropic drug prescribed and dispensed during the study period. Among medicated youths, almost half received concomitant therapy. Medicated youth were significantly more likely to be non-Hispanic and to endorse one or more diagnoses. Antidepressants, antipsychotics and antihistamines were the most commonly dispensed agents. The most common drug class combinations were an antidepressant plus an antipsychotic and an antidepressant plus another antidepressant. Our findings revealed that the rate of psychotropic medication use was low, concomitant medication use was common, and ethnic/race differences in psychopharmacologic treatment were present in this sample of youths in post-adjudicatory secure facilities.

REFERENCES

Wasserman GA, McReynolds LS, Lucas CP, et al: The voice DISC-IV with incarcerated male youths: prevalence of disorder. J Am Acad Child Adolescent Psychiatry 41:314-21, 2002

Teplin LA, Abram KM, McClelland GM, et al: Detecting mental disorder in juvenile detainees: who receives services. Am J Public Health 95:1773-80, 2005

SELF ASSESSMENT QUESTIONS

1. Which of the following psychotropic drug classes is the least commonly prescribed in this sample?
a. Antidepressant
b. Antipsychotic
c. Mood Stabilizer
d. Stimulant
ANSWER: d

2. How many youths in this sample meet criteria for at least one psychiatric disorder?
a. Approximately 10 percent
b. Approximately 25 percent
c. Approximately 50 percent
d. Approximately 75 percent
ANSWER: c

F23 BRIEF RATING OF AGGRESSION BY CHILDREN AND ADOLESCENTS

Drew Barzman, MD, Wyoming, OH
Douglas Mossman, MD, Cincinnati, OH
Loretta Sonnier, MD, Cincinnati, OH

EDUCATIONAL OBJECTIVE

At the conclusion of this presentation, attendees will describe: the workings of a new tool for assessing in-hospital risk of aggression; key factors that contribute to risk of aggression by hospitalized children; and how risk assessment tools are developed, based on the example presented.

SUMMARY
This study describes findings on the performance of the Brief Rating of Aggression by Children and Adolescents-Preliminary Version (BRACHA 0.8), a new instrument for assessing the risk of aggressive behavior by hospitalized children and adolescents. Licensed psychiatric social workers used a 16-item questionnaire to assess all patients seen in the Emergency Department of a major urban children's hospital. Over a six-month period, 418 patients (age range 3.5-19.0 years) underwent psychiatric hospitalization after evaluation. Hospital nursing staff recorded patient behavior using the Overt Aggression Scale (OAS). Statistical evaluation of results utilized factor analyses, logistic regression models, and receiver operating characteristic (ROC) methods. One hundred twenty (29%) patients committed a total of 292 aggressive acts; within this 120-member group, 63 (15% of the 418 patients) were aggressive toward others. Fourteen of the 16 items predicted ($p < .007$) inpatient aggression and showed good internal consistency (Cronbach's alpha = 0.837). Age was inversely related to probability of aggression and was incorporated into the final assessment instrument. Predictive power was comparable to other published risk assessment instruments (ROC areas of 0.75 for any aggression and 0.82 for aggression toward others). The BRACHA 0.8 shows promise in rapidly assessing risk of inpatient aggression.

REFERENCES
Mossman D: Assessing predictions of violence: being accurate about accuracy. J Consult and Clin Psychology 62:783-92, 1994
Vivona JM, Ecker B, Halgin R, Cates D, Garrison W, Friedman M: Self-and other-directed aggression in child and adolescent psychiatric inpatients. J Am Acad Child Adolescent Psychiatry 34:434-444, 1995

SELF ASSESSMENT QUESTIONS
1. Name two readily detectable factors that appear to increase risk of aggression by children who will undergo psychiatric hospitalization.

ANSWER: Younger age; impulsiveness exhibited in the emergency department.

2. What is the area under the ROC curve (AUC)?

ANSWER: In this context, AUC equals the probability that the instrument will assign a patient randomly chosen from the aggressive subgroup a higher score (i.e., a higher likelihood of aggression) than a patient randomly chosen from the nonaggressive subgroup.

FRIDAY

F24 PSYCHIATRY TRAINING AND THE PARAPHILIC DISORDERS

Paul Noroian, MD, Worcester, MA
Christopher Myers, MD, Bridgewater, MA
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
To establish a better understanding of how psychiatry residents are trained in the assessment and treatment of paraphilic disorders. To improve educational curricula for psychiatry trainees.

SUMMARY
Sexual disorders, including the paraphilias, represent a major source of psychiatric morbidity. Patients with paraphilic disorders are at risk for comorbid mood and anxiety disorders, and may be at greater risk to engage in sex offending behaviors. 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 familiar with risk assessments and current treatment modalities. The topic of how psychiatrists are trained to diagnose and treat patients with paraphilic disorders has not received much attention in the literature. We surveyed psychiatry residency programs in the United States to assess whether individual programs offer didactics and/or clinical supervision specific to the treatment of paraphilic disorders. Data from our study was presented in a poster at the 2009 AAPL meeting. Our data indicate that few residency programs offer specific training in the assessment and treatment of paraphilic disorders. We will review the limitations to the expansion of training, as noted by the programs. We will discuss the current state of residency training in this facet of psychiatry.

REFERENCES
Bradford JMW: The neurobiology, neuropharmacology, and pharmacological treatment of the paraphilias and compulsive sexual behavior. Can J Psychiatry 46:26-33, 2001
Kafka MP, Hennen J: A DSM-IV Axis I comorbidity study of males with paraphilias and paraphilia related disorders. Sexual Abuse 14:349-366, 2002

SELF ASSESSMENT QUESTIONS

1. 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

2. The paraphilias include all of the following disorders except:
a. fetishism
b. gender identity disorder
c. frotteurism
d. exhibitionism
ANSWER: b

F25 HOW DO SYMPTOM LEVELS RELATE TO ALCOHOL IN PATIENT VIOLENCE?

Suzanne Yang, MD, Pittsburgh, PA
Edward Mulvey, PhD, (I) Pittsburgh, PA

EDUCATIONAL OBJECTIVE

Participants will understand the conceptual issues raised by past studies on the relationship of mental illness and violence in psychiatric patients. They will also learn to critically assess methodological choices in such studies and interpret results that indicate complex interactions between dynamic variables (e.g., symptom levels and alcohol use).

SUMMARY

Numerous studies have examined the relationship between a categorical diagnosis of mental illness and violence, generally showing a modest but significant association. Substance abuse diagnoses have been more strongly associated with an outcome of violence. Yet, few studies have attempted to characterize dynamic fluctuations in symptom levels and the amount of alcohol use over time in relationship to future violence. We identified subjects in the MacArthur Violence Risk Assessment Study with a primary diagnosis of Depression (n = 443) or a Psychotic Disorder (n = 245). Levels of affective or positive symptoms in these defined groups were associated with involvement in violence within a 10-week period. With alcohol consumption included in a logistic model with these symptoms to predict involvement in violence, affective symptoms were no longer significant. Models including interaction terms were, however, suggestive of a complex relationship between affective or positive symptoms and the amount of alcohol use. Structural Equation Modeling (SEM) was chosen to assess the combination of these main effects and their interactions and to characterize their relative importance in relation to an outcome of violence. We will present preliminary findings and discuss the advantages and limitations of the SEM technique in studies of dynamic risk.

REFERENCES

Monahan J, Steadman HJ, Silver E, et al: Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence. New York: Oxford University Press, 2001
Skeem JL, Schubert C, Odgers C, et al: Psychiatric symptoms and community violence among high-risk patients: A test of the relationship at the weekly level. J Consult Clin Psychol 74:967-79, 2006

SELF ASSESSMENT QUESTIONS

1. Which of the following has been demonstrated in prior studies of dynamic risk for violence?
a. Patients with a primary diagnosis of depression are at higher risk for violence when they have paranoid ideation.
b. Patients with a primary diagnosis of schizophrenia are at higher risk for violence when they are sad or anxious.
c. In psychiatric outpatients, heavy alcohol use is associated with increased violence.
d. A change in levels of depressive or positive psychotic symptoms has been associated with an increase in violence risk.
ANSWER: c

2. Which of the following is not true of Structural Equation Modeling (SEM)?
a. In principle, the researcher should input an initial model based on theory.
b. The technique uses a statistical test to confirm the directionality of causal pathways within the model.
c. The technique allows the researcher to make causal inferences more readily than linear regression.
d. The technique can model effects of latent constructs that are not directly measured.
ANSWER: b

F26 **WHAT'S NEW IN AAPL ADVOCACY AT THE AMA AND APA**

Barry Wall, MD, Providence, RI
Stuart Anfang, MD, Worcester, MA
Robert Philips, MD, PhD, Annapolis, MD
Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE
AAPL's AMA Delegation and former APA Assembly Representative will provide an update on issues pertinent to psychiatry within the House of Medicine and organized psychiatry. Health system reform, ethics, and clinical psychiatric issues will be reviewed. In addition, the structure and function of the AMA House of Delegates and the APA Assembly will be discussed.

SUMMARY
Four topic areas will be discussed: 1) Health System Reform. AMA has seven critical policy components that it wishes to achieve. The travel of health-system-reform efforts within AMA, as well as a current update on where the AMA and APA stand with regard to health care reform, will be provided. 2) Ethics and Professional Behavior. Updates will be provided on AMA's, particularly within its Council on Ethical and Judicial Affairs, regarding online physician professionalism; ethical guidance on managing potential conflicts of interest associated with industry funding of continuing medical education; prohibitions on physician participation in torture; and end-of-life care matters. 3) Clinical Psychiatric Issues. AMA and APA's advocacy work on legislation, programs and activities in support of psychiatry and its impact on those suffering from mental illnesses will be discussed. 4) The complex structure and working of the AMA House of Delegates and the APA Assembly will be discussed in detail.

REFERENCES
AMA Code of Medical Ethics. Available at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml. Accessed February 24, 2010.
American Psychiatric Association Principles for Health Care Reform for Psychiatry Position Statement Approved by the Assembly, November 2008 Approved by the Board of Trustees, December 2008

SELF ASSESSMENT QUESTIONS
1. AMA and APA opposes which of the following health system alternatives?
a. publicly funded health insurance plans
b. freedom of choice
c. freedom of physician practice
d. universal access for patients
e. none of the above
ANSWER: e

2. AMA and APA policies oppose or do not support all the following, except?
a. physician-assisted suicide
b. the presence of a physician when torture is used
c. the presence of a physician when torture is threatened
d. legal immunity for physicians who withdraw end-of-life care they believe to be futile
ANSWER: d

F27 **JUVENILE MALINGERING: HOW DO WE ASSESS CHILDREN AND ADOLESCENTS WHO FALSIFY INFORMATION?**

Matthew Soulier, MD, Sacramento, CA
Barbara McDermott, PhD, (I) Sacramento, CA
Charles Scott, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
To discuss assessment approaches, important factors to consider, and the validity of structured instruments including the SIMS, MMPI-A, SIRS, and TOMM when evaluating child and adolescent malingering in civil and criminal matters.

SUMMARY

It is essential to consider and assess malingering in civil and criminal matters that involve children and adolescents. Dr. Soulier will review definitions and the developmental context for children who falsify information. Critical investigation of malingering during assessments of juvenile competency to stand trial, waiver of Miranda rights, disposition for sexual offenses, and child witness testimony will be discussed. Dr. McDermott will discuss the use of structured assessments in the detection of juvenile malingering. The evidence-based validity of instruments including the SIMS, MMPI-A, SIRS, and TOMM will be reviewed and discussed in the context of children and adolescents. Dr. Scott will review the importance of considering malingering and other forms of symptom misrepresentation by children and adolescents who are plaintiffs in civil litigation. Important assessment approaches during the forensic medical examination will be discussed to include the evaluation of coaching by parents or others, the potential influence from peers and investigators on claimed emotional damages, and key collateral records and interviews unique to this population. Dr. Scott will highlight various types of PTSD claims by children and adolescents to include emotional damages arising from alleged sexual abuse, accident and/or sustained injuries, and witnessing of traumatic events.

REFERENCES

Rogers R, Hinds JD, Sewell KW: Feigning psychopathology among adolescent offenders: Validation of the SIRS, MMPI-A, and SIMS. J Personality Assessment 67:244–257, 1996

McCann, JT: Malingering and Deception in Adolescents: Assessing Credibility in Clinical and Forensic Settings. Washington, DC: American Psychological Association, 1998

SELF ASSESSMENT QUESTIONS

1. The SIRS should be used in an adolescent population:
a. To definitively determine if a juvenile is malingering
b. As corroborative data in the assessment of adolescent malingering
c. Only if the juvenile claims to suffer from PTSD
ANSWER: b

2. When evaluating the validity of a juvenile's confession, which factor is most important to the assessment?
a. The style of the interrogation
b. The defendant's intellectual functioning
c. The circumstances of the arrest
d. All of the above
ANSWER: d

F28 CRIMINAL RESPONSIBILITY CASE CONFERENCE USING A DVD FORMAT

Debra Pinals, MD, Worcester, MA
Aimee Kaempf, MD, Tucson, AZ
David Siegel, JD, (I) Boston, MA

EDUCATIONAL OBJECTIVE

At the end of this workshop, participants will be able: to discuss a case regarding criminal responsibility and attempt to form their opinions and defend them under cross examination; and describe how a standardized approach to teaching might be utilized across training programs.

SUMMARY

Forensic psychiatry requires the development of core competencies through training experiences. Case-based learning is an excellent method to enhance medical knowledge and practice-based learning and improvement, among others of these competencies. Rarely, however, are there opportunities to facilitate teaching using a "standardized patient" concept across training programs. Utilizing this concept, and with the support of an educational grant from the AAPL Institute for Education and Research, a DVD was developed that provides a complete case file related to the issue of criminal responsibility. This case file can serve as the basis for a clinical case conference and didactic training across programs. Included in the DVD are instructions for educators, with projected flexible approaches to utilizing the DVD as well as background information related to the insanity defense, videotaped interviews of a hypothetical defendant, summaries of collateral records, a sample report, cross examination questions, and a few multiple choice questions to assess knowledge in the area. In this workshop, a criminal responsibility case conference will be presented using the DVD. Participants will walk through the case as students or prospective educators who may wish to use the DVD in their own residency and fellowship education programs.

REFERENCES
Giorgi-Guarnieri D, et al: AAPL practice guideline for forensic psychiatric evaluation of defendants raising the insanity defense. Am Acad Psychiatry Law 30(2 Suppl):S3-40, 2002
Packer IK: Evaluation of Criminal Responsibility. New York: Oxford University Press, 2009

SELF ASSESSMENT QUESTIONS
1. Which of the following is true?
a. The insanity defense and the diminished capacity defense are both "complete defenses" resulting in acquittal.
b. Neither the insanity defense nor the diminished capacity defense is a "complete defense."
c. The insanity defense is a "complete defense," but diminished capacity typically results in conviction on a lesser charge.
d. If successful in using either an insanity defense or a diminished capacity defense, a defendant is likely to be committed to a psychiatric hospital.
ANSWER: c

2. Teaching using a standardized case format can target which of the following core competencies:
a. Medical knowledge
b. Practice-based learning and improvement
c. Interpersonal and communication skills
d. Systems-based practice
e. All of the above
ANSWER: e

F29 BEYOND SUICIDE PREVENTION: A MULTIFACETED EXPLORATION OF RISK MANAGEMENT

Cheryl Wills, MD, Cleveland, OH
Marilyn Price, MD, CM, Cambridge, MA
Anne Ryan, EdD, (I) Vancouver, WA

EDUCATIONAL OBJECTIVE
Participants will examine various types of forensic mental health risk management of youth and adults in private and public sector institutions and programs, including hospitals, educational settings, residential programs, and community-based programs.

SUMMARY
Although suicide prevention is an important part of mental health risk management, other components of risk reduction are also essential to forensic psychiatric practice. This workshop will introduce participants to elements of mental health risk management, apart from suicide prevention, that forensic mental health professionals may encounter. A forensic psychiatrist will use case examples to illustrate approaches to educating physicians about root cause analysis, failure modes and effects analysis as critical components of risk reduction in hospital risk management. Also, an education specialist will describe how alternative schools approach risk reduction in programs that are designed to educate at-risk adolescents and young adults. Students enrolled in alternative education programs may be involved with rehabilitative programs, including penal facilities, drug rehabilitation programs, and mental health programs. The educator's perspective will be contrasted with a psychiatrist's perspective of containing risk with this same population of individuals when they are in residential facilities and when they reenter the community. Case examples will be used to illustrate how education and mental health experts reduce community-based risk for individuals with mental illness. Participants will appreciate how mental health risk management is an interdisciplinary collaborative challenge that can be effectively orchestrated in various environments.

REFERENCES
Price M, Recupero PR: Risk management and safety, in Textbook of Hospital Psychiatry. Edited by Sharfstein SS, Dickerson FB, Oldham JM. Washington DC: American Psychiatric Publishing, 2008, pp 411-428
Biancosino B, Delmonte S, Grassi L, Santone G: Violent behavior in acute psychiatric inpatient facilities: a national survey in Italy. Nerv Ment Dis 197:772-82, 2009

SELF ASSESSMENT QUESTIONS

1. A Root Cause Analysis:
a. Is a retrospective risk management technique
b. Involves an analysis of the various systems that may have contributed to a sentinel event
c. Should be conducted within 45 days of a sentinel event according to the Joint Commission on Accreditation of Healthcare Organizations
d. All of the above
ANSWER: d

2. Female sexual abuse victims:
a. Are at higher risk for substance use disorders
b. Use healthcare services less often than other women
c. Are less likely to be incarcerated
d. Are less likely to be involved in abusive relationship
ANSWER: a

F30 INDIGENOUS WAYS OF JUSTICE: HEALING INDIVIDUALS AND COMMUNITIES

Carole Goldberg, Esq., (I) Los Angeles, CA
Duane Champagne, PhD, (I) Los Angeles, CA

EDUCATIONAL OBJECTIVE

To provide an overview of indigenous justice systems in the United States, and show how tribal control of justice contributes to healthier communities. Case studies will illustrate how healing strategies have been successfully incorporated into contemporary tribal justice systems to address problems of substance abuse, domestic violence, and repeat offending.

SUMMARY

Problems of substance abuse, domestic violence, and repeat offending afflict much of Indian country. A complex array of culturally specific institutional arrangements applies to criminal justice on reservations, with tribal cultures and understandings of justice often suppressed or marginalized in favor of state and federal control. This presentation conceptualizes criminal justice as an interrelated model of administrative control, cultural compatibility, resources, fairness, program delivery, and intergovernmental relations. Data suggest that the current system of justice in Indian country contributes to patterns of social and psychological distress; but under some conditions, tribal communities that have greater control, greater resources, and emphasis on traditional healing methods appear to be producing more positive outcomes.

REFERENCES

McCaslin W (editor): Justice as Healing: Indigenous Ways: Writings on Community Peacemaking and Restorative Justice from the Native Law Centre. St. Paul, MN: Living Justice Press, 2005
Ross R: Returning to the Teachings: Exploring Aboriginal Justice. Toronto, ON: Penguin Books, 1996

SELF ASSESSMENT QUESTIONS

1. What are the most serious law and order problems in tribal communities?
a. car theft
b. murder
c. absence of intergovernmental agreements
d. substance abuse and related offenses
ANSWER: d

2. How well does concurrent criminal jurisdiction operate in Indian country?
a. Works best in PL-280 (state) jurisdictions
b. Works best when there are intergovernmental agreements
c. Works best when tribes don't contract to carry out federal services
d. Works best when tribes enjoy substantial gaming revenues
ANSWER: b

F31 **CAN'T WORK OR WON'T WORK? PSYCHIATRIC DISABILITY EVALUATIONS**

Liza Gold, MD, Arlington, VA
Donna Vanderpool, JD, (I) Arlington, VA
William Stejskal, PhD, (I) Charlottesville, VA

EDUCATIONAL OBJECTIVE

To provide concepts and guidelines for conducting psychiatric disability evaluations. Psychiatrists often provide disability assessments but typically receive little formal training in doing so. This course will review legal and administrative contexts of disability evaluations and provide a model and guidelines to assist in addressing commonly sought opinions.

SUMMARY

Disability evaluations are functional assessments intended to provide administrative or legal systems with information they can translate into concrete actions, such as awards of benefits or legal damages. Work disability is the result of a dynamic process between factors internal to the individual and external factors not limited to work impairment. The presence of a psychiatric diagnosis does not automatically imply functional impairment, and functional impairment, when present, does not necessarily result in disability. Psychiatrists are not the final arbiters of disability decisions: their role is to provide information to arbiters that facilitates fair and reasonable decision-making. Providing the needed information and requested opinions is facilitated by developing a case formulation to explain the complex relationship between impairment and disability. Comprehensive disability evaluations should consider medical, psychiatric, personal, social, economic, and workplace factors, utilizing a work capacity model. Evaluations should provide information about specific psychiatric impairments and associated dysfunction, correlated with specific job requirements and work skills. This course will review information gathering, assessment models, typical requested opinions, relevant psychological testing, guidelines for assessment, and risk management and legal liability issues.

REFERENCES

Gold LH, Shuman W: Evaluating Mental Health Disability in the Workplace: Model, Process, and Analysis. New York: Springer, 2009
Gold LH, Anfang, SA, Drukteinis AM, et al: Practice Guidelines for Forensic Evaluation of Psychiatric Disability. J Am Acad Psychiatry Law 36:S1-S50, 2008

SELF ASSESSMENT QUESTIONS

1. Clinicians can make the assessment of impairment and disability more objective by all of the following, except?
a. Obtaining corroboration of the evaluee's subjective report
b. Assuming that an individual's impairments began with the onset of a diagnosable psychiatric disorder
c. Probing categories of function in detail
d. Seeking clear examples of impairment
ANSWER: b

2. In making a diagnosis of a personality disorder in the context of a disability evaluation, examiners should:
a. Consider the diagnosis of Axis I and Axis II disorders mutually exclusive.
b. Focus on repetitive patterns and symptoms evident primarily in work related functioning
c. Rely on their behavioral observations of the evaluee during the clinical interview
d. Distinguish the personality traits that define these disorders from characteristics that emerge in response to specific situational stressors
ANSWER: b

F32 **MASS VIOLENCE: MASS LIABILITIES**

Stuart Kleinman, MD, New York, NY
Matthew Miklave, JD, (I) New York, NY
Joseph Napoli, MD, (I) New York, NY
Anand Pandya, MD, Los Angeles, CA
Jeffrey Schlanger, Esq. (I) New York, NY

EDUCATIONAL OBJECTIVE

To learn: 1) which acute interventions following an incident of mass violence may cause psychological harm; 2) sources of liability attendant on those intervening immediately after such an incident; 3) screening techniques potentially useful for helping identify those significantly disposed to harm people or property; and 4) means of enhancing psychological resilience.

SUMMARY
Various acutely applied and briefly administered interventions following an incident of mass violence may help prevent development of clinically significant psychological difficulties. However, seemingly too often providers or provider entities promise more than they can actually achieve. Most problematically, some interventions may harm certain populations. Further, overly optimistic assurances of help and failure to appropriately warn of potential harm may generate legal liability for both the provider and the retaining entity. Preemptively indentifying those disposed to commit mass acts of violence or importantly compromising nonviolent acts, e.g., corporate espionage, has assumed particularly great importance in the post-911/post-Virginia Tech world. Those who own or occupy buildings considered particular potential terrorist targets have particular security responsibility to those both in and immediately around their buildings. Certain screening measures may help reduce the likelihood of harm to person, property, or business/government functioning by potential employees. Such measures, may, however, also cause harm should they support incorrect employment actions. Recently rapid expanding understanding of resilience may foster developing techniques for inoculating some against certain high magnitude stressors.

REFERENCES
Kleinman S: Managing the managers: supporting functioning of employees facing threats of terrorism. Psychiatr Serv Frontline Report 53(10):1340-1341, 2002
Kehayan VA, Napoli, JC: Resiliency in the Face of Disaster and Terrorism: 10 Things to Do to Survive. California: Personhood Press, 2005

SELF ASSESSMENT QUESTIONS
1. Apart from the psychological and medical impact of workplace violence, which of the following individuals, groups or entities could face legal liability from the victims of a violent workplace event?
a. The employer
b. The building owner
c. The building security contractor
d. First responders
e. Medical/psychological response teams
f. The attacker
g. All of the above
ANSWER: g

2. Predictors of resilience include all of the following, except:
a. High levels of Neuropeptide Y under stress
b. Personal faith
c. Active problem solving
d. Ability to gain positive attention from others
e. All of the Above
ANSWER: a

F33 **PUNITIVE SEGREGATION AND SMI: HUMAN RIGHTS, LITIGATION AND NEW YORK 'S MULTI-MILLION DOLLAR SOLUTION**

Andrew Kaufman, MD, Fayetteville, NY
Jamie Fellner, JD, (I) New York, NY
James Knoll, IV, MD, Syracuse, NY
Fred Cohen, LLB, LLM, (I) Tucson, AZ

EDUCATIONAL OBJECTIVE
To review the use of punitive isolation to manage disruptive inmates with severe mental illness; to examine these practices in the context of human rights and constitutional law; and to describe a unique, new approach recently begun in New York as an alternative that emphasizes treatment as well as security.

SUMMARY
Corrections officials struggle with disruptive and difficult prisoners, including those who have a serious mental illness. For management or disciplinary reasons, they confine such prisoners under conditions of extreme social isolation, lack of meaningful activities and limited mental health services -- conditions which many clinicians consider damaging, and human rights experts and some courts consider unconstitutionally cruel. Pressed by a lawsuit, New York has adopted new strategies for managing mentally ill prisoners, including the development of two new multi-million-dollar facilities to provide a therapeutic alternative that is unique in the U.S. We will review the historical use of isolation in the U.S. to respond to mentally ill inmates who pose safety or security concerns, the human rights consequences, and recent litigation. We will then describe the novel practices and treatment approach being pioneered in New York.

REFERENCES
Human Rights Perspective on Segregating the Mentally Ill. Correctional Mental Health Report, May/June 2009
Fellner J: Afterwords. Crim Justice Behav 35(8):1079-1087, August 2008

SELF ASSESSMENT QUESTIONS
1. Completed suicides in secure housing units (punitive segregation) typically take place:
a. In the first 2 weeks
b. In the first 2 months
c. In the first 2 years
d. In the first 72 hours
ANSWER: b

2. Which of the following is recommended in the literature on punitive segregation reform?
a. Removal of mentally ill inmates
b. Providing meaningful activities and programming
c. Step-down programming
d. Strict time limits
e. all of the above
ANSWER: e

F34 FORENSIC SAMPLER: COMPUTER CRIME

Alan Felthous, MD, St. Louis, MO
Marcus Rogers, PhD, (I) West Lafayette, IN
Robert Weinstock, MD, Los Angeles, CA
Edward Fischer, PhD, (I) Long Beach, CA

EDUCATIONAL OBJECTIVE
Attendees will learn what types of deviant conduct occur online and, from recent research, what psychological characteristics are associated with criminal behavior online.

SUMMARY
Computer crime appears to be on the rise. This panel will examine types of anomalous, deviant, and criminal behavior online and mental disorders or behavioral syndromes, such as "internet addiction" associated with the use of the computer. A considerable amount of research has been directed at technology based-solutions to computer crime, but very few studies examining the behavioral aspects of this type of criminal behavior have been done. It is important that we understand the human aspect of computer crime. The panel presentation will examine research focusing on personality and behavior-based risk models for criminal computer behavior. In order to deal with this new criminal phenomena effectively, we must more fully understand not only the "how," but also the "who" and the "why." Additionally, the panel will address criminal assessment and dangerousness of sexual offenders in the context of criminal and noncriminal sexual activity on the internet including exhibitionistic "sexting" of self-photos, downloading erotic film, and accessing contraband material. Progression from common to child pornography and the distinction between ephebiphilic and pedophilic pornography are relevant to the assessment of users of internet pornography.

REFERENCES
Black DW, Belsare G, Schlosser S: Clinical feature, psychiatric comorbidity, and health-related quality of life in persons reporting compulsive computer use behavior. J Clin Psychiatry 60(12):839-44, 1999
Rogers M, Smoak N, Lui J: Self-reported criminal computer behavior: a big-5, moral choice and manipulative exploitive behavior analysis. J Deviant Behav 27(3):245-268, 2006

SELF ASSESSMENT QUESTIONS
1. The category of computer crime activity that is most costly, on average, to businesses is:
a. malware attacks
b. insider attacks
c. identity theft
d. phishing exploits
ANSWER: b

2. Common findings in persons who report compulsive computer use include all of the following, except?
a. school/occupational problems
b. personality disorder
c. superior academic performance
d. impulse control disorder
ANSWER: c

F35 ISAAC RAY: LESSONS LEARNED, LESSONS FORGOTTEN

John Bradford, MB, Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

To educate about the enormous contributions made by Isaac Ray to forensic psychiatry and, in particular, his observations related to the criminalization of the mentally ill.

SUMMARY

Isaac Ray (1807-1881) wrote the classic of medical literature entitled "A Treatise on the Medical Jurisprudence of Insanity" in 1838 when he was 31 years of age and 11 years after he received his M.D. The treatise was the first text of its kind to appear in English that dealt with mental disorder and the law. He spent a number of years visiting medical facilities in New England, England and France in the year after he received his medical degree from Harvard in 1827. His book became the authoritative text in forensic psychiatry for many years and was an integral part of the Daniel M'Naughten trial in 1843. He went on to publish at least one article on insanity and the law between 1828 and 1880. He was instrumental in setting up the system of how mentally abnormal offenders would be dealt with by the criminal justice system in order to receive treatment and rehabilitation. In more recent years throughout the Western World, particularly in Canada and the United States, these lessons have been forgotten, and criminalization of the mentally ill is the norm in most of these countries. The author believes that, in the name of Isaac Ray, advocacy against the criminalization of the mentally ill is a responsibility of the leaders of forensic psychiatry throughout the Western World. The author has developed a program of forensic psychiatry in Canada that is sensitive to criminalization and geared towards diversion of the mentally abnormal offender away from the criminal justice system to the health care system at every point that this is available. The author hopes to inspire forensic psychiatrists to continue the calling of Isaac Ray.

REFERENCES

Ray I: A Treatise on the Medical Jurisprudence of Insanity. Washington, DC: Beard Books, 1838. Charles C. Little and James Brown. Reprinted 2000 by Beard Books, Washington, DC
Schneider RD: The Lunatic and the Lord. Toronto: Irwin Law, 2009

SELF ASSESSMENT QUESTIONS

1. Which statement is incorrect?
a. Isaac Ray is one of the founders of the Disciplines of Forensic Psychiatry.
b. Isaac Ray is one of the founding members of the forerunners of the American Psychiatric Association known as the Association of Medical Superintendents.
c. Isaac Ray's book "A Treatise on the Medical Jurisprudence of Insanity" was quoted extensively at the trial of Daniel M'Naughton in 1853.
d. Isaac Ray was a graduate of Harvard Medical School.
ANSWER: d

2. In the book ,"A Treatise on the Medical Jurisprudence of Insanity," Isaac Ray:
a. Addressed criminal responsibility related to somnambulism.
b. Addressed criminal responsibility of dementia.
c. Addressed criminal responsibility related to drunkenness.
d. Did not address the pathology and symptoms of mania.
ANSWER: d

F36 **SHOULD VIDEOTAPING BE REQUIRED FOR CHILD FORENSIC EVALUATION?**

Eileen Ryan, DO, Fisherville, VA
R. Gregg Dwyer, MD, EdD, Columbia, SC
Joseph Kenan, MD, Los Angeles, CA
Manuel Lopez-Leon, MD, New York, NY
Christopher Thompson, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE
Participants will become aware of the questions and concerns driving the debate over whether videotaping of pediatric forensic evaluations should be recommended or even required.

SUMMARY
Controversy remains as to whether videotaping forensic evaluations of adults in the civil and criminal arenas is prudent and desirable, and considerably more debate on whether videotaping should be required of forensic evaluations when possible, or at least strongly recommended. There is little research on this area, and the issue has been even less studied in the area of pediatric forensic evalution. This debate will focus on the risks and benefits of videotaping forensic psychiatric evaluations, with a specific focus on those issues pertaining to children, including the suggestibility of children and allegations of sexual abuse within and outside of child custody evaluations.

REFERENCES
AAPL Task Force, American Academy of Psychiatry and the Law: Videotaping of forensic psychiatric evaluations. J Am Acad Psychiatry Law 27(2):345-58, 1999
Wettstein RM: Quality and quality improvement in forensic mental health evaluations. J Am Acad Psychiatry Law 33(2):158-75, 2005

SELF ASSESSMENT QUESTIONS
1. What are two reasons to require that pediatric forensic psychiatric evaluations be taped?
ANSWER: Memorializing the interview is a shield against allegations that the examiner inaccurately portrayed the child's responses. Taped forensic evaluation is an excellent teaching tool for residents and fellows.

2. Name two potential drawbacks to the taping of pediatric forensic evaluations:
ANSWER: Excerpts of taped interviews may be taken out of context and used inappropriately by attorneys. Taping equipment can be expensive.

F37 **THE AAPL/APLS FORENSIC RESEARCH COLLABORATIVE**

Robert Trestman, PhD, MD, Farmington, CT
Edward Mulvey, PhD, (I) Pittsburgh, PA
Denise Juliano-Bult, MSW, (I) Bethesda, MD
John Bradford, MB, Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE
To enhance the awareness of participants of the need for research to advance the fields of forensic psychiatry and psychology, of the potential benefits of collaborative research with members of the APLS, and of the developing relationship between AAPL and APLS to support this work.

SUMMARY
The sophistication of forensic psychiatry and psychology continues to grow, yet the research to support the demands of the field lags behind. To address this, the American Psychology-Law Society (APLS) and AAPL are working to foster collaborative research efforts among their members. Dr. Trestman, Chair of the AAPL Research Committee, will describe the background to this project. Dr. Mulvey, the Immediate Past President of APLS, will introduce the interests and motivation to build collaborative research models with AAPL members. Dr. Bradford, from the AAPL Institute, will discuss the potential benefit to AAPL members to advance their own academic careers, as roughly 50% of AAPL members have faculty appointments that, while generally clinical/ administrative, have the potential to benefit from research participation. Ms. Juliano-Bult, Chief, Systems Research and Disparities in Mental Health Services Research Programs at the NIMH will focus on the needs for evidence-based research to advance the field, as well as the grant opportunities from the NIMH perspective. Exemplars will be presented and discussed, including collaborations regarding real-world research questions and design relevance, expanded research sites, opportunities to receive research mentorship, and potentials for pilot study funding. Audience participation will include active exploration of process and potential projects.

REFERENCES
Gunn J: Future directions for treatment in forensic psychiatry. Brit J Psychiatry 176:332-338, 2000
Mullen PE: Forensic mental health. Brit J Psychiatry 176:307-311, 2000

SELF ASSESSMENT QUESTIONS
1. What are some of the key challenges facing the practice of forensic psychiatry and psychology in the years ahead?
ANSWER: Having credible applied research, having practitioner-researchers to drive the research agenda, and having an interdisciplinary approach that stimulates sustainable advances in an increasingly complex field.

2. How might more forensic psychiatrists with limited academic time meaningfully engage in research?
ANSWER: Through interdisciplinary collaboration with forensic research psychologists.

F38 **PTSD GONE WILD: NIGHTMARE CASES IN COURT**

Charles Scott, MD, Sacramento, CA
H. Eric Bender, MD, Sacramento, CA
William Newman, MD, Sacramento, CA
Christopher Wadsworth, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
This presentation will improve the knowledge, skills, and performance of forensic psychiatrists who consult to attorneys and courts on issues related to the forensic assessment of PTSD. New scientific data on specific PTSD criteria will be reviewed as well as the proposed DSM-5 PTSD criteria.

SUMMARY
PTSD malingering is estimated to occur in at least 20-30% of personal injury claimants and at least 20% of combat seeking veterans. Concerns have arisen regarding the expansion of the PTSD diagnosis to include a variety of isolated symptoms and ill defined syndromes. Dr. Wadsworth will review the evolution of the PTSD diagnosis with an emphasis on newly proposed DSM-V criteria and the potential impact of these suggested criteria on future civil litigation. Dr. Bender will discuss the application of PTSD criteria to children and adolescents and common civil litigation cases involving alleged emotional damages to youth. Dr. Newman will provide updates to the forensic evaluation of specific PTSD criteria to include nightmares and flashbacks. Dr. Newman will review emerging evaluation tools to assess malingering of PTSD symptoms to include the use of the SIMS and SIRS as well as structured questionnaires. Dr. Scott will discuss the relationship of psychopathy to civil litigation claims, the term "Pseudo-PTSD" and various reported emotional distress claims that have been equated with PTSD. Dr. Scott will also review court limitations placed on a forensic expert's testimony regarding a plaintiff's credibility.

REFERENCES
APA Proposed Revision DSM-5. Available at http://www.dsm5.org/ProposedRevisions/PAges/propossedrevision.aspx?rid=165. Accessed February 28, 2010
Hall CW, Hall RCW: Detection of malingered PTSD: An overview of clinical, psychometric, and physiological assessment: Where do we stand? J Forensic Sci 52:717-725, 2007

SELF ASSESSMENT QUESTIONS
1. All of the following are included in the proposed DSM-5 revised PTSD criteria except:
a. Learning that a traumatic event occurred to a close relative or close friend is sufficient to cause PTSD
b. Pervasive negative emotional state
c. Persistent inability to experience positive emotions
d. Feelings of guilt regarding surviving stressor
ANSWER: d

2. What percentage of women exposed to a traumatic stressor will develop PTSD?
a. 5%
b. 10%
c. 20%
d. 30%
e. 50%
ANSWER: c

F39 I DID WHAT? ZOLPIDEM AND THE COURTS

Christopher Daley, MD, San Francisco, CA
Dale McNiel, PhD, (I) San Francisco, CA
Renée Binder, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

Attendees will learn the psychopharmacologic basis for zolpidem to cause sleep-related complex behaviors as a tool to evaluate cases where these involuntary behaviors are used to mitigate liability.

SUMMARY

Zolpidem is a non-benzodiazepine hypnotic medication. It has been widely prescribed since its introduction to the United States market in 1992. Attention has been drawn recently to its potential to cause sleep-related complex behaviors such as sleepwalking and sleepdriving. These automatic behaviors have led to a deluge of claims in the legal system. In criminal courts, defendants have raised the argument of involuntary intoxication to mitigate their responsibility. In civil courts, plaintiffs have sued for damages alleged to have been induced by zolpidem. To the authors' knowledge, this is the first review in the forensic literature of the legal ramifications of zolpidem. The medical literature will be reviewed to explore the current understanding of zolpidem's unique psychopharmacology. Case law will also be examined to determine how the courts have handled the issues raised in zolpidem cases. Finally, recommendations will be given for mental health professionals asked to evaluate these claims.

REFERENCES

Dolder CR, Nelson MH: Hypnosedative-induced complex behaviours. CNS Drugs 22(12):1021-1036, 2008
Gibson v. Sanofi-Aventis US, LLC. US District Court for the Western District of Kentucky; Civil Action No. 3:07CV-192-S (2009)

SELF ASSESSMENT QUESTIONS

1. Which of the following psychopharmacologic properties of zolpidem are true?
a. Zolpidem is a selective agonist of the benzodiazepine GABA-A alpha-1 receptor.
b. Zolpidem has a high affinity for the benzodiazepine receptor complex.
c. Zolpidem has a rapid onset of action.
d. Zolpidem has a half life of 2-3 hours.
e. All of the above
ANSWER: e

2. In Gibson v. Sanofi-Aventis, the District Court excluded expert testimony on zolpidem on what basis?
a. The experts failed to examine Ms. Gibson.
b. The experts were not licensed physicians.
c. The experts did not rely on scientific techniques in forming their opinions.
d. The experts failed to testify to the ultimate issue of involuntary intoxication.
e. The experts showed no proof of aberrant sleep related behaviors.
ANSWER: c

F40 TASING-A RARE EVENT THAT CAN PROVIDE PSYCHIATRIC CLUES IN FORENSIC CASES

B. Todd Thatcher, DO, Salt Lake City, UT

EDUCATIONAL OBJECTIVE

The reader will be able to discuss the current state of taser research, the frequency of taser use, and the percentage of tased suspects with mental illness or substance abuse. The reader will also learn how this information can provide diagnostic clues and support for forensic opinions.

SUMMARY

Tasers are used by police to take into custody suspects who are not compliant with behavioral commands. Most of the research literature focuses on medical complications, but some reports have correlated their use with substance abusers and the mentally ill. Is tasing common? And what clues can it provide for the forensic examiner? Methods: Police department reports made public on the internet were reviewed. Data included the number of tasings needed to bring suspects under control, aiming to firing ratios, number of suspects with mental illness or substance abuse. Arrest to tasing ratios were calculated from these data. Results: Tasers are used in less than 3% of arrests, of which less than 30% require more than one tasing. Between 35% to 75% of tased suspects are mentally ill, using illegal substances, or both. Conclusions: When a suspect has been tased it is a rare and unusual event

that strongly suggests impaired cognitive functioning through mental illness or substance abuse. This information can be used to guide forensic examinations. Two examples are discussed. Given the high rate of taser use on potential forensic suspects, more research should be conducted by mental health professionals.

REFERENCES

U. S. Government Accountability Office: Taser weapons-use of tasers by selected law enforcement agencies. Publication no. GAO-05-464. Washington, DC: U.S. Government Printing Office, May, 2005

Jenkinson E, Neeson C, Bleetman A: The relative risk of police use-of-force options: evaluating the potential for deployment of electronic weaponry. J Clin Forensic Med 13(5):229-4, 2006

SELF ASSESSMENT QUESTIONS

1. What percentage of arrested suspects are tased?
a. 1% or less
b. 1% to 3%
c. 5% to 10% d) 10% to 20%
d. More than 20%
ANSWER: b

2. What psychiatric problem is the most common in tased suspects?
a. Schizophrenia
b. Bipolar mania
c. Alcohol abuse
d. PTSD
e. Anxiety
ANSWER: c

F41 THE MENTALLY ILL DEFENDANT AND MENTAL ILLNESS VERDICTS: PERCEPTIONS OF THE CRIMINAL BAR

Richard Frierson, MD, Columbia, SC

EDUCATIONAL OBJECTIVE

To understand how defense attorneys, prosecutors, and judges view mentally ill defendants, to assess their attitudes about these defendants and mental illness verdicts, and to assess attorney characteristics that are associated with a more favorable attitude toward defending the mentally ill,

SUMMARY

This research involved a 32-item written survey of the 492 members of a state criminal bar. Fifty-two percent (n=257) of surveys were returned. Demographic variables were gathered and attorneys were asked three questions about psychotic mental illness and to define the legal criteria and dispositional outcomes for mental illness verdicts. Attitudes about mental illness verdicts and about working with mentally ill defendants were also surveyed. Results indicate that attorneys are fairly knowledgeable about mental illness but not mental illness verdicts, particularly the legal definition and dispositional outcome of "Guilty But Mentally Ill." Most attorneys prefer to work with clients who are not mentally ill. However, as they become more experienced with mentally ill defendants, they become more knowledgeable, they view the insanity defense more favorably, and they are more willing to defend the mentally ill. Results indicate that a large majority received no education about mental illness and mental health law, and believed that their law school education about mental health issues was inadequate. In comparing attorney occupations, public defenders were the most knowledgeable about mental illness and mental health defenses, followed by prosecutors, and private defense attorneys. Judges were the least knowledgeable group.

REFERENCES

Sloat LM, Frierson RL: Juror knowledge and attitudes regarding mental illness verdicts. J Am Acad Psychiatry Law 33:208-13, 2005

Lamb HR, Weinberger LE: The shift of psychiatric inpatient care from hospitals to jails and prisons. J Am Acad Psychiatry Law 33:529-34, 2005

SELF ASSESSMENT QUESTIONS

1. Which attorney characteristic is associated with a more favorable attitude towards the mentally ill criminal defendant?
a. Having prior education about mental illness
b. Having personal experience with mental illness in self, family, or friend
c. Having prior experience with defending mentally ill clients
d. Having worked as a private defense attorney
ANSWER: c

2. Which attorney type believes jurors should be informed of dispositional outcomes of mental illness verdicts prior to deliberation?
a. Public defender
b. Prosecutor
c. Private defense attorney
d. Judge
ANSWER: a

F42 **BURNING ISSUES: FIRE SETTING, ARSON, PYROMANIA, AND THE FORENSIC MENTAL HEALTH EXPERT**

Paul Burton, MD, San Francisco, CA
Renée Binder, MD, San Francisco, CA
Dale McNiel, PhD, ABPP, (I) San Francisco, CA

EDUCATIONAL OBJECTIVE

Participants will be able to understand the differences between fire setting, arson, and pyromania; recognize common characteristics of those who set fires; describe fire setting recidivism assessments, classification systems, and treatment options; and appreciate how the courts have approached criminal and civil fire-setting-related evaluations referred to forensic experts.

SUMMARY

Fire setting is a common behavior that is frequently encountered by forensic mental health experts consulting on criminal and civil legal cases. Despite its prevalence, minimal attention has been paid in the literature to conducting fire-setting-related forensic evaluations. This presentation discusses the differences between the behavior of fire setting, the crime of arson, and the diagnosis of pyromania. The literature on adult fire-setter characteristics, classification systems, recidivism, and treatment is reviewed. Several common criminal and civil fire-setting-related evaluations referred to forensic mental health experts are discussed with legal case examples illustrating how the courts have approached these issues. Attention is paid towards criminal responsibility evaluations, sentencing evaluations, and negligence claims against mental health clinicians. A discussion on conducting a fire setting risk assessment is introduced.

REFERENCES

Rice ME, Harris GT: Predicting the recidivism of mentally disordered firesetters. J Interpers Violence 11:364-75, 1996
Geller JL, Erlen J, Pinkus RL: A historical appraisal of America's experience with "pyromania" – a diagnosis in search of a disorder. Int J Law Psychiatry 9:201-29, 1986

SELF ASSESSMENT QUESTIONS

1. Which of the following is true regarding criminal and civil fire setting-related forensic evaluations?
a. Pyromania is often successful as a NGRI defense for arson charges.
b. Arson is a specific intent crime and therefore diminished capacity defenses are common.
c. Risk assessments are of little utility during sentencing hearings for arson.
d. The standard of care in psychiatry is to routinely conduct fire setting risk assessments.
e. Mental health providers may be sued for negligence after fire setting by patients.
ANSWER: e

2. Which of the following variables has not been shown to be associated with an increased risk of arson recidivism in mentally disordered arsonists?
a. A history of childhood fire setting behavior
b. Setting fires alone as opposed to with others
c. A high number of previous fire setting offenses
d. Cruelty to animals and enuresis
e. A younger age of first fire setting incident
ANSWER: d

SATURDAY, OCTOBER 23, 2010

AAPL BUSINESS MEETING (MEMBERS ONLY) | 8:00 AM - 9:00 AM | **SALON 6**

PANEL AND DISCUSSION | 9:00 AM - 9:45 AM | **SALON 6**

S1 Illegal Aliens in the Twilight Zone of SB1070

Barry Morenz, MD, Tucson, AZ
Scott McNamara, Esq. (I) Tucson, AZ

COFFEE BREAK | **9:45AM - 10:00AM** | **ARIZONA FOYER**

A/V SESSION | 10:00AM - 12:00PM | **SALON 6**

S2 Dr. Kreizler to Hannibal: Forensic Psychiatrists in Fiction

ARS

Cathleen Cerny, MD, Cleveland, OH
Susan Hatters Friedman, MD, Cleveland, OH
Sherif Soliman, MD, Cleveland, OH
Sara West, MD, Cleveland, OH

PANEL | 10:00AM - 12:00PM | **SALON 1-3**

S3 Towards a National Institute of Forensic Science?
Research Committee

Suzanne Yang, MD, Pittsburg, PA
Alan Felthous, MD, St. Louis, MO
Robert Trestman, PhD, MD, Farmington, CT
John Young, MD, MTh, New Haven, CT

PANEL | 10:00AM - 12:00PM | **SALON 11-12**

S4 Lies, Psychopathy and More: fMRI Goes to Court

Lynn Maskel, MD, San Diego, CA
Kent Kiehl, PhD, (I) Albuquerque, NM
David Faigman, MA, JD, (I) San Francisco, CA
James Corcoran, MD, Downers Grove, IL

WORKSHOP | 10:00AM - 12:00PM | **SALON 8-10**

S5 Current Issues in Punishing Adolescents
Child and Adolescent Psychiatry Committee

ARS

Peter Ash, MD, Atlanta, GA
Eraka Bath, MD, Los Angeles, CA
Stephen Billick, MD, New York, NY
Roy O'Shaughnessy, MD, Vancouver, BC, Canada
Fabian Saleh, MD, Boston, MA

RESEARCH IN PROGRESS #3 | 10:00AM - 12:00PM | **SALON 4/5**

S6 Relevance of Actuarial Assessment for Mental Health Commitment

Douglas Mossman, MD, Cincinnati, OH
Allison Schwartz, JD, (I) Laconia, NH

S7 After Commitment of Sexual Predators: A Survey of States

Joseph Smith, MD, (I) New Haven, CT
Madelon Baranoski, PhD, (I) New Haven , CT
Reena Kapoor, MD, New Haven, CT

S8 A Global Assessment of Functioning Scale for Corrections
Research Committee

Robert Trestman, PhD, MD, Farmington, CT

LUNCH (TICKET REQUIRED) | 12 NOON - 2:00PM | **SALON 7**

S9 Reevaluating Juvenile Culpability and Evolving Standards of Decency

Bryan Stevenson, Esq., (I) Montgomery, AL

ISAAC RAY LECTURE — 2:15PM - 4:00PM — **SALON 6**

S10 Identity, Representation, and Oral Performance in Forensic Psychiatry

Ezra Griffith, MD, New Haven, CT
Discussant: Gwen Adshead, MBBS, Berks, United Kingdom

COURSE (TICKET REQUIRED) — 2:15PM - 6:15PM — **SALON 1-3**

S11 Psychological Testing for Forensic Psychiatrists

William Campbell, MD, Seattle, WA
Madelon Baranoski, PhD, (I) New Haven, CT

WORKSHOP — 2:15PM - 4:00PM — **SALON 11-12**

S12 Technology and Changing Standards of Care

ARS

Delaney Smith, MD, Columbus, OH
Cathleen Cerny, MD, Cleveland, OH
Susan Hatters Friedman, MD, Cleveland, OH
Sherif Soliman, MD, Cleveland, OH

WORKSHOP — 2:15PM - 4:00PM — **SALON 8-10**

S13 Neurotoxin Exposure in Forensic Assessment
Forensic Neuropsychiatry Committee

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

PANEL — 2:15PM - 4:00PM — **SALON 4/5**

S14 New Approaches to Risk Assessment: UK and US Perspectives
International Relations Committee

Kenneth Busch, MD, Chicago, IL
Frank Farnham, MRCPsych, Enfield, United Kingdom
David James, FRCPsych, (I) London, United Kingdom
Anthony Maden, FRCPsych, (I) London, United Kingdom

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

DEBATE — 4:15PM - 6:15PM — **SALON 6**

S15 Stirring the DSM-5 Cauldron
Sexual Offenders Committee

Lynn Maskel, MD, San Diego, CA
John Bradford, MB, Ottawa, ON, Canada
Douglas Tucker, MD, San Francisco, CA
Richard Krueger, MD, New York, NY
David Thornton, PhD, (I) Mauston, WI
Thomas Zander, PsyD, JD, (I) Milwaukee, WI
Karen Franklin, PhD, (I) San Francisco, CA

WORKSHOP — 4:15PM - 6:15PM — **SALON 11-12**

S16 God's Law, Man's Law, and the Meaning of M'Naughten Wrongfulness

Sherif Soliman, MD, Cleveland, OH
John Fabian, PsyD, JD, (I) Cleveland, OH
Susan Hatters Friedman, MD, Cleveland, OH
Phillip Resnick, MD, Cleveland, OH

WORKSHOP — 4:15PM - 6:15PM — **SALON 8-10**

S17 Inquiring Minds Want to Know: Privacy in Forensic Psychiatry

ARS

Patricia Recupero, MD, JD, Providence, RI
Paul Christopher, MD, Providence, RI
Brian Daly, MD, Providence, RI
Marilyn Price, MD, CM, Cambridge, MA

RESEARCH IN PROGRESS #4 4:15PM - 6:15PM **SALON 4/5**

S18 Toward a Model Curriculum for Teaching Forensic Psychiatry to General Psychiatry Residents
Research Committee

Philip Pan, MD, Springfield, IL
Manisha Punwani, MD, Springfield, IL

S19 Strength-Based Assessments of Violence Risk using the START: Early Encouraging Results

Johann Brink, MB,ChB, FRCPC, Vancouver, BC, Canada
Sarah Desmarais, PhD, (I) Tampa, FL
Tonia Nicholls, PhD, (I) Vancouver, BC, Canada

S20 The Utility of the COVR as a Screening Tool for Institutional Aggression

Barbara McDermott, PhD, (I) Sacramento, CA
Isah Dualan, MS, (I) Sacramento, CA
Tony Rabin, PhD, (I) Napa, CA
Diane Rackliffe, PhD, (I) Napa, CA
Chad Woofter, MD, Napa, CA

S21 Development of a Brief Violence Risk Screening Tool

Michael Greenspan, MD, Bronx, NY
Ali Khadivi, PhD, (I) Bronx, NY
Li-Wen Lee, MD, New York, NY
Barry Rosenfeld, PhD, (I) Bronx, NY
Merrill Rotter, MD, Bronx, NY

S1 ILLEGAL ALIENS IN THE TWILIGHT ZONE OF SB1070

Barry Morenz, MD, Tucson, AZ
Scott McNamara, Esq., (I) Tucson, AZ

EDUCATIONAL OBJECTIVE
Become familiar with the legal dilemmas and paradoxes for illegal aliens from a forensic psychiatric perspective.

SUMMARY
It is estimated that there are 12 million illegal aliens living and working in the United States. Many of the employers in the United States are dependent on these individuals to supply needed labor, especially agricultural labor. Yet, with the poor economy there has been a growing hostility towards illegal aliens. SB1070, as it is referred to in Arizona, was a law passed that would require police to certify the legality of people they have reason to suspect might be illegal aliens. This law has been challenged by the Obama administration; its implementation stayed by a federal judge, and is now awaiting further legal review. It is thus unclear how the law will function if implemented. However, there is a surprising amount of pressure from the public to allow the law to be implemented while legal review is pending. Psychiatrists and psychologists in southern Arizona are routinely asked to complete Competence to Stand Trial and other forensic evaluations on individuals who are in this country illegally. A not uncommon scenario is that of a young man who was born in Mexico but brought by his family to the United States when he was still a young child, educated in the United States and may not even speak Spanish, who then commits a minor crime and is deported for being in the country illegally. When he tries to return because he has no family or means of support in Mexico, he is arrested for illegal re-entry and faces years in federal prison. SB1070 presents the specter of police being provided the power and mandate to identify any individual with suspicions of being here illegally and arresting them if they cannot prove their citizenship, which would likely lead to many more deportation cases. This presentation will discuss the dilemmas posed by these kinds of cases from the point of view of a forensic psychiatrist and from the point of view of an attorney who routinely represents such individuals. Audience discussion will be encouraged.

REFERENCES
Archibold, R: Arizona Enacts Stringent Law on Immigration
New York Times, April 23, 2010
Finnegan, W: Borderlines, New Yorker, July 26,2010

SELF ASSESSMENT QUESTIONS
1. What is the estimated number of people living in this country illegally?
a. 200,000
b. 5,000
c. 25 million
d. 12 million
ANSWER: d

2. In 2009 the number of people caught at or near the Arizona border attempting to cross into the country illegally, who are then returned immediately to Mexico, is approximately:
a. 2,500
b. 25,000
c. 250,000
d. 2.5 million
ANSWER: b

S2 DR. KREIZLER TO HANNIBAL: FORENSIC PSYCHIATRISTS IN FICTION

Cathleen Cerny, MD, Cleveland, OH
Susan Hatters Friedman, MD, Cleveland, OH
Sherif Soliman, MD, Cleveland, OH
Sara West, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE
Using fictional psychiatrist examples from film, TV and audiobooks, we will teach how popular culture impacts public perception of our field. Public perception can strongly influence political opinion which, in turn, has implications for public policy. Public perception of forensic psychiatry also can influence jury decisions.

SATURDAY

SUMMARY
Fiction in all its forms abounds with examples of forensic psychiatrists. From The Alienist's wise and empathic Dr. Laszlo Kreizler to the cunning and diabolical Dr. Hannibal Lector, the public has been provided with a variety of vivid characters to mold their perceptions of our work. This presentation will start by exploring how psychiatrists, in general, have been portrayed in the mediums of popular culture. We will discuss the work of psychiatrist film scholars such as Glenn Gabbard and Irving Schneider. Next, we will narrow our focus to the field of forensic psychiatry and discuss fictional depictions of psychiatric experts. Numerous examples will be used to highlight the ways in which forensic experts have been criticized. We will link our fictional examples to public perception of forensic psychiatry. Finally, we will discuss how public perception influences political opinion, public policy and jury decision-making. All of these objectives will be accomplished utilizing film, TV and audiobook clips.

REFERENCES
Gabbard G: The cinematic psychiatrist. Psychiatric Times, 14(7):1, 1999 http://www.psychiatrictimes.com/display/article/10168/50141?pageNumber=1
Resnick P: Perceptions of psychiatric testimony: a historical perspective on the hysterical invective. Bull Am Acad Psychiatry Law 14(3):203-219, 1986

SELF ASSESSMENT QUESTIONS
1. Please list at least three cinematic stereotypes as described by Glen O. Gabbard and Krin Gabbard in their book, "Psychiatry and the Cinema, Second Edition" (American Psychiatric Press 1999). Alternately, name Dr. Irving Schneider's three categories of movie psychiatrists.

ANSWER: Gabbard and Gabbard (1999): Faceless—Leaving Las Vegas, The Lonely Guy; Active—Ordinary People; Oracular—Psycho; Social Agent—One Flew Over the Cuckoo's Nest; Eccentric—The Snake Pit; Emotional—Agnes of God; Sexual—Spell Bound, Lovesick, Prince of Tides. Irving Schneider (1987): Dr. Dippy–Dr. Dippy's Sanitarium, What's New Pussycat?; Dr. Evil–Silence of the Lambs, Dressed to Kill; Dr. Wonderful–Ordinary People, Good Will Hunting.

2. Please list at least three criticisms of psychiatrists/psychologists providing expert testimony.

ANSWER: Excusers of wrong-doing; give confusing, subjective, jargon-filled testimony; dictate the law; guns for hire; never agree; give conclusory opinions.

S3 **TOWARDS A NATIONAL INSTITUTE OF FORENSIC SCIENCE?**

Suzanne Yang, MD, Pittsburgh, PA
Alan Felthous, MD, St. Louis, MO
Robert Trestman, PhD, MD, Farmington, CT
John Young, MD, MTh, New Haven, CT

EDUCATIONAL OBJECTIVE
Participants will learn about recent recommendations made by the National Academy of Sciences for improving the quality of scientific testimony in legal proceedings, and implications for the practice of forensic psychiatry. Participants will understand issues that are unique to psychiatry, as well as those shared with other disciplines.

SUMMARY
In February 2009, the National Academy of Sciences published recommendations for improvement in the validity and reliability of forensic evidence presented in legal proceedings. Although behavioral sciences were not specifically addressed in the report, guidelines for the assessment of scientific rigor in testimony will likely have an impact on the practice of forensic psychiatry. We present an overview of these recommendations, with a focus on the proposed creation of a National Institute of Forensic Science. We outline the intended purposes of such an institute and the regulatory function that it may have through the establishment of guidelines for expert testimony and for interpretation of evidence in an adversarial setting. We then situate psychiatry within the broader scope of forensic sciences, highlighting features that psychiatry has in common with other disciplines. We discuss points of divergence and unique characteristics of psychiatry, such as involvement principally during the trial phase rather than in the apprehension of criminals. Benefits and pitfalls of including psychiatry and the behavioral sciences within consensus guidelines for best practices will be examined. The proposed role of a National Institute of Forensic Science in setting a research agenda will also be addressed.

REFERENCES
National Research Council, Committee on Identifying the Needs of the Forensic Sciences Community: Strengthening Forensic Science in the United States: A Path Forward. Washington DC: The National Academies Press, 2009. Executive Summary at http://www.nap.edu/catalog.php?record_id=12589, accessed February 27, 2010
Faigman DL, Monahan J: Psychological evidence at the dawn of the law's scientific age. Ann Rev Psychol 56:631-59, 2005

SELF ASSESSMENT QUESTIONS

1. Which of the following reasons underlie the recommendation to create a National Institute of Forensic Science?
a. Forensic sciences share a common goal of striving for optimal validity and reliability of findings.
b. Forensic sciences include many different disciplines and there is a need to unify the field through consensus guidelines for best practices.
c. There is a need for an institutional structure with strong ties to the scientific community as well as to state and local forensic entities.
d. There is a need for an independent body that is not tied to law enforcement agencies.
e. All of the above.
ANSWER: e

2. Which of the following distinguishes psychiatry from other forensic disciplines?
a. Psychiatric evidence has an unknown error rate.
b. Test-retest reliability is not relevant in psychiatric evaluations.
c. The object of inquiry in psychiatric evaluation is dynamically malleable and accessible primarily through the evaluee's self-report.
d. There are no reliable methods for applying information obtained from aggregate data to the individual case.
ANSWER: c

S4 LIES, PSYCHOPATHIC LIARS AND MORE: FMRI GOES TO COURT

Lynn Maskel, MD, San Diego, CA
Kent Kiehl, PhD, (I) Albuquerque, NM
David Faigman, MA, JD, (I) San Francisco, CA
James Corcoran, MD, Downers Grove, IL

EDUCATIONAL OBJECTIVE

To examine how technological advances in the form of fMRI may contribute to several areas of criminal and civil legal matters including lie detection, psychopathy and beyond; and to understand how Frye and Daubert concerns affect the acceptance of testimony, now and as the science progresses.

SUMMARY

Cutting edge technology, the fMRI, is being considered for use in a range of types of court cases Just this year has seen preparation for potential submission of fMRI results regarding lie detection in a San Diego Dependency Court case (although ultimately testimony was not offered). The Dugan case in Illinois had a courtroom first, using fMRI testimony in November 2009 to help establish psychopathy as a mitigation factor in a death penalty case. Dr. Kiehl will talk about paralimbic abnormalities in criminal psychopaths as indexed by abnormal fMRI results. Dr Kiehl will discuss how this latter research has been used in death penalty mitigation such as the Dugan case in which he testified. Professor David Faigman will outline the basic standards of admissibility that apply to fMRI evidence in court, both state and federal, and consider the likely prospects for this new technology in a variety of settings. Some substantive areas he will consider include lie detection, and habeas petitions involving claims of wrongful conviction in sentencing (both ordinary and capital cases) and in civil commitment. Moreover, Professor Faigman will consider challenges involved in validating general population-based research on brain imaging and its use in individual cases in court.

REFERENCES

Kiehl KA: A cognitive neuroscience perspective on psychopathy: evidence for paralimbic system dysfunction. Psychiatry Research 142:107-128, 2006
Kiehl KA, Bates AT, Laurens KR, Hare RD, Liddle PF: Brain potentials implicate temporal lobe abnormalities in criminal psychopaths. J Abnormal Psychology 115:443-453, 2006

SELF ASSESSMENT QUESTIONS

1. The use of fMRI in legal matters, as the science develops, may include:
a. civil commitment including sexually violent predators
b. death penalty and other mitigation matters
c. wrongful conviction habeas corpus
d. lie detection
e. all of the above
ANSWER: e

2. The Dugan case resulted in:
a. a positive outcome for the defense, resulting in life imprisonment as opposed to death
b. a new precedent and standard for death penalty cases throughout the country
c. admission of fMRI evidence and testimony, which is potentially easier due to the nature of the case (as opposed to criminal trials to establish guilt)
d. establishing that the defendant gave a false confession when he admitted to the sexual homicide of a 10-year-old girl
ANSWER: c

S5 CURRENT ISSUES IN PUNISHING ADOLESCENTS

Peter Ash, MD, Atlanta, GA
Eraka Bath, MD, Los Angeles, CA
Stephen Billick, MD, New York, NY
Roy O'Shaughnessy, MD, Vancouver, BC, Canada
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
To update forensic psychiatrists who consult on the issues related to the disposition of juvenile offenders on factors that are changing the landscape in juvenile punishment.

SUMMARY
In deciding on procedures and punishment for adolescents, the legal system weighs a variety of factors, including possibilities of rehabilitation, degree of adolescent culpability, protection of society, and just retribution, when it decides procedures (e.g., juvenile vs. adult court) and punishment. With changing crime rates, increased knowledge of adolescent functioning, and improving treatments, these factors change, leading both to general shifts in how classes of adolescents are treated, as well as to how case-specific data is used in the disposition of individual cases. The panel will explore aspects of these changes, focusing on the nature of the change and considerations that an evaluating forensic psychiatrist might wish to consider addressing in a report. Dr. Ash will provide an overview and discussion of the recent U.S. Supreme Court holdings in adolescent life without parole cases (Graham v. Florida and Sullivan v. Florida). Dr. Bath will discuss juvenile mental health courts. Dr. Saleh will discuss ethics and shortcomings of sex offender treatment in juvenile facilities in the context of how such treatment affects dispositions of such youth when they turn 18. Dr. Billick will discuss alternative sentencing. Dr. O'Shaugnessy will provide a perspective on changes in juvenile punishment in Canada.

REFERENCES
Graham v. Florida, 560 U.S. __ (2010)
National Center for Mental Health and Juvenile Justice: Juvenile Mental Health Courts: Program Descriptions: Processes and Procedures. Delmar, NY: Author, 2005

SELF ASSESSMENT QUESTIONS
1. In the debate over severe penalties for adolescents (death, life without parole), other than age, what are the characteristics of adolescents that are emphasized as distinguishing them from adults?
ANSWER: Decreased culpability and impulsivity

2. All of the following are true statements, except:
a. Juvenile sex offenders have been identified as responsible for approximately 25% of sexual assaults.
b. Recidivism rates are lower for sexual crimes than nonsexual crimes.
c. Some states allow for juveniles to be committed under their SVP statutes.
d. There is a high incidence of ADHD among juvenile sex offenders.
e. Antiandrogens are contraindicated in the treatment of juvenile sex offenders.
ANSWER: e

S6 RELEVANCE OF ACTUARIAL ASSESSMENT FOR MENTAL HEALTH COMMITMENT

Douglas Mossman, MD, Cincinnati, OH
Allison Schwartz, JD, (I) Laconia, NH

EDUCATIONAL OBJECTIVE
After this presentation, attendees will: describe the meaning and significance of the "overt act" requirement in civil commitment law; report one or more possible candidate instruments for civil commitment risk assessment; and explain why data from risk assessment instruments may not suffice for purposes of mental health commitments.

SUMMARY
Determining eligibility for involuntary mental health commitment seems like an appropriate, natural, obvious application of actuarial risk assessment instruments (ARAIs). ARAIs such as the STATIC-99 have become popular, legally recognized tools in decision-making about sex offender commitments where (as with mental health commitment) social policy ostensibly aims to protect the public from harmful acts by persons with mental abnormalities. All evidence suggests actuarial judgment is superior to other ways of assessing the risk of future violence. Recently, some authors have suggested that only by incorporating findings from ARAIs can mental health experts provide evidence-based testimony in commitment hearings. Yet for historical reasons, mental health commitment law in many jurisdictions actually precludes using possible future behavior as the sole basis for ordering hospitalization, because case law or statutes require clear and convincing evidence showing that a respondent actually did something—committed an "overt act"— that caused or could have led to harm. Our research describes which and how many jurisdictions might allow mental health experts to use ARAIs as the primary evidence supporting a respondent's eligibility for involuntary psychiatric hospitalization. The results have clear implications for the potential relevance of ARAIs in mental health commitment proceedings.

REFERENCES
Scurich N, John RS: The normative threshold for psychiatric civil commitment. Jurimetrics J (in press)
Monahan J, Steadman HJ, Robbins PC, et al: An actuarial model of violence risk assessment for persons with mental disorders. Psychiatr Serv 56:810-815, 2005

SELF ASSESSMENT QUESTIONS
1. In U.S. jurisdictions that require "overt acts" as proof of dangerousness for purposes of civil commitment, which two of the following items would typically not satisfy this requirement?
a. telling your mother that you plan to kill yourself
b. scoring in the "high" risk category on a risk assessment instrument
c. spending hours outdoors in frigid weather wearing only your T-shirt
d. going to a public park every day for weeks, talking incoherently to everyone there
e. yelling menacingly at a neighbor while holding a gun in your hand
f. b and d
ANSWER: f

2. For the most part, scientific evidence supporting accuracy of actuarial methods to assess risk of violence to others utilizes follow-up periods of:
a. 3 to 7 days
b. 2 to 4 weeks
c. 1 to 2 months
d. up to 4 months
e. several months or years
ANSWER: e

S7 **AFTER COMMITMENT OF SEXUAL PREDATORS: A SURVEY OF STATES**

Joseph Smith, MD, (I) New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Reena Kapoor, MD, New Haven, CT

EDUCATIONAL OBJECTIVE
At the completion of this presentation the participant will understand the various patterns of commitment and release enacted by the states in response to the sexual predator statutes and will learn the benefit of survey research and tracking on policy and legislative initiatives.

SUMMARY
Sexual predator laws in many states were designed as a means of protecting the public in response to predatory and violent sexual crimes. The laws, however well intentioned, usually lack specific plans for long-term resolution of persons who fit the profile of sexual predators. The pragmatic fulfillment of the law usually falls to state mental health agencies that must manage long-term confinement without efficient and effective treatment modalities. This survey of states and the federal system was designed to identify the number of persons confined, length of confinement, release assessments and policy, post release follow-up and care, and diagnostic profiles for persons who are committed under sexual predator laws and civil commitment. The research methodology, barriers to data collections, and the gaps in monitoring and record-keeping will also be presented along with plans for further investigation and suggestions for universal and confidential tracking and reporting mechanisms.

REFERENCES

Buckland JJ, Frierson RL: Constitutionality of the Federal Sex-Offender Commitment Law: indefinite civil commitment of sex-offenders by the federal government found unconstitutional. J Am Acad Psychiatry Law 37(4):556-558, 2009

Janus ES, Prentky, RA: Sexual predator laws a two-decade retrospective. Federal Sentencing Reporter 21(2):90-97, December 2008. DOI 10.1525/fsr.2008.21.2.90 Posted online on March 6, 2009. (doi:10.1525/fsr.2008.21.2.90)

SELF ASSESSMENT QUESTIONS

1. Sexual predator laws:
a. Allow sex offenders with mental illness to be diverted from the criminal justice system.
b. Are increasing in number across the states because of the generation of effective treatment protocols for sexual disorders.
c. Result in confinement post sentence usually in psychiatric facilities.
d. Have been determined to be unconstitutional under the Hendricks decision.
ANSWER: c

2. The burden for mental health systems from sexual predator legislation comes from:
a. The lack of effective treatment modalities for sexual deviance.
b. Zero-risk demand in release decisions.
c. Lack of fit with other patients committed long term.
d. Lack of options for after care.
e. All of the above
ANSWER: e

S8 A GLOBAL ASSESSMENT OF FUNCTIONING SCALE FOR CORRECTIONS

Robert Trestman, PhD, MD, Farmington, CT

EDUCATIONAL OBJECTIVE

Participants will describe a process for developing instruments for use in correctional settings. (IRB processes; literature review; consensus building; focus group methods; data reduction; validation) and will visualize the three domains and their role in assessing prisoner functioning (habitation/behavioral domain; social domain; symptom domain).

SUMMARY

This presentation provides outcomes of the first phase of a study conducted to refine a newly modified assessment tool, the Corrections Modified-Global Assessment of Functioning (CM-GAF) as a standardized tool for monitoring behavior and functioning of offenders in prison. The development of the CM-GAF, funded by NIMH (#5R24-MH67030-04) has implications for the safety and security of inmates and correctional staff during periods of incarceration and for post-release treatment planning. Methods: Four focus groups were conducted with 36 correctional and clinical staff to determine how they perceived the CM-GAF ratings as representative of safe male and female inmate behavior within prison settings. Findings: The CM-GAF is divided into three domains: habitation/behavioral, social, and symptoms; divided across the 10 incremental levels of functioning. Gender differences emerged in the discussions of cleanliness, relationships, and coping strategies. The functional cutoff score is lower than would be found on the community comparison score and is attributed to the effect of the structure of the correctional environment. Conclusions: The high structure of the environment alters the capability of the inmate's functioning. The limited activity available within the prison supports offender function/participation, shifting the descriptors lower on the scale.

REFERENCES

American Psychiatric Association: DSM-IV-TR. Washington, DC: American Psychiatric Association, 2002

Bates L, Lyons J, Shaw JB: Effects of brief training on application of the Global Assessment of Functioning Scale. Psychol Reports 91:999-1006, 2002. Journal Citation

SELF ASSESSMENT QUESTIONS

1. The current Global Assessment of Functioning:
a. is well suited to correctional settings
b. has been validated for use in jails
c. is not well suited for use in jails or prisons
d. is never used in jails or prisons
ANSWER: c

2. Adapting the GAF for correctional use requires:
a. focus group involvement
b. multidisciplinary input, including custodial perspectives
c. new anchoring for corrections-specific functional domains
d. testing for validity and reliability
e. all of the above
ANSWER: e

S9 **REEVALUATING JUVENILE CULPABILITY AND EVOLVING STANDARDS OF DECENCY**

Bryan Stevenson, Esq., (I) Montgomery, AL

EDUCATIONAL OBJECTIVE
To provide a broader context for the extremely harsh sentencing of children arrested for crimes in the U.S. that has increased dramatically over the last 30 years and resulted in hundreds of kids now being sentenced to death in prison. Additionally, to analyze the legal and medical implications of these developments.

SUMMARY
Mass incarceration and the politics of fear and anger surrounding crime have fueled inaccurate predictions about juvenile delinquency, and some degree of hysteria has resulted in unprecedented levels of adult prosecution of children over the last 20 years. The consequence has resulted in extremely harsh, punitive sentences for juveniles, including a great deal of mandatory sentencing that does not permit a sentencer to consider the age of the offender. These developments have been aggravated by race and class which also play a role in evaluations of the potential for rehabilitation of kids. During the same period, adolescent experts have made great progress in documenting the neurological, developmental and behavioral differences between kids and adults that could be highly relevant when it comes to assessing the criminal culpability of children and what constitutes appropriate punishment. Constitutional theory has recently incorporated psychological and psychiatric science to create new ways of thinking about legal punishments for kids and resulted in a landmark ruling banning life imprisonment without parole for juveniles convicted of most crimes. The implications of this ruling and the broader advocacy associated with this issue have important implications for practitioners and experts who work with children or the criminal justice system.

REFERENCES
Brief for the American Psychological Association, the American Psychiatric Association, National Association of Social Workers, Mental Health America as Amicus Curiae in Support of Petitioners, Graham v. Florida, No. 08-7412 (July 2009) at http://eji.org/eji/files/APA%20Amicus.pdf.
Graham v. Florida, 130 S.Ct. 2011 (2010).

SELF ASSESSMENT QUESTIONS
1. Which country has refused to sign the International Covenant on the Rights of the Child because it prohibits the death penalty and life sentences imposed on children?
a. Saudi Arabia
b. China
c. North Korea
d. United States
e. All of the Above
ANSWER: d

2. What percentage of children under the age of 14 who have been sentenced to death in prison in the United States for non-homicides are African American or Latino?
a. 100 percent
b. 75 percent
c. 50 percent
d. 25 percent
ANSWER: a

S10 IDENTITY, REPRESENTATION, AND ORAL PERFORMANCE IN FORENSIC PSYCHIATRY

Ezra Griffith, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

To aid forensic psychiatrists in appreciating the significance of oral and written performance in their daily work; and to clarify the elements that characterize the construction of oral narrative in forensic psychiatry.

SUMMARY

Recently there has been renewed emphasis placed on the notion that polished written and oral skills are fundamental to successful execution of the forensic psychiatrist's work. The primary exemplar of forensic written work is generally acknowledged to be the written report. A number of authors have characterized the structure of the written report and have included consideration of the roles played by narrative, ethics, and other elements. This has transformed the written report into an exercise in performative writing. The present work builds on the earlier preoccupation with written performance and focuses attention on the activity of oral performance in forensic psychiatry. There will first be a review of some of the earlier conceptualizations of the use of the spoken word in forensic psychiatry, noting that such work has been hampered by hesitancy in considering the performative dimensions of the psychiatrist's verbal activity. It will also be pointed out that there is unrecognized influence of the processes of identity formation and representation on the phenomenon of oral performance. Clarifying and emphasizing these elements should help in translating and explicating to the trainee practitioner the significance of oral performance in the work of the forensic psychiatrist.

REFERENCES

Griffith EEH, Stankovic A, Baranoski B: Conceptualizing the forensic psychiatry report as performative narrative. J Am Acad Psychiatry Law 38:32-42, 2010

Scheub H: Body and image in oral narrative performance. New Literary History 8:345-367, 1977

SELF ASSESSMENT QUESTIONS

1.What is "labeling" in the context of narrative?
ANSWER: It is the process of finding a way to describe the central theme of a story.

2.May the forensic professional be said to stand outside of the narrative he creates?
ANSWER: No. He is a participant in the process, bearing witness himself, and working to persuade others of the soundness of the story he is creating.

S11 PSYCHOLOGICAL TESTING FOR FORENSIC PSYCHIATRISTS

William Campbell, MD, Seattle, WA
Madelon Baranoski, PhD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE

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

SUMMARY

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

REFERENCES

Melton GB, Petrila J, Poythress NG, Slobogin C: Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers, 3rd Edition. New York: The Guilford Press, 2007

Strauss E, Sherman EMS, Spreen O: A Compendium of Neuropsychological Tests: Administration, Norms, and Commentary, 3rd Edition. New York: Oxford University Press, 2006

SELF ASSESSMENT QUESTIONS

1. In the assessment of intelligence, which statement is true?
a. Intelligence tests are based on the assumption that intellectual abilities are distributed normally.
b. The Stanford-Binet test is the most widely used intelligence test.
c. The IQ is a measure of future potential.
d. The highest divisor in the IQ formula is 25.
ANSWER: a

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

S12 TECHNOLOGY AND CHANGING STANDARDS OF CARE

Delaney Smith, MD, Columbus, OH
Cathleen Cerny, MD, Cleveland, OH
Susan Hatters Friedman, MD, Cleveland, OH
Sherif Soliman, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

By reviewing the impact of technology on the practice of medicine and the standard of care, psychiatrists will gain a better appreciation of the clinical, ethical and malpractice implications of these advances. Electronic medical records, prescription reporting services, and drug interaction tools will be discussed along with other medical technologies.

SUMMARY

While the medical field in general has been quick to adopt technological advances, psychiatrists have not had as many opportunities to do so as our more procedurally-based colleagues. Recently, with the widespread use of electronic medical records and prescriptions, online literature reviews and drug interaction tools, prescription reporting services, telemedicine and e-medicine, psychiatrists have moved to the technological forefront of medicine. Each new technology brings with it new opportunities for abuse, misuse, or failure to use, as well as, the associated malpractice risk. We will briefly discuss the ways in which these technologies can improve psychiatric care, with a particular focus on forensic psychiatry, and the possible pitfalls associated with them. We will consider at what point these advances become the standard of care. Attention will be given to concerns that some courts have expected adoption of those technologies which, while not used by most psychiatrists, are cheap, easy, and would improve outcomes as in the frequently cited tugboat case, The T.J. Hooper, 60 F.2d 737 (2nd cir. 1932).

REFERENCES

Hanfer AW, Filipowicz AB, Whitely WP: Computers in medicine: liability issues for physicians. Int J Clin Monit Comput 6(3):185-194, 1989
Miller TW, Clark JC, Veltkamp LJ, Burton DC, Swope M: Teleconferencing model for forensic consultation, court testimony, and continuing education. Behav Sci Law 26:301-313, 2008

SELF ASSESSMENT QUESTIONS

1. The Federation of State Medical Boards identified each of the following as a component of appropriate use of the internet by medical practitioners in their 2002 report, except which?
a. Physicians have an obligation to prevent unauthorized access to personal patient information.
b. Patients should be made aware of non-email means to contact the physician in an emergency.
c. While informed consent is required for delivery of medical services via the internet, it is less stringent due to the lack of face-to-face interaction.
d. Turnaround time should be established for patient-physician e-mails.
e. Physicians must possess the appropriate licensure for telemedicine for the jurisdiction where they practice.
ANSWER: c

2. Which of the following new technologies are possible focuses of malpractice cases?
a. Not using electronic prescriptions.
b. Failure to review electronic medical records with appropriate regularity.
c. Lack of review of medication interactions in an online database.
d. Inappropriate template used in a patient's record.
e. All of the above.
ANSWER: e

S13 NEUROTOXIN EXPOSURE IN FORENSIC ASSESSMENT

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

EDUCATIONAL OBJECTIVE
To explore how claimed neurotoxin exposure can be evaluated and presented in legal cases through the illustration of several case examples.

SUMMARY
Several case examples will be presented for neurotoxin exposure in civil and criminal legal proceedings including: carbon monoxide, lead, toluene diisocyanate and mefloquine. Information on how to evaluate potential neurotoxins with ATSDR data on chemicals and MSDS sheets will also be presented.

REFERENCES
Allport DC, et al.(editors): MDI and TDI: Safety, Health and the Environment. Manchester, UK: Wiley, 2003
Schlagenhauf P, et al: Tolerability of malaria chemoprophylaxis in non-immune travellers to sub-Saharan Africa: multicentre, randomised, double blind, four arm study. BMJ 327(7423):1078, November 8, 2003

SELF ASSESSMENT QUESTIONS
1. Which test modality is most specific for the cognitive effects of neurotoxins?
a. Structural neuroimaging
b. Neuropsychological testing
c. EEG
d. PET Scan
e. Clinical Exam
ANSWER: b

2. Effects from neurotoxin exposure are usually most pronounced:
a. Immediately after the exposure.
b. 1-4 weeks after exposure
c. 6-12 months after exposure
d. At variable intervals depending on the mechanism of action
e. Consistently and permanently
ANSWER: d

S14 NEW APPROACHES TO RISK ASSESSMENT: UK AND US PERSPECTIVES

Kenneth Busch, MD, Chicago, IL
Frank Farnham, MRCPsych, Enfield, United Kingdom
David James, FRCPsych, (I) London, United Kingdom
Anthony Maden, FRCPsych, (I) London, United Kingdom

EDUCATIONAL OBJECTIVE
To learn about risk assessment tools for stalking and public threat assessment; to learn about risk assessment of offenders with dangerous and severe personality disorders; and to learn about risk factors in the assessment for youth violence.

SUMMARY
Assessing and managing the risk of violence is a core task of forensic psychiatrists working in the criminal justice system in the UK and US. New approaches and research studies determine that the field is changing rapidly. This panel will address specific areas of violence risk assessment: 1) The Stalking Risk Profile: an introduction to the new stalking tool

from Australia/UK. This is a manualized instrument based on a structured professional judgment model. It is constructed around the realization that risk factors vary according to domain of risk and underlying motivation. 2) The convergence of the fields of stalking and public figure threat assessment. Research results from the UK Fixated Research Group are used to highlight emerging evidence of the substantial overlap between the two fields in terms of factors associated with different forms of adverse outcome. 3) New assessment tools to identify those individuals in the UK with dangerous and severe personality disorders. These offenders require specialized treatment programs based on the risk assessment for violence. 4) New research studies for the assessment of risk factors in the US for youth violence.

REFERENCES

Zagar RJ, Busch KG, Grove WM, Hughes JR, Arbit J: Looking forward and backward in records for risks among homicidal youth. Psychological Reports 104:103-127, 2009
MacKenzie RD, McEwan TE, Pathé MT, James DV, Ogloff JRP, Mullen PE: The Stalking Risk Profile: guidelines for the assessment and management of stalkers. Melbourne: Stalking. & Centre for Forensic Behavioural Science, 2009, pp.88

SELF ASSESSMENT QUESTIONS

1. Which of the following factors is associated with an increased risk of violence in stalking?
a. delusions of love in women
b. age of 30
c. suicidal ideation
d. text messaging
ANSWER: c

2. Which of the following risk factors are important in the assessment of youth violence?
a. alcohol and drugs
b. participating in bullying
c. poor behavioral control
d. all of the above
ANSWER: d

S15 STIRRING THE DSM-5 CAULDRON

Lynn Maskel, MD, San Diego, CA
John Bradford, MB, Ottawa, ON, Canada
Douglas Tucker, MD, San Francisco, CA
Richard Krueger, MD, New York, NY
David Thornton, PhD, (I) Milwaukee, WI
Karen Franklin, PhD, (I) San Francisco, CA

EDUCATIONAL OBJECTIVE

To understand the arguments for and against the proposed inclusion of Paraphilic Coercive Disorder, Pedohebephilic Disorder, Hebephilic Type and to a lesser extent, Hypersexual Disorder, in the DSM-5. This will include developing an understanding of the relevant potential implications specific to the forensic field.

SUMMARY

It was back in 1986 that a rape paraphilia diagnosis was batted around in aDSM-IV workgroup before it was given an early burial. Well, it's back now as Paraphilic Coercive Disorder and brought two companions to join it, Pedohebephilic Disorder, Hebephilic Type and Hypersexual Disorder. We have three AAPL psychiatrists and three psychologists prepared to vigorously debate the issue of whether to include each proposed diagnosis and expand the envelope or to hold the fort with what we already have in the DSM-IV. It should be a lively battle with well-armed experts (some are DSM-5 Workgroup members and consultants) championing each side. The pro team is Dr. Krueger, Dr. Tucker and Dr. Thornton. The con team will be Dr. Bradford, Dr. Zander and Dr. Franklin. The DSM-5 should be in field trials at this time and it is not too late to give your feedback to the DSM-5 Task Force. It is anticipated this could spark more peer-reviewed articles and other professional writings to catch the attention of DSM-5 before it is a done deal and the next revision would be literally years later as DSM-6. Stakes are high for the forensic community on these issues.

REFERENCES

Knight RA: Is a diagnostic category for paraphilic coercive disorder defensible? Arch Sex Behav. Nov 3, 2009 [Epub ahead of print]. DOI 10.1007/s10508-009-9571-x
Thornton D: Evidence regarding the need for a diagnostic category for a coercive paraphilia. Arch Sex Behav, 2009. MO DA [Epub ahead of print]. DOI 10.1007/s10508-009-9583-6

SELF ASSESSMENT QUESTIONS

1. Criticism of the proposed DSM-5 diagnosis of Paraphilic Coercive Disorder includes all except which of the following?
a. Many nonoffending men have fantasies about coercive sex.
b. Research shows most offenders who are phallometrically aroused by stimuli depicting non-consensual sex show such arousal when the stimuli depict particularly brutal and sadistic scenes that are suggestive of sexual sadism.
c. No rapists are ever aroused by the nonconsensual nature of rape.
d. There is insufficient research to support the premise that there is a distinct group of rapists who are specifically aroused by nonconsensual sexual activity but are not aroused by sexually sadistic stimuli.
ANSWER: c

2. Criticism of the proposed DSM-5 diagnosis of Pedohebephilic Disorder, Hebephilic Type includes all except which of the following?
a. The difficulties of diagnosing the condition would invite arbitrary, inconsisent, unreliable, and biased application.
b. The condition is too rare to warrant separate clinical attention.
c. A single research group has conducted all of the research and controls the journal in which the research has been published.
d. The validity of the condition has not been independently established.
ANSWER: b

S16 **GOD'S LAW, MAN'S LAW, AND THE MEANING OF M'NAUGHTEN WRONGFULNESS**

Sherif Soliman, MD, Cleveland, OH
John Fabian, PsyD, JD, (I) Cleveland, OH
Susan Hatters Friedman, MD, Cleveland, OH
Phillip Resnick, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

The audience will learn about different types of moral and legal wrongfulness as applied to the insanity defense. The audience will be able to apply these concepts to sanity assessments. The audience will have the opportunity to practice applying these concepts to a challenging double filicide case.

SUMMARY

The standard for defining wrongfulness in the insanity defense has been a topic of much controversy. States have differed in their recognition and definition of moral wrongfulness as part of the insanity defense. This presentation will discuss the different types of wrongfulness and illustrate each with examples. Dr. Soliman will begin by reviewing selected case law and brief vignettes illustrating the different types of moral and legal wrongfulness. Legal wrongfulness, subjective moral wrongfulness, and objective moral wrongfulness will be discussed. Selected state case law that has addressed wrongfulness standards will be reviewed. Dr. Hatters-Friedman will then discuss ways to apply different standards for wrongfulness to filicide cases. This will be followed by a question and answer session. Next, Dr. Fabian will present a double filicide case and portions of a recorded interview in the case. The audience will then have the opportunity to apply the concepts discussed by forming an opinion on the wrongfulness issue. The audience will be invited to discuss issues of moral and legal wrongfulness in this case example. Dr. Resnick will serve as the discussant for this case and will offer commentary on insanity defense evaluations with emphasis on filicide cases.

REFERENCES

Daniel M: M'Naughten's Case. St. Tr. N.S. 847, 1843
Goldstein RL: The psychiatrist's guide to right and wrong Part II: a systematic analysis of exculpatory delusions. Bull Am Acad Psychiatry Law 17(1):61-7, 1989

SELF ASSESSMENT QUESTIONS

1. Subjective moral wrongfulness is:
a. Society's view of the wrongfulness of an act
b. The actor's view of the wrongfulness of an act
c. Whether the act would be seen as a sin by most religions
d. Whether the act is a malum in se (inherently wrong)
ANSWER: b

2. In the M'Naughten case wrongfulness was defined as:
a. Subjective moral
b. Objective moral
c. a and b
d. None of the above
ANSWER: d

S17 INQUIRING MINDS WANT TO KNOW: PRIVACY IN FORENSIC PSYCHIATRY

Patricia Recupero, MD, JD, Providence, RI
Paul Christopher, MD, Providence, RI
Brian Daly, MD, Providence, RI
Marilyn Price, MD, CM, Cambridge, MA

EDUCATIONAL OBJECTIVE

At the conclusion of this workshop, participants should understand the legal and ethical privacy concerns related to storing DNA samples in criminal forensic databases, "Googling" evaluees or patients on the internet, conducting physical searches of patients in emergency settings, and performing psychiatric evaluations for civil litigation.

SUMMARY

In recent years the field of forensic psychiatry has seen rapid growth in the types of issues that raise ethical and legal concerns about patients' and evaluees' privacy. With the rise of the internet and forensic databases, there has been an exponential growth in the amount of personal data available and searchable at the click of a mouse. Dr. Recupero will discuss the legal and ethical implications of conducting internet searches of psychiatric patients and forensic evaluees, and Dr. Christopher will discuss privacy concerns and review several federal court cases relating to the collection, storing, retention, and use of genetic information from criminal forensic DNA databases. Dr. Daly will focus on cases (lawsuits) involving physical searches of patients in emergency settings and will discuss existing research concerning statistics of violence and weapon possession by patients, outlining the risk management and privacy implications of physical searches. Dr. Price will discuss privacy issues in the context of forensic psychiatric evaluations for civil litigation, particularly regarding "garden variety" distress claims in the context of sexual harassment litigation and similar cases. This workshop will identify the major legal and ethical concerns for forensic psychiatrists to consider regarding patients' and evaluees' privacy and risk management.

REFERENCES

Abril PS: Recasting privacy torts in a spaceless world. Harvard J Law Technology 21:1-47, 2007
Kaye DH: Who needs special needs? On the constitutionality of collecting DNA and other biometric data from arrestees. J Law Medicine Ethics 34(2):188-198, 2006

SELF ASSESSMENT QUESTIONS

1. Which of the following does NOT represent one of the four social values of privacy, as expressed by Alan Westin in the late 1960s:
a. Solitude
b. Intimacy
c. Security
d. Anonymity
e. Reserve
ANSWER: c

2. Which of the following groups are required to submit DNA samples for database storage in certain states?
a. Sex offenders
b. Felons
c. Some misdemeanants
d. Felon arrestees
e. a and b
f. All of the above
ANSWER: f

S18 **TOWARD A MODEL CURRICULUM FOR TEACHING FORENSIC PSYCHIATRY TO GENERAL PSYCHIATRY RESIDENTS**

Philip Pan, MD, Springfield, IL
Manisha Punwani, MD, Springfield, IL

EDUCATIONAL OBJECTIVE

To familiarize participants with the most current ACGME requirements for forensic psychiatry training in general psychiatry residency programs; to familiarize participants with topics in forensic psychiatry that should be covered in general psychiatry training; and to explore innovative educational methods for teaching forensic psychiatry, including problem-based learning.

SUMMARY

Previous Annual Meetings have included presentations describing the work of members of the American Academy of Psychiatry and the Law, working collaboratively with members of the American Association of Directors of Psychiatric Residency Training toward development of a model curriculum for teaching forensic psychiatry to general psychiatry residents. In this presentation, faculty from the Southern Illinois University Department of Psychiatry Residency Training Program hope to advance this discussion, by describing the forensic psychiatry educational activities in their program. This includes a resident seminar series, which consists of lectures, a final examination, and a series of writing exercises addressing several medicolegal topics utilizing standardized scenarios. This year, a live mock-testimony experience for involuntary commitment will be included. The clinical experience of the Residents Forensic Clinic will also be described, which consists mainly of performing fitness-to-stand-trial evaluations on criminal defendants in neighboring counties. The presenters will also discuss where they hope to go to improve these educational experiences further.

REFERENCES

Accreditation Council of Graduate Medical Education: Program Requirements for Graduate Medical Education in Psychiatry. Chicago: ACGME, 2007
Schultz-Ross R, Kline A: Using problem-based learning to teach forensic psychiatry. Academic Psychiatry 23:1, Spring 1999

SELF ASSESSMENT QUESTIONS

1. The current ACGME Program Requirements specifically mandates which of the following activities as part of a trainee's forensic psychiatry experience?
a. Treatment of jail or prison inmates
b. Evaluation for fitness to stand trial
c. Writing a forensic report
d. Giving live testimony in court
e. Evaluation of sex offenders
ANSWER: c

2. Training in forensic psychiatry for general psychiatry residents should focus primarily upon:
a. Helping residents be successful on the PRITE and standardized examinations
b. Exposing trainees to medicolegal issues that they will encounter in practice
c. Encouraging trainees to apply for a forensic fellowship program
ANSWER: b

S19 **STRENGTH-BASED ASSESSMENTS OF VIOLENCE RISK USING THE START: EARLY ENCOURAGING RESULTS**

Johann Brink, MB, ChB, FRCPC, Vancouver, BC, Canada
Sarah Desmarais, PhD, (I) Tampa, FL
Tonia Nicholls, PhD, (I) Vancouver, BC, Canada

EDUCATIONAL OBJECTIVE

After the presentation, attendees will be aware of the need for strength-based forensic risk assessment; and will be familiar with the Short-Term Assessment of Risk and Treatability (START) and the predictive validity of strength scores in violence risk assessment.

SUMMARY

Scholars have commented on deficit-based biases in forensic practice, with emphasis on risk markers to the exclusion of strengths or protective factors. The Short-Term Assessment of Risk and Treatability (START) is a guide to assist forensic

clinicians in the short-term assessment (weeks to months) of seven, frequently co-occurring risk domains (violence to others, suicide, self harm, self neglect, substance misuse, supervision failure and being victimized), with vulnerabilities and strengths coded respectively on 20 dynamic factors using a 0-1-2 scale. The 190-bed British Columbia Forensic Psychiatric Hospital (FPH), with units ranging from maximum to minimum security, has implemented START, with assessments completed by treatment teams at three-month intervals. Preliminary data from the first 291 STARTs are presented. Total, vulnerability and strength scores varied as a function of security level. Mean strength scores were lowest in maximum secure wards (M = 15.65, SD = 6.54) and increased significantly across less secure units (medium: M = 20.00, SD = 5.57; minimum: M = 24.36 SD = 3.93) p = .000). Preliminary strength-based predictive validity data (higher strength scores correlated with lower or absent violence rates) from this and other sites are presented.

REFERENCES

Rogers R: The uncritical acceptance of risk assessment in forensic practice. Law Hum Behav 24:595-605, 2000
Webster CD, Nicholls TL, Martin ML, Desmarais SL, Brink J: Short Term Assessment of Risk and Treatability (START): the case for a new violence risk structured professional judgment scheme. Behav Sci Law 24:747-766, 2006

SELF ASSESSMENT QUESTIONS

1. Strength and vulnerability items are scored on what scale in the START?
ANSWER: 0-1-2

2. The Short Term Assessment of Risk and Treatability (START) allows for the consideration of vulnerabilities and what other factors when conducting forensic risk assessment?
ANSWER: Strengths

S20 THE UTILITY OF THE COVR AS A SCREENING TOOL FOR INSTITUTIONAL AGGRESSION

Barbara McDermott, PhD, (I) Sacramento, CA
Isah Dualan, MS, (I) Sacramento, CA
Tony Rabin, PhD, (I) Napa, CA
Diane Rackliffe, PhD, (I) Napa, CA
Chad Woofter, MD, Napa, CA

EDUCATIONAL OBJECTIVE

The attendee will develop an understanding of the utility of the COVR as a screening tool for risk of institutional aggression.

SUMMARY

The Classification of Violence Risk (COVR) is a newly published actuarial risk instrument designed to estimate the risk that an acute civil psychiatric patient will exhibit aggressive behavior over the following several months. The COVR implements the classification tree methodology used in the MacArthur study of violence risk via an interactive, computerized program. Recent research has indicated that the COVR is also applicable in the identification of potentially aggressive forensic patients. The COVR was implemented as a screening tool for risk of institutional aggression at Napa State Hospital (NSH), a large state psychiatric hospital in Northern California. NSH houses approximately 1200 patients, with almost 1000 of these patients committed by the criminal justice system. Over 500 patients, both civil and forensic, have been screened using the COVR. As suggested by the manual, the COVR results are combined with clinical judgment and adjusted when the clinician believes the estimate is either too low or too high. Patients were followed for 20 weeks post-assessment to document incidents of aggression. These data will be presented examining the utility of the COVR as an initial screen for institutional risk.

REFERENCES

Snowden RJ, Gray NS, Taylor J, Fitzgerald S: Assessing risk of future violence among forensic psychiatric inpatients with the Classification of Violence Risk (COVR). Psychiatr Serv 60:1522-1526, 2009
Monahan J, Steadman HJ, Appelbaum PS, et al: The Classification of Violence Risk. Behav Sci Law 24: 721-730, 2006

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. psychopathy
c. alcohol or drug abuse
d. intellectual deficits
ANSWER: d

2. Which of the following factors is not included in the COVR software?
a. childhood abuse
b. psychopathy
c. recent violence
d. anger
ANSWER: b

S21 DEVELOPMENT OF A BRIEF VIOLENCE RISK SCREENING TOOL

Michael Greenspan, MD, Bronx, NY
Ali Khadivi, PhD, (I) Bronx, NY
Li-Wen Lee, MD, New York, NY
Barry Rosenfeld, PhD, (I) Bronx, NY
Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE

To educate the audience regarding current approaches to violence risk screening among psychiatric patients. To introduce a data validated approach to easily screen patients for the risk of violence with data readily available at the time of admission to a psychiatric hospital.

SUMMARY

Formal and intensive risk management approaches (including, but not limited to, actuarial and other structured clinical aides) assist clinicians in the tasks of detecting and, more importantly, preventing violence in psychiatric patients. Such approaches, however, are resource intensive, as they both consume time and benefit from clinicians with specialty training. Consequently, they have not been widely applied to inpatient psychiatric populations. This disconnect is concerning, especially considering the high relative base rate of community violence in psychiatric patients (25.2% in a one-year follow-up period, according to the MacArthur Study of Mental Disorder and Violence). This study aims to develop a brief and easily administered screening tool which would assist clinicians in identifying a high risk population, for whom more intensive risk assessment and management would be warranted. Limited research in this field seems to indicate that a small number of variables, readily available at the time of admission to a psychiatric hospital, may be adequate in accurate high-risk identification. As the first step in the development process, screening variables will be selected and piloted using the MacArthur Study data set. Results will be presented regarding the utility, correlation and sensitivity of the developed screen.

REFERENCES

Monahan J, Steadman HJ, Silver E, Appelbaum PS, Robbins PC, Mulvey E, Roth L, Grisso T, Banks S: Rethinking Risk Assessment--The MacArthur Study of Mental Disorder and Violence. New York: Oxford University Press, 2001, pp 30
Wooton L, Buchanan A, Leese M, Tyrer P, Burns T, Creed F, Fahy T, Walsh E: Violence in psychosis: Estimating the predictive validity of readily accessible clinical information in a community sample. Schizophrenia Research 101:176-184, 2008

SELF ASSESSMENT QUESTIONS

1. According to the MacArthur Study of Mental Disorder and Violence, the prevalence for violence among discharged psychiatric patients over a one-year period following discharge is approximately:
a. 5%
b. 10%
c. 15%
d. 25%
e. 45%
ANSWER: d

2. All but which of the following are important to consider in the development of a test designed to screen for the likelihood of violent behavior in psychiatric patients?
a. Ease of availability of required data
b. Sensitivity
c. Specificity
d. Time required to administer
e. Likelihood that clinicians will find the screening results useful in the provision of care
ANSWER: c

SUNDAY, OCTOBER 24, 2010

PANEL — 8:00AM - 10:00AM — **SALON 8/9**

Z1 Substance-Induced Psychoses: Intoxication, Insanity and Interventions
Addiction Psychiatry Committee

Gregory Sokolov, MD, Davis, CA
Robert Johnson, DO, (I) Tucson, AZ
Charles Scott, MD, Sacramento, CA
Douglas Tucker, MD, San Francisco, CA

WORKSHOP — 8:00AM - 10:00AM — **SALON 6**

Z2 Privilege and Discharge Practices: A Multi-State Comparison

Debra Pinals, MD, Worcester, MA
Annette Hanson, MD, Baltimore, MD
Li-Wen Lee, MD, New York, NY
Michael Norko, MD, New Haven, CT

PANEL — 8:00AM - 10:00AM — **SAN PEDRO 1/2**

Z3 Why Research Matters: Applying Science to Cases
Research Committee

S.H. Dinwiddie, MD, Chicago, IL
Ryan Hall, MD, Lake Mary, FL
Michael Harlow, MD, JD, Mankato, MN
Susan Hatters Friedman, MD, Cleveland, OH
Suzanne Yang, MD, Pittsburgh, PA

PANEL — 8:00AM - 10:00AM — **GRAND 10/11**

Z4 Elder Financial Abuse and Forensic Psychiatry
Forensic Neuropsychiatry Committee

Bennett Blum, MD, Tucson, AZ
Robert Weinstock, MD, Los Angeles, CA
Det. James Williamson, (I) Tucson, AZ
Paul Bartlett, Esq., (I) Tucson, AZ
Paul Greenwood, Esq. (I) San Diego, CA

RESEARCH IN PROGRESS #5 — 8:00AM - 10:00AM — **SALON 1-3**

Z5 Identifying Correlates of Competency to Stand Trial (CST) Among Youth Admitted to a Juvenile Mental Health Court

Lauren Reba-Harrelson, PhD, (I) Westwood, CA
Eraka Bath, MD, Los Angeles, CA

Z6 Genetic Vulnerabilities in Aggression, Impulsivity and Substance Use Disorders

Tracy Gunter, MD, St. Louis, MO

Z7 Law Enforcement Attitudes and Knowledge of Mental Health Law

Leah Frazier, MD, San Antonio, TX
Kaustubh Joshi, MD, San Antonio, TX
Nicholas McKinnon, MD, San Antonio, TX

Z8 Suicide Risk Assessment - Educational Training Project

Erick Hung, MD, San Francisco, CA

COFFEE BREAK — 10:00AM - 10:15AM — ARIZONA FOYER

WORKSHOP — 10:15AM - 12:15PM — **SALON 8/9**

Z9 Helping Mothers Who Need Help

Shabneet Hira-Brar, MD, Levittown, NY
Larissa Chism, MD, South Bend, IN
Charles Scott, MD, Sacramento, CA
Layla Soliman, MD, Pittsburgh, PA

WORKSHOP — 10:15AM - 12:15PM — **SALON 10/11**

Z10 WITHDRAWN

PANEL 10:15AM - 12:15PM **SALON 1-3**

Z11 Whose Life Is It? Case of a Young Competent Man Requesting Withdrawal of a Life-Sustaining Ventilator (Advanced)

Richard Martinez, MD, Denver, CO
Rebecca Brendel, MD, JD, Boston, MA
Philip Candilis, MD, Worcester, MA
Philippe Weintraub, MD, (I) Denver, CO

WORKSHOP 10:15AM - 12:15PM **SALON 6**

Z12 Ethics, Lies, and Videotape: Recording Forensic Interviews

Brian Cooke, MD, New Haven, CT
Paul Thomas, MD, New Haven, CT
Howard Zonana, MD, New Haven, CT

PANEL 10:15AM - 12:15PM **SAN PEDRO 1/2**

Z13 The Myth of Criminalization: Refocusing Reentry (CORE)

Merrill Rotter, MD, Bronx, NY
John Bettencourt, (I) Modesto, CA
J. Steven Lamberti, MD, (I) Rochester , NY
Eric Olson, LCPC, (I) Bonneville County, ID
Henry Steadman, PhD, (I) Delmar, NY

Z1 **SUBSTANCE-INDUCED PSYCHOSES: INTOXICATION, INSANITY AND INTERVENTIONS**

Gregory Sokolov, MD, Davis, CA
Robert Johnson, DO, (I) Tucson, AZ
Charles Scott, MD, Sacramento, CA
Douglas Tucker, MD, San Franciso, CA

EDUCATIONAL OBJECTIVE

To update developments in the assessment and treatment of drug-induced psychotic disorders, including for forensic (i.e., insanity defense) evaluations.

SUMMARY

Substance-induced (namely cannabis and methamphetamine) psychotic disorders are widely seen in many treatment settings, and can have forensic implications that frequently emerge in civil and criminal cases, including effects on violent behavior, driving impairment, and criminal responsibility. Dr. Sokolov, chair of the Addiction Psychiatry Committee, will introduce the panel and provide a general overview of substance-induced psychoses, including current epidemiological characteristics. Dr. Johnson, medical director of the renowned Sierra Tucson Treatment Facility, will discuss treatment interventions, including those that are court-ordered, for individuals with methamphetamine-induced psychosis. Dr. Tucker will discuss recent developments in cannabis-induced psychosis, including neurobiology and risk for early-onset schizophrenia. Lastly, Dr. Scott will conclude with a discussion of the challenges in using voluntary intoxication as the basis of an insanity defense, including results of his previous research which reviewed reports of five hundred insanity acquittees for evidence of substance use intoxication preceding their instant offenses.

REFERENCES

McKetin R, et al: The prevalence of psychotic symptoms among methamphetamine users. Addiction 101(10): 1473-78, 2006
Niveau G: Criminal responsibility and cannabis use: psychiatric review and proposed guidelines. J Forensic Sci 47 (3):451-8, 2002

SELF ASSESSMENT QUESTIONS

1. Which of the following are associated with drug-induced psychosis?
a. Delusions
b. Hallucinations
c. Diminished impulse control
d. Agitation
e. All of the above
ANSWER: e

2. Which of the following are examples where intoxication can be used in the insanity defense?
a. Idiosyncractic reaction
b. "Settled" psychosis
c. Involuntary ingestion
d. Withdrawal/delirium
e. All of the above
ANSWER: e

Z2 **PRIVILEGE AND DISCHARGE PRACTICES: A MULTI-STATE COMPARISON**

Debra Pinals, MD, Worcester, MA
Annette Hanson, MD, Baltimore, MD
Li-Wen Lee, MD, New York, NY
Michael Norko, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

At the end of this presentation, participants will be able: to describe policies and practices of privilege and discharge decisions across four jurisdictions; discuss practical aspects of formalized risk assessment methods/instruments in these decisions; and discuss how legal and policy issues intersect as clinical discharge decisions are made.

SUMMARY
Negligent release litigation often centers around whether clinicians operated within the standard of care in performing adequate risk assessments. Clinical decision-making related to increasing privileges and authorizing discharges can be complex and may not always be relevantly informed by the extant violence-risk-assessment literature. In long-term-care forensic facilities, there may be legal oversight of these decisions for patients, such as those for insanity acquittees. Prior to presenting a case for increased privileges or discharge to a legal authority, clinicians generally follow specific policies/practices related to the determination of patient readiness. These actions may include second opinions and the completion of specialized risk-related documentation and even the administration of risk-assessment instruments to buttress the clinical opinion. The relevance of such instruments to the clinical tasks will be discussed. The presenters (lead forensic administrators from four states) will provide a comparison regarding local practices of privilege and discharge decision-making in public mental health hospitals. Policies and related statutes and regulations across jurisdictions will be reviewed. Clinical case examples will be described for better understanding of the strengths and pitfalls of each jurisdiction's practice, with an opportunity for audience discussion of best practices.

REFERENCES
Dvoskin JA, Heilbrun K: Risk assessment and release decision-making: toward resolving the great debate. J Am Acad Psychiatry Law 29:6-10, 2001
Douglas KS, Skeem JL: Violence Risk Assessment: Getting specific about being dynamic. Psychology Public Policy Law 11:347-383, 2005

SELF ASSESSMENT QUESTIONS
1. Disadvantages of risk assessment instruments in clinical privilege and discharge decisions include:
a. They may not provide direct information that leads to a conclusion of readiness for the privilege or discharge.
b. They do not address Tarasoff issues.
c. They have not been validated with forensic populations.
d. None of the above.
ANSWER: a

2. Policy decisions related to patient privileges and discharges:
a. Are generally based on an evidence-based understanding of violence risk assessment
b. Can vary according to the legal status of the patient
c. Are usually amended based on outcome data
d. None of the above
ANSWER: b

Z3 **WHY RESEARCH MATTERS: APPLYING SCIENCE TO CASES**

S.H. Dinwiddie, MD, Chicago, IL
Ryan Hall, MD, Lake Mary, FL
Michael Harlow, MD, JD, Mankato, MN
Susan Hatters Friedman, MD, Cleveland, OH
Suzanne Yang, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE
Participants will learn a range of definitions and applications of research in forensic psychiatry. Participants will also understand how scientific principles apply to the review and synthesis of the existing research literature and how research contributes to an opinion in the individual case.

SUMMARY
The U.S. Supreme Court's 1993 opinion in Daubert v. Merrill Dow (509 U.S. 579) specified criteria for the admissibility of expert testimony, based on scientific method. In the face of expanding knowledge in neuroscience, genetics, and epidemiology, as well as larger and better-designed studies of the efficacy of clinical treatments, psychiatric experts will be more and more closely scrutinized in court regarding their understanding of scientific principles and results. This presentation begins with an illustration of some lines of questioning that might be used to cross-examine psychiatric experts regarding their application of research findings. We will explore the range of research relevant to the practice of forensic psychiatry, and describe ways that the scientific method has been applied to the study of very low base-rate phenomena such as serial homicide and school shootings. We will also discuss guidelines for the rigorous synthesis of research findings in areas where multiple large quantitative studies exist, sometimes with differing conclusions. We then discuss how expert evaluation itself applies the scientific method to data obtained in the individual case, highlighting differences between clinical and research viewpoints and how these two perspectives interact synergistically in the formulation of an opinion.

REFERENCES
Glancy GD, Saini M: The confluence of evidence-based practice and Daubert within the fields of forensic psychiatry and the law. J Am Acad Psychiatry Law 37: 438-41, 2009
Garland B, Glimcher PW: Cognitive neuroscience and the law. Curr Opin Neurobiol 16:130-134, 2006

SELF ASSESSMENT QUESTIONS
1. Which of the following does not involve the application of the scientific method?
a. An epidemiological study comparing the rate of property crime in mentally disordered persons with those with no mental illness
b. A psychiatric examination for guardianship proceedings
c. A clinical trial of a new medication for reducing recidivism in sex offenders
d. A review of the literature on the relationship between symptoms of mental illness and stalking behavior
e. All of the above involve application of the scientific method
ANSWER: e

2. Which of the following is a likely consequence of inadequate understanding of the research base relevant to forensic psychiatry?
a. Improved general credibility of the profession
b. Increased validity and reliability of psychiatric expert opinions
c. Loss of credibility on the witness stand
d. Increased fairness in legal proceedings
e. More options for therapeutic intervention in correctional populations
ANSWER: c

Z4 **ELDER FINANCIAL ABUSE AND FORENSIC PSYCHIATRY**

Bennett Blum, MD, Tucson, AZ
Robert Weinstock, MD, Los Angeles, CA
Det. James Williamson, (I) Tucson, AZ
Paul Bartlett, Esq., (I) Tucson, AZ
Paul Greenwood, Esq., (I) San Diego, CA

EDUCATIONAL OBJECTIVE
Attendees will learn about the potential roles for general forensic psychiatry input in cases of elder financial abuse, including behavior-based methods for assessment of undue influence.

SUMMARY
This panel discussion, submitted by the Geriatrics Committee, is intended to benefit the general forensic psychiatry audience. As the elderly demographic increases, so does the incidence of elder financial abuse (EFA), and the need for forensic evaluations of victims and perpetrators. EFA is connected to both violent and white-collar crimes. It has been estimated that there are ~ 5 million elderly victims at any given time, resulting in direct losses of more than $2.6 billion annually. Forensic psychiatrists are increasingly asked to evaluate claims of: 1) diminished capabilities of victims; 2) Axis I and II conditions relevant to victims and perpetrators; 3) susceptibility to, and behavioral evidence of, undue influence; and 4) psychological harm to victims. Using case examples, speakers will discuss the potential roles for forensic psychiatry input at various stages of investigation and litigation. Criminal, civil and probate litigation will be covered.

REFERENCES
Naimark D, Haroun A, Saks, E: Forensic Aspects, in chapter entitled "Geriatric Psychiatry" in Kaplan and Sadock's Comprehensive Textbook of Psychiatry, Ninth Edition. Edited by Sadock B, Sadock V. Baltimore: Lippincott, Williams and Wilkins, 2009, pp 4202-4207
Broken Trust: Elders, Family and Finances: A Study on Elder Financial Abuse Prevention, by the MetLife Mature Market Institute, the National Committee for the Prevention of Elder Abuse, and the Center for Gerontology at Virginia Polytechnic Institute and State University, March 2009 (http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf)

SELF ASSESSMENT QUESTIONS

1. What percentage of elder financial abuse cases are reported to authorities, and of those, how often are family members or caregivers the offenders?

ANSWER: Percentage reported - 5 to 20%; Family or caregivers as perpetrators- 55% of reported cases

2. What are the commonly used behavior-based models for evaluation of undue influence claims?

ANSWER: SODR, SCAM, IDEAL, Undue Influence Wheel, Singer's "Cult" Model

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Z5 IDENTIFYING CORRELATES OF COMPETENCY TO STAND TRIAL (CST) AMONG YOUTH ADMITTED TO A JUVENILE MENTAL HEALTH COURT

Lauren Reba-Harrelson, PhD, (I) Westwood, CA
Eraka Bath, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE

This papers aims to provide skills to forensic professionals for conducting or assessing research, and for understanding factors associated with juvenile competency status. A strong research methodology and novel data on the understudied area of competency assessment within juvenile mental health court will be presented.

SUMMARY

The assessment of competency to stand trail (CST) in juvenile delinquents is a relatively new and under-studied phenomenon. As the number of mentally ill youth who have contact with the legal system grows, the need for evaluation of CST status has increased and become more complex. Furthermore, there is limited data regarding factors associated with CST status, which may have significant impact on efforts for competency restoration. This study aims to describe the prevalence of demographic, psychological, offense, treatment, and cognitive factors associated with CST among 420 youth admitted to the Los Angeles County Juvenile Mental Health Court (JMHC) since its inception in 2001. Of juveniles in JMHC, 80% were male, the mean age was 15.4, and 52.2% were found incompetent to stand trail (IST). Overall, compared to their CST counterparts, juveniles found IST were more likely to be younger, be mentally retarded, have a lower FSIQ, commit a forcible sexual offense, have received an individualized educational plan in school, and have had a psychological evaluation in court. Determining factors associated with IST is imperative for identifying those who may benefit from competency restoration, and may also provide guidance on the mental health, educational and rehabilitative service needs in this group.

REFERENCES

Ash P: Commentary: risk markers for incompetence in juvenile defendants. J Am Acad Psychiatry Law 31:310-13, 2003
Grisso T, Steinberg L, Woodlard J, et al: Juvenile's competence to stand trial: a comparison of adolescents' and adults'capacities as trial defendants. J Law Hum Behav 27:333-63, 2003

SELF ASSESSMENT QUESTIONS

1. What demographic and psychological factors most significantly differentiate juvenile offenders who are competent to stand trail versus those who are incompetent?

ANSWER: Overall, compared to their CST counterparts, juveniles found IST were more likely to be younger, be mentally retarded, have a lower FSIQ, commit a forcible sexual offense, have received an individualized educational plan in school, have received Regional Center services, and have had a psychological evaluation in court.

2. What are the implications of these findings for juvenile offenders?

ANSWER: Better understanding the association between age, intellectual impairment, offense type, services received, and competency status is imperative for identifying those who may benefit from competency restoration, as well as adapting restorative methods accordingly. Further, taking these factors into consideration is necessary to provide tailored treatment, rehabilitative, and restoration services to those who have been found incompetent to stand trial.

Z6 GENETIC VULNERABILITIES IN AGGRESSION, IMPULSIVITY AND SUBSTANCE USE DISORDERS

Tracy Gunter, MD, St. Louis, MO

EDUCATIONAL OBJECTIVE

Familiarize the participant with the latest molecular techniques being used to interrogate the biology of externalizing spectrum disorders.

SUMMARY
In this presentation, a brief overview of existing research involving genetic vulnerabilities to impulsivity, aggression, psychopathy, and substance use disorders will be presented using a review of the literature and epigenetic profiling data from two distinct study populations: a community population at increased genetic risk for these behaviors, and a severely affected correctional population. While genotyping studies have yielded some important clues about the externalizing spectrum of behavior, more recent studies involving epigenetic and gene expression profiling provide additional information about how the regulation of the genome is impacted by the environment. Future implications of this line of research for courtroom testimony will be touched on briefly.

REFERENCES
Gunter TD, Vaughn MG, Philibert, RA: Behavioral genetics in antisocial spectrum disorders and psychopathy: a review of the recent literature. Behav Sci Law (2010, in press)
Beach SRH, Brody GH, Todorov AA, Gunter TD, Philibert RA: Methylation at SLC6A4 is linked to family history of child abuse: an examination of the Iowa Adoptee sample. Am J Med Genetics Part B: Neuropsychiatric Genetics, Epub ahead of print September 8, 2009

SELF ASSESSMENT QUESTIONS
1. Behavioral genetics research in the area of externalizing behavior is:
a. consistent and transparent across research groups and study designs
b. hampered by genetic determinism, oversimplification, and sensationalism
c. likely to yield a violence gene or warrior gene
d. static and homogenous
e. requires only a single level of inquiry
ANSWER: b

2. In order to interrogate the biology of complex behavioral disorders:
a. large sample sizes are needed
b. multiple levels of inquiry must be undertaken, preferably simultaneously
c. effects of gender must be carefully controlled
d. environmental factors must be scrutinized with the same care as biological factors
e. all of the above
ANSWER: e

Z7 LAW ENFORCEMENT ATTITUDES AND KNOWLEDGE OF MENTAL HEALTH LAW

Leah Frazier, MD, San Antonio, TX
Kaustubh Joshi, MD, San Antonio, TX
Nicholas McKinnon, MD, San Antonio, TX

EDUCATIONAL OBJECTIVE
The purpose of this study is to determine the correlation between police attitudes towards mental illness and knowledge of mental health law. We will also identify workforce characteristics associated with positive attitudes toward the mentally ill and knowledge of mental health law.

SUMMARY
Law enforcement frequently interacts with patients suffering from mental illness. There have been many public mental health efforts to improve police officers' knowledge and attitudes toward those with mental illness. The desired outcome of these interventions is that they will reduce criminalization of the mentally ill by helping officers identify more appropriate disposition options such as transfer to community crisis centers or emergency psychiatry centers as opposed to overcrowded jails. The investigators have designed a survey to gather data on demographics, mental health attitudes, and knowledge of mental health law. This survey will be administered to the peace officers of Bexar and surrounding counties during Crisis Intervention Training. This training is held several times a year and is mandatory for Bexar County. The survey will be administered at the beginning each training session over the next two years. If it can be shown that a positive attitude towards mental illness correlates with knowledge of mental health law, this will lend support to ongoing community education workshops.

REFERENCES
Lamb HR, Weinberger, LE, Decuir WJ: The police and mental health. Psychiatr Serv 53:1266-1271, 2002
Compton MT, Esterberg MI, McGee R, et al: Crisis intervention team training: changes in knowledge, attitudes, and stigma related to schizophrenia. Psychiatr Serv 57:1199-1202, 2006

SELF ASSESSMENT QUESTIONS

1. What is the standard in Texas required to place an individual under emergency detention?
a. Beyond a reasonable doubt
b. Probable cause
c. Clear and convincing evidence
d. A preponderance of the evidence
ANSWER: b

2. In prior studies, peace officers have been found to view those with schizophrenia as:
a. More responsible for their situation
b. Less worthy of help
c. More dangerous than persons without mental illness
ANSWER: c

Z8 SUICIDE RISK ASSESSMENT EDUCATIONAL TRAINING PROJECT

Erick Hung, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

To describe a variety of teaching methods in suicide risk assessment; and how to use this educational training kit in teaching suicide risk assessment.

SUMMARY

Suicide risk assessment is an essential skill for clinicians who evaluate and treat mental illness. The ACGME emphasizes that suicide risk assessment is a requirement for all general psychiatry residents. This skill, however, is not only essential for psychiatrists but also for other mental health clinicians and other medical specialties who are generally held to the same standard of care in risk assessment. Teaching suicide risk assessment to trainees requires an educator to deliver knowledge and skills to the learner in an engaging and optimal learning climate. For some learners this may involve didactics. For others, learning may involve case vignettes, problem-based learning (PBL), small group discussions, or an observed structured clinical evaluation (OSCE). The purpose of this research project is to develop an innovative training kit for mental health educators that includes specific instructions, materials, and tools using these various training methods. This project is funded by the AAPL Institute for Education and Research. The product is aimed at educators who teach risk assessment in their clinics or institutions. Disciplines may include physicians (e.g., psychiatry, internal medicine, family medicine, pediatrics, etc.) and other health care clinicians in mental health (i.e., psychology, nursing, occupational therapy, social work, etc.).

REFERENCES

Scheiber SC, Kramer TA, Adamowski SE: Core Competencies for Psychiatric Practice: What Clinicians Need to Know: A Report of the American Board of Psychiatry and Neurology, Inc., American Psychiatric Pub, 2003
McNiel DE, et al: Effects of training on suicide risk assessment. Psychiatr Serv 59:1462-1465, 2008

SELF ASSESSMENT QUESTIONS

1. Effective teaching in suicide risk assessment can include which of the following?
a. didactics
b. small group discussion
c. problem-based learning
d. observed structured clinical evaluation (OSCE)
e. all of the above
ANSWER: e

2. An observed structured clinical evaluation (OSCE) includes all of the following components except which?
a. case vignette
b. standardized patient
c. learner d actuarial tool
d. evaluator or rater
ANSWER: d

Z9 **HELPING MOTHERS WHO NEED HELP**

Shabneet Hira-Brar, MD, Levittown, NY
Larissa Chism, MD, South Bend, IN
Charles Scott, MD, Sacramento, CA
Layla Soliman, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE

Child abuse by mothers in the active phase of mental illness has not been substantially studied in the literature. Case studies increase awareness of this infrequently reported phenomenon. Combined with a literature review, interactive case discussions will educate participants on proposed methods of assessment, intervention, and prevention.

SUMMARY

While performing court-ordered, competence-to-stand-trial evaluations, mothers accused of non-fatal child abuse or neglect were identified. In most instances, the offenses occurred in the context of mental illness. Abuse and neglect were not typical of these mothers. Little exists in the current literature about this topic. After researching available options for assessment and intervention in these cases, the panel formulated suggestions for approaching patients with these issues. The workshop will begin with a presentation of three cases followed by a review of the literature. Various skill-building and problem-solving techniques will be presented, including risk assessment. A review of biopsychosocial interventions will follow. Information obtained from an interview with the regional director for Children Youth and Family Services in Allegheny County regarding the supports they offer and the manner in which families' needs are assessed will be presented. Additional cases will be assigned to small groups, and each group will generate ideas for approaching these cases. Finally, a forensically trained expert in child psychiatry will present a closing discussion. This interactive workshop will raise awareness of the challenges posed by mothers with mental illness and generate discussion of their assessment and treatment.

REFERENCES

Mullick M, Miller LJ, Jacobsen T: Insight into mental illness and child maltreatment risk among mothers with major psychiatric disorders. Psychiatr Serv 52(4):488-492, 2001
Friedman SH, Sorrentino RM, Stankowski JE, Holden CE, Resnick PJ: Psychiatrists' knowledge about maternal filicidal thoughts. Comp Psychiatry 49:106-110, 2008

SELF ASSESSMENT QUESTIONS

1. The literature on mothers with mental illness does not address which of the following?
a. Post Partum Depression
b. Infanticide
c. Filicide
d. Child Abuse
ANSWER: d

2. Which of the following is/are risk factors for child abuse in mothers with mental illness?
a. History of substance abuse
b. Poor frustration tolerance
c. Having a child with a disability
d. Poor social support
e. All of the above
ANSWER: e

Z10 **WITHDRAWN**

Z11 WHOSE LIFE IS IT? CASE OF A YOUNG COMPETENT MAN REQUESTING WITHDRAWAL OF A LIFE-SUSTAINING VENTILATOR

Richard Martinez, MD, Denver, CO
Rebecca Brendel, MD, JD, Boston, MA
Philip Candilis, MD, Worcester, MA
Philippe Weintraub, MD, (I) Denver, CO

EDUCATIONAL OBJECTIVE

Members of the panel will review current understanding of the legal/ethical aspects of withdrawal of ventilators in severely injured spinal cord survivors. The panel will discuss distinctions between physician-aid-in-dying and withdrawal of treatment, review current thinking about competency assessments, and consider the role of forensic experts in these cases.

SUMMARY

Dr. Martinez will chair this panel and present a 20-minute DVD of a 33-year-old man with a recent high tetraplegia who requested that his ventilator be removed two months after his injury. Many issues developed in this case including questions about competency and the role of the forensic psychiatrist as a consultative psychiatrist. Members of the panel will discuss the legal aspects of withdrawal of life-sustaining treatment in severely injured spinal cord survivors, consider the legal and ethical distinctions between physician aid in dying and withdrawal of care, discuss current understanding of "non-cognitive" considerations in competency assessments, and discuss the role of the forensic psychiatrist involved in a complex multiple role context where consultant and therapeutic roles were joined. Lastly, the panel will review the "moral distress" that is common in hospitals and other institutions when such requests for withdrawal are made.

REFERENCES

Appelbaum PS: Assessment of patients' competence to consent to treatment. N Engl J Med 357:1834-40, 2007
Kirschner KL: Calling it quits: when patients or proxies request to withdraw or withhold life-sustaining treatment after spinal cord injury. Topics in Spinal Cord Injury and Rehabilitation 13(3):30-44, 2008

SELF ASSESSMENT QUESTIONS

1. What did the U.S. Supreme Court decide in the Nancy Cruzan case?
ANSWER: That the state of Missouri could require a "clear and convincing" standard of evidence for a substitute decision maker to end medical treatment of an incompetent, non-terminal patient.

2. What is the major psychiatric diagnosis usually involved in non-cognitive assessment of competency to make medical decisions?
ANSWER: Depression

Z12 ETHICS, LIES, AND VIDEOTAPE: RECORDING FORENSIC INTERVIEWS

Brian Cooke, MD, New Haven, CT
Paul Thomas, MD, New Haven, CT
Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

At the conclusion of the workshop, participants will be able to describe the clinical, ethical, and legal arguments of videotaping forensic interviews; and know what practical steps are necessary to use video recording.

SUMMARY

In 1999, an AAPL Task Force on Videotaping Forensic Interviews reviewed the case law relevant to this practice, considered the advantages and disadvantages of videotaping interviews, and sought to give guidance to psychiatrists working as legal consultants. More than a decade has passed since that important report. The results of a recent survey will be discussed to illustrate the current practice of videotaping interviews. An updated review of the case law will be provided. The workshop will present a framework for videotaping interviews based on a critical evaluation of clinical, ethical, and legal perspectives. The audience will participate in an exercise applying the principles of the framework to encourage analysis and discussion.

REFERENCES

Zonana HV, Bradford JM, Giorgi-Guarnieri DL, et al: Videotaping of forensic psychiatric evaluations. J Am Acad Psychiatry Law 27:345-358, 1999
Lande RG: Videotaping, informed consent, and forensic psychiatry. J Psychiatry Law 29:53-63, 2001

SELF ASSESSMENT QUESTIONS

1. Which of the following was a recommendation from the AAPL Task Force on Videotaping Forensic Interviews?
a. The option of videotaping is legal but an ethically questionable medical practice.
b. Other legal and professional sources (e.g., statutes, case law, and practice guidelines) may require or recommend videotaping in certain circumstances.
c. Forensic training programs should require that trainees use videotaping equipment.
d. Videotaped forensic interviews can be shared with colleagues and presented at national conferences without consent.
e. All of the above.
ANSWER: b

2. Which of the following are recommended before videotaping a forensic psychiatric interview?
a. Technical familiarity with the recording device
b. Informing the retaining counsel
c. Obtaining administrative approval from the site where the interview will be conducted (e.g., a prison or court clinic)
d. Establishing a secure location to store the videotapes
e. All of the above
ANSWER: e

Z13 THE MYTH OF CRIMINALIZATION: REFOCUSING REENTRY

Merrill Rotter, MD, Bronx, NY
John Bettencourt, (I) Modesto, CA
J. Steven Lamberti, MD, (I) Rochester, NY
Eric Olson, LCPC, (I) Bonneville County, ID
Henry Steadman, PhD, (I) Delmar, NY

EDUCATIONAL OBJECTIVE

Participants will have increased appreciation for the challenges to the notion that the antidote to the criminalization of the mentally ill is better mental health treatment, improved understanding of the factors that predict recurrent criminality and more knowledge about specific, structured case management and cognitive strategies that address recidivism directly.

SUMMARY

The most common explanation for the demonstrated overrepresentation of the mentally ill in the criminal justice system is that their symptoms are being "criminalized" and that ensuring good treatment will address this inequity. In this panel, we will challenge this popular hypothesis, suggest alternative explanations for the arrest and re-arrest of individuals with mental illness, and present examples of the adjunctive interventions necessary to address the problem of recidivism. Dr. Rotter will introduce the criminalization hypothesis and present data suggesting that mental health issues alone do not explain offending behavior in individuals with mental illness. Dr. Steadman will provide recent diversion data supporting the need to look for alternative hypotheses. Dr. Lamberti will follow with a review of the eight factors associated with criminal justice recidivism among mentally ill offenders and introduce specialized probation and case management service interventions. Dr. Rotter's further discussion will focus on structured cognitive strategies from the worlds of criminal justice and mental health that target recidivism. Finally, Officer Bettencourt and Mr. Olson, will present their experience implementing specialized probation services and cognitive behavioral interventions (Moral Reconation Therapy), respectively. Ample time will be provided for debate and discussion.

REFERENCES

Lamberti J S: Understanding and preventing criminal recidivism among adults with psychotic disorders. Psychiatr Serv 58(6):773-781, 2007
Duncan EA, Nicol MM, Ager A, Dalgleish L: A systematic review of structured interventions with mentally disordered offenders. Crim Behav Mental Health 16:217-241, 2006

SELF ASSESSMENT QUESTIONS

1. The percentage of mentally ill offender cases in which the mental illness is directly associated with the instant offense is:

a. under 10%
b. 10-25%
c. 25%-50%
d. 50-75%
e. over 75%
ANSWER: a

2. Which of the following interventions have demonstrated efficacy in decreasing criminal recidivism in mentally ill offenders?

a. Reasoning and Rehabilitation
b. Specialized Probation
c. Symptom Reduction-focused treatment
d. a and b
e. all of the above
ANSWER: d

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