

AMERICAN ACADEMY
OF
PSYCHIATRY AND THE LAW

42ND ANNUAL MEETING

October 27-30, 2011
Boston, Massachusetts



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

**Forty-second Annual Meeting
American Academy of Psychiatry and the Law
October 27-30, 2011
Boston, Massachusetts**

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PAST PRESIDENTS

Stephen B. Billick, MD	2009-10	Kathleen M. Quinn, MD	1991-92
Patricia R. Recupero, MD, JD	2008-09	Richard T. Rada, MD	1990-91
Jeffrey S. Janofsky, MD	2007-08	Joseph D. Bloom, MD	1989-90
Alan R. Felthous, MD	2006-07	William H. Reid, MD, MPH	1988-89
Robert I. Simon, MD	2005-06	Richard Rosner, MD	1987-88
Robert T.M. Phillips, MD, PhD	2004-05	J. Richard Ciccone, MD	1986-87
Robert Wettstein, MD	2003-04	Selwyn M. Smith, MD	1985-86
Roy J. O'Shaughnessy, MD	2002-03	Phillip J. Resnick, MD	1984-85
Larry H. Strasburger, MD	2001-02	Loren H. Roth, MD	1983-84
Jefrey L. Metzner, MD	2000-01	Abraham L. Halpern, MD	1982-83
Thomas G. Gutheil, MD	1999-00	Stanley L. Portnow, MD	1981-82
Larry R. Faulkner, M.D	1998-99	Herbert E. Thomas, MD	1980-81
Renée L. Binder, MD	1997-98	Nathan T. Sidley, MD	1979-80
Ezra E. H. Griffith, MD	1996-97	Irwin N. Perr, MD	1977-79
Paul S. Appelbaum, MD	1995-96	G. Sarwer-Foner, MD	1975-77
Park E. Dietz, MD, PhD, MPH	1994-95	Seymour Pollack, MD	1973-75
John M. Bradford, MB	1993-94	Robert L. Sadoff, MD	1971-73
Howard V. Zonana, MD	1992-93	Jonas R. Rapoport, MD	1969-71

2011 ANNUAL MEETING CO-CHAIRS

Charles Scott, MD, and Christopher Thompson, MD

EXECUTIVE OFFICES OF THE ACADEMY

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

Howard V. Zonana, MD
Medical Director

Jacquelyn T. Coleman, CAE
Executive Director

CALL FOR PAPERS 2012

The 43rd Annual Meeting of the
American Academy of Psychiatry and the Law will be held in
Montreal, Canada October 25-28, 2012

Inquiries may be directed to,
James L. Knoll, IV, MD Program Chair.

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, 2012



FUTURE ANNUAL MEETING DATES and LOCATIONS

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

Table of Contents

Awardees	3
CME Information	114
Call for Papers - 2011	ii
Evaluation Form	116
Future Meeting Dates	ii
AAPL Policies	v
Financial Disclosures	vii
Index of Authors	124
Invited Speakers	5
Meeting Facilities	x
Opening Ceremony	1
Program	7
Special Events	ix

REGISTRATION DESK

(Exeter Foyer, 2nd Floor)

Hours of Operation

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

AAPL BOOKSTORE

Exeter Foyer, 2nd Floor

MONDO DIGITAL SOLUTIONS, INC.

Exeter 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
- (SA) Designates sessions that qualify for self-assessment CME credit



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.

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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.

Richard Frierson, MD, 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 ensure 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:

Aaker, E.; Abbas, H.; Adams, S.; Allen, T.; Amrhein, C.; Anderson, B.; Annas, G.; Antoniak, S.; Appelbaum, K.; Appelbaum, P.; Ash, P.; Aspinwall, L.; Baksheev, G.; Baranoski, M.; Barber Rioja, V.; Barzman, D.; Beadles, B.; Beckham, B.; Belous, L.; Benjamin, D.; Benoit, T.; Berberian, S.; Berenson, J.; Berger, O.; Bethel, W.; Binder, R.; Bissett, R.; Bobb Jr., D.; Bourget, D.; Bradford, J.; Bradstreet, G.; Brendel, R.; Brodie, J.; Brown, P.; Brown, T.; Buchanan, A.; Bullard, C.; Busch, K.; Candilis, P.; Carson, N.; Cervantes, A.; Chlebowski, S.; Christopher, P.; Chu, J.; Cipriano, T.; Collins, G.; Cook, B.; Cooke, B.; Cote, I.; Crowley, B.; Cumming, I.; Czarnecki, K.; Darby, P.; Davidson, C.; De Crisce, D.; DeBofsky, M.; DePrato, D.; DeTrana, C.; DeYoung, N.; DiGiovanna, B.; Dike, C.; Druhn, N.; Dualan, I.; Dugbarty, A.; Dvoskin, J.; Earley, P.; Elian, A.; Eliason, S.; Ellison, J.; Eth, S.; Farnham, F.; Farrell, H.; Fedoroff, JP.; Felthous, A.; Fisher, W.; Fishman, S.; Fitch, WL.; Folger, K.; Ford, E.; Fox, P.; Fozdar, M.; Freeman, B.; Freeman, N.; Frierson, R.; Frischer, K.; Fulwiler, C.; Gagne, P.; Garabedian, M.; Garakani, A.; Ginory, A.; Glancy, G.; Glezer, A.; Goddard, E.; Goldberg, S.; Gould, D.; Granacher, R.; Gray, S.; Greenspan, M.; Griffith, E.; Grudzinskas, Jr., A.; Gunter, T.; Gur, R.; Gutheil, T.; Guy, L.; Hall, A.; Hall, R.; Hanson, A.; Harlow, M.; Harmon, R.; Harris, A.; Harris, R.; Hartwell, S.; Hatters Friedman, S.; Hauser, B.; Hauser, M.; Heering, E.; Heller, B.; Hemphill, M.; Henley, S.; Higgins-Brooks, B.; Hill, C.; Hoge, S.; Holmberg, T.; Holzer, J.; Hoyt, C.; Humphreys, S.; Husain, M.; Hustings, E.; James, D.; Jimenez, J.; Johnson, S.; Jones, T.; Judge, A.; Kafka, M.; Kanitz, J.; Kaplan, J.; Kapoor, R.; Kaufman, A.; Khadivi, A.; Kleinman, S.; Kletzka, N.; Knoll IV, J.; Kokubun, S.; Kolla, N.; Korenis, P.; Krober, H.; Kuroski-Mazzei, A.; LaCroix, C.; Larkin, E.; Lee, E.; Lee, L.; Leistedt, S.; Lemmen, C.; Leonard, C.; Leverntz, A.; Levin, J.; Levine, H.; Lewis, C.; Ligas, A.; Lilly, S.; Linkowski, P.; Logan, W.; MacKenzie, R.; Maher, D.; Makki, M.; Martone, C.; Martone, L.; Matheson, R.; Mayol Sabatier, L.; McCabe, P.; McDermott, B.; McGauley, G.; McKenney, J.; McMaster, J.; McNiel, D.; Mehta, S.; Metzner, J.; Miraglia, R.; Moffitt, C.; Morris, D.; Mossman, D.; Mulbry, L.; Murphy, L.; Myers, W.; Nanton, A.; Nau, M.; Naylor, M.; Nelson, K.; Newman, A.; Newman, W.; Nineberg, A.; Norko, M.; Noroian, P.; Obrocea, G.; Ochoa, K.; O'Shaugnessy, R.; Panbehi, B.; Parker, G.; Patole, S.; Pearce, A.; Penn, J.; Penney, S.; Phillips, G.; Phillips, R.; Pinals, D.; Pomichalek, M.; Post, J.; Prabhu, M.; Price, M.; Purcell, R.; Rachal, F.; Racine, C.; Rajan, A.; Raley, J.; Raub, J.; Read, S.; Reid, R.; Resnick, P.; Reynolds, J.; Rice, S.; Rodgers, C.; Roof, J.; Rosenbaum, K.; Roskes, E.; Rosmarin, D.; Rosner, R.; Ross, C.; Roth, V.; Rotter, M.; Roy-Bujnowski, K.; Rushing, S.; Ryan, E.; Sagar, A.; Saleem, M.; Saleh, F.; Samuel, R.; Sanderson, S.; Savageau, J.; Savatta, S.; Sawyer, D.; Scott, C.; Sevilla, C.; Shebairo, K.; Shen, F.; Siegel, D.; Silverman, S.; Simmer, E.; Simon, A.; Simpson, A.; Singh, A.; Smarty, S.; Smelson, D.; Smith, J.; Snyder, S.; Sohn, I.; Sokolov, G.; Soliman, L.; Soliman, S.; Sorrentino, R.; Soysal, N.; Stathopoulou, G.; Steinberg, A.; Stevens, K.; Stroud, R.; Suardi, E.; Suddle, A.; Tabery, J.; Taylor, R.; Thompson, C.; Tolou-Shams, M.; Torry, Z.; Trestman, R.; Troneci, L.; Trupin, E.; Venters, H.; Vincent, G.; Warburton, K.; Wasan, A.; Way, B.; Weinstock, R.; Weiss, K.; Wendt, F.; Werner, T.; West, S.; Whitehead, P.; Williams, A.; Woods, S.; Woolfer, C.; Wortzel, H.; Wyshak, G.; Yakeley, J.; Yang, S.; Yoo, T.; Yoon, M.; Zerby, S.; Zonana, H.; Zuchowski, S.

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

Neil Kaye, MD: Received speaker honoraria from Pfizer and Sunovion Pharmaceuticals, Inc.

Richard Krueger, MD: Dr. Krueger's wife Dr. Meg Kaplan received travel support to speak at a conference in Israel sponsored by Ferring Pharmaceuticals. Dr. Krueger spoke at the same conference but did not receive any compensation.

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.

Alizai-Cowan, S.; Anfang, S.; Benedek, E.; Billick, S.; Christopher, P.; Coleman, J.; Decker, K.; Fozdar, M.; Frierson, R.; Gold, L.; Greiner, C.; Halavonich, R.; Henry, S.; Holzer, J.; Hung, E.; Johnson, N.; Kaempf, A.; Keram, E.; Knoll, IV, J.; LeBourgeois, H.; Newman, A.; Newman, W.; Ostermeyer, B.; Parker, G.; Pearlson, S.; Pinals, D.; Pozios, V.; Preven, D.; Price, M.; Rosmarin, D.; Schiffman, E.; Scott, C.; Silberberg, J.; Sokolov, G.; Srinivasaraghavan, J.; Stolar, A.; Thompson, C.; Trueblood, K.; Wall, B.; Wills, C.

The following Program and Education committee members made a declaration of a financial relationship and agreed to recuse themselves from discussions where a potential bias could exist.

Neil Kaye, MD: Received speaker honoraria from Pfizer and Sunovion Pharmaceuticals, Inc.

Richard Krueger, MD: Dr. Krueger's wife Dr. Meg Kaplan received travel support to speak at a conference in Israel sponsored by Ferring Pharmaceuticals. Dr. Krueger spoke at the same conference but did not receive any compensation.



SPECIAL EVENTS

THURSDAY, OCTOBER 27

Past Presidents' Breakfast	7:00 a.m. - 8:00 a.m.	Cambridge 4th Floor
Opening Ceremony - President's Address (open to all attendees)	8:00 a.m. - 10:00 a.m.	Imperial Ballroom 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.	Plaza Ballroom 2nd Floor

FRIDAY, OCTOBER 28

Rappeport Fellows Breakfast (Rappeport Fellows and Committee)	7:00 a.m. - 8:00 a.m.	Cambridge 4th Floor
Maintenance of Certification Information Session	7:00 a.m. - 8:00 a.m.	Whittier 4th Floor
Reception (for all meeting attendees)	6:00 p.m. - 7:30 p.m.	Plaza Ballroom 2nd Floor

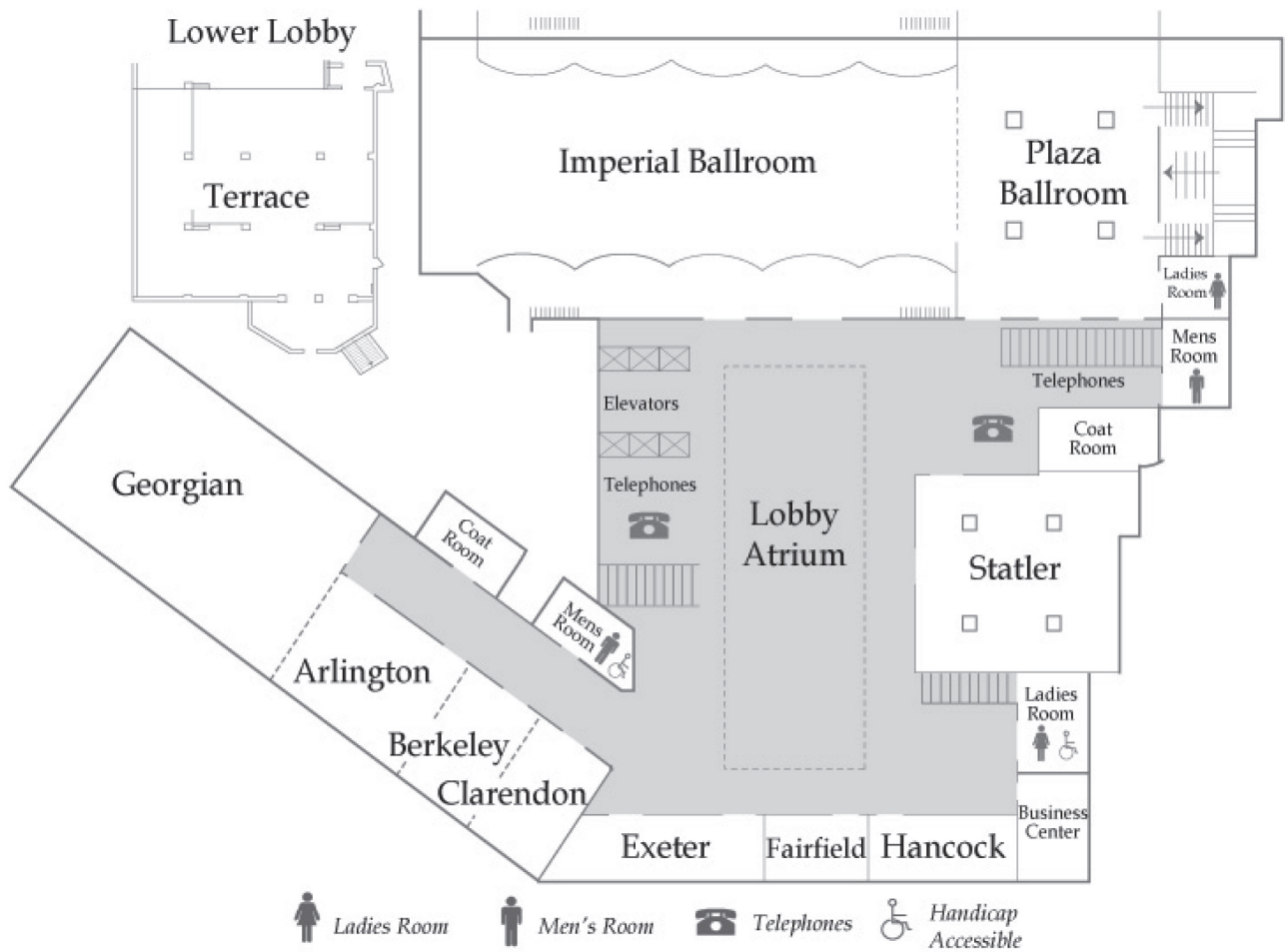
SATURDAY, OCTOBER 29

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.	Cambridge 4th Floor
AAPL Business Meeting (members only)	8:00 a.m. - 9:30 a.m.	Imperial Ballroom 2nd Floor
Mid-west AAPL Chapter Meeting (Chapter Meetings by request only, please contact AAPL Staff)	6:15 p.m. - 7:30 p.m.	Arlington 2nd Floor

COFFEE BREAKS WILL BE HELD IN THE EXETER FOYER

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

MEZZANINE MEETING ROOMS - SECOND FLOOR



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-second Annual Meeting**



OPENING CEREMONY

Thursday, October 27, 2011

8:00 a.m. - 10:00 a.m.

WELCOME, INTRODUCTIONS

Peter Ash, MD
President

PRESENTATION OF RAPPEPORT FELLOWS

Victoria L. Harris, MD, MPH
Chair, Rappeport Fellows Committee

Sandra Antoniak, MD
University of Iowa Children's Hospital

Abilash Gopal, MD
University of California, San Francisco

John Jimenez, MD
University of Southern California Medical Center

Kevin Marra, MD
University of North Carolina

Monifa Seawell, MD
Wayne State University, Detroit Medical Center

Melissa Spanggaard, DO
*University of South Dakota,
Sanford School of Medicine*

AWARD PRESENTATIONS

Renée L. Binder, MD
Chair, Awards Committee

Golden Apple Award

Ezra E.H. Griffith, MD

Seymour Pollack Award

Liza Gold, MD

Red Apple Award

Jagannathan Srinivasaraghavan, MD

Award for Outstanding Teaching in a Forensic Fellowship Program

Kenneth Weiss, MD

Young Investigator Award

Paul Christopher, MD

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

Charles Scott, MD
Christopher Thompson, MD
Program Co-Chairs

INTRODUCTION OF THE PRESIDENT

Stephen B. Billick, MD

PRESIDENT'S ADDRESS

Peter Ash, MD

ADJOURNMENT

Charles Scott, MD
Christopher Thompson, MD

AWARD RECIPIENTS

GOLDEN AAPL AWARD

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

EZRA E.H. GRIFFITH, MD

Dr. Ezra Griffith received his B.A. from Harvard University and his M.D. from the University of Strasbourg in France. He is currently the Deputy Chairman for Diversity and Organizational Ethics in the Department of Psychiatry at Yale University and an Emeritus Professor of Psychiatry and African-American Studies. He is also Acting Medical Director of the Department of Mental Health and Addiction Services for the State of Connecticut.

Dr. Griffith has broad consultation experience in mental health service systems and has written extensively in the areas of cultural and forensic psychiatry. From 1987 to 1996, Dr. Griffith directed the Connecticut Mental Health Center, a joint endeavor of the Yale University School of Medicine and Connecticut's Department of Mental Health and Addiction Services. Dr. Griffith has written 66 articles, 59 book chapters and commentaries, and 9 books. His recent books include: Race and Excellence: My Dialogue with Chester Pierce, I'm Your Father, Boy—a mixed biographical and autobiographical narrative, and Ye Shall Dream: Patriarch Granville Williams and the Barbados Spiritual Baptists. In 2010, Dr. Griffith received the Isaac Ray Award for outstanding contributions to forensic psychiatry and the psychiatric aspects of jurisprudence. Since 1999, Dr. Griffith has served as the Editor of the *Journal of the American Academy of Psychiatry and the Law*.

Dr. Griffith has served as President of multiple organizations including: Black Psychiatrists of America, American Orthopsychiatric Association, the Connecticut District Branch, the Board of Directors of the American Board of Forensic Psychiatry, and the American Academy of Psychiatry and the Law. He has served on multiple components of the American Psychiatric Association including: Council on Psychiatry and the Law, Commission on Judicial Action, Task Force on Consent to Voluntary Hospitalization, and the Council on International Affairs. He currently serves as the Chair of the Ethics Committee of the Connecticut District Branch, and as a member of the APA Ethics Committee, the Committee on Peer Review of AAPL, the State of Connecticut's Mental Health Strategy Board and the Sentinel Event Advisory Group of JCAHO.

For his significant contributions to the field of forensic psychiatry, the American Academy of Psychiatry and the Law presents the 2011 Golden AAPL Award to Dr. Ezra Griffith.

SEYMOUR POLLACK AWARD

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

LIZA GOLD, MD

Dr. Liza Gold graduated magna cum laude from Harvard/Radcliffe and then went to medical school at New York University. She completed her residency at Boston University and has been a clinical professor of Psychiatry at Georgetown University in Washington D.C. since 2006. She holds medical licenses in Virginia, the District of Columbia, New York, and New Jersey.

Dr. Gold currently is in private practice and serves as a consultant to the Arlington County District and Circuit Courts and the Department of Mental Health. She is also Associate Director of the Georgetown Program in Psychiatry and the Law and is a member of the American Board of Psychiatry and Neurology Forensic Psychiatry Certification Examination Committee. Dr. Gold has held many leadership positions in AAPL and the APA. She is currently Vice President-elect of AAPL and has been a Councilor and a member of the Nominating Committee, the Education Committee, the Trauma and Stress Committee, the Suicidology Committee and the Gender Issues Committee. She was Program Chair of the 2006 Annual Meeting of AAPL. In the APA, she served as Chair of the Tellers Committee and has been a member of the Council on Psychiatry and the Law, the Isaac Ray Award Committee, the Committee on Judicial Action, and the Committee on History and Library.

Dr. Gold has won the Manfred S. Guttmacher Award twice: in 2006 for her book Sexual Harassment: Psychiatric Assessment in Employment Litigation, and in 2011 for her book, co-authored with Daniel Shuman, Evaluating Mental Health Disability in the Workplace: Model, Process. She is the co-editor, with Dr. Robert Simon, of The American Psychiatric Textbook of Forensic Psychiatry, issued in its second edition in April 2009, and the Chair of the AAPL Task Force on the Development of Disability Evaluation Guidelines. In addition, she is the author or co-author of 14 book chapters and 19 articles on forensic psychiatry topics.

In recognition of her significant contributions to the teaching and educational functions of forensic psychiatry, the American Academy of Psychiatry and the Law presents the 2011 Seymour Pollack Distinguished Achievement Award to Dr. Liza Gold.

RED AAPL OUTSTANDING SERVICE AWARD

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

JAGANNATHAN SRINIVASARAGHAVAN (ASHOK VAN), MD

Dr. Ashok Van received his medical degree from the Thanjavur Medical College in India and did his residency at the University of Health Sciences/Chicago Medical School. He is currently a Professor Emeritus at the Southern Illinois University School of Medicine where he served as Chief of the Division of Public and Community Psychiatry for 8 years and lectured at the Southern Illinois University School of Law.

Dr. Van has been an active member of AAPL for many years, and has made innumerable contributions to the organization. He has served as a member of the Geriatric Psychiatry and Law Committee, the Suicidology Committee, the Program Committee, the International Relations Committee, and the Cross-Cultural Issues in Forensic Psychiatry Committee. His energy, enthusiasm and leadership are reflected in the fact that he became chair of 4 of those 5 groups, revitalizing the committees, organizing presentations at the annual meeting, and contributing columns to the AAPL Newsletter. He was particularly enthusiastic in developing liaisons with forensic psychiatrists in other countries and originating the Wednesday site visits at the annual meeting. One of his most substantive contributions as a committee chair was in 2006-7, when he served as Program Chair for our excellent meeting in Miami Beach. In addition to his committee roles, Dr. Van served as Associate Editor of the Newsletter for 5 years, as a Councilor, and as Vice President of AAPL.

These many contributions come in the context of active involvement in other psychiatric organizations, including the APA, the Illinois Psychiatric Society (for which he has just completed his service as president), and the Indo-American Psychiatric Association (where he also served as president). In 2005, Dr. Van went to the worst affected areas in Sri Lanka after the tsunami and trained community volunteers in identifying psychosocial issues in Sri Lanka.

In recognition of his years of devoted service to AAPL as well as his establishment of international liaisons, the American Academy of Psychiatry and the Law presents the 2011 Red AAPL Outstanding Service Award to Dr. Ashok Van.

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.

KENNETH WEISS, MD

Dr. Kenneth Weiss received his medical degree from Hahnemann Medical College, did his internship at the University of Pennsylvania Philadelphia General Hospital and his residency at Massachusetts Mental Health Center. He completed his fellowship in Social and Legal Psychiatry at the University of Pennsylvania. For nine years, Dr. Weiss chaired the Task Force on Mental Retardation of the American Academy of Psychiatry and the Law. In 2009, he received the American Psychiatric Association's Irma Bland Award for excellence in teaching residents.

For 27 years, Dr. Weiss was an Adjunct Clinical Professor of Psychiatry at the University of Medicine and Dentistry of New Jersey, RWJ Medical School. During that time, he was Director of the Residency Program, and Head of both the Division of Ambulatory Care and the Division of Forensic Psychiatry. Dr. Weiss is currently a Clinical Associate Professor of Psychiatry and the Associate Director of the Forensic Psychiatry Fellowship Program at the University of Pennsylvania School of Medicine.

Dr. Weiss is an excellent educator. Here are some of the comments about him:

"Dr. Weiss reflects the essence of a teacher. This is evidenced not only by the success of his students, residents, and fellows as well as by his numerous accolades but also by the unequivocally positive response he undoubtedly receives by students and colleagues." "Dr. Weiss makes each moment a teaching experience rather than waiting for one to knock on his door. I learned an immense amount from his lectures, discussions, articles, as well as by accompanying him on his private forensic evaluations where he personally mentored me." "He has encouraged and supported me to follow and pursue my own forensic interests."

"He not only makes learning an enjoyable experience, but he also makes the lessons memorable." "He has organized grand rounds at various hospitals to bring academia to the state hospitals at which the fellows work." "Ken is the ultimate teacher in a low key fashion."

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

DISTINGUISHED LECTURERS

Thursday, October 27

PETE EARLEY

Crazy: A Father's Search Through America's Mental Health Madness

In a Washingtonian Magazine cover story entitled, *Top Journalists: Washington's Media Elite*, Pete Earley was described as one of a handful of journalists in America who "have the power to introduce new ideas and give them currency." A former reporter for The Washington Post, he is the author of nine nonfiction books and three novels. His first book, *Family of Spies: Inside the John Walker Spy Ring*, was a New York Times bestseller and was made into a five hour miniseries shown on CBS television. For his book, *The Hot House: Life Inside Leavenworth Prison*, Earley spent a full year as a reporter inside a maximum security prison. His book, *Circumstantial Evidence* helped lead to the release of a black man from death row after he had been wrongly convicted of murdering a white teenager in Alabama.

His book, *CRAZY: A Father's Search Through America's Mental Health Madness*, was one of two finalists for the 2007 Pulitzer Prize and describes Earley's attempts to get his son help after he is diagnosed with bipolar disorder. It has won awards from the American Psychiatric Association, Mental Health America and the National Alliance on Mental Illness.

Friday, October 28

DENNIS MAHER

Counseling Innocent Prisoners: An Exoneree's Perspective

Dennis Maher was a sergeant in the army when he was misidentified as the perpetrator of a series of sexual assaults in Lowell, Massachusetts, and wrongfully convicted of the crimes. Maher spent 19 years behind bars, from 1984 to 2003, before post-conviction DNA testing proved his innocence. Today, he works as a mechanic for Waste Management and is married with two children. His daughter is named Aliza, after his attorney, former Innocence Project staff attorney Aliza Kaplan. Maher also advocates for criminal justice reform in New England, speaking to criminal justice professionals and legislators about his experience of wrongful conviction.

Saturday, October 29

GARY PHILLIPS

Child Exploitation in Southeast Asia: Can It Get Any Worse?

Gary Phillips graduated from the University of Wisconsin in May 1986, earning a B.S. degree in Biology with a minor in chemistry. After a short time working in the corporate world for Morton Thiokol, he was hired as a special agent with the United States Customs Service in San Diego, California. While serving a 14-year tour in San Diego, he served 5 years on the Special Response Team, which targeted individuals that posed a high risk to the safety of law enforcement and innocent bystanders due to their high propensity for violence.

As the case agent of hundreds of criminal investigations, he investigated federal violations involving narcotics trafficking, money laundering, fraud, illicit weapon smugglers, child exploitation, white collar crimes, illegal exportation of munitions and acted as the undercover agent in a multitude of different cases. Agent Phillips has served on many federal drug task forces such as the high intensity drug trafficking area team, a DEA task force, the air/marine task force and the undercover commercial truck squad.

In May 2002, Agent Phillips was transferred to the U.S. Embassy in Bangkok, Thailand where he was the Assistant Attaché. While overseas, he was responsible for conducting criminal investigations focusing on counter-terrorism, child exploitation, narcotics, fraud, white-collar crime, weapons violations and maintaining an undercover storefront.

While overseas, Agent Phillips was the first to investigate and utilize a new law called the U.S. PROTECT ACT of 2003, U.S. v. Michael CLARK. Furthermore, he was also the first to take a case to trial using the PROTECT ACT, U.S. v. Kent FRANK.

After serving overseas for 6½ years, Agent Phillips was transferred to Washington, D.C. and Washington State. In June 2011, Agent Phillips retired after 23 year of federal law enforcement service and now is pursuing his M.S. and Ph.D. at the University of Nebraska.

THURSDAY, OCTOBER 27, 2011

THURSDAY

POSTER SESSION A

7:00AM – 8:00AM/
9:30AM – 10:15AM

MEZZANINE FOYER

- T1 Jailhouse Tattoos: A Review and Forensic Implications**
Adam Ligas, MD, Pittsburgh, PA
Suzanne Yang, MD, Pittsburgh, PA
Stephen Zerby, MD, Pittsburgh, PA
- T2 Predictors of Utilization of Sleep Medications for Youth in State Custody**
Shaw Woods, MD, Chicago, IL
Mojgan Makki, MD, (I) Chicago, IL
Huma Abbas, MD, (I) Chicago, IL
Angela Sagar, MD, (I) Chicago, IL
Michael Naylor, MD, (I) Chicago, IL
- T3 Psycholegal Abilities and Successful Competence Restoration**
Douglas Morris, MD, Logansport, IN
Nathaniel DeYoung, MS, (I) Logansport, IN
- T4 Are Sovereign Citizens Competent to Stand Trial?**
George Parker, MD Indianapolis, IN
- T5 A Review of Factors Associated with Police Homicide**
Barbara Beadles, MD, Pittsburgh, PA
Louis Martone, MD, New York, NY
Stephen Zerby, MD, Pittsburgh, PA
- T6 False Confessions: Coercion, Confusion and Court**
Helen M. Farrell, MD, Boston, MA
- T7 A Chilling Trifecta: Child Murder, Serial Murder, Serial Arson in One Woman**
Susan Chlebowski, MD, Syracuse, NY
James Knoll IV, MD, Syracuse, NY
- T8 DSM V Paraphilic Coercive Disorder: Is There Room for Mental State?**
Roger Harris, MD, White Plains, NY
- T9 An Overview of Diminished-Capacity Defense Within the Last Decade: Its Implications for Forensic Psychiatry**
Nesibe Soysal, MD, Washington, DC
Alan W. Newman, Washington, DC
- T10 Suicide Risk Assessment in Veterans**
Paul Noroian, MD, Worcester, MA
Fabian Saleh, MD, Boston, MA
- T11 Child Pornography Sentencing Guidelines-A Fiction**
Seth Silverman, MD, Houston, TX
Jerry McKenney, JD, (I) Houston, TX
- T12 Civil Commitment of Sexually Violent Predators: A State by State Comparison**
Cheryl A. Hill, MD, PhD, (I) Morgantown, WV
Georgette A. Bradstreet, MA, (I) Weston, WV
- T13 fMRI as Court Evidence**
Muhammad Saleem, MD, Bakersfield, CA
Gabriella Obrocea, MD, (I) Bakersfield, CA
Conrado Sevilla, MD, (I) Bakersfield, CA
Tai Yoo, MD, MSBA, (I) Bakersfield, CA
- T14 The Dilemma of the Art of Criminals and Illegal Art**
Stephen Zerby, MD, Pittsburgh, PA
Layla Soliman, MD, Pittsburgh, PA
Anjana Rajan, PsyD, (I) Cambridge, MA

T15 **Standardized Treatment Paths as a Way of Decreasing the Duration of Retention Time of Imprisoned Schizophrenic Offenders in Germany**
Hans-Ludwig Kröber, PhD, (I) Berlin, Germany
Frank Wendt, MD, (I) Berlin, Germany

T16 **Mechanical Restraints in Psychiatric Settings: Findings and Future Perspectives**
John Jimenez, MD, (I) Los Angeles, CA

T17 **Voluntary Admission and Patient-Driven Discharge Procedures**
Amir Garakani, MD, New Canaan, CT

OPENING CEREMONY 8:00AM – 10:00AM **IMPERIAL BALLROOM**

T18 **But He Knew It Was Wrong: Evaluating Juvenile Culpability**
Peter Ash, MD, Atlanta, GA



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

PANEL 10:15AM - 12:00 NOON **IMPERIAL BALLROOM**

T19 **Lights, Camera, Civil Action: Psychiatrists and the Media**
Brian Cooke, MD, Gainesville, FL
Emily Goddard, MD, Gainesville, FL
Tonia Werner, MD, Alachua, FL
Ezra Griffith, MD, New Haven, CT

PANEL 10:15AM - 12:00 NOON **GEORGIAN**

T20 **No, You Can't Leave Me: Issues and Efficacy of Coercive Outpatient Treatment**
Gary Collins, MD, New York, NY
Steven Hoge, MD, New York, NY
Paul Appelbaum, MD, New York, NY

PANEL 10:15AM - 12:00 NOON **STATLER**

T21 **Child Pornography and the Internet: Legal and Clinical Perspectives**
Abigail Judge, PhD, (I) Boston, MA
Fabian Saleh, MD, Boston, MA
Albert Grudzinskas Jr., JD, (I) Worcester, MA
Michael Yoon, JD, (I) Boston, MA

WORKSHOP 10:15AM - 12:00 NOON **BERKELEY/CLARENDON**

T22 **Self-Injurious Behavior in the Nation's Prison Systems: Results and Implications of a National Survey**
Kenneth Appelbaum, MD, Shrewsbury, MA
Judith Savageau, MPH, (I) Worcester, MA
Robert Trestman, PhD, MD, Farmington, CT
Jeffrey Metzner, MD, Denver, CO

RESEARCH IN PROGRESS #1 10:15AM - 12:00 NOON **ARLINGTON**

T23 **Testing the Blades on the "Double-Edged Sword": A National, Experimental Survey of US Trial Court Judges**
James Tabery, PhD, (I) Salt Lake City, UT
Teneille Brown, JD, (I) Salt Lake City, UT
Lisa Aspinwall, PhD, (I) Salt Lake City, UT

T24 **Does Forensic Training Improve Court Reports?**
Barbara McDermott, PhD, (I) Sacramento, CA
Chad Woofter, MD, Napa, CA
Richard Matheson, BA, (I) Napa, CA
Amarpreet Singh, MD, Napa, CA
Shoko Kokubun, PhD, (I) Napa, CA
Isah Dualan, MS, (I) Sacramento, CA


T25 **How Evaluatees Hear Testimony: Forensic Experts' Views**
Suzanne Yang, MD, Pittsburgh, PA
Susan Hatters Friedman, MD, Cleveland Heights, OH
Sherif Soliman, MD, Beachwood, OH

LUNCH (TICKET REQUIRED) 12 NOON – 2:00PM **PLAZA BALLROOM**
T26 CRAZY: A Father's Search Through America's Mental Health Madness
 Pete Earley, (I) Fairfax, VA

WORKSHOP 2:15PM - 4:00PM **BERKELEY/CLARENDON**
T27 Contemporary Analysis of Colin Ferguson's Pro Se Competence
 Robert Phillips, MD, PhD, Annapolis, MD
 W. Lawrence Fitch, JD, (I) Jessup, MD
 Keith Shebairo, MD, JD, New Haven, CT
 Howard Zonana, MD, New Haven, CT

COURSE (TICKET REQUIRED) 2:15PM – 6:15PM **GEORGIAN**
T28 Applying Risk Assessment in Psychiatry
 Michael Norko, MD, New Haven, CT
 Madelon Baranoski, PhD, (I) New Haven, CT

PANEL 2:15PM - 4:00PM **STATLER**
T29 Black Box or Pandora's Box-How Black Boxes Affect our Field
Psychopharmacology Committee
 Henry Levine, MD, Bellingham, WA
 Ryan Hall, MD, Lake Mary, FL
 Neil Kaye, MD, Hockessin, DE

PANEL 2:15PM - 4:00PM **IMPERIAL BALLROOM**
T30 Bullying, An Update: What You Need to Know When Called to Consult
Child & Adolescent Psychiatry Committee

 Bradley Freeman, MD, Brentwood, TN
 Karen Rosenbaum, MD, New York, NY
 Eileen Ryan, DO, Fishersville, VA
 Fabian Saleh, MD, Boston, MA
 Christopher Thompson, MD, Los Angeles, CA

RESEARCH IN PROGRESS #2 2:15PM - 4:00PM **ARLINGTON**
T31 Efficacy of a Web Based Module to Teach Risk Assessment
 Catherine Lewis, MD, Farmington, CT

T32 Restoration of CST: What is Jackson's Reasonable Period of Time?
 Andrew Kaufman, MD, Fayetteville, NY
 Enrico Suardi, MD, Fayetteville, NY

T33 Gender Differences Among Sex Offenders
 Susan Hatters Friedman, MD, Cleveland Heights, OH
 Sara West, MD, Cleveland Heights, OH

COFFEE BREAK 4:00PM - 4:15PM MEZZANINE FOYER

PANEL 4:15PM - 6:15PM **IMPERIAL BALLROOM**
T34 10 Years Later: Clergy Sexual Abuse in Boston
 Allan Nineberg, MD, Cambridge, MA
 Mitchell Garabedian, Esq., (I) Boston, MA
 James Chu, MD, (I) Concord, MA

WORKSHOP 4:15PM - 6:15PM **STATLER**
T35 Traumatic Brain Injury, Amnesia and Competency to Stand Trial: Practical Considerations
 Steven Zuchowski, MD, Reno, NV
 Rich Bissett, PhD, (I) Sparks, NV
 Renee Sorrentino, MD, Quincy, MA
 Susan Hatters Friedman, MD, Cleveland Heights, OH

WORKSHOP		4:15PM - 6:15PM	BERKELEY/CLARENDON
T36	<i>In the Lion's Den II: Surviving Cross-Examination</i>	Roger Samuel, MD, Boca Raton, FL Mark DeBofsky, JD, (I) Chicago, IL Marla Hemphill, MD, Clarksville, TN	
SCIENTIFIC PAPER SESSION #1		4:15PM - 6:15PM	ARLINGTON
T37	<i>Legal Involvement in Severe Mania: Prevalence and Associated Symptoms</i>	Paul Christopher, MD, Rumford, RI Patrick McCabe, MPH, (I) Worcester, MA William Fisher, PhD, (I) Worcester, MA	
T38	<i>Postpartum Psychosis and the Courts</i>	Melissa Nau, MD, San Francisco, CA Renée Binder, MD, San Francisco, CA Dale McNiel, PhD, (I) San Francisco, CA	
T39	<i>PTSD as a Criminal Defense: A Review of Case Law</i>	Omri Berger, MD, San Francisco, CA Renée Binder, MD, San Francisco, CA Dale McNiel, PhD, (I) San Francisco, CA	
T40	<i>Malingering in Homicide Defendants: Use of the MMSE and FIT</i>	Wade Myers, MD, Providence, RI Ryan Hall, MD, Lake Mary, FL Marina Tolou-Shams, PhD, (I) Providence, RI	
MOCK TRIAL		7:00PM - 9:00PM	IMPERIAL BALLROOM
T41	<i>Commonwealth of Massachusetts v. Shanley - Recovered Memories on Trial: Priests, Pedophilia, and Parishioners</i>	Debra Pinals, MD, Worcester, MA James Chu, MD, (I) Concord, MA Christopher Thompson, MD, Los Angeles, CA Charles Scott, MD, Sacramento, CA Katharine Folger, Esq., (I) Woburn, MA	



T1

JAILHOUSE TATTOOS: A REVIEW AND FORENSIC IMPLICATIONS

Adam Ligas, MD, Pittsburgh, PA
Suzanne Yang, MD, Pittsburgh, PA
Stephen Zerby, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE

To review the process of amateur tattooing in incarcerated populations and assess the clinical relevance of tattoos in the forensic population via a literature review.

SUMMARY

Tattooing has been in practice since antiquity, and is described in religious texts such as the Bible and the Koran. Tattoos have even been discovered on Ice Age mummies. In the research literature, modern tattoos have been associated with marginalized groups such as prisoners, gang members and substance abusers. However, the relevance of these observed associations for the interpretation of current tattooing practices may be shifting and changing, given the recent increase in "mainstream" tattooing and the presence of tattooing in popular television shows such as Miami Ink and Marked. We examine the available literature regarding tattooing in forensic populations and discuss tattooing practices that are common in the jail setting. Recent and historical literature regarding the associations between tattooing and risk taking behaviors (such as substance abuse, violence, crime) as well as mental disorders will be reviewed. A discussion of common tattooing practices and equipment used during incarceration will assist in the understanding of tattooing and its risks. Photographs of representative jailhouse tattoos and amateur jailhouse tattooing equipment will add a visual dimension to the presentation. The poster will conclude with questions for further research regarding contemporary tattooing practices in correctional populations.

REFERENCES

Laumann, A, Derick, J: Tattoos and body piercings in the United States: A national data set. J Am Acad Dermatol 55:413-421, 2006
Borokhov, A, et al: Tattoo designs among drug users. Isr J Psychiatry Sci. 43(1):28-33, 2006

SELF ASSESSMENT QUESTIONS

1. A common method of amateur tattooing in jails and prisons may involve any of the following EXCEPT:

- a. guitar string and India ink
- b. electric tattoo gun
- c. needle and ink
- d. manually-operated tattoo gun

ANSWER: b

2. Underlying motivations of prisoners to obtain tattoos may include the following EXCEPT:

- a. gang or group identification
- b. to convey messages to others
- c. tattooing feels good
- d. psychic gratification/self-fulfillment

ANSWER: c

T2

PREDICTORS OF UTILIZATION OF SLEEP MEDICATIONS FOR YOUTH IN STATE CUSTODY

Shaw Woods, MD, Chicago, IL
Mojgan Makki, MD, (I) Chicago, IL
Huma Abbas, MD, (I) Chicago, IL
Angela Sagar, MD, (I) Chicago, IL
Michael Naylor, MD, (I) Chicago, IL

EDUCATIONAL OBJECTIVE

To determine whether there is an association between the type of placement and type of psychiatric diagnosis and the type of sleep medication requested.

SUMMARY

Children and adolescents removed from their homes and placed in state custody have typically been highly stressed and thus are at increased risk for sleep disorders. We hypothesized that (1) the more placements a youth has been in, the more diagnoses the youth would have received and (2) prescriptions for sleep medications for these youth will be positively correlated both with the number of Axis I diagnoses the youth received and the number of placements utilized. These hypotheses are tested utilizing a large (N> 8000) state database of children and adolescents in the custody of the Illinois Department of Child and Family Services (DCFS) who were placed in foster care, residential care, juvenile detention, and inpatient units.

REFERENCES

Caldwell BA, Redeker N. Sleep and trauma: an overview. *Issues in Mental Health Nursing* 26:721-738, 2005
Owens J, Rosen C, Mindell J, Kirchner H. Use of pharmacotherapy for insomnia in child psychiatry practice: a national survey. *Sleep Medicine* 11:692-700, 2010

SELF ASSESSMENT QUESTIONS

1. What is the impact of trauma on sleep in children and adolescents?

ANSWER: Children and adolescents who have experienced traumatic events tend to exhibit various symptomatology, including disturbances of mood, increased anxiety, and nightmares. These can all negatively impact sleep if left untreated.

2. Is there an association with the type of Axis I diagnosis given to a child/adolescent and the type of sleep medication requested?

ANSWER: Typically, children with a mood/anxiety disorder diagnosis are given certain antidepressants for sleep, children with disruptive behavior disorders are typically given a-2 agonists for sleep, and children with psychotic disorders are typically given anti-psychotics for sleep.

T3

PSYCHOLEGAL ABILITIES AND SUCCESSFUL COMPETENCE RESTORATION

Douglas Morris, MD, Logansport, IN

Nathaniel DeYoung, MS, (I) Logansport, IN

EDUCATIONAL OBJECTIVE

This presentation will increase clinicians' awareness of recent research identifying the roles of defendants' competency-related abilities and demographic, clinical, and legal variables as they relate to successful restoration of competence to stand trial.

SUMMARY

Effective and efficient treatment of individuals referred to state hospitals for restoration of competence to stand trial involves important individual liberty and state budgetary interests. In an effort to identify factors associated with successful and timely competence restoration, we retrospectively reviewed hospital records of 460 individuals admitted to an Indiana state hospital forensic treatment center for competence restoration from 2001-2009. Clinical, legal, and demographic variables were subjected regression analyses in an effort to identify those factors related to successful competence restoration. Additionally, review of competency assessments allowed identification of subjects' relevant competency-related legal abilities and the association of these abilities with restoration success. The findings of these analyses are presented and discussed.

REFERENCES

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

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

SELF ASSESSMENT QUESTIONS

1. Assessment of the McGarry Criteria is central to which competency to stand trial assessment tool?

a. MacArthur Competence Assessment Tool – Criminal Adjudication (MacCAT-CA)

b. Fitness Interview Test – Revised (FIT-R)

c. Competency to Stand Trial Assessment Instrument (CAI)

d. Georgia Court Competency Test – Mississippi State Hospital (GCCT-MSH)

e. Evaluation of Competency to Stand Trial – Revised (ECST-R)

ANSWER: c

2. Which of the following regarding the McGarry Criteria is/are true?

a. The McGarry Criteria involve 13 areas of a defendant's functioning relevant to understanding of the nature of one's proceedings and ability to assist one's attorney.

b. The McGarry Criteria involve evaluatees' responses to a standardized vignette regarding an alleged assault.

c. The McGarry Criteria involve evaluatees' descriptions of a standardized courtroom scene.

d. The McGarry Criteria may be used a guide to structure a competency assessment without calculation of a total score.

e. a and d

ANSWER: e

EDUCATIONAL OBJECTIVE

Participants will gain an understanding of the belief system of the sovereign citizen movement; appreciate how these beliefs could cause consternation in the courts; and learn how sovereign citizens might or might not meet the Dusky standard.

SUMMARY

Introduction: Sovereign citizens are adherents to a fringe political group which believes the US legal system is invalid. As a result, they typically cause great difficulty when they appear in court. Methods: Competence evaluations on several sovereign citizens were reviewed. Information on their belief system was obtained from several websites. Results: Adherents to the sovereign citizen movement typically assert that the Uniform Commercial Code is the primary law of the land, which allows the use of sight drafts to settle all transactions and reduces all court participants to either debtors or secured parties. They believe civil and criminal courts are actually admiralty courts. They often refuse to pay taxes or to pay license or registration fees of any kind. They typically represent themselves in court. On evaluation, sovereign citizens firmly held their beliefs but rarely showed evidence of serious mental illness. Discussion: Adherents to the sovereign citizen movement were generally found to have the capacity to understand the proceedings and assist an attorney. Judges and attorneys appreciated receiving guidance on appropriate management of sovereign citizens during court proceedings.

REFERENCES

MacNab JJ: Sovereign Citizen Kane; and The Sovereigns: A Dictionary of the Peculiar. Southern Poverty Law Center Intelligence Report 139, 2010

U.S. v. Frank Svoboda, 6th Circuit Court of Appeals, No. 10-3794, 2011; available at : http://courtlister.com/pdf/2011/02/03/USA_v_Frank_Svoboda.pdf. Accessed February 28, 2011

SELF ASSESSMENT QUESTIONS

1. Which of the following questions about the sovereign citizen's movement is not correct?

- Adherents believe all domestic courts are admiralty courts.
- Adherents believe they can convert government actions into commercial transactions by writing accepted for value on a document.
- Adherents believe they can file a UCC form to reclaim their identity from the government.
- Adherents believe they can issue their own licenses and registration documents.
- Adherents believe they must respect the legal authority of the sheriff.

ANSWER: e

2. Assessment of competence to stand trial in adherents to the sovereign citizen movement can be challenging because:

- Their beliefs can appear to be of delusional intensity, with grandiose and paranoid elements.
- They may have submitted a large volume of documents to the courts written with unusual grammar and unusual claims.
- They may be uncooperative with the psychiatric evaluation, rejecting any suggestion of mental illness.
- They typically insist on representing themselves but make repeated inappropriate verbal motions and objections.
- All of the above.

ANSWER: e

Barbara Beadles, MD, Pittsburgh, PA

Louis Martone, MD, New York, NY

Stephen Zerby, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE

Participants will learn the factors involved in the murder of police officers in the line of duty, based on a review of the published literature. An examination of individual cases will provide examples of the diverse motives of the perpetrators as well as characteristics of perpetrators and victims.

SUMMARY

The murder of police officers in the line of duty is a rare crime that has received little attention in the literature, particularly within forensic psychiatry. However, the murder rate of police officers is approximately twice that of civilians. As the recent killings of police officers in Philadelphia, Pittsburgh, and Oakland, CA have shown, this act is committed by individuals from diverse backgrounds with a variety of motives. We will present a review of the

most recent demographic and statistical data collected on police homicides focusing on circumstances, perpetrators, and victims. We will then present a literature review specifically focusing on studies correlating sociological variables to the intentional police officer mortality rate. A design for future study will also be presented.

REFERENCES

Kyriacou D, Monkkonen E, Peek A, Lucke R, Labbett S, Pearlman K, Hutson H: Police Deaths in New York and London during the Twentieth Century. *Inj Prev* 12 (4):219-224, 2006
Peterson R, Bailey W: Structural influences on the killing of police: a comparison with general homicides. *Justice Quarterly* 5: 207 - 233, 1988

SELF ASSESSMENT QUESTIONS

1. Which of the following factors has not been associated with the murder of police officers in the line of duty?
 - a. Poverty level
 - b. Being a police officer in the South
 - c. Divorce rate
 - d. Extensive criminal background of the offender

ANSWER: d

2. According to the FBI's Uniform Crime Report: Law Enforcement Officers Killed and Assaulted, from 1996 - 2007, which was the state that most frequently had the highest annual number of police officers killed?

- a. New York
- b. California
- c. Texas
- d. Florida

ANSWER: c

T6

FALSE CONFESSIONS: COERCION, CONFUSION AND COURT

Helen M. Farrell, MD, Boston, MA

EDUCATIONAL OBJECTIVE

1. Understand that hundreds of convictions based on false confessions have been overturned from DNA evidence
2. Classify false confessions into three distinct areas
3. Appreciate the phenomenology that contributes to false confessions
4. Define the interrogation techniques used by law enforcement agencies
5. Provide effective and helpful expert testimony

SUMMARY

False confessions are counterintuitive to the average person. Numerous convicts who were subsequently exonerated for their crimes initially provided confessions that supported their wrongful convictions. Many factors play a role in false confessions including interrogation techniques, dispositional vulnerabilities, situational pressure, and innocence itself. The 6th and 14th Amendments to the US Constitution entitle criminal defendants to a complete defense, including the right to confront state's evidence. Defense counsel might therefore hire a forensic psychiatrist to educate the trier of fact about the scientific evidence available on false confessions. Expert witnesses must understand this controversial topic, admissibility criteria in court, and how to effectively testify.

REFERENCES

Davis D: Commentary: Overcoming judicial preferences for person versus situation-based analyses of interrogation-induced confessions. *J Am Acad Psychiatry Law* 38(2):187-194, 2010
Watson C: False confessions, expert testimony, and admissibility. *J Am Acad Psychiatry Law* 38(2):174-86, 2010

SELF ASSESSMENT QUESTIONS

1. List and describe the three categories of false confessions.

ANSWER: Voluntary false confessions: There is an absence of overwhelming external stressors by law enforcement. The individual confessing may seek notoriety, may have guilty feelings about some other transgression, may be unable to distinguish reality from fantasy, or may attempt to protect another. Coerced-compliant confessions: The confession is offered in an attempt to avoid external pressure or to obtain a reward. The confessor subjectively does not accept that the confession is true. Coerced-internalized confessions: An innocent person, who because of confusion and the stress of interrogation, begins to accept responsibility.

2. What are some tips for expert witnesses to consider when testifying about false confessions?

Testify to a reasonable degree of medical certainty. Opine if the confession was made knowingly, intelligently and voluntarily. Assert "there are certain characteristics of humans in stressful situations that give rise to adaptations that would be considered self-defeating." Currently there is no empirical evidence that links any particular psychiatric diagnosis with giving false confessions.

T7

A CHILLING TRIFECTA: CHILD MURDER, SERIAL MURDER, SERIAL ARSON IN ONE WOMAN

Susan Chlebowski, MD, Syracuse, NY
James Knoll, IV, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

To understand the forensic aspects and psychodynamic underpinnings in a woman who murdered her 3 children, and 4 unrelated children and set numerous fires.

SUMMARY

Maternal filicide, female serial murder and female serial arson are very rare events. We present here the case of a woman who demonstrated all three of these unusual phenomena. The subject killed three of her own children, as well as four children of social contacts. She was suspected of having set 17 fires, and several of her child victims died as a result of the fires she set. Her life was characterized by severe character pathology, childhood sexual abuse and early deaths of her three siblings. This poster presentation will briefly discuss the rarity of these three phenomena, and present this highly unusual case report. The case details allow for a theoretical discussion of the forensic psychiatric aspects of these three violent behaviors, as well as psychodynamic considerations. It is concluded that a combination of disruptive childhood development, severe character pathology (including antisocial features), substance abuse and traumatic reenactment were strong contributors to this woman's life long violent behavior. Treatment implications of these findings are discussed.

REFERENCES

Bourget D, Grace J, Whitehurst L: A review of maternal and paternal filicide. *J Am Acad Psychiatry Law* 35(1):74-82, 2007
Noblett S, Nelson B: A psychosocial approach to arson: a case controlled study of female offenders. *Med Sci Law* 41(4):325-30, 2001

SELF ASSESSMENT QUESTIONS

1. The motives for female arson include:

- a. Depression
- b. Cry for help
- c. Anger/revenge
- d. Attention getting
- e. All of the above

ANSWER: e

2. The motives for female serial murder include:

- a. "Black Widow"
- b. "Angel of Death"
- c. Revenge
- d. Sexual predator
- e. All of the above

ANSWER: e

T8

DSM V PARAPHILIC COERCIVE DISORDER: IS THERE ROOM FOR MENTAL STATE?

Roger Harris, MD, White Plains, NY

EDUCATIONAL OBJECTIVE

This poster will help individuals who conduct sex offense evaluations integrate research into their assessments. The DSM V Paraphilia Subwork Group will be reviewed to see how mental state can increase its diagnostic specificity.

SUMMARY

The Paraphilias Subworkgroup has made several proposals for DSM V including Paraphilic Coercive Disorder (PCD). The workgroup's criteria for PCD: "The person is distressed or impaired by these attractions, or has sought sexual stimulation from forcing sex on three or more nonconsenting persons on separate occasions." Although the 'A' criterion reports: "Over a period of at least six months, recurrent, intense sexually arousing fantasies or sexual urges focused on sexual coercion" the criteria for PCD is notable for its lack of a description of what urges or fantasies can motivate an individual to act in this manner. This omission means that it is going to be difficult for clinicians to decide if reports by these men would meet criteria for PCD. Without detailing internal motivations or mental events which lead to the offense, one is left with just the behavior, coercing an individual to comply with their sexual demands. This does not move the field forward and gives us no additional information.

REFERENCES

- Drieschner K, Lange A: A review of cognitive factors in the aetiology of rape: theories, empirical studies and implications. *Clinical Psychology Review* 19:57-77, 1999
- McKibben A., Proulx J, Lusignan R: Relationships between conflict, affect and deviant sexual behaviors in rapists and child molesters. *Behaviour Research and Therapy* 32: 571-575, 1994

SELF ASSESSMENT QUESTIONS

1. What are the three categories of cognitive distortions for men who commit rape?

ANSWER: 1. The overperception hypothesis: sexual aggressors tend to misperceive women's friendly behavior as seductive and assertive behavior as hostile; 2. The positivity bias hypothesis: rapists misperceive negative dismissive cues from women as positive and encouraging in ambiguous situations; 3. The suspicious schema hypothesis states: rapists generally mistrust women's communications, independent of the type of affective cues emitted.

2. What are the mood states which appear to increase violent sexual fantasies in men who rape?

ANSWER: For rapists, negative mood and the presence of conflicts coincided with deviant sexual fantasies and increased masturbatory activities during these fantasies. The emotions most frequently reported by rapists following conflicts were loneliness, humiliation, anger and feelings of inadequacy and rejection.

T9

AN OVERVIEW OF DIMINISHED-CAPACITY DEFENSE WITHIN THE LAST DECADE: ITS IMPLICATIONS FOR FORENSIC PSYCHIATRY

Nesibe Soysal, MD, Washington, DC

Alan W. Newman, MD, Washington, DC

EDUCATIONAL OBJECTIVE

To provide information on the recent trends in the use of diminished capacity defense and discuss the ethical and practical implications on forensic psychiatry

SUMMARY

The concept of diminished (mental) capacity is used in the courts as an evidence to indicate that the defendant was not able to form the specific intent during the premeditation and deliberation of the alleged offense, that is, he suffered from a mental disorder or defect that prevented him forming the *mens rea* knowingly, and intentionally. When successful, it may result in reduction of specific intent crime to a general intent crime or in acquittal. This poster provides a synopsis of diminished capacity defense in history and reviews cases with an emphasis on the US Supreme Court and other higher courts decisions to delineate the trends in its applications. The trends discussed include the type of offenses, the scope of mental illness or defect, and the final decisions. The concept of "mental disease or defect" in diminished capacity defenses seems to be much broader in diminished capacity defense compared to that of insanity defenses and, at times, tends to observe the boundaries of DSM IV-TR and evidenced-based psychiatry. The poster summarizes the implications of diminished capacity defense on the evidence-based and ethical practice of forensic psychiatry.

REFERENCES

- Fradella H: From insanity to beyond diminished capacity: mental illness and criminal excuse in post-Clark era. 18 U. Fla. J.L. & Pub. Pol'y 7, 2007
- Brakel SJ, Brooks AD: Diminished capacity and related defenses, in *Law and Psychiatry in the Criminal Justice System*. Littleton, Colorado: Fred B. Rothman & Co, 2001

SELF ASSESSMENT QUESTIONS

1. What are the legal differences between diminished capacity and diminished responsibility?

ANSWER: Diminished capacity is related to the capacity to form specific intent as a prong of *mens rea* and used as a defense for reduction of the offense or for acquittal whereas diminished responsibility is used for mitigation of sentencing.

2. What are some of the diagnoses that were used as an evidence for constructing mental capacity and related defenses?

ANSWER: Intoxication, battered woman syndrome, black rage syndrome, media intoxication, transient amnesia due to head trauma, premenstrual syndrome.

T10

SUICIDE RISK ASSESSMENT IN VETERANS

Paul Noroian, MD, Worcester, MA

Fabian Saleh, MD, (I) Boston, MA

EDUCATIONAL OBJECTIVE

To review current literature regarding mental health treatment and suicidal behaviors in veterans of the US armed forces; to help identify suicide risk factors in veterans, with the goal of improving suicide risk assessment in this population

SUMMARY

Suicides by veterans of the US armed forces have received much attention in the news media. The conflicts in Afghanistan and Iraq have led to an increase in the utilization of mental health services by veterans, and the military has begun mental health screening programs for returning service members. Studies of suicides in the veteran population appear to show an increase in the incidence of suicide in certain sub-groups, prompting an examination of how this population is assessed and treated. This poster involves a review of the current literature on veterans and suicide, looking specifically at risk factors that may be unique to this population. Recommendations for assessment and implications for treatment will be outlined.

REFERENCES

Bruce ML: Suicide risk and prevention in veteran populations. *Annals of the New York Academy of Sciences* 1208:98-103, 2010
Kaplan MS, Huguet N, *et al*: Suicide among male veterans: a prospective population-based study. *J of Epidemiology and Community Health* 61:619-624, 2007

SELF ASSESSMENT QUESTIONS

1. Suicide risk factors in VA patients have been reported to include:

- a. Male sex
- b. Psychiatric Disorders
- c. Availability of firearms
- d. Advanced age
- e. All of the above

ANSWER: e

2. Clinical disorders associated with increased suicide risk include:

- a. Schizophrenia
- b. Major depression
- c. Alcohol dependence
- d. All of the above

ANSWER: d

T11

CHILD PORNOGRAPHY SENTENCING GUIDELINES-A FICTION

Seth Silverman, MD, Houston, TX
Jerry McKenney, JD, (I) Houston, TX

EDUCATIONAL OBJECTIVE

To review psychiatric and legal perspectives and how those perspectives have resulted in sentencing guidelines that are archaic and destructive

SUMMARY

Child pornography literature is reviewed from a psychiatric and legal perspective. The psychiatric literature review focuses on etiology, diagnosis, and risk to reoffend while the legal history focuses on the history of Child Pornography on Federal Guidelines and their current state of affairs. The psychological history is presented by the first author and the legal history by the second author. Three child pornography cases presented by the first author were interviewed and sentenced during the past year. They illustrate a group of offenders who might be at very low risk to reoffend and how this information was utilized by the court in its sentencing decisions. Risk factors consistent with those individuals who do not form healthy attachments in life and consistent with statistical analysis of the characteristics of those that reoffend, such as those found in the SORAQ, are modified and extrapolated. Recommendations are made for modifications of the Federal Sentencing Guidelines.

REFERENCES

Endraa J, Rossegger, A: Child pornography as a risk factor for hands on sex-offending? *European Psychiatry* 25(1):676-676, 2010
Eke AW, Seto, MC, Williams, J: Examining the criminal history and future offending of child pornography offenders: an extended prospective follow-up study. *Law Hum Behav* 2010 Nov 19

SELF ASSESSMENT QUESTIONS

1. Explain why current Federal Sentencing Guidelines have been mandated by legislation, not by data or recommendations from sentencing committees:

ANSWER: It has been politically expedient to lump all offenders together and treat them as if they were all in the highest likely group to reoffend.

2. What are the characteristics of convicted child pornographers who are at lowest risk to reoffend or progress to becoming predators?

ANSWER: Relatively good work history, school history, minimal priors and antisocial behavior, reasonable relationships, and insight and motivation.

T12

**CIVIL COMMITMENT OF SEXUALLY VIOLENT PREDATORS:
A STATE BY STATE COMPARISON**

Cheryl A. Hill, MD, PhD, Morgantown, WV
Georgette A. Bradstreet, MA, (I) Weston, WV

EDUCATIONAL OBJECTIVE

To gain an understanding of civil commitment statutes for sexually violent predators.

SUMMARY

Currently 20 states have legislation regarding the civil commitment of sexually violent predators (SVP) after their release from jail. This practice stems from a desire to protect society from sex offenders who are deemed unlikely to be capable of controlling their behaviors and are consequently at high risk for re-offense. There has been much debate about whether this role should fall to the mental health community or to the Department of Corrections. Frequently, the argument for civil commitment rather than continued incarceration is that these offenders have a mental illness and require treatment rather than incarceration. States vary in how they determine the likelihood of sexual recidivism and with regard to where the SVPs are housed after they are civilly committed and the length of the commitment. We present a state by state comparison of civil commitment statutes.

REFERENCES

Fitch WL, Ann NY: Sexual offender commitment in the United States: legislative and policy concerns. Acad Sci. 989:489-501, 2003
Kendall WD, Cheung M: Sexually violent predators and civil commitment laws. J Child Sex Abuse 13(2):41-57, 2004

SELF ASSESSMENT QUESTIONS

1. In 2010 what was the estimated number of civilly committed SVPs in the USA?

ANSWER: Approximately 4,000

2. How many states have statutes for the civil commitment of SVPs?

ANSWER: 20

T13

fMRI AS COURT EVIDENCE

Muhammad Saleem, MD, Bakersfield, CA
Gabriella Obrocea, MD, (I) Bakersfield, CA
Conrado Sevilla, MD, (I) Bakersfield, CA
Tai Yoo, MD, MSBA, (I) Bakersfield, CA

EDUCATIONAL OBJECTIVE

The participant will be able to 1) Appreciate the history of functional magnetic resonance imaging, basic concepts, and how it works. 2) Understand the advantages of functional Magnetic Resonance Imaging and basic research findings. 3) Understand the role of functional MRI in court and the challenges of expert witness.

SUMMARY

BOLD fMRI is a newly developed diagnostic modality, which indirectly measures the brain activity during different brain functions, by measuring the blood flow to a particular area of brain and hence localizes the areas involved in a specific act or behavior including, sociopathy, lying, pedophilia or other crimes. We performed a literature search in duration ranging from 1991 to 2010. We explored PubMed, Psychiatry online and the Web. BOLD fMRI has initiated a great interest among researchers. We found 177 articles, publications and abstracts relevant to the topic of presentation. Many studies have shown functional MRI as a useful tool in mapping neurological basis of behaviors including sociopathy, pedophilia, aggression and lying behaviors. BOLD fMRI is being used for lie detection but with skepticism. With increasing frequency, criminal defense attorneys are integrating neuro-imaging data into hearings related to determinations of guilt and sentencing mitigation. However, the critics are concerned; fMRI may wrongfully sway the jury. The presentation includes a list of questions the fMRI expert witness should expect or face in the court.

REFERENCES

Kozel FA, Johnson KA, Grenesko EL *et al*: Functional MRI detection of deception after committing a mock sabotage crime. J Forensic Sci 54(1):220-31. 2009
Brown T, Murphy E: Through a scanner darkly: functional neuroimaging as evidence of a criminal defendant's past mental states. Stanford Law Rev. 62(4):1119-208, 2010

SELF ASSESSMENT QUESTIONS

1. How is fMRI different than MRI?

ANSWER: fMRI shows the function during thought processes while MRI shows the structure of brain.

2. Is fMRI admissible as court evidence for guilt determination?

ANSWER: No

T14

THE DILEMMA OF THE ART OF CRIMINALS AND ILLEGAL ART

Stephen Zerby, MD, Pittsburgh, PA
 Layla Soliman, MD, Pittsburgh, PA
 Anjana Rajan, PsyD, (I) Cambridge, MA

EDUCATIONAL OBJECTIVE

Since antiquity humans have exhibited a psychological need to create art. Participants will be introduced to the subcultural interest in the art of convicted criminals, depiction of crime in art, and the ethics controversies they raise. The psychological and developmental underpinnings of controversial illegal art will be explored.

SUMMARY

Subcultural interest exists in the artwork of convicted criminals such as serial murderers. While prison art therapy is well-established, the promotion and distribution of such works has generated controversy. The ethics of financial reimbursement and self-promotion for prison art has ignited debate in the worlds of art, criminal justice, law, and advocates for civil liberties. Legislative attempts to impose restrictions on such artwork have raised First Amendment issues. The question of whether art can promote crime will be explored focusing on the case of the murders in Perpignan and their suggested connection to the work of Salvador Dali. Literature on the psychological study of such art will be reviewed. Graffiti has been a human activity since antiquity. In recent years graffiti has been an evolving phenomenon, for example the practice of compulsive “tagging.” Aesthetic issues caused by graffiti are now known to be accompanied by the financial cost and health risks associated with graffiti removal. A greater understanding of the problem of the illegal art of graffiti will be presented as a public policy initiative. A review of the associated sociodemographic and psychopathological factors influencing graffiti will be discussed. Representative images of street art will be displayed and discussed.

REFERENCES

Catheline-Antipoff N, Soulayrol R: White walls for black holes: essay on graffiti psychopathology. *Psychiatr Enfant*. 38(2):625-653, 1995
 The Dali Murder Mystery. *The Guardian*. Available at <http://www.guardian.co.uk>. Accessed July 27, 2011

SELF ASSESSMENT QUESTIONS

1. Prisoners may gain benefit from prison art through all of the following except:

- a. Financial gain
- b. Increased notoriety
- c. Psychotherapeutic benefit
- d. Greater sympathy from victims’ rights groups

ANSWER: d

2. Which of the following statements concerning art and crime is true?

- a. Artwork-inspired crime is a well-proven phenomenon.
- b. The costs to society of illegal art are negligible.
- c. Underlying psychological and developmental motivations may drive some forms of vandalistic art.
- d. The majority of “tagging” adolescents are eventually diagnosed with antisocial personality disorder as adults.

ANSWER: c

T15

STANDARDIZED TREATMENT PATHS AS A WAY OF DECREASING THE DURATION OF RETENTION TIME OF IMPRISONED SCHIZOPHRENIC OFFENDERS IN GERMANY

Hans-Ludwig Krober, PhD, (I) Berlin, Germany
 Frank Wendt, MD, (I) Berlin, Germany

EDUCATIONAL OBJECTIVE

To improve information about problems and new solutions concerning treatment of imprisoned schizophrenic offenders in Germany

SUMMARY

Over the last decade, Germany has to deal with an increasing number of offenders suffering from schizophrenia and being sentenced to imprisonment. In order to change this development, it will be necessary to create and establish optimized procedures of treatment for offenders with schizophrenia (treatment paths) in penal institutions. Binding standards must be developed in cooperation with forensic hospitals in order to shorten the retention time and improve after-care by networking with ambulant psychiatric systems. This will be the only way to improve the cooperation with a general psychiatry that is more focused on ambulant structures of care and has more difficulties to deal with aggression or non-compliance of schizophrenic patients. Furthermore, such treatment paths are a way to shorten the retention time of these mentally ill persons in penal institutions by making their re-integration into general psychiatry easier.

REFERENCES

Kröber HL: The historical debate on brain and legal responsibility - revisited. Behavioral Sciences & the Law 25: 251-261, 2007
Kröber HL: Concepts of intentional control. Behav Sci Law 27:209-21, 2009

SELF ASSESSMENT QUESTIONS

1. What problems for schizophrenic offenders result from changes in general psychiatry?

ANSWER: A general psychiatry that is more focused on ambulant structures has problems to cope with aggressive and in-compliant patients.

2. How can these problems for schizophrenic offenders be solved?

ANSWER: By creating new treatment pathways.

T16

MECHANICAL RESTRAINTS IN PSYCHIATRIC SETTINGS: FINDINGS AND FUTURE PERSPECTIVES

John Jimenez, MD, (I) Los Angeles, CA

EDUCATIONAL OBJECTIVE

The poster will provide the reader with: 1. basic information on the historical background of seclusion and restraint. 2. overview of findings from past research into trends of restraint episodes; 3. overview of selected interventions demonstrated to reduce restraint episodes; 4. examination of gaps in current literature.

SUMMARY

The history of restraints is inextricably tied to the history of psychiatry, mental institutions, and prevailing perceptions of mental illness. Psychiatric treatments reflected their respective historical contexts, especially in terms of that time's understanding of the causes of mental illness. Restraints, as a form of treatment, developed in a parallel manner. With the growing awareness of appropriate indications for restraints, measures to evaluate the incidence and circumstances of restraint episodes have been undertaken at many institutions, but the data varies considerably. Efforts to reduce usage and reliance on restraints have been driven by clients, providers, and institutions. Successful institutional programs to reduce restraints share common approaches, and these measures can be reproduced with some reliability. Still, despite the existing body of literature regarding restraint trends, indications, and efforts to minimize exposure, generalizable conclusions are difficult, and more research must be directed to understanding this ethical and clinical dilemma.

REFERENCES

Fisher WA: Restraint and seclusion: a review of the literature. Am J Psychiatry 151: 1584-1591, 1994
Belkin GS: Self-restraint, self-examination: a historical perspective on restraints and ethics in psychiatry. Psychiatric Services 53(6):663-4, 2002

SELF ASSESSMENT QUESTIONS

1. What are several forms of restraints used in historical practice?

ANSWER: Several antiquated, extreme forms include handcuffs, the straightjacket, the coercion chair, and the crib box.

2. Does the literature suggest a possible elimination of restraints?

ANSWER: Many institutional efforts have had considerable success in reducing both incidence and prevalence of restraints, but very few instances demonstrate a complete eradication of this intervention. In fact, many institutions appear to operate under the axiom that some measure of restraint is sometimes ultimately necessary.

EDUCATIONAL OBJECTIVE

The purpose is to examine voluntary psychiatric hospitalization in the United States, in particular, the state-by-state regulations regarding patient requests for discharge after being admitted and whether patients understand their rights and whether the current statutory provisions for protecting their rights are adequate.

SUMMARY

Voluntary psychiatric hospitalizations have changed the shape of mental health care in the United States. Today, persons seeking inpatient hospitalization are offered voluntary admission unless they lack capacity or are refusing hospitalization and are deemed a danger to self or others or are gravely disabled, depending on the state's definitions for commitment. One area that has gone unstudied is the patient's right to request discharge and how various states stipulate that such patients are managed. We conducted a review of the history of hospitalization for mental illness in the United States and an analysis of varying state laws. The voluntary status is believed to result in patients seeking treatment earlier in their illness in part due to its giving the patient a feeling of increased responsibility for their treatment. Our hypothesis is that most states would have clearly stated provisions for patients seeking discharge and for the treatment team to manage such cases. Our findings of a legal and literature review indicate that 46 states have stipulations about patients requesting discharge, with the majority of states employing a 72-hour period in which patients can be held before discharge or initiation of involuntary commitment through a court hearing.

REFERENCES

- Stone DH: The benefits of voluntary inpatient psychiatric hospitalization: myth or reality? *Boston Univ Public Interest Law J* 9:25-52, 1999
 Gilboy JA, Schmidt JR: "Voluntary" hospitalization of the mentally ill. *Northwest Univ Law Rev* 66:429-453, 1971

SELF ASSESSMENT QUESTIONS

1. Do the statutory guidelines for patient requests for discharge make stipulations for patient capacity at the time of signing voluntary papers?

ANSWER: Only a few states, like Florida, require capacity assessments at the time of hospitalization. Patients requesting discharge at the time of admission may not have had capacity to sign in, thereby making their initial consent to admission invalid. Several research investigations have reported that patients admitted on voluntary legal papers at the time of admission were found to have had diminished capacity at the time they signed themselves in voluntarily. Since capacity is a fluid state, it is clear that the treatment team must be continually assessing the patient's state to determine if he/she understands the ramifications their being admitted and risks and benefits of early discharge.

2. Can any psychiatric hospitalization truly be voluntary, or are certain (or all) patients unwittingly being coerced into hospitalization which may result in the person's indefinite commitment?

ANSWER: Voluntary admission affords rights to patients they normally would not have in cases of involuntary commitment but come with a price. Although patients may request hospitalization they may not be adequately informed, at the time of admissions (usually in an emergency room), of the place where they will be going: a locked unit, with potentially unstable and violent peers, loss (or perceived loss) of privacy and control and freedom, including rights to have their own belongings, cigarettes, food, visitors, etc. In addition, patients who refuse or are even ambivalent about admission may be told at time of admission that they are committable, thereby laying the groundwork for coercion to sign into the hospital voluntarily, or risk being committed. One possible solution to the patients' complaints of feeling blindsided may be better education by mental health providers of the community of the process of voluntary admission and the nature of psychiatric hospitalization.

EDUCATIONAL OBJECTIVE

To assist evaluators of adolescents in understanding and assessing partial criminal responsibility of adolescent defendants.

SUMMARY

Forensic psychiatric evaluators of adolescent defendants are often asked to address open-ended questions that affect what court an adolescent will be tried in and what sentence he might receive. Such questions often involve issues regarding the extent to which the adolescent should be considered less culpable than an adult who has committed

a similar offense. Unlike with adults, who are typically considered either fully responsible or NGRI, with adolescents the question is typically one of partial responsibility. Assessing partial culpability of an adolescent is difficult because the concept of partial culpability is complex, assessment methods are inexact, and the implications for legal disposition are often not clear. This presentation discusses a number of factors a forensic evaluator may wish to consider in reaching opinions about an adolescent's culpability.

REFERENCES

Steinberg L, Scott ES: Less guilty by reason of adolescence: developmental immaturity, diminished responsibility, and the juvenile death penalty. *Am Psychol* 58:1009-18, 2003
Graham v. Florida, 130 S. Ct. 2011, 560 U.S._ (2010)

SELF-ASSESSMENT QUESTIONS

1. What is the concept of psychosocial maturity as used in research on adolescent culpability?

ANSWER: Psychosocial maturity is a construct that includes responsibility (tapping self-perceptions of self-reliance, identity, and work orientation), time perspective (ability to see short and long term consequences), social perspective (the ability to take another person's point of view into account), and temperance (impulse control and suppression of aggression). Psychosocial maturity changes (improves) through adolescence and is a better (inverse) predictor of a propensity to engage in antisocial behavior than is age.

2. What is the main reason environmental circumstances are more relevant to assessing culpability in adolescents as compared to assessing adults' culpability?

ANSWER: Key aspects of adolescents' environment, such as where they live and what school they attend, are imposed and adolescents are less able to change them than are adults.

T19

LIGHTS, CAMERA, CIVIL ACTION: PSYCHIATRISTS AND THE MEDIA

Brian Cooke, MD, Gainesville, FL
Emily Goddard, MD, Gainesville, FL
Tonia Werner, MD, Alachua, FL
Ezra Griffith, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

At the conclusion of the workshop, participants will be able to describe the clinical, ethics, and legal considerations of psychiatrists' interactions with the media.

SUMMARY

The American Psychiatric Association's creation of the "Goldwater Rule" limits psychiatrists from offering professional opinions on public figures. This rule serves as an ethics foundation and may not be applicable to all interactions with the media. Psychiatrists are often called to the public spotlight and asked to provide a variety of services that may include educating the public, breaching confidentiality, or providing consultation to media productions. Violent tragedies often prompt reporters to seek explanations from mental health experts. These roles will be discussed using actual cases and analysis of ethics principles. The workshop will also provide framework for general and forensic psychiatrists who publically market their services. The audience will participate in an exercise applying these principles to encourage discussion of best practices.

REFERENCES

American Psychiatric Association: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, 2010 Edition
Levin A: Tucson tragedy reignites long-standing controversies. *Psychiatric News*. 46: 1, 2011

SELF ASSESSMENT QUESTIONS

1. The American Psychiatric Association states that it is unethical for a psychiatrist to offer a professional opinion unless which of the following conditions have been met?

- he or she has conducted an examination
- proper authorization has been granted
- the person of interest is deceased
- the psychiatrist is certified in forensics
- a and b
- none of the above

ANSWER: e

2. Interactions with the media allow a psychiatrist to engage in which of the following roles?
- Educating the public about mental illness
 - Disseminating resources for people to access mental health treatment
 - Analyzing public testimony and discourse
 - Providing media productions accurate depictions of mental illness
 - All of the above

ANSWER: e

T20

NO, YOU CAN'T LEAVE ME: ISSUES AND EFFICACY OF COERCIVE OUTPATIENT TREATMENT

Gary Collins, MD, New York, NY
 Steven K. Hoge, MD, New York, NY
 Paul Appelbaum, MD, New York, NY

EDUCATIONAL OBJECTIVE

To learn the contemporary efficacy, implementation and challenges of coercive outpatient treatment; understand first and second generational studies and synthesis of the MacArthur Network's "coercive studies" and "the leverage"; and to discuss contemporary problems and dynamics of working with patients coerced into outpatient treatment.

SUMMARY

The use of involuntary treatment is common in the practice of psychiatry but remains controversial. In this workshop, Dr. Hoge will summarize data from the MacArthur Foundation Network on Mental and the Law's Coercion Study, which explored the factors that led patients to feel coerced to accept inpatient treatment and produced a scale for quantifying perceptions. Dr. Appelbaum will summarize research from the Network's studies on the use of leverage in outpatient treatment, that includes data regarding the frequency of a variety of methods employed to bring about compliance. Dr. Collins will review the first and second generational studies of outpatient commitment. He will focus on his experiences in the implementation and practice of New York State's Kendra Law, the largest outpatient commitment program in the USA. His presentation will lead to a discussion of the dynamics and challenges frequently associated with patients coerced into various treatment modalities.

REFERENCES

Appelbaum PS: Assessing Kendra's law: five years of outpatient commitment in New York. *Psychiatric Services* 56(7): 791-792, 2005
 Swartz MS *et al*: Assessment of four stakeholder groups preferences concerning outpatient commitment for person with schizophrenia. *Am J of Psych* 160:1139-1146, 2003

SELF ASSESSMENT QUESTIONS

1. Schizophrenic patients with histories of treatment noncompliance and violence who are mandated into outpatient commitment programs are most likely to show which of the following?
- Immediate granting of "time served" probation
 - Reduced re-hospitalization rates
 - Increased victimization rates
 - Increased intoxication periods and substance relapse rates
 - Increased rates of divorce and familial discord

ANSWER: b

2. Treatment providers working with court-mandated outpatients are more likely to experience each of the following early in the treatment course except:
- anger
 - embarrassment
 - denial
 - unwillingness to participate in treatment
 - gratitude

ANSWER: e

T21

**CHILD PORNOGRAPHY AND THE INTERNET:
LEGAL AND CLINICAL PERSPECTIVES**

Abigail Judge, PhD, (I) Boston, MA
Fabian Saleh, MD, (I) Boston, MA
Albert Grudzinkas, Jr., JD, (I) Worcester, MA
Michael Yoon, JD, (I) Boston, MA

EDUCATIONAL OBJECTIVE

After attending this presentation, participants will be familiar with the legal structure of state and federal CP statutes and their effects on adult offenders and child victims, understand the empirical association between online CP and offline sexual contact offenses, and how CP statutes interface with contemporary adolescent sexual behavior.

SUMMARY

The proposed panel will address topics related to child pornography (CP) and emerging technology (i.e., the Internet) from legal, forensic and clinical perspectives. Consensus exists that the Internet has contributed to the proliferation of CP, although the associated legal and clinical dilemmas remain complex and controversial. The proposed interdisciplinary panel will highlight a range of dilemmas related to this rapidly emerging nexus among CP, technology and the law. Topics to be addressed include: (1) An overview of relevant law in this area, including a summary of landmark cases, the effects of new federal sentencing guidelines for CP on adult defendants, and current judicial controversy about the application these guidelines to CP offenders; (2) Prosecutorial challenges associated with Internet-based CP cases and their effects on child victims; (3) Review of the empirical relationship between online pornography use and offline contact offenses, including implications for forensic and risk evaluation; and (4) The emerging social topic of self-produced child pornography, or what is colloquially referred to as “sexting” (i.e., the exchange of sexually explicit images between minors by cell phone), and its problematic intersection with CP statutes.

REFERENCES

Alexy EM, Burgess AW, Baker T: Internet offenders: traders, travelers, and combination trader-travelers. *J of Interpersonal Violence* 20(7): 804-12, 2005
Seto MC, Cantor JM, Blanchard R: Child pornography offenses are a valid diagnostic indicator of pedophilia. *J of Abnormal Psychology* 115(3): 610-5, 2006

SELF ASSESSMENT QUESTIONS

1. How do forensic psychiatrists evaluate the relationship between online child pornography use and offline contact sexual offenses?

ANSWER: Sex offenders are a heterogeneous population, and their assessment requires specialized knowledge of the pathology and methods used to assess risk and treatment needs, as well as the state of scientific research on the association between CP use and contact offenses.

2. What are the legal consequences of minor teens producing and disseminating sexually explicit images to one another via cell phone?

ANSWER: In general, courts have found that provided an image meets the statutory definition for CP, minors can be prosecuted under CP statutes unless the statute specifies otherwise. Legislative reforms have, however, been proposed and implemented in many states.

T22

**SELF-INJURIOUS BEHAVIOR IN THE NATION'S PRISON SYSTEMS:
RESULTS AND IMPLICATIONS OF A NATIONAL SURVEY**

Kenneth Appelbaum, MD, Shrewsbury, MA
Judith Savageau, MPH, (I) Worcester, MA
Robert Trestman, PhD, MD, Farmington, CT
Jeffrey Metzner, MD, Denver, CO

EDUCATIONAL OBJECTIVE

Participants will become familiar with aspects of inmate self-injurious behavior from a nationwide perspective; understand intervention and management strategies for inmate self-injurious behavior; and appreciate areas in need of additional research.

SUMMARY

Self-injurious behavior (SIB) by inmates has serious health, safety, operational, security and fiscal consequences. Serious incidents require a freeze in normal facility operations. Injuries that need outside medical attention create additional security risks, including potential escape attempts. The interruption of normal operations, diversion of staff, cost of outside care, and drain on medical and mental health resources all have significant fiscal consequences. This session will present the results and implications of a survey of the Mental Health Directors in all 51 state and federal prison

systems on the extent of SIB by inmates, including incidence and prevalence, adverse consequences, and management. Thirty-nine of the state and federal correctional systems (77%) responded to the survey. Fewer than 2% of inmates per year engage in SIB, but in 29 (85%) of systems these events occur at least weekly to more than once per day. The highest rates of occurrence of these behaviors are in maximum security and lock-down units, and most often involve inmates with Axis II disorders. Despite the seriousness of the problem, systems typically collect little, if any, data on self-injurious behaviors, and management approaches lack widespread consistency.

REFERENCES

Appelbaum KL, Savageau J, Trestman R, *et al*: A national survey of self injurious behavior in American prisons. Psychiatric Services, In Press
 Smith HP, Kaminski RJ: Inmate self-injurious behaviors: distinguishing characteristics within a retrospective study. Criminal Justice and Behavior 37:81-96, 2010

SELF ASSESSMENT QUESTIONS

1. Which prison housing unit has the highest rate of self-injurious behaviors by inmates?
 - a. Maximum security general population units
 - b. Non-maximum security general population units
 - c. Segregation and other lock-down units
 - d. Residential treatment units

ANSWER: c.
2. What is the most prevalent psychiatric diagnosis among inmates who self-injure?
 - a. Cluster B personality disorder
 - b. Psychotic disorder
 - c. Mood disorder
 - d. Pervasive developmental disorder

ANSWER: a.

T23

**TESTING THE BLADES ON THE “DOUBLE-EDGED SWORD”:
 A NATIONAL, EXPERIMENTAL SURVEY OF US TRIAL COURT JUDGES**

James Tabery, PhD, (I) Salt Lake City, UT
 Teneille Brown, JD, (I) Salt Lake City, UT
 Lisa Aspinwall, PhD, (I) Salt Lake City, UT

EDUCATIONAL OBJECTIVE

To become familiar with novel research investigating whether scientific evidence concerning the causes of bad behavior will mitigate punishment (because the convicted is deemed less responsible in light of their biology) or aggravate punishment (because the convicted is deemed a continuing threat to society).

SUMMARY

Scientific evidence concerning the causes of bad behavior is growing increasingly common in the courtroom. Will such evidence mitigate punishment (because the convicted is deemed less responsible in light of their biology) or aggravate punishment (because the convicted is deemed a continuing threat to society)? Because the same scientific evidence could be used to either decrease or increase punishment, it has been referred to as a double-edged sword. We report the results of a national, experimental survey of US trial court judges, which was designed to assess precisely which way the double-edged sword cuts. Roughly 220 judges responded from 22 states. All participating judges received information about the same crime (aggravated battery) and the same verdict (guilty). All participating judges learned that the convicted was a diagnosed psychopath. Judges were then divided into four groups based on whether they received additional scientific evidence about the genetic, neurobiological, and developmental causes of psychopathy or not, and on whether the prosecution or the defense introduced the scientific evidence. By comparing group differences in the participating judges’ assessments of responsibility and punishment, we are able to provide the first empirical evidence determining which way the double-edged sword cuts in an externally valid population.

REFERENCES

Bernet W, Farahany N, Vnencak-Jones CL, *et al*: Bad nature, bad nurture, and testimony in murder trials. J of Forensic Science 52:1362, 2007
 Schopp RF: Two-edged swords, dangerousness, and expert testimony in capital sentencing. Law and Psychology Review 30:57, 2006

SELF ASSESSMENT QUESTIONS

1. What of the following disorders is diagnosed with the PCL-R?

- a. Sociopathy
- b. Psychopathy
- c. Psychopathology
- d. Schizophrenia

ANSWER: Psychopathy

2. In which country did a judge recent mitigate a sentence for murder after learning of the convicted individual's genetic and neurobiological risk of violence?

- a. United States
- b. United Kingdom
- c. Germany
- d. Italy

ANSWER: d

T24

DOES FORENSIC TRAINING IMPROVE COURT REPORTS?

Barbara McDermott, PhD, (I) Sacramento, CA

Chad Woofter, MD, Napa, CA

Richard Matheson, BA, (I) Napa, CA

Amarpreet Singh, MD, Napa, CA

Shoko Kokubun, PhD, (I) Napa, CA

Isah Dualan, MS, (I) Sacramento, CA

EDUCATIONAL OBJECTIVE

The attendee will gain an understanding of the importance of forensic training when conducting evaluations for the court.

SUMMARY

Competence to stand trial is requisite for criminal defendants. Recent estimates indicate that between 50,000 and 60,000 defendants in the US raise competence as an issue, with approximately 20% found incompetent to stand trial (IST). Malingering is a not uncommon problem with these evaluations, with rates varying between 8 and 21%. With a conservative estimate of 15% malingering, this suggests that over 8000 defendants annually may attempt to malingering psychiatric illness. The skill level of evaluators can vary widely, which may affect rates of malingering. To reduce the length of stay in our IST patients, NSH implemented a triage process to evaluate several aspects relevant to competence, including an evaluation of malingering. The triage evaluations are followed-up by a team of forensically trained clinicians who administer additional assessments and write court reports returning patients as competent. Of the 1000 assessments completed, our results indicate that approximately 17% of IST admissions may be malingering. Data will be presented examining the relationship between malingering assessments, the diagnoses of patients returned to court as competent and lengths of stay. Results indicate that court reports written by forensically trained staff are superior and may result in fewer numbers of patients returned as IST.

REFERENCES

Warren JI, Murrie DC, Stejskal W *et al*: Opinion formation in evaluating the adjudicative competence and restorability of criminal defendants: A review of 8,000 evaluations. *Behavioral Sciences and the Law* 24:113-122, 2006
Allan A, Martin M, Allan MM: Assessments for the courts: A survey of Australian psychologists. *Psychiatry, Psychology and Law* 7:150-158, 2000

SELF ASSESSMENT QUESTIONS

1. Which of the following may be a barrier to speedy restoration to competence?

- a. Malingering
- b. Cognitive deficits
- c. Cultural issues
- d. All of the above

ANSWER: d

2. Which of the following assessments does not evaluate the feigning of psychiatric symptoms?

- a. TOMM
 - b. SIMS
 - c. M-FAST
 - d. SIRS
- ANSWER: a

T25

HOW EVALUEES HEAR TESTIMONY: FORENSIC EXPERTS' VIEWS

Suzanne Yang, MD, Pittsburgh, PA
 Susan Hatters Friedman, MD, Cleveland Heights, OH
 Sherif Soliman, MD, Beachwood, OH

EDUCATIONAL OBJECTIVE

To identify ways that a therapeutic jurisprudence framework may be relevant to testimony; describe how experts engage in behavior that may be guided by therapeutic concerns; and identify areas for further exploration regarding the effects of testimony on evaluatee perceptions of mental illness.

SUMMARY

Psychiatric care requires attention to the patient's perception of illness and his understanding of the need for treatment. In contrast, a psychiatrist providing expert testimony owes a duty to the truth, whether or not it is helpful to the evaluatee. And yet, the evaluatee is often present during testimony. Can psychiatric testimony meet the primary aims of assisting the court in adjudication, all the while taking into account the evaluatee's perception of the testimony, shaping testimony as a potential form of education about illness? We present findings from a survey distributed to forensic practitioners, which addresses questions such as whether and under what conditions mental health experts engage in behavior that can be considered educational for the evaluatee and/or oriented towards the evaluatee's treatment needs. The survey examines the extent to which experts currently take into account the evaluatee's point of view during evaluation and testimony, and what additional practices are considered plausible by experts, within the scope of their role in the courtroom. As health care professionals providing testimony regarding the evaluatee's mental state, diagnosis and prognosis, mental health experts may have an opportunity to influence how this testimony is heard or construed by the person.

REFERENCES

Gould KA: A therapeutic jurisprudence analysis of competency evaluation requests: the defense attorney's dilemma. *Intl J Law Psych* 18(1): 83-100, 1995
 Roe D, Ronen Y: Hospitalization as experienced by the psychiatric patient: a therapeutic jurisprudence perspective. *Intl J Law Psych* 26(3): 317-332, 2003

SELF ASSESSMENT QUESTIONS

1. Which of the following statements is not true?
 - a. The psychiatric expert's primary duty is to the truth.
 - b. The psychiatric expert's main interlocutors during testimony are attorneys and the judge.
 - c. Studies have established that evaluatees are indifferent to what psychiatric experts say about them during testimony.
 - d. Evaluatees are often present in the courtroom during psychiatric testimony, in both civil and criminal cases.

ANSWER: c

2. Which of the following statements is true?
 - a. Due to lack of a treatment relationship, forensic experts should have no ethical concerns about the way that results of their evaluations are perceived by evaluatees.
 - b. Due to procedural rules and constraints in the courtroom, forensic psychiatrists are unable to constructively educate the evaluatee about his/her illness during testimony.
 - c. Forensic psychiatrists are justified in engaging in educational or potentially therapeutic behavior when they are retained by the defense, but this excluded when the expert is retained by the prosecution.
 - d. Some psychiatrists engage in behavior that can be considered educational or potentially therapeutic in the course of performing their duties as forensic experts.

ANSWER: d

**CRAZY: A FATHER'S SEARCH THROUGH AMERICA'S
MENTAL HEALTH MADNESS**

Pete Earley, (I) Fairfax, VA

EDUCATIONAL OBJECTIVE

To explain why jails and prisons have become our new asylums, what is being done nationwide to reverse this trend and how tax dollars can be saved by providing evidence based services rather than punishment.

SUMMARY

Former Washington Post reporter Pete Earley will use his personal story to illustrate how difficult it is to get his loved one with a severe mental illness meaningful help. His son Mike developed a mental illness while in college and Earley was unable to help him. This led to Mike's being arrested after he broke into a stranger's house to take a bubble bath. He also was tasered by the police. In addition to telling his family's story, Earley will describe the results of a ten month investigation that he conducted as a journalist inside the Miami Dade County jail where he followed persons with severe mental illnesses through the criminal justice system into the community to observe what services were available to them. He will specifically discuss crisis intervention training for law enforcement officers, mental health courts, jail diversion services, Housing First programs and pre-release services and how these wrap around services can actually save tax dollars and help end the revolving door that many persons with mental disorders get trapped in.

REFERENCES

Torrey F, Kennard A *et al*: More mentally ill persons are in jails and prisons than hospitals: a survey of the states. Treatment Advocacy Center/National Sheriff's Association, May, 2010

Earley P: Finding funding: states should link mental health funding to dedicated revenue sources, The American Prospect, Available at http://prospect.org/cs/archive_by_subject?id=178 Accessed June 23, 2008.

SELF ASSESSMENT QUESTIONS

1. What is the largest, public mental health facility in the United States?

- a. St. Elizabeths Hospital, Washington, DC
- b. Bellevue Hospital, New York, NY
- c. Twin Towers Correctional Facility, Los Angeles, CA
- d. Oregon State Hospital, Salem, OR

ANSWER: c

2. What is an ACT team?

- a. Aggressive Cognitive Therapy Team
- b. Action, Care, Treatment Team
- c. Acute Care Treatment Team
- d. Assertive Community Treatment Team

ANSWER: d

CONTEMPORARY ANALYSIS OF COLIN FERGUSON'S PRO SE COMPETENCE

Robert Phillips, MD, PhD, Annapolis, MD

W. Lawrence Fitch, JD, (I) Jessup, MD

Keith Shebairo, MD, JD, New Haven, CT

Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

To illustrate the requirements for *pro se* competence, as suggested by *Indiana v. Edwards*, by examining the case of Colin Ferguson, a mentally ill man who represented himself on charges stemming from the 1993 shootings of 25 passengers on the Long Island Rail Road (LIRR) in Garden City, New York.

SUMMARY

Colin Ferguson was charged with shooting 25 passengers on the Long Island Railroad in December 1993. Based on evaluations by two court-appointed experts, the court found Ferguson competent to stand trial (CST). When Ferguson asked to discharge his attorneys (including William Kunstler) and proceed to trial *pro se*, the court agreed, noting the U.S. Supreme Court's June 1993 decision in *Godinez v. Moran* that the legal standard for waiver of counsel was no higher than the standard for CST. Ferguson's presentation at trial, though superficially in keeping with protocol, was infused with psychosis. He was convicted and sentenced to 315 years to life. In 2008, the U.S. Supreme Court revisited the question of competence without counsel, ruling in the case of *Indiana v. Edwards* that, although waiver of counsel requires no greater competence than CST, a state may (arguably must) require more before allowing a defendant to proceed to

trial *pro se* (to “conduct trial proceedings”). The Court did not establish a legal standard for *pro se* competence, however, leaving the question to judicial discretion as circumstances dictate. Using video clips including from the trial, the panel will examine Mr. Ferguson’s *pro se* performance and reconsider his competence by contemporary standards.

REFERENCES

Indiana v. Edwards, 554 U.S. 164 (2008)
 Bardwell MC, Arrigo BA: Criminal competency on trial: the case of Colin Ferguson. Carolina Academic Press, 2002

SELF ASSESSMENT QUESTIONS

1. How does the level of competence constitutionally required for a defendant to waive the right to counsel compare to the Constitutional standard for competence to stand trial with counsel?
 - a. the same as competency to stand trial
 - b. greater than competency to stand trial
 - c. less than competency to stand trial
 - d. competency not required by the constitution

ANSWER: a

2. After finding a defendant competent to stand trial with counsel a court may:
 - a. deny the defendant’s waiver of the right to counsel
 - b. accept the defendant’s waiver of the right to counsel
 - c. deny that defendant the right to represent himself or herself at trial on grounds of incompetence
 - d. grant that defendant the right to represent himself or herself at trial
 - e. all of the above

ANSWER: e

T28

APPLYING RISK ASSESSMENT IN PSYCHIATRY

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

EDUCATIONAL OBJECTIVE

Participants will understand how to approach risk assessment tasks utilizing available research data, appropriate actuarial tools, and appropriate clinical methodology; how to apply functional risk assessment techniques; and the strengths and limitations of various approaches to risk assessment and management.

SUMMARY

The assessment of risk for violence in psychiatric patients is a significant factor in clinical, policy, legislative, and forensic decisions. The advancement of population-based and community-controlled studies of mental illness and violence, and the emergence of valid and reliable risk assessment measures are defining the practice, policies, and standards for risk assessment. Familiarity with the relevant research, legal and clinical issues that shape practice and the relative merits and limitations (especially as applied to individuals) of the different assessment tools is essential to this area of forensic practice. However, research does not translate directly to practice around complex risk assessments. This course will present a framework for applying risk assessment in psychiatry. We will explore the strengths and limitations of various risk-assessment approaches through a case-based teaching methodology, inviting participants’ discussion, comments and questions. Discussion will include an analysis of the appropriate use of actuarial versus clinical assessment methodologies, as well as a review of recent critiques (including ethical concerns) regarding risk assessment. Models of risk assessment and management that accommodate a synthesis of available research will be presented. Finally, we will describe an alternative approach to risk management, based on the assessment and enhancement of the individual’s functional capacities.

REFERENCES

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

SELF ASSESSMENT QUESTIONS

1. Actuarial measures of risk assessment:
 - a. are the most accurate in assessing imminent risk of violence to self or others
 - b. inform the life-long risk for violence
 - c. can not inform policy development and management of services
 - d. are not useful in sentencing evaluations

ANSWER: b

2. Research findings do not translate directly to clinical practice because:
 - a. they are outdated by the time they are published
 - b. researchers rarely have exposure to actual clinical situations
 - c. statistical methods in risk assessment include but do not differentiate different levels of violence
 - d. findings of group-based studies cannot be directly applied to specific clinical decisions for an individual

ANSWER: d

T29

BLACK BOX OR PANDORA'S BOX-HOW BLACK BOXES AFFECT OUR FIELD

Henry Levine, MD, Bellingham, WA
 Ryan Hall, MD, Lake Mary, FL
 Neil Kaye, MD, Hockessin, DE

EDUCATIONAL OBJECTIVE

To review the history of the FDA's "Black Boxes," formally called Boxed Warnings; to cite and review those Boxed Warnings most relevant to psychiatry today; to review their impact on the clinical practice of psychiatry To review their impact on forensic psychiatric practice.

SUMMARY

The US FDA considers their "Black Boxes," or Boxed Warnings, to be their highest impact vehicle for warning physicians and the public about what they perceive as dangers in the use of medications approved in the US. Boxed Warnings have increased in frequency of use over their 32 year lifespan. They have had an especially profound and controversial impact on psychotropic use here and abroad in the last 10 years. Many decisions by the FDA to issue Boxed Warnings have been highly contested, with argument about the data bases used to justify them, and whether the "cure" (Boxed Warning) has been worse than the "disease" (more permissive medication use). Our panel will review the history of Boxed Warnings, and will highlight and explain those concerning psychotropic medications. The panel will then review the impact of psychotropic Boxed Warnings on clinical psychiatric practice, and finally, on forensic psychiatric practice. Audience input on the last two sections will be particularly welcomed.

REFERENCES

Murphy S, Roberts R: Black Box 101: How the Food and Drug Administration evaluates, communicates, and manages drug benefit/risk. *J Allergy Clin Immunol* 117(1):34-9, 2006
 Libby AM, Orton HD, Valuck RJ: Persisting decline in depression treatment after FDA warnings. *Arch Gen Psychiatry* 66(6):633-9, 2009

SELF ASSESSMENT QUESTIONS

1. The FDA obtained authority to issue black box warnings in:
 - a. 1969
 - b. 1979
 - c. 1989
 - d. 1999

ANSWER: b

2. Black box warnings have been issued for which categories of psychotropics?
 - a. Antidepressants only
 - b. Antidepressants and antipsychotics only
 - c. Antidepressants, antipsychotics and antiepileptics only
 - d. Antidepressants, antipsychotics, antiepileptics

ANSWER: c

T30

BULLYING, AN UPDATE: WHAT YOU NEED TO KNOW WHEN CALLED TO CONSULT

Bradley Freeman, MD, Brentwood, TN
 Karen Rosenbaum, MD, New York, NY
 Eileen Ryan, DO, Fishersville, VA
 Fabian Saleh, MD, (I) Boston, MA
 Christopher Thompson, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE

The audience will appreciate current topics related to bullying behaviors which include suicidality and violence, psychiatric comorbidity of bullies and targets, the utilization of social networking, realistic interventions, and forensic implications.

SUMMARY

Bullying has become a significant problem as evidenced by the overt damage it has on students, families, and educational systems. Although this social phenomenon is identified in many settings, there is little evidence based support for successful interventions. Those involved include the bully, the target, and the system in which the bullying occurs. Traditional bullying behavior is giving way to technology and social networking. Psychological aspects of bullying are becoming more pronounced as non-physical assaults are made against the target. Suicide risk is increased for those involved as well as other psychological sequela and future risk of mental illness. There are, of course, protective and risk factors that individuals or systems might possess with regard to bullying behavior and its effects. This presentation will address these issues and provide a framework for evaluators to objectively examine the behaviors for forensic purposes. Interventions at the individual and system levels are discussed with an emphasis on the need for cultural change to alleviate the behavior. In addition to performing evaluations of bullies or targets, forensic psychiatrists may be asked to help identify, develop, or implement interventions for clients as well.

REFERENCES

Bostic JQ, Brunt CC: Cornered: an approach to school bullying and cyberbullying and forensic implications. *Chld Adol Psy Clin N. Am.* 20(3):447-465, 2011
 Obermann ML: Moral disengagement in self-reported and peer-nominated school bullying. *Aggress Behav* 37(2):133-44, 2011

SELF ASSESSMENT QUESTIONS

1. When asked to consult with a school in regard to alleviating problems with bullying, which of the following is the most important aspect to focus on?
 - a. the culture of the school
 - b. the strength of the parent teacher association
 - c. the children identified as being the bullies
 - d. the victim population
 - e. the presence of aggressive groups such as gangs

ANSWER: a

2. Cyberbullying is a new phenomenon which uses technology to threaten, intimidate, ridicule, and bully other individuals. The avenues used for cyberbullying include all of the following except:

- a. online chatting
- b. social networking
- c. cell phone texting
- d. phone calling
- e. blogging

ANSWER: d

T31

EFFICACY OF A WEB BASED MODULE TO TEACH RISK ASSESSMENT

Catherine Lewis, MD, Farmington, CT

EDUCATIONAL OBJECTIVE

To recognize strengths and limitations of web based instruction for students, gain exposure to an actual web-based module on risk assessment and identify methods of assessing basic efficacy of a web-based module.

SUMMARY

The AAMC and APA have reviewed and endorsed the addition of computerized instruction as a method of standardizing and enhancing medical education across the United States. Medical students receive limited exposure to forensic psychiatry. This study examines the efficacy of a web based, interactive case designed to teach basics of risk assessment. Methods: The study was carried out at University of Connecticut Health Center over a one-year period. Third year medical students (N=50) took a brief Likert scaled questionnaire about their perceived level of knowledge of and comfort with performing risk assessments; they also completed a short assessment of their actual knowledge. Subjects then completed the web-based case. After completion, their actual and perceived knowledge as well as comfort level were again assessed. Results: 50 students enrolled in the study and completed questionnaires. All students felt the module was helpful. Mean scores on the assessment of knowledge increased significantly (p<. 02 on paired T-test). Similarly, students' self-rating of comfort level and knowledge significantly improved post test (p<. 03 on paired T-test). Conclusion: Web based instruction in forensic psychiatry is an effective and enjoyable adjunct to classroom learning during the third year clerkship.

REFERENCES

Greenhalgh T: Computer assisted learning in undergraduate medical education. *Br Med J* 322: 40-44, 2001
Leong SL, Baldwin CD, Adelman AM: Integrating web-based computer cases into a required clerkship: development and evaluation. *Acad Med* 78(3):295-301, 2003

SELF ASSESSMENT QUESTIONS

1. Web based learning modules are:
 - a. Able to be constructed quite rapidly
 - b. Superior to power point lectures for knowledge retention
 - c. Preferred by students to small seminars
 - d. A useful method to provide learning on targeted topics

ANSWER: d

2. Students who completed a web based module on risk assessment:
 - a. had a knowledge base comparable to first year residents who completed the module.
 - b. reported greater confidence about their ability to perform basic risk assessment.
 - c. demonstrated actual increase in knowledge objectively measured after completing module.
 - d. did not find it useful if they had done readings before
- b and c

T32

RESTORATION OF CST: WHAT IS JACKSON'S REASONABLE PERIOD OF TIME?

Andrew Kaufman, MD, Fayetteville, NY
Enrico Suardi, MD, Fayetteville, NY

EDUCATIONAL OBJECTIVE

Participants will review *Jackson v. Indiana's* decision, including the underlying constitutional principles and implications for public policy. Participants will learn of the states' adherence to the decision since its inception. Participants will be presented with empirical research addressing the length of stay required for restoration of competency to stand trial.

SUMMARY

In *Jackson v. Indiana* (1972), the USSC held that states may not indefinitely confine criminal defendants solely on the basis of incompetence to stand trial, but must adopt standards similar to these for mentally ill persons not involved in criminal proceedings. The Court ruled that the duration of commitment be limited based upon the likelihood of restorability. However, due to lack of empirical evidence, the Court did not provide specific time limits. Nearly four decades later, striking heterogeneity still exists among states regarding the allowable length of confinement for restoration of competency, ranging from <1 year to life. NY state statutes link the period of restoration to the duration of the criminal sentence for the charged offense. In this study, we will obtain data on approximately 1200 felony defendants in NY committed for restoration of CST to determine the variables related to length of stay and the proportion of defendants successfully restored to competency. Variables to be collected include: criminal offense, psychiatric diagnosis, GAF, demographics, number of prior CST confinements, and number of prior hospitalizations. We will further attempt to determine the time threshold required for successful restoration, with the goal of informing public policy adherence to the Jackson mandate.

REFERENCES

Jackson v Indiana, 406 U.S. 715 (1972)
Mossman, D *et al*: (2007). AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial. *J Am Acad Psychiatry Law* 35(4): 2007

SELF ASSESSMENT QUESTIONS

1. As of 2007, the percentage of states in which the duration of confinement for restoration of competency is indeterminate is:
 - a. 10%
 - b. 30%;
 - c. 50%
 - d. 80%
 - e. none of the above

ANSWER: b

2. The U.S. Supreme Court's decision in Jackson v. Indiana called for states to adopt standards comparable to those in place for civil commitment for the purpose of confining criminal defendants for restoration of competency to stand trial. The reasoning was based upon:

- a. substantive due process
- b. procedural due process
- c. equal protection
- d. double jeopardy
- e. fundamental fairness

ANSWER: c

T33

GENDER DIFFERENCES AMONG SEX OFFENDERS

Susan Hatters Friedman, MD, Cleveland Heights, OH
Sara West, MD, Cleveland Heights, OH

EDUCATIONAL OBJECTIVE

After attending this session, the attendee will be able to: list differences between female and male sex offenders evaluated in a court-ordered forensic clinic; and describe future research needed to better understand female sex offenders.

SUMMARY

Female sex offenders are approximately 3% of all sex offenders, likely underestimated based on societal views and biases. Because this behavior stands in stark contrast with what society expects of women, many assume that those who commit these crimes are mentally ill. Very few studies have examined the characteristics of these offenders. We retrospectively compiled data on alleged female and (matched) male sex offenders who were referred for psychiatric evaluation to a large midwestern city's court psychiatric clinic. Data were abstracted regarding: crimes, charges, demographics, social history, medical history, legal history, violence history, substance use, sexual history, psychiatric history, and their victims. Women's charges most frequently included rape or gross sexual imposition. Ages ranged from 19-50 and the majority had children. Most had prior arrests. One-third had a history of psychiatric hospitalization, and most were given a psychiatric diagnosis. Multiple women reported past histories of victimization. This study yields a better understanding of the phenomenon of sexual offending by women.

REFERENCES

Lewis CF, Stanley CR: Women accused of sexual offenses. Behavioral Sciences & the Law 18: 73-81, 2000
Vandiver DM, Kercher G: Offender and victim characteristics of registered female sexual offenders in Texas: a proposed typology of female sexual offenders. Sexual Abuse: Journal of Research & Treatment 16: 121-37, 2004

SELF ASSESSMENT QUESTIONS

1. Which of the following is true regarding this sample of accused sex offenders evaluated in a court psychiatric clinic?

- a. most of the women had themselves been raised in foster care
- b. for most offenders, this was their first arrest
- c. the mean age of offenders was 21
- d. the majority of both women and men were parents themselves
- e. all of the above

ANSWER: d

2. Which of the following is true when comparing female with male sex offenders?

- a. Sexual victimization histories are more common among female sex offenders than male sex offenders.
- b. Women are more likely than men to commit sex offenses with a co-offending male.
- c. Female offenses are more likely to occur in caregiving situations.
- d. all of the above

ANSWER: d

T34

10 YEARS LATER: CLERGY SEXUAL ABUSE IN BOSTON

Allan Nineberg, MD, Cambridge, MA
Mitchell Garabedian, Esq., (I) Boston, MA
James Chu, MD, (I) Concord, MA

EDUCATIONAL OBJECTIVE

To explore the effects of the sexual abuse crisis from several perspectives: review the clinical impact of clergy abuse, discuss dealings with courts, media, and the Catholic Church, and review issues relevant to traumatic memory and knowing if one was harmed.

SUMMARY

The Boston Globe began publishing an expose in January 2002 about widespread clergy sexual abuse in the Boston area. It is probably not an understatement to say that this has had worldwide effects over the past 10 years. Dr. Allan Nineberg has served as plaintiff's expert in almost 100 of these cases and will present his observations on the traumatic effects of the sexual abuse, particularly as it relates to having been abused by Catholic clergy. He will also discuss some of the particular issues in interviewing individuals who have kept the abuse to themselves for upwards of 50 years. Attorney Mitchell Garabedian has represented more than 750 individuals who have been abused by clergy and will discuss his experience dealing with the media, Catholic Church, and the courts. Dr. James Chu has taught and written extensively on post-traumatic stress and will review issues relevant to the "memory wars": amnesia and partial amnesia after sexual trauma, as well as knowing and not knowing that one was harmed by the trauma.

REFERENCES

Carney v. Roman Catholic Archbishop of Boston 2003 WL 1689627 (Mass. Super. 2003)/opinion.
Chu JA, Frey JM, Ganzel BL, et al: Memories of childhood abuse: dissociation, amnesia, and corroboration. *Am J Psychiatry* 156: 749-755, 1999

SELF ASSESSMENT QUESTIONS

1. Specific effects of having been sexually abused by Catholic clergy include:
 - a. loss of one's community
 - b. loss of faith in a just and loving God
 - c. profound self-doubt that a priest could be a sexual predator
 - d. fear that one's family would never believe one's word over that of a priest
 - e. fear that one's family would believe one and that their religious faith and community would be destroyed
 - f. amplification of the trauma because of the special status of priests as God's representatives on earth
 - g. all of the above

ANSWER: g

2. Severe and chronic early childhood sexual abuse is associated with:
 - a. conduct disorders, substance abuse, and problems with social and academic functioning
 - b. complete or partial amnesia of memories of abuse experiences
 - c. failure to define the childhood trauma as abuse
 - d. all of the above

ANSWER: d

T35

TRAUMATIC BRAIN INJURY, AMNESIA AND COMPETENCY TO STAND TRIAL: PRACTICAL CONSIDERATIONS

Steven Zuchowski, MD, Reno, NV
Rich Bissett, PhD, (I) Sparks, NV
Renée Sorrentino, MD, Quincy, MA
Susan Hatters Friedman, MD, Cleveland Heights, OH

EDUCATIONAL OBJECTIVE

Summarize the current literature on TBI, amnesia and competency to stand trial; Review approaches to evaluating brain injured and allegedly amnesic defendants for CTS; Discuss principles of forensic report writing as applied to amnesic defendants; Demonstrate and practice responding to likely cross examination challenges to mental health expert opinions

SUMMARY

The holding of *Wilson v. United States* (1968) is well known in forensic psychiatry and psychology. However, evaluating the competency to stand trial of a brain injured individual who is allegedly amnesic for his or her crime is far from a straightforward endeavor. These individuals present with complex neuropsychiatric problems involving not only a claim of amnesia for the time surrounding their alleged crime but also the potential for subtle deficits in current cognitive functioning. These defendants may also be accompanied by a plethora of conflicting and confusing neuropsychological reports. After a brief review of the current case law and literature related to the topic of amnesia and competency to stand trial, this workshop will provide hands on experience in developing a plan for evaluating defendants with TBI and alleged amnesia. Additionally, practical experience will be provided in formulating a written opinion that incorporates elements of the *Wilson* case without straying too far into the judge's province. Finally, several counterarguments seen during cross examination will be discussed, demonstrated and practiced.

REFERENCES

Wilson v. United States 391 F.2d 460 D.C. Cir. 1968
Roesch R, Golding S: Amnesia and competency to stand trial: a review of legal and clinical issues. Behavioral Sciences & the Law 4(1):87-97, 1986 (1986)

SELF ASSESSMENT QUESTIONS

1. After the Wilson court held that even authentic amnesia is not necessarily a per se bar to competency to stand trial, most courts have subsequently held that:
 - a. A second competency hearing must be held at the conclusion of the trial to ensure that the defendant's amnesia didn't significantly impact the fairness of their trial.
 - b. The organic nature of the amnesia is the main critical point in determining competency.
 - c. After an initial determination of competency, no subsequent hearing is necessary to determine the fairness of the proceedings.
 - d. Amnesia does bar competency in most cases.

ANSWER: c

2. The gold standard test for determining the authenticity of a defendant's alleged retrospective amnesia for their crime is:
 - a. Test of Malingered Memory (TOMM)
 - b. Miller Forensic Assessment of Symptoms Test (M-FAST)
 - c. Magnetic Resonance Imaging with clear post-traumatic findings
 - d. none of the above

ANSWER: d

T36

IN THE LION'S DEN II: SURVIVING CROSS-EXAMINATION

Roger Samuel, MD, Boca Raton, FL
Mark DeBofsky, JD, (I) Chicago, IL
Marla Hemphill, MD, Clarksville, TN

EDUCATIONAL OBJECTIVE

This workshop will hone and enhance the skills and competence of expert witnesses in dealing with cross-examinations by attorneys in depositions and court.

SUMMARY

The workshop is a sequel to a previous workshop on the same topic. This one will use new vignettes and examples to illustrate different issues to further improve testimony skills under cross-examination. It will be presented by a disability attorney Mr. DeBofsky and two psychiatrists. Mr. DeBofsky will provide an overview of direct and cross-examination. Following that, various vignettes of simulated courtroom testimony - derived from real cases and testimony - will be utilized. Mr. DeBofsky will examine one psychiatrist first in a demonstration of poor cross-examination performance. The audience will be asked to offer comments and criticism, following which the vignette will be repeated to demonstrate a better performance by the second psychiatrist. The vignettes are expected to include how to handle the use of documents by cross-examining attorney, and how to handle previous testimony and publications, among other skills. After all the vignettes are completed, Mr. DeBofsky will provide an attorney's perspective on expert testimony.

REFERENCES

Babitsky S, Mangraviti JJ: Cross-Examination: The comprehensive guide for experts. Falmouth, MA: SEAK Inc., 2003
Brodsky S: The expert expert witness: more maxims and guidelines for testifying in court. Washington, DC: American Psychological Association, 2003

SELF ASSESSMENT QUESTIONS

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

ANSWER: e

2. Success during cross-examination is best enhanced by:
- knowing the “right” answer to all possible questions
 - depending on opposing attorney to correct errors on direct examination
 - preparation
 - all of the above

ANSWER: c

T37

LEGAL INVOLVEMENT IN SEVERE MANIA: PREVALENCE AND ASSOCIATED SYMPTOMS

Paul Christopher, MD, Rumford, RI
Patrick McCabe, MPH, (I) Worcester, MA
William Fisher, PhD, (I) Worcester, MA

EDUCATIONAL OBJECTIVE

To inform participants of the prevalence of legal involvement among individuals with Bipolar I Disorder during their most severe lifetime manic episodes and the episode-specific symptoms of mania associated with this risk.

SUMMARY

Persons with Bipolar I Disorder (BD-I) are at elevated risk for criminal justice involvement. This study used the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions to identify the prevalence of legal involvement (being arrested, held at the police station or put in jail) during respondents' most severe lifetime manic episode and whether specific manic symptoms contribute to this risk. Legal involvement occurred in 13% of respondents with BD-I during their most severe manic episode and was significantly more likely among persons with increased self-esteem/grandiosity, increased libido, excessive engagement in pleasurable activities with a high risk for painful consequences, >6 DSM-IV Criterion B symptoms, and both social and occupational impairment. Hyper-talkativeness or pressured speech lowered this risk. Legal involvement for persons with Bipolar I Disorder during the most severe manic episode is substantial and is associated with specific manic symptoms, in addition to demographic and psychiatric factors previously known to increase this risk. Efforts to reduce criminal justice involvement among patients during periods of mania would be enhanced by focusing attention and resources on those in this high-risk group.

REFERENCES

Fisher WH, Simon L, Roy-Bujnowski K, Grudzinskas AJ, Wolff N, Crockett E, Banks SMH: Risk of arrest among public mental health services recipients and the general public. *Psychiatr Serv.* 62(1):67-72, 2011
Fazel S, Lichtenstein P, Grann M, Goodwin GM, Långström N: Bipolar disorder and violent crime: new evidence from population-based longitudinal studies and systematic review. *Arch Gen Psychiatry* 67(9):931-8, 2010

SELF ASSESSMENT QUESTIONS

1. Which of the following DSM-IV Criterion B symptoms is associated with the highest risk for legal involvement during severe mania?
- Inflated self-esteem or grandiosity
 - Decreased need for sleep
 - More talkative than usual or pressure to keep talking
 - Flight of ideas or subjective experience that thoughts are racing
 - Distractibility
 - Increase in goal-directed activity or psychomotor agitation
 - Excessive involvement in pleasurable activities that have a high potential for painful consequences

ANSWER: g

2. For severe mania characterized by increased libido, the risk of legal involvement is highest in which group?
- Males
 - Females
 - The risk is equally high in males and females

ANSWER: b

T38

POSTPARTUM PSYCHOSIS AND THE COURTS

Melissa Nau, MD, San Francisco, CA
 Renée Binder, MD, San Francisco, CA
 Dale McNiel, PhD, (I) San Francisco, CA

EDUCATIONAL OBJECTIVE

To examine the ways in which courts have addressed postpartum psychosis as a defense in cases of infanticide.

SUMMARY

The authors examine the use of postpartum psychosis as a defense in cases of infanticide. The authors review the definition and etiology of postpartum psychosis, including differences between postpartum psychosis and psychoses of other etiologies. Next, the authors review postpartum psychosis in the context of infanticide cases, focusing on a comparison of the use of postpartum psychosis as a defense in M’Naghten versus Model Penal Code states. Finally, international standards for infanticide are discussed and contrasted with United States law. The paper concludes with considerations for forensic evaluators testifying in infanticide cases. Method: The authors conducted systematic Westlaw and LexisNexis searches of relevant case law, legal precedent, and law review journal articles related to infanticide. Google and other web search engines were used to identify unpublished cases. Results: Despite the difference between the M’Naghten the Model Penal Code standards for insanity, there was little state-specific difference in how cases of women charged with infanticide were adjudicated. Postpartum psychosis was the only defense considered applicable in the cases of infanticide surveyed; other postpartum syndromes were not successfully used in the insanity defense. Conclusions: The authors review issues relevant to forensic mental health professionals testifying in postpartum psychosis cases.

REFERENCES

Hatters-Friedman S, Horwitz S, Resnick P:Child murder by mothers: A critical analysis of the current state of knowledge and a research agenda. *Am J Psychiatry*, 162, 1578-1587, 2005
 Marrs CR, Durette RT, Ferraro DP, Cross CL:Dimensions of postpartum psychiatric distress: Preliminary evidence for broadening clinical scope. *J Affect Disord* 115, 100-111, 2009

SELF ASSESSMENT QUESTIONS

1. According to recent studies, what percentage of postpartum women suffer from postpartum psychosis?
 - a. 0.01-0.04%
 - b. 0.1-0.4%,
 - c. 1%-4%
 - d. 10-40%

ANSWER: b

2. What postpartum defenses have been successfully used in cases of infanticide?
 - a. postpartum psychosis
 - b. postpartum depression
 - c. posttraumatic stress disorder
 - d. generalized anxiety disorder
 - e. dissociative disorder

ANSWER: a

T39

PTSD AS A CRIMINAL DEFENSE: A REVIEW OF CASE LAW

Omri Berger, MD, San Francisco, CA
 Renée Binder, MD, San Francisco, CA
 Dale McNiel, PhD, (I) San Francisco, CA

EDUCATIONAL OBJECTIVE

Attendees will learn about the different criminal defenses for which PTSD testimony has been presented. Case law from different US jurisdictions will be reviewed to determine how courts have received such testimony.

SUMMARY

PTSD has been offered as a basis for multiple criminal defenses, including insanity, unconsciousness, self-defense, diminished capacity, and sentencing mitigation. Examination of case law (e.g. appellate decisions) involving PTSD reveals that when offered as a criminal defense, PTSD has received mixed treatment by the criminal courts. Overall, courts have recognized testimony about PTSD as scientifically reliable. Additionally, PTSD has been recognized by appellate courts in multiple different U.S. jurisdictions as a valid basis for insanity, unconsciousness, and self defense. However, courts have not always found the presentation of PTSD testimony to be relevant, admissible, or compelling in such cases, particularly when expert testimony failed to show how PTSD met the standard for the given defense. In

cases that did not meet the standard for one of the complete defenses, PTSD has been presented as a partial defense or mitigating circumstance, again with mixed success.

REFERENCES

- Sparr LF: Mental defenses and posttraumatic stress disorder: assessment of criminal intent. *J Trauma Stress* 9(3): 405-25, 1996
Friel A, White T, Hull A: Posttraumatic stress disorder and criminal responsibility. *J Forensic Psych and Psychol* 19(1): 64-85, 2008

SELF ASSESSMENT QUESTIONS

1. For which of the following types of criminal defenses has PTSD expert witness testimony been deemed relevant by the courts?

- a. insanity
- b. unconsciousness
- c. self-defense
- d. diminished capacity
- e. all of the above

ANSWER: e

2. Which of the following factors have led courts to favorably consider PTSD testimony as a basis for criminal defenses?

- a. direct evaluation of the defendant
- b. directly and clearly connecting the defendant's PTSD to the charged offense
- c. demonstrating how the effects of PTSD meet the criteria for the given defense.
- d. all of the above

ANSWER: d

T40

MALINGERING IN HOMICIDE DEFENDANTS: USE OF THE MMSE AND FIT

Wade Myers, MD, Providence, RI

Ryan Hall, MD, Lake Mary, FL

Marina Tolou-Shams, PhD, (I) Providence, RI

EDUCATIONAL OBJECTIVE

To increase participants' understanding of the prevalence of malingering and the use of the MMSE and the FIT in assessing malingering in homicide defendants.

SUMMARY

The purpose of this study was twofold. First, we wanted to survey the prevalence of malingering in a population of pre-trial homicide defendants. Second, we were interested in assessing the usefulness of the Mini-mental State Examination (MMSE) and the Rey Fifteen-Item Memory Test (FIT) in detecting malingering in this population of pre-trial homicide defendants. It was hypothesized that the MMSE and FIT scores would be significantly lower in the malingerers, and that these lower scores would be positively intercorrelated. The prevalence of malingering in this sample, excluding amnesia for the homicidal act, was 17%. Both the MMSE and FIT, while of some clinical usefulness, were still relatively poor predictors of malingering. Positive predictive value was 67% and 43% respectively. They were of more use in supporting true negative cases than in identifying true positive cases, with their negative predictive values at 93% and 90%. Surprisingly, there was a trend for the MMSE, not a traditional test for malingering, to be of more clinical utility in detecting malingering than the FIT. Future studies with larger sample sizes are needed to increase our understanding of the practicality of malingering tests in the assessment of homicide defendants.

REFERENCES

- Rogers R: Clinical assessment of malingering and deception. The Guilford Press; New York, 2008
Slick DJ, Tan JE, Strauss EH, *et al*: Detecting malingering: a survey of experts' practices. *Arch Clin Neuropsychol* 19(4):465-73, 2004

SELF ASSESSMENT QUESTIONS

1. The FIT:

- a. is best suited for ruling in malingering.
- b. is best suited for ruling out malingering.
- c. should not be used in forensic settings.
- d. is expensive and time consuming.

ANSWER: b

2. Which statement is not true about malingering?
 - a. Malingering can involve feigning psychotic or cognitive symptoms.
 - b. Malingering is more common in those with antisocial personality disorder.
 - c. The best way to detect malingering is through a combined approach taking into account interview results, collateral data, and psychometric testing.
 - d. Malingering occurs in less than 5% of forensic evaluations.
- ANSWER: c

T41

COMMONWEALTH OF MASSACHUSETTS V. SHANLEY – RECOVERED MEMORIES ON TRIAL: PRIESTS, PEDOPHILIA, AND PARISHIONERS

Debra Pinals, MD, Worcester, MA
 James Chu, MD, (I) Concord, MA
 Christopher Thompson, MD, Los Angeles, CA
 Charles Scott, MD, Sacramento, CA
 Katharine Folger, Esq., (I) Woburn, MA

EDUCATIONAL OBJECTIVE

The audience participant will understand current arguments for and against the admissibility of expert witness testimony on the issue of recovered memories and Massachusetts Supreme Judicial Court ruling on this issue.

SUMMARY

On February 7, 2005, Father Paul Shanley was convicted of sexual abuse of a child. The abuse allegedly occurred between 1983 and 1989 when victim Paul Busa was attending Confraternity of Christian Doctrine (CCD) classes at the church where the defendant served as a Catholic priest. Mr. Busa testified that he did not remember being abused by the defendant until nearly twenty years later, when he learned that other individuals had publicly made allegations that the defendant had sexually abused them when they were children. After his conviction, Father Shanley appealed contending that the trial judge erred in admitting expert testimony. This mock trial recreates the Massachusetts Supreme Judicial Court hearing in January 2010 to decide on the admissibility of expert witness testimony regarding recovered memories. Dr. Charles Scott will review the underlying facts of the case. Dr. James Chu, the prosecution’s expert, will present his testimony and Dr. Debra Pinals will present the exact testimony provided by the defense expert witness, Dr. Elizabeth Loftus. Assistant District Attorney Katharine Folger will recreate the role of the prosecuting attorney and Dr. Christopher Thompson will act in the role of defense counsel. AAPL members will vote as to which side’s presentation was most persuasive and this result will be compared with the court’s ultimate decision.

REFERENCES

Commonwealth v. Paul Shanley, Massachusetts Supreme Judicial Court, 10382, January 15, 2010
 Hyman IE, Loftus EF: Some people recover memories of childhood trauma that never really happened *In Trauma and Memory-Clinical and Legal Perspectives* New York, NY Oxford University Press, 1997, pp 3-24

SELF ASSESSMENT QUESTIONS

1. The trial court judge cited all of the following as reasons to allow recovered memory testimony at trial except:
 - a. The diagnosis of Dissociative Identity Disorder is noted in the DSM-IV.
 - b. The lack of scientific evidence regarding recovered memories rendered the theory unreliable.
 - c. Both the APA and AMA have stated that “memories of traumatic events can be forgotten but that pseudomemory formation is also possible” indicating that recovered memories is generally accepted in the scientific field.
 - d. A review of 85 studies of childhood trauma and amnesia indicates that recovered memories do occur.

ANSWER: b

2. Arguments presented by the defense that recovered memories were unreliable and should not be admitted into evidence included all of the following EXCEPT?
 - a. There was a lack of scientific evidence to render the theory reliable.
 - b. Research indicates that a number of suggestive influences can produce false memories.
 - c. The DSM-IV had a cautionary statement regarding the use of the DSM-IV in forensic settings.
 - d. There was no controlled methodology for assessing recovered memories.
 - e. The victim’s psychotic disorder interfered with his ability to distinguish true vs. false memories.

ANSWER: e

FRIDAY, OCTOBER 28, 2011

POSTER SESSION B

7:00AM – 8:00AM/
9:30AM – 10:15AM

MEZZANINE FOYER

- F1 *Addressing Therapeutic Boundaries in Social Networking***
Almari Ginory, DO, Davie, FL
Laura Mayol Sabatier, MD, (I) Miami, FL
Spencer Eth, MD, Aventura, FL
- F2 *Electronic Monitoring of Psychiatric Prescribing Practices in New York State Prisons***
Stephanie Lilly, MA, (I) Marcy, NY
Jonathan Kaplan, MD, Marcy, NY
Catherine Moffitt, PhD, (I) Marcy, NY
Donald Sawyer, PhD, (I) Marcy, NY
- F3 *The Link Between Mental Illness and Violence: Fact or Fiction?***
George Annas, MD, Ann Arbor, MI
- F4 *Rising Forensic Demand in Ontario: Trends, Potential Causes and International Comparisons***
Alexander Simpson, FRANZCP, Toronto, ON, Canada
Padraig Darby, MD, (I) Toronto, ON, Canada
Stephanie Penney, PhD, (I) Toronto, ON, Canada
- F5 *Improvement of Forensic Hospital Treatment and External Risk Assessments***
Eberhard Heering, MD, (I) Berlin, Germany
Hans-Ludwig Kröber, PhD, (I) Berlin, Germany
- F6 *Football Follies: How Biological, Clinical and Legal Implications of Chronic Traumatic Encephalopathy (CTE) Affect the NFL***
Helen M. Farrell, MD, Boston, MA
Manish Fozdar, MD, Wake Forest, NC
- F7 *Automatism: The Only Defense Available to the Honest Man or the Last Refuge of the Scoundrel***
Muzaffar Husain, MRCPsych, (I) Bromley, United Kingdom
Asim Suddle, MRCPsych, (I) Middlesex, United Kingdom
- F8 *Prison Pornography Policies: A Fifty-State Survey***
Reena Kapoor, MD, New Haven, CT
- F9 *Mental Illness and Legal Fitness (Competence) to Stand Trial in New York State***
Eugene Lee, MD New York, NY
Richard Rosner, MD, New York, NY
Ronnie Harmon, PhD, (I) New York, NY
- F10 *A “Civil Forensic Unit” in an Inner City Community Hospital***
Lizica Troneci, MD, Floral Park, NY
Katya Frischer, MD, JD, New York, NY
Panagiota Korenis, MD, Bronx, NY
Bahram Panbehi, MD, (I) Bronx, NY
Ali Khadivi, PhD, (I) Providence, RI
- F11 *Management of Forensic Patients with Litigious Paranoia***
Susan Adams, MRCPsych, FRCPC, North Bay, ON, Canada
Milan Pomichalek, PhD, (I) North Bay, ON, Canada
- F12 *Arrest Types and Co-Occurring Disorders in Persons with Schizophrenia or Related Psychoses***
Patrick McCabe, MPH, (I) Worcester, MA
Paul Christopher, MD, Rumford, RI
Nicholas Druhn, PsyD, (I) St. Peter, MN
Kristen Roy-Bujnowski, MA, (I) Worcester, MA
Albert Grudzinskas Jr., JD, (I) Worcester, MA
William Fisher, PhD, (I) Worcester, MA

FRIDAY

F13	<i>A Survey of Crisis Unit Training for Law Enforcement in the Wake, Durham, and Orange Counties of North Carolina</i>	Sonal Patole, MD, Carrboro, NC Jacqueline Smith, MD, Chapel Hill, NC Alyson Kuroski-Mazzei, DO, Chapel Hill, NC
F14	<i>The Young and The Incompetent to Proceed: A Review of State Statutes and Case Law Regarding Disposition of These Youth</i>	Jacqueline Smith, MD, Chapel Hill, NC Ivy Sohn, MD, JD, Butner, NC Sally Johnson, MD, Raleigh, NC
F15	<i>Forensic Psychiatry Within a Physician Health Program</i>	Scott Humphreys, MD, Denver, CO
F16	<i>A Preservative of Insanity: Embalming Fluid</i>	Susan Chlebowski, MD, Rochester, NY Cecelia Leonard, MD, Syracuse, NY James Knoll IV, MD, Syracuse, NY
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DEBATE		8:00AM - 10:00AM IMPERIAL BALLROOM
F17	<i>Caught in the Headlights: Hare's Psychopathy Checklist</i>	Callum Ross, MBChB, (I) Crowthorne, United Kingdom Ian Cumming, MBBS, (I) London, United Kingdom Fintan Larkin, MB BCh, (I) Crowthorne, United Kingdom Penelope Brown, BM BCh, (I) Crowthorne, United Kingdom Kenneth Busch, MD, Chicago, IL
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COURSE (TICKET REQUIRED)		8:00AM - 12:00 NOON GEORGIAN
F18	<i>Do's and Don'ts of Depositions (Core) Education Committee</i>	Thomas Gutheil, MD, Brookline, MA David Gould, JD, (I) Boston, MA David Benjamin, PhD, (I) Chestnut Hill, MA
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PANEL		8:00AM - 10:00AM STATLER
F19	<i>Geriatric Assessment by Forensic Psychiatrists: Ethical Challenges Geriatric Psychiatry and the Law Committee</i>	Robert Weinstock, MD, Los Angeles, CA Paul Appelbaum, MD, New York, NY Phillip Candilis, MD, Arlington, MA Stephen Read, MD, San Pedro, CA James Ellison, MD, Belmont, MA
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WORKSHOP		8:00AM - 10:00AM BERKELEY/CLARENDON
F20	<i>The DSM-5 Sexual Disorders: Forensic Implications</i>	Renée Sorrentino, MD, Quincy, MA Richard Krueger, MD, New York, NY Martin Kafka, MD, (I) Arlington, MA
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SCIENTIFIC PAPER SESSION #2		8:00AM - 10:00AM ARLINGTON
F21	<i>Selling Meds for Competence Restoration: The Details Emerge</i>	Douglas Mossman, MD, Cincinnati, OH Sarah Sanderson, JD, (I) Cincinnati, OH
F22	<i>Quetiapine (Seroquel) Abuse and Misuse in Forensic Settings</i>	Leonard Mulbry, Jr., MD, Charleston, SC Amanda Pearce, MD, (I) Charleston, SC
F23	<i>Pro Se Competence: Toward an Evidence-Based Standard</i>	Andrew Kaufman, MD, Fayetteville, NY James Knoll IV, MD, Syracuse, NY Bruce Way, PhD, (I) Ottawa, ON, Canada
F24	<i>Family Violence Perpetrated by Juveniles</i>	Gennady Baksheev, BA, (I) Parkville, Victoria, Australia Rosemary Purcell, PhD, (I) Parkville, Victoria, Australia

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

PANEL

F25 Civil "Harassment" Lawsuits: Bullies, Bosses, and Bigots**SA**

10:15AM - 12:00 NOON

IMPERIAL BALLROOM

William Newman, MD, Sacramento, CA
 David Bobb, Jr., MD, Sacramento, CA
 Rodney Reid, MD, PhD, Sacramento, CA
 Jason Roof, MD, Sacramento, CA

PANEL

F26 Evidenced Based Practices for Adolescents: Relevance and Application to Forensic Psychiatry

10:15AM - 12:00 NOON

STATLER

Debra DePrato, MD, Baton Rouge, LA
 Thomas Grisso, PhD, (I) Worcester, MA
 Eric Trupin, PhD, (I) Seattle, WA

PANEL

F27 Legal Regulation of Sex Offenders in the Community

10:15AM - 12:00 NOON

BERKELEY/CLARENDON

Paul Appelbaum, MD, New York, NY
 Jacqueline Berenson, MD, New York, NY
 Andrew Harris, PhD, (I) Lowell, MA
 Wayne Logan, JD, (I) Tallahassee, FL

RESEARCH IN PROGRESS #3

F28 Cerebral Glucose Metabolism in Persons Convicted of Capital Murder

10:15AM - 12:00 NOON

ARLINGTON

Susan Rushing, MD, JD, Philadelphia, PA
 Ruben Gur, MD, (I) Philadelphia, PA

F29 Psychiatric Characteristics of a Representative Sample of Homicide Defendants

Christine Martone, MD, Pittsburgh, PA
 Suzanne Yang, MD, Pittsburgh, PA
 Layla Soliman, MD, Pittsburgh, PA
 Richard Frierson, MD, Columbia, SC

F30 Women Who Kill Their Mate

Dominique Bourget, MD, Ottawa, ON, Canada
 Pierre Gagne, MD, FRCPC, Sherbrooke, PQ, Canada

LUNCH (TICKET REQUIRED)

F31 Child Exploitation in Southeast Asia: Can It Get Any Worse?

12 NOON - 2:00PM

PLAZA BALLROOM

Special Agent Gary Phillips, (I) Kearney, NE

A/V SESSION

F32 Dissociative Identity Disorder: Assessment of Criminal Responsibility, and Diminished Capacity

2:15PM - 4:00PM

IMPERIAL BALLROOM

David Rosmarin, MD, Newton, MA

COURSE (TICKET REQUIRED)

F33 Sexual Offenders: Identification, Risk Assessment, Treatment and Legal Issues Sexual Offenders Committee

2:15PM - 6:15PM

GEORGIAN

John Paul Fedoroff, MD, Ottawa, ON, Canada
 Roy O'Shaugnessy, MD, Vancouver, BC, Canada
 Fabian Saleh, MD, Boston, MA
 Charles Scott, MD, Sacramento, CA
 Howard Zonana, MD, New Haven, CT
 John Bradford, MBChB, Ottawa, ON, Canada

PANEL

F34 "Hearsay... Hearsay!" Considerations for Forensic Psychiatrists

2:15PM - 4:00PM

STATLER

Michael Greenspan, MD, Bronx, NY
 Merrill Rotter, MD, Bronx, NY
 Albert Grudzinskas Jr., JD, (I) Worcester, MA
 Kenneth Appelbaum, MD, Shrewsbury, MA

FRIDAY

PANEL
F35 **Stalking: Recent Advances in Assessment and Treatment (Core)** 2:15PM - 4:00PM **BERKELEY/CLARENDON**
David James, MD, Oxford, United Kingdom
Frank Farnham, MD, Enfield/Middlesex, United Kingdom
Rachel MacKenzie, DPsych, (I) Clifton Hill, Australia
Sara Henley, DPsych, (I) North London, United Kingdom

RESEARCH IN PROGRESS #4
F36 **Initial Treatment Outcomes in a Dialectical Behavior Therapy Program** 2:15PM - 4:00PM **ARLINGTON**
Nicole Kletzka, PhD, (I) Saline, MI
Jean Kanitz, PhD, (I) Saline, MI
Craig Lemmen, MD, Ann Arbor, MI

F37 **Trauma, PTSD, and Self-Injurious Behavior in Two Corrections Samples**
Tracy Gunter, MD, St. Louis, MO
Sandra Antoniak, MD, Iowa City, IA


F38 **Women's Mental Health in Correctional Settings**
Anna Glezer, MD, Boston, MA
Rebecca Brendel, MD, JD, Boston, MA

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

WORKSHOP
F39 **The Psychology of Political Crime: Terrorism, Torture, and Genocide** 4:15PM - 6:15PM **ARLINGTON**
Jerrold Post, MD, (I) Bethesda, MD

WORKSHOP
F40 **Computers and Technology in Forensic Psychiatry** 4:15PM - 6:15PM **STATLER**
Computers and Forensic Psychiatry Committee
Mark Hauser, MD, Newton, MA
Alan Newman, MD, Washington, DC
Tyler Jones, MD, Washington, DC
Andrew Nanton, MD, Orlando, FL

PANEL
F41 **Seriously Mentally Ill Persons in U.S. Immigration Detention** 4:15PM - 6:15PM **BERKELEY/CLARENDON**
Kristen Ochoa, MD, Los Angeles, CA
Joseph Penn, MD, Huntsville, TX
Homer Venters, MD, (I) New York, NY
Erin Hustings, Esq., (I) Washington, DC
Sarah Mehta, Esq., (I) New York, NY
Laura Belous, Esq., (I) Florence, AZ

PANEL
F42 **Complicated Child Custody Issues: What Evaluators Should Know About Autistic Children, Homosexual Parents, and Native Americans** 4:15PM - 6:15PM **IMPERIAL BALLROOM**

Jesse Raley, MD, Columbia, SC
Alicia Hall, PhD, (I) Columbia, SC
Crystal Bullard, MD, (I) Columbia, SC

Almar Ginory, DO, Davie, FL

Laura Mayol Sabatier, MD, (I) Miami, FL

Spencer Eth, MD, Aventura, FL

EDUCATIONAL OBJECTIVE

Participants will learn about the ways psychiatric residents use Facebook and internet tools in clinical practice, identify areas of concern regarding the posting of personal information on social networking sites and recognize gaps in guidelines regarding the use of social networking.

SUMMARY

Facebook is an expanding social networking site with over 400 million users, and the use of social networking among psychiatry residents has been understudied. This study will examine ethical and legal issues raised by the use of Facebook. **Methods:** An email was sent to members of the APA resident's list serve requesting their participation in an anonymous online survey regarding their use of Facebook. As of time of submission, 111 psychiatry residents completed the survey. Of those, 86.5% reported having had a Facebook profile, with 11.4% relating that their profile is public and 37.2% admitting to posting work-related comments. Of those with a current profile, 22.7% have looked up a patient's profile. The reasons given for looking up a patient's profile include curiosity, obtaining collateral information, and verifying information given in sessions. In addition, 57.7% of residents have used an internet search engine to inquire information about patients. Most residents surveyed have used Facebook and the internet to search for information about patients. This phenomenon raises both ethics and legal concerns that should be addressed in the professional literature and in training programs.

REFERENCES

Moubarak G, Guiot A, Benhamou Y: Facebook activity of residents and fellows and its impact on the doctor-patient relationship. *J Med Ethics* 2: 1-4, 2010

Guseh J, Brendel R, Brendel D: Medical professionalism in the age of online social networking. *J Med Ethics* 35:584-586, 2009

SELF ASSESSMENT QUESTIONS

1. According to the AMA Council on Ethics and Judicial Affairs Guidelines on Professionalism in the use of Social Media, which of following statements is not correct?
 - a. Physicians must refrain from posting identifiable patient information online.
 - b. When physicians see unprofessional content posted by colleagues, they have a responsibility to report it to that individual and if necessary report the matter to the appropriate authorities.
 - c. Professional ethics guidelines for interactions with patients on the internet are different than those of face-to-face contact.
 - d. Inappropriate online contact may negatively affect the careers of physicians, especially physicians in training and medical students.

ANSWER: c

2. According to published accounts which of the following statements are correct?
 - a. Medical schools have reported disciplinary student expulsions for improper use of social networking sites.
 - b. Psychiatrists have been criticized for their social network sites.
 - c. Clinical programs have Facebook sites.
 - d. Psychiatric resident applicants share information and gossip about residency programs on listserves.
 - e. all of the above

ANSWER: e

ELECTRONIC MONITORING OF PSYCHIATRIC PRESCRIBING PRACTICES IN NEW YORK STATE PRISONS

Stephanie Lilly, MA, (I) Marcy, NY

Jonathan Kaplan, MD, Marcy, NY

Catherine Moffitt, PhD, (I) Marcy, NY

Donald Sawyer, PhD, (I) Marcy, NY

EDUCATIONAL OBJECTIVE

To provide an overview and efficacy of a computer-based software application which monitors psychotropic prescribing patterns in New York State prisons.

SUMMARY

Clinical decision support tools when used appropriately have been found to improve patient safety. Moreover, there is also evidence that additional information technology tools could be used to further enhance treatment. Central New York Psychiatric Center (CNYPC) under the auspices of the New York State Office of Mental Health, provides mental health treatment to inmates residing in New York State prisons. CNYPC has implemented an internal web-based software application in order to monitor a number of indicators including psychotropic medication prescribing patterns. This has facilitated assessment to the approximate 12,000 inmate-patients seen annually. The practices assessed include tracking the appropriate use of the more commonly abused medications and the use of polypharmacy. Preliminary data suggest that there has been demonstrated improvement in both prescribing parameters as a result of the electronic monitoring.

REFERENCES

Bates DW, Cohen M, Leape LL, et al: Reading the frequency of errors in medicine using information technology. *Journal of the American Medical Informants Association* 8(4):299-308, 2001
Correll CU, Fredrickson AM, Kane JM, et al: Does antipsychotic polypharmacy increase the risk for metabolic syndrome? *Schizophrenia Research* 89:91-100, 2007

SELF ASSESSMENT QUESTIONS

1. The prescribing of which antipsychotic has been associated with significant inmate abuse in New York State prisons?

- a. Haloperidol
- b. Quetiapine
- c. Chlorpromazine
- d. Ziprasidone

ANSWER: b

2. Approximately, how many inmate-patients are seen annually by mental health staff in New York State prisons?

- a. 6,000
- b. 12,000
- c. 18,000
- d. 24,000

ANSWER: b

F3

THE LINK BETWEEN MENTAL ILLNESS AND VIOLENCE: FACT OR FICTION?

George Annas, MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE

Review the literature to attempt an assessment of the potential link between mental illness and violence. The objective will be to work towards more clarity in regard to this issue as well as to stimulate further debate in some of the laws banning firearms from the mentally ill.

SUMMARY

Beliefs about those with mental illness being more prone to violence abound in society today. This is despite a great deal of literature suggesting that those with mental illness, with the exception of comorbid or entirely substance abuse diagnoses, do not pose a greater risk of violence. This poster reviews the literature to examine if there is a link between mental illness and violence. If so, how substantial is the risk? If not, are gun laws banning those with some diagnosed mental illnesses discriminatory in nature? Do such laws perpetuate a stereotype that leads to further myths about this link?

REFERENCES

Van Dorn R, Volavka J, Johnson N: Mental disorder and violence: is there a relationship beyond substance use? *Soc Psychiatry Psychiatr Epidemiol* February 26, 2011 [Epub ahead of print] PubMed PMID: 21359532
Elbogen E, Johnson S: The intricate link between violence and mental disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions . *Arch Gen Psychiatry* 66(2):152-161, 2009

SELF ASSESSMENT QUESTIONS

1. When reviewing NESARC data, Elbogen and Johnson found that those with severe mental illness (SMI):

- a. Had no statistically higher risk for violence without co-morbid substance abuse.
- b. Had a statistically higher risk for violence with or without co-morbid substance abuse.
- c. Had a statistically lower risk for violence with or without co-morbid substance abuse.

ANSWER: a

2. When reviewing NESARC data, with the focus on a causal relationship between SMI and violence over 12 months, Elbogen and Johnson found that those with severe mental illness:
- Had no statistically higher likelihood for violent acts without co-morbid substance abuse.
 - Had a statistically higher likelihood for violent acts with or without co-morbid substance abuse.
 - Had a statistically lower likelihood for violent acts with or without co-morbid substance abuse.
- ANSWER: b

F4

**RISING FORENSIC DEMAND IN ONTARIO:
TRENDS, POTENTIAL CAUSES AND INTERNATIONAL COMPARISONS**

Alexander Simpson, FRANZCP, Toronto, ON, Canada
 Padrig Darby, MD, (I) Toronto, ON, Canada
 Stephanie Penney, PhD, (I) Toronto, ON, Canada

EDUCATIONAL OBJECTIVE

To understand patterns of rising numbers of forensic patients in Ontario: similarities in these patterns in other jurisdictions raise questions to be explored about what factors may drive forensic demand and service and research directions that may inform clinical and public policy.

SUMMARY

The number of persons subject to the supervision of the Ontario Review Board has risen from approximately 400 to 1500 since 1992. This is a compounding annual increase of 5% per annum. Such persons are all adjudicated not criminally responsible or unfit to stand trial. There is little evidence to suggest core issues of mental illness and violence has increased so much in this time period, but a series of legislative changes, key judicial interpretations and the increased perception of the forensic services as the answer for people in the community who are difficult to engage in community mental health services may all have contributed. Similar trends are not uniform across Canada, even though the Criminal Code is the same in all provinces. Internationally, other jurisdictions have seen similar rises. Such comparisons suggest key similarities and differences that will be reviewed, and service design challenges to the forensic continuum in Ontario will be discussed. A research agenda to further describe these factors will be proposed.

REFERENCES

Simpson AIF, Skipworth J, McKenna B, et al: Mentally abnormal homicide in New Zealand as defined by legal and clinical criteria: a national study. *Australian and New Zealand J of Psychiatry* 40: 804-809, 2006
 Schanda H, Stompe T, Ortwein-Swoboda G: Psychiatry reforms and increasing criminal behavior of the severely mentally ill: any link? *International Journal of Forensic Mental Health* 8: 105-114, 2009

SELF ASSESSMENT QUESTIONS

- What factors drive the rise in forensic patient numbers?
 ANSWER: Changes in law, in its interpretation and use as a means of diverting persons not adequately cared for in general mental health services. Evidence for each of these options is present in the world literature, and some evidence for each can be found in Ontario.
- Is the nature of who is subject to forensic orders changing?
 ANSWER: There is little clear evidence of this through time, and there is no significant evidence that persons with serious mental illness are becoming more dangerous, but it appears people charged with less serious offenses may be coming under forensic service than was so 20 years ago.

F5

**IMPROVEMENT OF FORENSIC HOSPITAL TREATMENT AND
EXTERNAL RISK ASSESSMENTS**

Eberhard Heering, MD, (I) Berlin, Germany
 Hans-Ludwig Kröber, PhD, (I) Berlin, Germany

EDUCATIONAL OBJECTIVE

To provide information about the situation of schizophrenic offenders in the German forensic hospitals and how to improve their therapeutic pathway.

SUMMARY

In Germany, patients of forensic psychiatric hospitals are regularly examined by external experts in order to check their prognosis. These risk assessment reports collect a lot of data concerning the quality of treatment and the patients' progress during their therapeutic pathway. Which are the key findings of external reports regarding these topics and how can this data be used in order to improve therapy in forensic hospitals?

REFERENCES

Kröber HL: The historical debate on brain and legal responsibility – revisited. *Behav Sci Law* 25: 251-261, 2007
Kröber HL: Concepts of intentional control. *Behav Sci Law* 27:209-21, 2009

SELF ASSESSMENT QUESTIONS

1. Why can external risk assessment reports help to improve the treatment of patients in forensic hospitals?
ANSWER: They collect a lot of data about the patient's therapeutic pathway and uncover deficits that can be improved.
2. How are external risk assessments performed in Germany?
ANSWER: They have to be held regularly (every five years) in order to verify the prognosis of forensic hospitals' inmates.

F6

FOOTBALL FOLLIES: HOW BIOLOGICAL, CLINICAL AND LEGAL IMPLICATIONS OF CHRONIC TRAUMATIC ENCEPHALOPATHY (CTE) AFFECT THE NFL

Helen M. Farrell, MD, Boston, MA
Manish Fozdar, MD, Wake Forrest, NC

EDUCATIONAL OBJECTIVE

To understand the biological implications of repeated head injury and how chronic traumatic encephalopathy develops on both pathological and microscopic levels, correlate CTE with football trauma, know the clinical manifestations of CTE and learn how the NFL has been affected by lawsuits from players affected by CTE.

SUMMARY

Chronic traumatic encephalopathy (CTE) is a progressive neurodegenerative syndrome caused by single, episodic or repetitive blunt force impacts to the head and transfer of acceleration-deceleration forces to the brain. Contact sports that make the head susceptible to such injuries include American football, hockey, soccer, professional wrestling. The National Football League (NFL) has taken measures to protect players from such injuries, but the organization is nevertheless the target of many civil lawsuits filed by players. Helmets, rules for tackling players, imposed fines for illegal moves, and responsiveness to concussions suffered during play have been modified over the years. Nevertheless, CTE remains an ongoing problem for the NFL. Recent developments in the clinical manifestations of CTE, neuropathological changes, and microscopic changes have advanced this field of knowledge. Those advancements may have also contributed to player assertions that the NFL is responsible for injuries suffered during their football tenure. This research presents the medicolegal complications of CTE in American football and looks at the future of this popular sport which continues to undergo a robust debate over how the game should be played.

REFERENCES

Omalu BI, Hamilton RL, Kamboh MI: Chronic traumatic encephalopathy (CTE) in a National Football League Player: Case report and emerging medicolegal practice questions. *J Forensic Nurs Spring* 6(1):40-6, 2010
McKee AC, Cantu RC, Nowinski CJ: Chronic traumatic encephalopathy in athletes: progressive tauopathy after repetitive head injury. *J Neuropathol Exp Neurol* 68(7):709-35, 2009

SELF ASSESSMENT QUESTIONS

1. Name some of the clinical, neuropathological and microscopic changes associated with CTE:
ANSWER: Clinical: memory disturbances, behavioral and personality changes (apathy, impulsivity, depression, irritability, suicidality), parkinsonism (masked facies, tremor, bradykinesia, rigidity, hypophonia, micrographia). Neuropathologic: CTE is characterized by cerebral atrophy, cavum septi pellucidi with fenestrations, shrinkage of the mammillary bodies. Microscopic: there are extensive dense tau-immunoreactive inclusions (neurofibrillary tangles, astrocytic tangles, glial tangles, spindle-shaped and threadlike neuritis throughout the brain), and TDP-43 proteinopathy
2. Who is the original discoverer of CTE and is currently leading a university to collect cadaver brains for research?
ANSWER: Bennet Omalu from West Virginia University. Ann McKee, a co-director of Boston University's new Center for the Study of Traumatic Encephalopathy is leading the second largest group.

F7

AUTOMATISM: THE ONLY DEFENSE AVAILABLE TO THE HONEST MAN OF THE LAST REFUGE OF THE SCOUNDREL

Muzaffar Husain, MRCPsych, (I) Bromley, United Kingdom
Asim Suddle, MRCPsych, (I) Middlesex, United Kingdom

EDUCATIONAL OBJECTIVE

To clarify the nature of the automatism defense to criminal liability and the requirements of a forensic psychiatric assessment of such defendants. We also propose improvements in the law which will assist in delivering the required medical treatments to such defendants, as well as ensure public security.

SUMMARY

In English criminal law, the defense of automatism raises the issue of voluntariness at the time of the criminal act and refers to unconscious, involuntary behavior. It is accepted as a full defense in jurisdictions derived from English common law. Recent case law from Canada, Australia and the UK suggests that automatism negates the actus reus of the offense. Case law on automatism began in the 1950s when the courts felt a need to introduce a legal pathway distinct from legal insanity for those defendants who appeared to have acted involuntarily at the time of the offense, but who did not appear to have acted due to a "Disease of the Mind." Such defendants were offered the prospect of unqualified acquittal. However subsequent judicial reviews have entangled automatism with legal insanity, and introduced legal distinctions between insane automatism and non-insane automatism, even as this makes the law on automatism complex and confusing. There have been several inconsistent rulings. In this poster, we visit case law on automatism, the best advice for conducting medicolegal assessments, and the current framework for the operation of the defense in the courts of England and Wales. We also propose some reforms.

REFERENCES

Walker, N: Crime and insanity in England, Edinburgh University Press, 1968
R v. Harrison-Owen, 1951

SELF ASSESSMENT QUESTIONS

1. The legal defense of automatism negates which of the following elements of the offense?
 - a. The actus reus of the offense.
 - b. The mens rea of the offense.
 - c. It negates neither the actus reus or the mens rea of the offense, but is a separate defense which must be disproven by the prosecution to establish criminal liability.
 - d. a and b
- ANSWER: a

2. In current case law, the defendant merits an unqualified acquittal for the offense if they succeed in establishing which of the following defenses?
 - a. Insane Automatism
 - b. Insanity
 - c. Non-insane Automatism
 - d. Provocation
 - e. Lack of foresight
- ANSWER: c

F8**PRISON PORNOGRAPHY POLICIES: A FIFTY-STATE SURVEY**

Reena Kapoor, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will review the legal framework surrounding access to pornography in prisons, learn about the differences in the policies of the 50 state prison systems, and examine the scientific data that support (or do not support) these policies.

SUMMARY

Prison officials typically cite several reasons for banning prisoners' access to sexually explicit materials, most notably that pornography disrupts the security of the facility and that employees are unnecessarily exposed to graphic sexuality in the course of their work. Conversely, proponents of pornography access in prisons cite First Amendment rights and healthy stress relief in support of their position. Correctional psychiatrists, particularly those who work with sex offenders, may be affected by these policies but not have much influence over their creation or implementation. This study seeks to inform forensic psychiatrists about prison pornography policies by examining regulations across all 50 state prison systems and the Federal Bureau of Prisons. Preliminary results indicate that most states have superficially similar regulations that restrict access to pornography in prisons. However, upon closer inspection, subtle distinctions are apparent between the policies, particularly with regard to depictions of sex acts v. nudity, written v. pictorial representations of sex, personal photos v. commercial publications, and special restrictions for sex offenders. The medical literature linking the viewing of pornography to sex offending behavior is also examined, with the aim of determining whether the scientific data support the distinctions made in prison policies.

REFERENCES

Miness SA: Pornography behind bars. *Cornell L Rev* 85: 1702-1741, 2000
Kingston DA, Malamuth NM, et al: The importance of individual differences in pornography use: theoretical perspectives and implications for treating sexual offenders. *J Sex Res* 46: 216-32, 2009

SELF ASSESSMENT QUESTIONS

1. Prison officials must consider which of the following when censoring prisoners' access to publications, including pornography?
 - a. Whether the restriction placed upon the prisoner is reasonably related to legitimate penological interests.
 - b. Whether there are alternate means of achieving the government's interests that do not require censorship.
 - c. The impact of the censorship policy upon guards, other inmates, and the allocation of prison resources generally.
 - d. all of the above

ANSWER: d

2. The 1996 law prohibiting the use of federal funds to distribute sexually explicit materials in prisons is called:

- a. Megan's Law
- b. The Ensign Amendment
- c. The Turner Test
- d. The Prison Pornography Act

ANSWER: b

F9

MENTAL ILLNESS AND LEGAL FITNESS (COMPETENCE) TO STAND TRIAL IN NEW YORK STATE

Eugene Lee, MD, New York, NY

Richard Rosner, MD, New York, NY

Ronnie Harmon, PhD, (I) New York, NY

EDUCATIONAL OBJECTIVE

This learning experience will improve participants' access to new scientific data on the association between mental illness and fitness to stand trial.

SUMMARY

When adjudicating a criminal defendant, the assessment of the defendant's fitness to stand trial can be a crucial decision point in legal disposition. Most defendants are presumed fit (competent) to stand trial. When a defendant's competence is called into question, lawyers and judges consult psychiatrists and psychologists for forensic opinions on the defendant's capacity to stand trial. The authors have hypothesized there to be an inverse correlation between the capacity to stand trial and higher scores on a slightly modified version of the Brief Psychiatric Rating Scale (BPRS), an instrument developed to quantify psychiatric symptomatology. The poster will present data on whether there is a statistically significant association between findings of mental illness and forensic opinions on fitness to stand trial.

REFERENCES

- James DV, Duffield G, Blizard R, et al: Fitness to plead. A prospective study of the inter-relationships between expert opinion, legal criteria and specific symptomatology. *Psychological Medicine* 31:139-150, 2001
- Jacobs MS, Ryba NL, Zapf PA: Competence-related abilities and psychiatric symptoms: an analysis of the underlying structure and correlates of the MacCAT-CA and the BPRS. *Law Hum Behav* 32:64-77, 2008

SELF ASSESSMENT QUESTIONS

1. In 1960, *Dusky v. U.S.* (362 U.S. 402), a landmark case, established what is usually taken to be the minimal constitutional standard for adjudicative fitness in the United States. In this case the Supreme Court stated that the test for competence to stand trial was:

- a. whether Dusky had sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding.
- b. whether Dusky had a rational as well as factual understanding of the proceedings against him.
- c. a and b

ANSWER: c

2. The Brief Psychiatric Rating Scale (BPRS) is a widely used and relatively brief scale that measures major psychotic and nonpsychotic symptoms in individuals with major psychiatric disorders, particularly:

- a. Schizophrenia
- b. Bipolar Disorder
- c. Borderline Personality Disorder

ANSWER: a

Lizica Troneci, MD, Floral Park, NY
 Katya Frischer, MD, JD, New York, NY
 Panagiota Korenis, MD, Bronx, NY
 Bahram Panbehi, MD, (I) Bronx, NY
 Ali Khadivi, PhD, (I) Providence, RI

EDUCATIONAL OBJECTIVE

To determine if the course of treatment of patients who are admitted to a specialized acute inpatient unit is different from that of patients admitted to a regular acute inpatient unit.

SUMMARY

Bronx Lebanon Hospital Center created a specialized unit called the "Civil Forensic Unit" for the treatment of inpatients who require court intervention to be either retained or to receive treatment over objection. There is limited literature examining the different outcomes and course of treatment for these patients. This study utilizes a retrospective case controlled methodology. It compares inpatients admitted to the Civil Forensic Unit with those who are admitted to a regular acute inpatient unit. All non-overlapping consecutively admitted inpatients during the time period of October 1, 2010 until February 28, 2011 will be selected. Data collected will include demographic variables, diagnosis, substance abuse history, number of past psychiatric hospitalizations, and past history of violence. The outcome variables will include length of stay, number of violent incidents, number of seclusion or restraint episodes and number of episodes requiring stat medication.

REFERENCES

Zito JM, Routt WW, Mitchell JE, et al: Clinical characteristics of hospitalized psychotic patients who refuse antipsychotic drug therapy. *Am J Psychiatr* 142(7): 822-826, 1985
 Marder SR, et al: A comparison of patients who refuse consent to neuroleptic treatment. *Am J of Psychiatr* 140(4): 470-472, 1983

SELF ASSESSMENT QUESTIONS

- Are inpatients who require treatment over their objection associated with an increase in the number of violent incidents?
 - Yes
 - No
 - Unknown
 ANSWER: b
- Patients who require court treatment over objection are more likely than other civil inpatients to:
 - be homeless
 - have history of drug dependence
 - have history of noncompliance
 - have a mood disorder
 ANSWER: d

Susan Adams, MRCPsych, FRCPC, North Bay, ON, Canada
 Milan Pomichalek, PhD, (I) North Bay, ON, Canada

EDUCATIONAL OBJECTIVE

To learn about litigious paranoia and the most recent research about it, identify mechanisms contributing to the condition and learn about the risk management strategies and community reintegration challenges specific to patients with this condition.

SUMMARY

Litigious Paranoia is defined as "a form of paranoia in which the person seeks legal proof or justification for systematized delusions." It is considered to be treatment-refractory, with behavioral correlates including serious violence. The scant attention accorded to the condition in the medical journals is inversely related to the frequency with which it is described in the legal literature. As a result, there are "vexatious litigants" laws in a number of countries, and by 2007 variants of such laws were passed in 5 states. The challenges posed by vexatious litigants who come to the attention of forensic mental health services are largely ignored. A significant issue that needs to be addressed is the community reintegration challenges and the risk management strategies specific to such individuals when admitted to forensic services. We propose to address these issues by highlighting the commonalities

and differences seen in 4 patients with this condition who have been detained in our forensic psychiatric ward over several years. We will describe the difficulties these patients experience in progressing towards community reintegration, and the challenges they present to their caregivers. We will also summarize strategies that may be helpful in managing such individuals.

REFERENCES

Mullen PE, Lester G: Vexatious litigants and unusually persistent complainants and petitioners: from querulous paranoia to querulous behaviour. *Behav Sci Law* 24:333-349, 2006
Veale D: Over-valued ideas: a conceptual analysis. *Behav Research and Therapy* 40:383-400, 2002

SELF ASSESSMENT QUESTIONS

1. What mechanisms are hypothesized to underlie litigious paranoia?

ANSWER: There is no consensus at present. Some authorities believe that litigious paranoia is a medical illness, while others argue that it is a disorder of behavior with many contributing factors. Still others believe that it is a non-delusional condition driven by specific cognitive mechanisms.

2. What are some of the risk management challenges specific to forensic psychiatric patients with litigious paranoia?

ANSWER: Motivate the individuals who do not believe that the caregivers have judicial authority over them to nevertheless abide by the conditions imposed on them.

F12

ARREST TYPES AND CO-OCCURRING DISORDERS IN PERSONS WITH SCHIZOPHRENIA OR RELATED PSYCHOSES

Patrick McCabe, MPH, (I) Worcester, MA
Paul Christopher, MD, Rumford, RI
Nicholas Druhn, PsyD, (I) St. Peter, MN
Kristen Roy-Bujnowski, MA, (I) Worcester, MA
Albert Grudzinskas, Jr., (I) Worcester, MA
William Fisher, PhD, (I) Worcester, MA

EDUCATIONAL OBJECTIVE

To understand that risk for arrest for various crime types among persons with schizophrenia or related psychoses, with a history of arrest, receiving public mental health services is increased by co-occurring disorders.

SUMMARY

This study examined the patterns of criminal arrest and co-occurring psychiatric disorders among subjects with schizophrenia or related psychosis that were receiving public mental health services and had an arrest history. Within a ten-year period, 65% of subjects were arrested for crimes against public order, 50% for serious violent crimes, and 45% for property crimes. The presence of any co-occurring disorder increased the risk of arrest for all offense categories. For nearly all offense types, antisocial personality disorder and substance use disorders conferred the greatest increase in risk for arrest. Among anxiety disorders, post-traumatic stress disorder was associated with a greater risk of arrest for serious violent crimes but not other offense types. Criminal risk assessments and clinical management in this population should focus on co-occurring antisocial personality disorder and substance use disorders in addition to other clinical and non-clinical factors.

REFERENCES

National Commission on Correctional Health Care: Prevalence of communicable disease, chronic disease, and mental illness among the inmate population, in *The Health Status of Soon-to-Be-Released Inmates: A Report to Congress*. Washington, DC, National Commission on Correctional Health Care: 15-28, 2002. Available at <http://www.nchc.org/stbr/volume1/chapter3.pdf>. Accessed October 1, 2010
Steadman HJ, Osher FC, Robbins PC, et al: Prevalence of serious mental illness among jail inmates. *Psychiatr Serv* 60(6):761-765, 2009

SELF ASSESSMENT QUESTIONS

1. The history of any co-occurring disorder is associated with increased risk of arrest in what crime category?

- Violent crimes
 - Property crimes
 - Crimes against public order
 - All of the above
- ANSWER: d

2. What co-occurring disorder group increases risk for serious violent crime?
 - a. Alcohol use disorders
 - b. Impulse control disorders
 - c. Anxiety disorders
 - d. Mood disorders
- ANSWER: c

F13

A SURVEY OF CRISIS UNIT TRAINING FOR LAW ENFORCEMENT IN THE WAKE, DURHAM, AND ORANGE COUNTIES OF NORTH CAROLINA

Sonal Patole, MD, Carrboro, NC
 Jacqueline Smith, MD, Chapel Hill, NC
 Alyson Kuroski-Mazzei, DO, Chapel Hill, NC

EDUCATIONAL OBJECTIVE

To inform the audience about the level of training available to law enforcement officers who deal with patients with mental illness in Wake, Durham, and Orange Counties in NC. Viewers will also gain an appreciation of the benefit of survey research in this area.

SUMMARY

On Feb 10, 2011, during a hostage situation in Cary, NC (Wake County) at a Wachovia bank, the police shot and killed the 19-year old suspect later thought to be unarmed. Per his family, the suspect had struggled with mental illness. First responders to a scene of crisis potentially involving the mentally ill are law enforcement officers. Often, the officers report that they are not equipped to deal with these individuals in terms of having an adequate understanding of individuals with mental illness. Thus, they often find these situations frustrating and the situations may lead to increased arrests or the use of unnecessary force. In response to these difficult issues, many communities have implemented programs to educate law enforcement officers regarding mental illness. Models available for law enforcement training include police-based specialized response models such as Crisis Intervention Training (CIT), police-based specialized mental health services, or mental health-based specialized response models such as Mobile Crisis Units. This poster reviews the various types of training available to law enforcement in the Triangle area of North Carolina, which consists of Wake, Durham, and Orange counties, and discusses the need for outcomes-based research to demonstrate efficacy of these programs.

REFERENCES

Hails J, Borum R: Police training and specialized approaches to respond to people with mental illnesses. *Crime & Delinquency* 49(1): 52-61, 2003
 Vermette H, Pinals D, Appelbaum P: Mental health training for law enforcement professionals. *J Am Acad Psychiatry Law* 33: 42-46, 2005

SELF ASSESSMENT QUESTIONS

1. Crisis Intervention Training (CIT) is an example of what kind of program?
 - a. Pre-booking, jail diversion program
 - b. Post-booking, jail diversion program
 - c. All of the above
 - d. None of the above
- ANSWER: a
2. What are some of the benefits of CIT based on available research?
 - a. Decreased costs to the criminal justice system
 - b. Lower arrest rates
 - c. Increased officer knowledge, satisfaction, and preparedness
 - d. All of the above
- ANSWER: d

F14

THE YOUNG AND THE INCOMPETENT TO PROCEED: A REVIEW OF STATE STATUTES AND CASE LAW REGARDING DISPOSITION OF THESE YOUTH

Jacqueline Smith, MD, Chapel Hill, NC
 Ivy Sohn, MD, JD, Butner, NC
 Sally Johnson, MD, Raleigh, NC

EDUCATIONAL OBJECTIVE

To inform attendees of relevant state statutes and case law regarding the disposition of youth who are adjudicated incompetent to proceed. Members of the audience will be informed of available options in their jurisdictions and be made aware of alternative strategies to address this challenging issue.

FRIDAY

SUMMARY

Though competency to proceed is a well researched area in the adult literature, the same cannot be said for the issue of juvenile competency to proceed. Once a juvenile is evaluated and opined to be incompetent to proceed based upon having a mental illness, mental retardation, or developmental immaturity, their disposition can be unclear once adjudicated incompetent to proceed. Some states have explicit statutes or case law outlining how to handle youth who are adjudicated incompetent to proceed and restorable or not restorable while others do not address the issue at all. Disposition alternatives include civil commitment to competency restoration in the least restrictive setting, state-administered competency restoration programs, and dismissal of charges with concurrent development of a management plan. This poster will review state statutes and case law regarding directives for the disposition of juveniles found incompetent to proceed to trial. Further, it will highlight particular states with explicit instructions for the management of these youth (i.e., Florida) as well as states with evidence-based systems of care models for restoring juveniles' competency (i.e., Virginia).

REFERENCES

Johnson KM: Juvenile competency statutes: a model for state legislation. *Indiana Law Journal* 81:1068-1095, 2006
Warren JI, DuVal J, Komorovskaya I, et al: Developing a forensic service delivery system for juveniles adjudicated incompetent to stand trial. *Int J of Forensic Mental Health* 8:1-18, 2009

SELF ASSESSMENT QUESTIONS

1. Approximately how many states, out of 3 states, require juveniles be competent to stand trial either by statute or case law?

- a. 1 out of 3
- b. 2 out of 3
- c. 3 out of 3

ANSWER: b

2. What dispositional alternatives are available to juveniles who are incompetent to proceed?

- a. Community-based outpatient or residential restoration programs
- b. Dismissal of charges, especially in misdemeanor cases
- c. Civil commitment to state facilities for competency restoration
- d. All of the above

ANSWER: d

F15

FORENSIC PSYCHIATRY WITHIN A PHYSICIAN HEALTH PROGRAM

Scott Humphreys, MD, Denver, CO

EDUCATIONAL OBJECTIVE

To educate attendees on the role of a forensic psychiatrist in a physician health program. Information will be directed toward practicing forensic psychiatry at the highest attainable level within this context.

SUMMARY

Physician health plans offer confidential evaluation and monitoring services to physicians. But, physician health programs must consider reporting to the medical board when a physician may have a condition that could cause him or her to be unsafe to practice. Most programs were originally established to monitor substance dependent physicians. Over the years the role of physician health programs has evolved. For example, in Colorado self referral has become common. Although this shift is generally viewed as positive, the relationship between the health program and the medical board is less clear than in board-referred cases. The author will discuss his own experiences with legal challenges made to the physician health plan's ability to monitor and report physicians. These will include the attempt to get a restraining order against the health program to prevent reporting to the board. Also, the author will examine the possibility of civil charges.

REFERENCES

Hughes PH, Brandenburg N, et al: Prevalence of substance use among US physicians. *JAMA* 267: 2333-9,1992
Casper E, Dilts S, et al: Establishment of the Colorado physician health program with a legislative initiative. *JAMA* 260: 671-673,1988

SELF ASSESSMENT QUESTIONS

1. Who has the authority to assert disciplinary action against a physician's license?

ANSWER: The medical board of the states in which the physician has a license.

2. Does the physician health plan have a responsibility to report impaired physicians to the licensing board?
ANSWER: It depends on the laws of that state governing reporting requirements of all physicians as well as the contract between the physician health plan and the board.

F16

A PRESERVATIVE OF INSANITY: EMBALMING FLUID

Susan Chlebowski, MD, Rochester, NY
Cecelia Leonard, MD, Syracuse, NY
James Knoll, IV, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

To understand the prolonged clinical manifestations and neurocognitive effects of embalming fluid, cannabis and PCP. The increasing abuse of these neurotoxic substances and the persisting psychiatric symptoms will present a new complication for evaluations, such as settled insanity defense and fluctuating presentation on serial competency to stand trial evaluations.

SUMMARY

Embalming fluid applied to marijuana cigars or cigarettes with or without the addition of PCP has many names such as “water,” “wet,” “illy” or “fry.” Individuals who commit crimes under the influence of these substances are often violent and may appear psychotic with symptoms resembling schizophrenia or delirium. As a result, they may be referred for competency to stand trial evaluations. This is a case presentation of a man who abused “water” for three years and was sober for three months. He continued to have psychotic episodes resulting in a criminal act. Despite his abstinence, his chronic abuse impacted his CST evaluation. Drug-induced changes in mental status result in discrepancies between serial examinations for CST. The initial clinical evaluation and the diagnosis varied significantly from subsequent evaluations due to the timing of the evaluation, the type(s) of substance(s) ingested as well as the pharmacokinetics of the substance(s). Chronic use of these substances has effects which have been demonstrated on fMRI. Despite abstinence, individuals may have persistent psychosis. The use of settled intoxication in defense cases remains controversial among the jurisdictions. Given the increasing use of embalming fluid for prolonged periods, crimes committed by abusers will present for criminal court.

REFERENCES

Singer M, Mirhej G, Shaw S, et al: When the drug of choice is a drug of confusion: embalming fluid use in inner city Hartford, CT. *J Ethn Subst Abuse*, 2005
Modesto-Lowe V, Petry NM: Recognizing and managing “illy” intoxication. *Psychiatr Serv* 52(12):1660, 2001

SELF ASSESSMENT QUESTIONS

1. What are some of the components of embalming fluid?

Ethanol

- a. Methanol
- b. Formaldehyde
- c. Other Solvents
- d. All of the above

ANSWER: e

2. All of the following are names for the combination of embalming fluid, cannabis and PCP except:

- e. Water
- a. Fry
- b. Illy
- c. Frosty
- d. Hydro

ANSWER: d

F17

CAUGHT IN THE HEADLIGHTS: HARE'S PSYCHOPATHY CHECKLIST

Callum Ross, MBChB, (I) Crowthorne, United Kingdom
Ian Cumming, MBBS, (I) London, United Kingdom
Fintan Larkin, MB BCh, (I) Crowthorne, United Kingdom
Penelope Brown, BM BCh, (I) Crowthorne, United Kingdom
Kenneth Busch, MD, Chicago, IL

EDUCATIONAL OBJECTIVE

Four UK experts will debate the claims made about the PCL-R and discuss its influence on the delivery of care in British prisons and psychiatric hospitals. The motion is: “The PCL-R has no place in modern mental health care.” One team will propose. The other will oppose. Audience will vote.

SUMMARY

The PCL-R has been used to provide a means of identifying those who might be unsuitable for current interventions designed to reduce criminal reoffending. It has been heralded as the best means of assessing the future risk of violent recidivism. The emerging evidence base does not, however, support the early promise. This is a debate about the future usefulness of the PCL-R at a time when the UK government has just launched a huge consultation document about how best to reform services for personality disordered offenders. The speakers work in the personality disorder service of Broadmoor Hospital and in Britain 's largest Category A prison. They will consider the financial and political impact that the PCL-R has had on offender care in the United Kingdom in recent years, they will review the evidence for the various factor models of the PCL-R, and they will examine the use of the PCL-R as a basis for developing specific treatments for personality disorders. This is the stuff of lively debate. Given the expense of administering the PCL-R, it needs to perform significantly better than other risk instruments for its continued use to be justified.

REFERENCES

Consultation on the Offender Personality Disorder Pathway Implementation. Department of Health /NOMS Offender Personality Disorder Team (United Kingdom Government) http://www.dh.gov.uk/prod_consum_dh/g (Accessed February 17, 2011)

D'Silva K, Duggan C, McCarthy L: Does treatment really make psychopaths worse? A review of the evidence. *Journal of Personality Disorders* 18(2):163-77, 2004

SELF ASSESSMENT QUESTIONS

1. The per annum operating costs of looking after and treating a personality disordered individual in a specialist UK prison service is £85,000 (\$140,000). What are the equivalent per annum high-secure hospital costs?

ANSWER: £300,000 (\$490,000)

2. In the UK Prisoner Cohort Study (Coid J, et al, 2007) of 1396 adult male offenders, which was the best performing structured risk assessment tool?

ANSWER: The Offender Group Reconviction Scale (OGRS-2). OGRS-2 is a statistical tool developed from a study of 30,000 offenders sentenced to community sentences or discharged from UK prisons in 1995. OGRS is a predictor of re-offending based only on static risks – age, gender and criminal history. The new version, OGRS-3 was implemented in the Probation Service in England and Wales in March 2008.

F18

DO'S AND DON'TS OF DEPOSITIONS

Thomas Gutheil, MD, Brookline, MA

David Gould, JD, (I) Boston, MA

David Benjamin, PhD, (I) Chestnut Hill, MA

EDUCATIONAL OBJECTIVE

Participants will learn the fundamentals of expert depositions from three viewpoints: the expert witness's view of depositions; the principle of "active listening"; and the examining attorney's approach to the expert deposition. The course is aimed at early career experts, with some features suitable for more advanced forensic work.

SUMMARY

Dr.Gutheil will present the tips and traps of depositions as they affect the expert witness's approach and responses. Dr. Benjamin will describe the process of "active listening" during depositions with examples. Attorney Gould will present the attorney's approach to examining the opposing expert and provide tips for the retained expert. An extended question and answer segment and audience responses to hypothetical questions will be included.

REFERENCES

Gutheil TG, Dattilio FM: Practical approaches to forensic mental health testimony. Baltimore, Lippincott Williams and Wilkins, 2007

Gutheil TG: The psychiatrist as expert witness. 2d ed. Washington DC: American Psychiatric Press, 2009

SELF ASSESSMENT QUESTIONS

1. Who is the audience for a deposition?

- a. Jury
- b. Retaining attorney
- c. Examining attorney
- d. Court reporter
- e. None of the above

ANSWER: d

2. Why is it a good idea to pause before answering a question in deposition?
 - a. It permits mentally replaying the question to be sure of understanding it.
 - b. It allows the other attorney a chance to object.
 - c. It permits the deponent to rehearse the answer internally.
 - d. It permits the deponent to scan for possible hidden implications in the question as worded.
 - e. All of the above

ANSWER: e

F19

GERIATRIC ASSESSMENT BY FORENSIC PSYCHIATRISTS: ETHICAL CHALLENGES

Robert Weinstock, MD, Los Angeles, CA
 Paul Appelbaum, MD, New York, NY
 Phillip Candilis, MD, Arlington, MA
 Stephen Read, MD, San Pedro, CA
 James Ellison, MD, Belmont, MA

EDUCATIONAL OBJECTIVE

To increase awareness of some complex ethical dilemmas that can arise in assessments of the elderly and to heighten practitioner ability to think out complex ethical problems. Since most psychiatrists sometimes assess geriatric people even if not geriatric specialists, increased knowledge will help in such assessments.

SUMMARY

Dr. Weinstock will introduce a personal example of pressure to limit father's desired care- a relatively new problem. Dr. Appelbaum will present data demonstrating the capacity of a substantial proportion of people he studied to appoint a trusted surrogate decision maker for research despite lacking the capacity to make the substantive decision itself, consistent with the task-specific nature of decisional capacity. Dr. Ellison, Chief of Geriatrics, McLean Hospital, will discuss the ethics of neuroenhancement for a cognitive boost or cognitive preservation, optimization, and prevention or arrest of changes associated with normal aging or neurodegenerative disorders. An ethical analysis will be made of responses to such requests and potential forensic psychiatric relevance. Examples include caffeine, glucose, energy drinks, and prescribed stimulants. Dr. Candilis will discuss medical team and family decisions to withdraw life support when medical care interferes with patient competent wishes, and end-of-life neuroenhancement to prevent depression from interfering with decision-making. Ethics analysis will include problems predicting medical outcomes leading to possible excessive pressures to withdraw or stop treatment. Dr. Read will discuss when apparently "irrational" decisions to reject medical treatment may be overridden in different jurisdictions and institutions based on cultural and other values with particular emphasis on leaving AMA.

REFERENCES

Kim SYH, Karlawish J, Kim HM, et al: Preservation of the capacity to appoint a proxy decision maker: implications for dementia research. Archives of General Psychiatry (in press).
 Candilis P, Weinstock R, Martinez R: Forensic ethics and the expert witness, New York: Springer Science, 2007

SELF ASSESSMENT QUESTIONS

1. Assessment of a person's capacity to appoint a proxy decision maker for research should focus on which of the following: the person's
 - a. orientation to place, person and time
 - b. understanding of the risks and benefits of the research
 - c. understanding of the role of a proxy decision maker
 - d. appreciation of the differences between research and treatment

ANSWER: c

2. Potential models for diagnosing depression at the end of life include:
 - a. the inclusive approach
 - b. the exclusive approach
 - c. the etiologic approach
 - d. the substitutive approach
 - e. all of the above

ANSWER: e

Renée Sorrentino, MD, Quincy, MA
 Richard Krueger, MD, New York, NY
 Martin Kafka, MD, (I) Arlington, MA

EDUCATIONAL OBJECTIVE

To provide an overview of the proposed diagnostic criteria for the diagnoses of Hypersexual Disorder and Paraphilic Coercive Disorder and to discuss the forensic implications of including Hypersexual Disorder and Paraphilic Coercive Disorder in the DSM

SUMMARY

The DSM-5 will include two new sexual disorders, Hypersexual Disorder and Paraphilic Coercive Disorder. The DSM-5 proposed diagnostic criteria for Hypersexual and Paraphilic Coercive Disorders will be presented. The panel will discuss the epidemiology, hypothetical framework, and empirical data for each disorder. The question of whether Hypersexual Disorder and Paraphilic Coercive Disorder should be considered as psychiatric disorders will be discussed. The forensic implications of creating these new sexual disorders will be reviewed with respect to recent sexual predator legislation and criminal responsibility.

REFERENCES

Knight RA: Is a diagnostic category for paraphilic coercive disorder defensible? *Arch Sex Behav.* 39(2):419-26, 2010
 Kafka MP: Hypersexual disorder: a proposed diagnosis for DSM-5. *Arch Sex Behav.* 39(3):594-6, 2010

SELF ASSESSMENT QUESTIONS

1. Which of the following axis I psychiatric disorders have been reported to be prevalent among males with Hypersexual Disorder?

- a. Mood disorders
- b. Anxiety disorders
- c. Substance use disorders
- d. ADHD
- e. All of the above

ANSWER: e

2. Paraphilic Coercive Disorder is associated with:

- a. a self-reported willingness to rape among non-convicted samples.
- b. convicted rapists more commonly than in other offender groups.
- c. sadism as defined by the DSM-IV-TR.
- d. psychopathy or general criminality.
- e. a and b

ANSWER: e

Douglas Mossman, MD, Cincinnati, OH
 Sarah Sanderson, JD, (I) Cincinnati, OH

EDUCATIONAL OBJECTIVE

At the conclusion of this presentation, listeners will report clearer understanding of the Sell criteria for forcing medication to restore competence to stand trial, how lower courts have interpreted ambiguous phrases in the Sell decision, and differences between courts' and psychiatrists' opinions about the need for antipsychotic medication.

SUMMARY

Sell v. United States (2003) declared it permissible to medicate a criminal defendant involuntarily to render him competent to stand trial, but only if doing so would further an important government interest, was "substantially likely" to restore competence without causing significant side effects, was necessary given likely success of alternatives, and was "medically appropriate." *Sell* gives modest guidance, however, about what specific findings make a particular prosecution "important," what probability of response implies that restoration is "substantially likely," what makes medication "necessary," and what factors prove medical appropriateness. To learn how lower courts have worked out these details, the authors reviewed all cases citing *Sell* through December 2010. Federal courts typically regard offenses with ten-year maximum sentences as "serious" enough to warrant forced competence restoration. A 70% probability of successful restoration is deemed "substantially likely." Courts usually recognize that medication side effects are manageable and unlikely to make a trial unfair. Judgments of medical appropriateness often examine diagnoses, other medical problems, and details of the proposed medication plan. Though psychiatrists regard antipsychotic drugs as "the mainstay" of treatment for psychoses, courts sometimes encourage non-drug treatments when medication-refusing defendants have conditions for which antipsychotic therapy yields lower response rates.

REFERENCES

Siegel DM: Involuntary psychotropic medication to competence: no longer an easy Sell. *Mich St J L & Medicine* 12:1-16, 2008

Herbel BL, Stelmach H: Involuntary medication treatment for competency restoration of 22 defendants with delusional disorder. *J Am Acad Psychiatry Law* 35:47-59, 2007

SELF ASSESSMENT QUESTIONS

1. Legal decisions express the most skepticism about medical responses and successful restoration of incompetent defendants with which of the following diagnoses?

- a. Psychosis not otherwise specified
- b. Delusional disorder
- c. Schizophrenia, disorganized type
- d. Major depression with psychotic features
- e. Bipolar I disorder, manic, with psychotic features

ANSWER: b

2. Which of the following statements is true?

- a. Courts often threaten to cite defendants with contempt rather than impose involuntary medication.
- b. If a defendant has a 30% chance of regaining competence, courts regard this success as “substantially likely” and order forced medication.
- c. Federal courts usually regard any offense with a maximum sentence of two years or more to be “serious” enough to warrant forced medication.
- d. Federal courts account for most published decisions on the Sell criteria for involuntary competence restoration with medication.

ANSWER: d

F22

QUETIAPINE (SEROQUEL) ABUSE AND MISUSE IN FORENSIC SETTINGS

Leonard Mulbry, Jr., MD, Charleston, NC

Amanda Pearce, MD, (I) Charleston, NC

EDUCATIONAL OBJECTIVE

There is growing informal recognition of the abuse of quetiapine particularly in correctional institutions and other forensic settings. This paper will provide a review of the available cases, institutional responses to quetiapine abuse, and a review of the pharmacological mechanisms that may play a role in this phenomenon.

SUMMARY

The abuse and misuse of quetiapine is well-recognized informally by psychiatrists particularly in forensic settings. However the literature includes only a limited number of case studies, far less than the perceived level of abuse and misuse. We were only able to locate nine case studies in our review of the scientific literature and other informal sources. Quetiapine has a unique pharmacologic profile that may make it more likely to be abused than other antipsychotic medications. The unique mechanism or action of quetiapine relative to other antipsychotic and mood stabilizing medications is reviewed. There is limited literature available on the use of quetiapine as adjunct treatment for anxiety and substance abuse disorders but this may be related to quetiapine’s desirability. These are common diagnoses in correctional settings, in a population of patients who are prone to self-medication. We have attempted to collect the literature from pharmacologic, pharmacy, psychiatric and other sources. Notably there is little information in the forensic literature. This review is designed to educate forensic psychiatrists to this growing phenomenon both in and outside of a correctional settings.

REFERENCES

Tcheremissine OV: Is Quetiapine a drug of abuse? Reexamining the issue of addiction. *Expert Opinion on Drug Safety* 7: 739-748, 2008

Pierre JM, Shnyder I, Wirshing DA, Wirshing WC: Intranasal quetiapine abuse. *American Journal of Psychiatry* 161(9): 1718, 2004

SELF ASSESSMENT QUESTIONS

1. Quetiapine has been abused through which of the following routes of administration?

- a. crushing and intranasal
- b. per rectum
- c. crushing and injection
- d. all of the above

ANSWER: d

2. Quetiapine's characteristics among other atypical antipsychotic medications is more notable for?
- a. potent blockade of the D2 receptor
 - b. less potent blockade of the D2 receptor
 - c. potent blockade of the H1 histamine receptor
 - d. b and c

ANSWER: d

F23

PRO SE COMPETENCE: TOWARD AN EVIDENCE-BASED STANDARD

Andrew Kaufman, MD, Fayetteville, NY
James Knoll, IV, MD, Syracuse, NY
Bruce Way, PhD, (I) Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

To inform forensic mental health experts of the issues related to competence to represent oneself at trial and to propose an evidence-based standard for such competency.

SUMMARY

In *Indiana v. Edwards* (2008) the U.S. Supreme Court held that a higher standard may be required for pro se competence (PSC) than for competence to stand trial (CST), but provided little guidance for the trial court judge. This survey of forensic mental health experts studied potential PSC criteria. Sixty-eight (22.7%) forensic evaluators replied. The three McGarry criteria reported as requiring a much higher standard for PSC were: "to appraise the available legal defenses" (45.6%), "to plan a legal strategy" (51.5%) and "to question and challenge witnesses" (44.1%). A principal component analysis identified a significant factor with the same three criteria. Sixty percent agreed that SBC should be mandatory. Respondents opined that average intelligence (77.9%), literacy (69.1%), and verbal ability (70.6%) were sufficient. PSC examiners may wish to assess appraisal of available legal defenses, planning a legal strategy, and questioning and challenging witnesses for a higher standard than CST. Potential pro se defendants should possess at least average cognitive abilities. Evaluators should also assess the defendant's willingness to accept SBC and the defendant's motivation for attempting a pro se defense.

REFERENCES

Indiana v. Edwards, 554 U.S. 164 (2008)
Knoll JL, Leonard C, Kaufman AR, Way BB: A pilot survey of trial court judges' opinions on pro se competence after *Indiana v. Edwards*. *J Am Acad Psychiatry Law* 38:536-9, 2010

SELF ASSESSMENT QUESTIONS

1. In *Indiana v. Edwards* (2008), the US Supreme ruled that competency required to represent oneself at a criminal trial:
- a. is the same as competency to stand trial
 - b. must be higher than competency to stand trial
 - c. may be higher than competency to stand trial
 - d. should preserve the dignity of the individual
 - e. c and d

ANSWER: e

2. Forensic mental health experts opined the following regarding the requisite level of general intelligence required to represent oneself at trial:
- a. the defendant should possess higher than average intelligence
 - b. the defendant should score above the 75th percentile on the Law School Admission Test (LSAT)
 - c. the defendant should be of average intelligence
 - d. the defendant should have a minimum IQ of 70

ANSWER: c

F24

FAMILY VIOLENCE PERPETRATED BY JUVENILES

Gennady Baksheev, BA, (I) Parkville, Victoria, Australia
Rosemary Purcell, PhD, (I) Parkville, Victoria, Australia

EDUCATIONAL OBJECTIVE

Information regarding family violence perpetrated by juveniles against their parents or siblings is limited, including the nature and motivations of such violence. This presentation will advance knowledge by examining why and how juveniles perpetrate family violence, and the utility of protective (restraining) orders in managing this behavior.

SUMMARY

This study examines the nature and context of family violence by juveniles and the utility of obtaining protective (restraining) orders to manage such violence. The sample (n=437) was drawn from consecutive applications in a major metropolitan children’s court for a restraining order (RO) against a juvenile family member over a 3-year period. The majority of applications were sought by a parent (77%), mostly mothers (63%). Males comprised the majority of defendants (69%). One-parent households were over-represented among these court applications (66%). The most frequent forms of violence included property damage (61%), physical assaults (59%) and threats (53%). Most applicants were subjected to two (42%) or all three (17%) behaviors. Juvenile family violence emerged in several contexts, most commonly as a result of long-standing behavioral problems (49%), or a desire to intimidate the victim (12%) or retaliate against a grievance (8%). Some 30% of defendants reportedly had mental or substance use disorders that was related to their conduct. Overall, 38% of ROs were reported as having been breached. This study demonstrates that family violence by juveniles is a serious problem that requires effective interventions which are ideally psychosocial in nature, given the contexts in which such violence emerges.

REFERENCES

Walsh JA, Krienert JL: A decade of child-initiated family violence comparative analysis of child-parent violence and parricide examining offender, victim, and event characteristics in a national sample of reported incidents. *J Interpers Violenc* 1995-2005
 Harbin HT, Madden DJ: Battered parents - new syndrome. *Am J Psychiatry* 136: 1288-91, 1979

SELF ASSESSMENT QUESTIONS

1. What are the contexts in which family violence by juveniles emerges?
 ANSWER: Family violence by juveniles emerges in a range of contexts, including behavioral problems, intimidating the victim, retaliating to a perceived grievance by the victim, family problems, mental health problems and drug-related issues.
2. What types of households are over-represented among restraining order applications?
 ANSWER: Single-parent households

F25 **CIVIL “HARASSMENT” LAWSUITS: BULLIES, BOSSES, AND BIGOTS**
 William Newman, MD, Sacramento, CA
 David Bobb, Jr., MD, Sacramento, CA
 Rodney Reid, MD, PhD, Sacramento, CA
 Jason Roof, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

To improve the knowledge, skills, and performance of forensic psychiatrists who consult to attorneys and courts regarding the forensic assessment of individuals who have experienced harassment at schools and in the workplace.

SUMMARY

This panel reviews civil litigation issues related to both school and workplace harassment claims. Approximately 15 percent of U.S. students report experiencing significant school bullying. Between 37 and 59 percent of employees report directly experiencing workplace bullying, abuse, and harassment. The combined prevalence of these workplace events is approximately four times that of sexual harassment alone. Dr. Reid will discuss key factors to address when evaluating students who are victims of alleged harassment, including the constitutional parameters of a school’s “duty to protect” students and case law that shapes the standards for the forensic evaluation. Dr. Bobb will outline recent statutory and case law governing potential legal and clinical responses to “cyberbullying,” a form of Internet harassment. Dr. Roof will describe the process for evaluating tort claims involving harassment, including claims of intentional infliction of emotional distress and the evaluation of alleged “humiliation.” Dr. Roof will also highlight approaches to assessing malingered harassment claims and handling potential court-imposed limitations on forensic evaluations. Dr. Newman will discuss cases of employees who harass their employers and the relationship of employee harassment to Fitness for Duty evaluations. Dr. Newman will also discuss conducting “Direct Threat” evaluations in accordance with the ADA.

REFERENCES

Carter R, Forsyth JM: A guide to the forensic assessment of race-based traumatic stress reactions. *J Am Acad Psychiatry Law* 37:28-40, 2009
 Cass S, Levett LM, Kovera MB: The effects of harassment severity and organizational behavior on damage awards in a hostile work environment sexual harassment case. *Behav Sci Law* 28: 303–321, 2010

SELF ASSESSMENT QUESTIONS

1. What percentage of plaintiffs in racial discrimination/harassment cases prevail at trial?
 - a. 20%
 - b. 40%
 - c. 60%
 - d. 80%

ANSWER: a

2. Which of the following is incorrect regarding the standard set by the U.S. Supreme Court in analyzing school liability and student sexual harassment claims?
 - a. The school is liable if they are “deliberately indifferent” to sexual harassment.
 - b. The school must have actual knowledge of the harassment.
 - c. The harassment must be “severe, pervasive, and subjectively offensive.”
 - d. The harassment must deprive the alleged victim of access to educational opportunities or benefits provided by the school.

ANSWER: c

F26

EVIDENCED BASED PRACTICES FOR ADOLESCENTS: RELEVANCE AND APPLICATION TO FORENSIC PSYCHIATRY

Debra DePrato, MD, Baton Rouge, LA
Gina Vincent, PhD, (I) Worcester, MA
Eric Trupin, PhD, (I) Seattle, WA

EDUCATIONAL OBJECTIVE

To inform forensic psychiatrists of the relevant research on adolescent development, the use of validated screening and assessment tools, and research driven approaches to treatment of juvenile offenders with special emphasis of applying this body of knowledge, tools and strategies into their practice.

SUMMARY

All three panelists are heavily engaged within the John D. and Catherine T. MacArthur Foundation’s Models for Change, Systems Reform for Juvenile Justice Program. This multiyear multi-state grant program has allowed states to work with national consultants in applying the latest evidence from research in the fields of adolescent behavioral health and juvenile justice applying them practically “on the ground.” This panel presentation will first inform the audience of critical advances in the field of adolescent forensic mental health. This will include: 1) reviewing the relevant literature on adolescent brain development with application to forensic psychiatry, 2) highlighting best practice screening and assessment tools with direct application to this population, 3) demonstrating the use of evidence based treatment approaches. The panelists, all experts in their field, will bring to the audience the most relevant approaches and how they can and should be practically applied by forensic psychiatrists in the field. These approaches have been tested with local and state governments, courts, and legal and clinical practitioners via the Models for Change grant program. Thus, the practical application of these concepts will be a key focusing point to the discussion with information targeted to relevance to the field of forensic psychiatry.

REFERENCES

Phillippi S, DePrato D: Assessment and Treatment of Juvenile Offenders. Principles and Practice of Child and Adolescent Forensic Mental Health. Washington, DC: American Psychiatric Publishing, 2009
Vincent GM, Grisso T, Terry A: Mental Health Screening and Assessment in Juvenile Justice, in The Mental Health Needs of Young Offenders: Forging Paths toward Reintegration and Rehabilitation. Cambridge, MA: Cambridge Medicine, 2007

SELF ASSESSMENT QUESTIONS

1. Which of the following are risk factors associated with delinquent behavior?
 - a. peer rejection
 - b. poor social skills
 - c. family conflict
 - d. poor impulse control
 - e. female
 - f. All of the above

ANSWER: f

2. Studies show that prevalence of psychiatric disorders of detained juvenile delinquents is higher than the general population. Among the following DSM categories, the lowest prevalence rate among detained youth are in which category?

- a. Affective disorder
- b. Psychotic disorders
- c. Substance abuse disorders
- d. Disruptive behavior disorders
- e. Anxiety disorders

ANSWER: b

F27

LEGAL REGULATION OF SEX OFFENDERS IN THE COMMUNITY

Paul Appelbaum, MD, New York, NY
Jacqueline Berenson, MD, New York, NY
Andrew Harris, PhD, (I) Lowell, MA
Wayne Logan, JD, (I) Tallahassee, FL

EDUCATIONAL OBJECTIVE

To provide an overview of legal regulation of convicted sex offenders in the community, including laws governing registration, community notification, and residence location; and to discuss some of the most recent data on the impact--sometimes very different from expected--of these laws.

SUMMARY

Sex offenders in the community have been an increasing focus of legislation over the last two decades. Spurred by federal laws intended to encourage states to regulate convicted sex offenders, all states have adopted laws requiring sex offender registration and community notification of offenders' identity, offense, and location. In addition, many states and localities have implemented restrictions on where sex offenders can live and work. This panel will examine the nature and effectiveness of this extensive regulatory structure. Dr. Appelbaum will provide an overview of the statutes, their underlying premises, and the reasons why their effectiveness may be questionable. Dr. Berenson will present the surprising results of a study examining the implementation of residence restrictions in two counties in New York, which raises questions about enforcement of the statutes. Prof. Harris will critically examine the current state of knowledge regarding the patterns and prevalence of transience among registered sex offenders and the presumptive relationship to re-offense risk. Finally, Prof. Logan will consider the forces that have contributed to the continued expansion of legal restrictions on sex offenders, despite research findings casting considerable doubt on their public safety efficacy, and indeed possible counterproductive, crime-producing effects.

REFERENCES

Berenson J, Appelbaum PS: A geospatial analysis of the impact of sex offender residency restrictions in two New York counties. *Law and Human Behavior* (in press). DOI 10.1007/s10979-010-9235-3.
Logan W: *Knowledge as Power: Criminal Registration and Community Notification Laws in America*. Stanford, CA: Stanford University Press, 2009.

SELF ASSESSMENT QUESTIONS

1. Statutes affecting sex offenders in the community include all of the following except:

- a. Limitations on the geographic areas within which they can live and work.
- b. Requirements for registering current address and other information.
- c. Restrictions on residing with children or in proximity to children's residences.
- d. Mandatory posting of their personal and offense information on the internet.

ANSWER: c

2. Reasons that laws restricting sex offender residence may not be enforced may include:

- a. Lack of resources for police to pursue sex offenders who are violating residence restrictions.
- b. Belief that such laws are likely to be counterproductive.
- c. Absence in geographic mapping software to indicate areas subject to restrictions.
- d. All of the above

Answer: d

CEREBRAL GLUCOSE METABOLISM IN PERSONS CONVICTED OF CAPITAL MURDER

Susan Rushing, MD, JD, Philadelphia, PA
Ruben Gur, MD, (I) Philadelphia, PA

EDUCATIONAL OBJECTIVE

To expose participants to new scientific data regarding FDG-PET analysis of brain function in persons convicted of capital murder.

SUMMARY

Compared to healthy controls, individuals with a history of violence have abnormal metabolic activity in the limbic regions including the amygdala and orbito-frontal areas. The abnormality may be that of reduced or increased activation. Defendants who present evidence of brain damage in court are less likely to receive the death penalty than defendants who do not present evidence of brain damage. Method: This study is an IRB approved archival review of forensic medical records obtained in the University of Pennsylvania Brain and Behavior Laboratory from 2000 until present. FDG-PET scans of 23 males convicted of capital murder were reviewed and comparison was made between subjects and against normal controls. Court transcripts and case citations were reviewed to ascertain whether neuroimaging scans and testimony regarding FDG-PET were admitted into evidence. The sentencing was recorded. In an analysis of region of interest (ROI) to whole-brain ratios covering 32 ROIs, decreased glucose metabolism was observed in the limbic regions including the amygdala in subjects convicted of capital murder when compared to normal controls. Cortical regions showed abnormally increased activation.

REFERENCES

Mehr S, Gerdes S: Medicolegal applications of PET scans. *NeuroRehabilitation* 16:87-92, 2001
Silverman D, Alavi A: PET imaging in the assessment of normal and impaired cognitive function. *Radiol Clin N Am* 43:67-77, 2005

SELF ASSESSMENT QUESTIONS

1. In which phase of a criminal trial is FDG-PET scan of the brain most likely to be admitted?
 - a. Pre-trial hearing
 - b. Guilt phase in a homicide trial
 - c. As mitigating evidence in the sentencing phase
 - d. Never admitted

ANSWER: c

2. In persons convicted of capital murder in this study, the glucose metabolism of the amygdala was _____ compared to normal controls?
 - a. increased
 - b. decreased
 - c. the same

ANSWER: b

PSYCHIATRIC CHARACTERISTICS OF A REPRESENTATIVE SAMPLE OF HOMICIDE DEFENDANTS

Christine Martone, MD, Pittsburgh, PA
Suzanne Yang, MD, Pittsburgh, PA
Layla Soliman, MD, Pittsburgh, PA
Richard Frierson, MD, Columbia, SC

EDUCATIONAL OBJECTIVE

To compare the characteristics of homicide defendants with and without mental illness, substance use disorder, and dual diagnoses, assess the correlation between mental illness and legal outcomes, compare findings in this study to prior studies using less representative samples and suggest directions for further research.

SUMMARY

This presentation provides analyses of data regarding a consecutive sample of 279 homicide defendants in Allegheny County. As a matter of local policy, all homicide defendants between 2001 and 2005 received psychiatric evaluations. Demographic data, psychiatric diagnoses, victim characteristics and legal outcomes were coded from these reports. Previous US homicide studies involve defendants referred for evaluation and European studies are not reflective of the United States. This study provides a unique view of the natural prevalence and impact of mental disorder in a US sample of individuals charged with homicide. Preliminary data from this study were reported in 2009. In addition to substantiating some earlier findings, we now can report new analyses. For example, female

defendants were significantly more likely to have an Axis I non-substance diagnoses, particularly a mood disorder, and personality disorder. Defendants over age 30 were also more likely to have a mood disorder. Of particular policy relevance, the prevalence of involvement in outpatient care by defendants in the three months preceding the homicide was very low: only 8% of those with Axis I diagnoses (only 3% of African American defendants). An outside discussant will critique the study. A design for a future study will be presented.

REFERENCES

Matejkowski JC, Cullen SW, Solomon PL: Characteristics of persons with severe mental illness who have been incarcerated for murder. *J Am Acad Psychiatry Law* 36:74-86, 2008
Frierson RL; Finkenbine RD: Psychiatric and neurological characteristics of murder defendants referred for pretrial evaluation. *J Forensic Sci* 49(3):604-9, 2004

SELF ASSESSMENT QUESTIONS

1. What potential problems may occur when generalizing findings from past studies of homicide defendants?
 - a. Cultural differences between the United States and Europe may result in different characteristics of crimes and outcomes.
 - b. Selection bias may skew results towards higher rates of incompetence to stand trial.
 - c. Selection bias may skew results towards higher rates of psychiatric diagnoses.
 - d. All of the above.

ANSWER: d

2. Analyses showed which of the following?
 - a. Male defendants were more likely to have personality disorders diagnosed.
 - b. Female defendants were more likely to be diagnosed with mood disorders.
 - c. Defendants over 30 years old were less likely to have an Axis I diagnosis.
 - d. All of the above.
 - e. None of the above.

ANSWER: b

F30

WOMEN WHO KILL THEIR MATE

Dominique Bourget, MD, Ottawa, ON, Canada
Pierre Gagné, MD, FRCPC, Sherbrooke, PQ, Canada

EDUCATIONAL OBJECTIVE

To gain a more extensive knowledge of the characteristics of spousal homicide and the major differences between male spousal and female spousal homicides, with a focus on women who kill and the medicolegal implications.

SUMMARY

Spousal murders accounted for approximately half of the solved family homicides in Canada between 1993 and 2010. Victims are females in the vast majority of homicides perpetrated by spouses, including persons in legal marriages and common-law relationships, and those separated or divorced from legal marriages. In contrast, females rarely kill their mate. While spousal murders frequently occur in the context of domestic violence, circumstances that lead to spousal homicide typically differ for men and women. The authors examined all consecutive coroners' files of victims of domestic homicide occurring from 1990 to 2010 in one of the largest Canadian provinces. Over a period of nearly twenty years, forty (40) victims were killed by their female partner. This represented nearly 15% of all spousal homicide during this time frame. The sample of female offenders will be compared to the sample of male offenders on relevant variables. The majority of cases occurred in the home. Demographic and clinical data on the female offenders will be presented. In contrast to the male offenders, women were less likely to attempt suicide after the homicide.

REFERENCES

Bourget D, Gagné P, Moamai J: Spousal homicide and suicide in Quebec. *J Am Acad Psychiatry Law* 28(2):179-82, 2000
Shackelford T: Partner-killing by women in cohabiting relationships and marital relationships. *Homicide Studies* 5(3):253-66, 2001

SELF ASSESSMENT QUESTIONS

1. Which of the following factors has not been found to elevate the risk of spousal homicide?
 - a. violence in the relationship
 - b. age disparity between partners
 - c. mental illness
 - d. use of alcohol
 - e. employment status

ANSWER: e

2. Which of the following statements is true with respect to spousal homicide?
 - a. Women are more likely to attempt suicide after killing their mate.
 - b. Nearly one-third of female spousal homicide involve the use of a firearm.
 - c. The percentage of diagnosable mental illness is higher in female offenders.
 - d. Male offenders are more likely to be intoxicated at the time of the homicide.
 - e. The BWS defense allows one to plea diminished responsibility.

ANSWER: b

F31

CHILD EXPLOITATION IN SOUTHEAST ASIA: CAN IT GET ANY WORSE?

Special Agent Gary Phillips, (I) Kearney, NE

EDUCATIONAL OBJECTIVE

To provide an overview of the state of affairs concerning child exploitation in Southeast Asia, specifically Thailand, Vietnam, Laos and Cambodia. Case studies from actual criminal investigations will illustrate how Special Agents and other law enforcement agents obtain information about the exploitation of children overseas.

SUMMARY

Criminal prosecution of Americans that travel overseas to engage in sex with children is difficult. A complex set of policies, protocols, and extraterritorial laws must be adhered to when investigating crimes against children in a third world country. Many challenges need to be overcome in order for evidence to be lawfully admitted into a United States court of law once an offender has been arrested, expelled or extradited back to the United States. This presentation will focus on grass roots techniques utilized by US law enforcement while working overseas to identify child offenders, gather sufficient evidence for prosecution, and what is needed to overcome the challenges of preparing a child for court.

REFERENCES

Newman WJ, Holt BW, Rabun JS, et al: Child sex tourism: extending the borders of sexual offender legislation. *Int J Law Psychiatry* 34:116-121, 2011
High J: The basis for jurisdiction over U.S. sex tourists: an examination of the case against Michael Lewis Clark. *UC Davis J Int Law Policy* 11:343-371, 2005

SELF ASSESSMENT QUESTIONS

1. What law does US law enforcement rely upon when investigating crimes against children while working overseas?

ANSWER: The U.S. PROTECT ACT of 2003 18USC 2423(c)

2. Who are the primary violators when it comes to trafficking children for sexual exploitation in a third world country?

ANSWER: the mother of the victim

F32

DISSOCIATIVE IDENTITY DISORDER: ASSESSMENT OF CRIMINAL RESPONSIBILITY, AND DIMINISHED CAPACITY

David Rosmarin, MD, Newton, MA

EDUCATIONAL OBJECTIVE

The attendee will become familiar with the clinical presentation of defendants with DID, the role of video examination, and relevant case law for insanity and diminished capacity.

SUMMARY

Popularized in the media, including malingering by Edward Norton in "Primal Fear," many clinicians doubt whether DID is an actual disorder, while some experts assert it is genuine but often missed. This presentation will provide an introduction to the clinical aspects of the disorder, clues to verisimilitude and malingering, and how different presentations square with insanity and diminished capacity standards. Case presentations and examinations of patients switching from host to alter will be presented. In criminal responsibility cases, the alter-focus approach asks whether the alter had knowledge of wrongfulness or ability to refrain. The host-focus approach, promulgated in US

v. Denny Schaffer, asks whether the host personality had knowledge or control of the alter committing the act. The unified-focus approach regards the defendant as a whole, irrespective of which personality was active. Concerning diminished capacity, NY code allows an affirmative defense to murder if a defendant acted under the influence of extreme emotional disturbance for which there was a reasonable explanation or excuse, the reasonableness of which is to be determined from the viewpoint of the person in the defendant's situation under the circumstances as the defendant believed them to be. Some states have no EED or diminished capacity defense.

REFERENCES

Commonwealth v. Roman 414 Mass. 235 (1993)

Chu JA, Loewenstein R, Dell PF, et al: International society for the study of dissociation. J Trauma Dissociation 6(4): 69-149, 2005

SELF ASSESSMENT QUESTIONS

1. Describe reported neurophysiologic correlates to DID.

ANSWER: Some studies have shown: decreased hippocampus and amygdala volume, differences in cerebral blood flow among identity states on PET and FMRI, EEG differences among identity states, and changes in visual evoked potentials.

2. According to some authorities, what are some of the characteristics of DID patients when switching identity states?

ANSWER: Facial appearance alteration, eye rolls, blinking, twitches, grimaces, voice/speech changes, headache, amnesia within interview.

F33

SEXUAL OFFENDERS: IDENTIFICATION, RISK ASSESSMENT, TREATMENT AND LEGAL ISSUES

John Paul Fedoroff, MD, Ottawa, ON, Canada
Roy O'Shaughnessy, MD, Vancouver, BC, Canada
Charles Scott, MD, Sacramento, CA
Howard Zonana, MD, New Haven, CT
John Bradford, MBChB, Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

Experts in the field will summarize work on their topic, provide updates and include a discussion on risk assessment. This course will be at the expert level but information will be of use to anyone who is involved in the assessment or treatment of current, past, or potential sex offenders.

SUMMARY

Dr. Bradford will review penile tumescence testing and visual reaction time measures designed to assess sexual interest. Use of these techniques in risk assessment and treatment will be discussed. Dr. O'Shaughnessy will review the concept of personality and how personality traits affect the way sex offenders present and respond to treatment options. He will also discuss personality and risk assessment. Dr. Saleh will review the scientific support for both psychotherapies including relapse prevention and the "good lives" model and drug treatment of sex offenders, including SSRIs, antiandrogens and GnRH analogues. Dr. Scott will discuss special issues arising in the assessment and treatment of juveniles accused of sex offenses at each stage of the legal process. He will also discuss waivers to adult court and waiver of Miranda rights in this population. Dr. Zonana will review ethics issues arising for forensic psychiatrists involved in sex offender evaluation and treatment. Topics will include evaluations and reports at the pretrial and presentencing stages; treatment in prison; sexually violent predator evaluations; and the ethics of risk assessment.

REFERENCES

Saleh F, Grudzinskas A, Bradford J, et al: Sexual Offenders: Identification, risk assessment, treatment and legal issues. New York, NY: Oxford University Press, 2009

Thibaut F, De La Barra F, Gordon H, et al: The World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the biological treatment of paraphilias. 11(4): 604-655, 2010

SELF ASSESSMENT QUESTIONS

1. Pharmacologic treatment of sex offenders may include:

- SSRIs
- Antiandrogens
- GNRHs
- Vitamin D
- All of the above

ANSWER: e

2. In the past 20 years the North American recidivism rate for sex offenders has:
- stayed the same
 - decreased
 - fluctuated
 - not been measured

ANSWER: b

F34

“HEARSAY... HEARSAY!” CONSIDERATIONS FOR FORENSIC PSYCHIATRISTS

Michael Greenspan, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY
Albert Grudzinskas, Jr., JD, (I) Worcester, MA
Kenneth Appelbaum, MD, Shrewsbury, MA

EDUCATIONAL OBJECTIVE

To provide a historical and theoretical legal background of hearsay considerations within forensic psychiatry. Pertinent case law and evidentiary guidelines will be reviewed. Participants will be introduced to both a review of state statutes and case law relevant to forensic testimony as well as a survey of local hearsay practices.

SUMMARY

Hearsay, derived from the 6th Amendment’s guarantee that a defendant will be afforded the opportunity to confront his accusers, bears profound impact on our forensic evaluations and testimony. Defined in the Federal Rules of Evidence (Article VIII), the practical application of hearsay is impacted by case law and statute. Data “reasonably relied upon by experts in the particular field in forming opinions” (Article VII) is typically protected from hearsay objections. The admissibility of out of court statements, such as those collected by forensic experts, changed with the Supreme Court’s 2004 Crawford decision. In Crawford, the Court held that “testimonial statements” be excluded at the time of trial, unless the primary source of information was either no longer available or the defense already had the opportunity for cross examination. Since Crawford, local courts have expanded on the specific definition and treatment of testimonial statements. To further our understanding of this important topic and so better be able to defend our work from hearsay objections, a legal review of state hearsay law will be discussed. In addition, a survey of local hearsay practices will be presented.

REFERENCES

Crawford v. Washington, 541 U.S. 36 (2004)
New York v. Goldstein, 6 N.Y.3d 119 (2005)

SELF ASSESSMENT QUESTIONS

1. Broadly stated, hearsay is derivative of which of the constitutional amendments?
- 1st Amendment
 - 3rd Amendment
 - 4th Amendment
 - 5th Amendment
 - 6th Amendment

ANSWER: e

2. Which 2004 Supreme Court decision profoundly affected the admissibility of out of court statements?

- Ohio v. Roberts
- Crawford v. Washington
- Baxstrom v. Herald
- Estelle v. Gamble
- Foucha v. Louisiana

ANSWER: b

F35

STALKING: RECENT ADVANCES IN ASSESSMENT AND TREATMENT

David James, MD, Oxford, United Kingdom
Frank Farnham, MD, Enfield/Middlesex, United Kingdom
Rachel MacKenzie, DPsych, (I) Clifton Hill, Australia
Sara Henley, DPsych, (I) North London, United Kingdom

EDUCATIONAL OBJECTIVE

To provide an understanding of recent developments in the assessment of stalking risk, and their practical advantages in constructing management plans and court reports. Additionally, to summarize new treatment approaches to stalkers, and to provide an appreciation of the overlap between the fields of stalking and public figure threat assessment.

SUMMARY

Structured professional judgement tools have now become available that enable the assessment of stalking risk in a way that ensures best practice, is reproducible, defensible, can measure change and points to management strategies. In addition, these take account of the different risk factors associated with separate domains of risk and the effect of underlying motivation. The advantages of using such tools will be demonstrated. Secondly, new developments in treatment strategies for stalkers will be summarised. Apart from the treatment of mental illness when present, there is the issue of treating the individual factors, personality characteristics and skills deficits which drive the behavior. Without such treatment, stalkers (analogously to sex offenders) are likely to emerge from incarceration with a high likelihood of recidivism. The session will then consider the recent research evidence that risk factors in public figure threat assessment are the same as those in stalking samples, once ex-intimate stalkers are excluded. This is of practical use in that the risk research in each field can be adapted for use by the other. Finally, a typology of warning behaviors in public figure stalking and harassment cases will be introduced and its practical usefulness in conceptualising accelerating risk will be described.

REFERENCES

MacKenzie RD, James DV: Management and treatment of stalkers: problems, options and solutions. Behav Sci Law 29(2): 220-239, 2011

McEwan TE, Pathé MT, Ogloff JR: Advances in stalking risk assessment. Behav Sci Law 29: 180-201, 2011

SELF ASSESSMENT QUESTIONS

1. Which of the following statements about risk in stalking is incorrect?
 - a. The risk factors for persistence (continued stalking) differ from those for violence.
 - b. The risks in men differ from those in women.
 - c. Risk factors differ according to the nature of the underlying motivation.
 - d. Police can identify high risk cases by using screening tools.
 - e. The risks in stalking cases differ from those in domestic violence cases.

ANSWER: b

2. Which of the following has no proven place in the treatment of stalkers?

- a. Cognitive behavior therapy
- b. Depot antipsychotic medication
- c. Transtheoretical model of behavioural change
- d. Psychodynamic psychotherapy
- e. Social cognition theory

ANSWER: d

F36

INITIAL TREATMENT OUTCOMES IN A DIALECTICAL BEHAVIOR THERAPY PROGRAM WITH A FORENSIC INPATIENT POPULATION

Nicole Klezka, PhD, (I) Saline, MI

Jean Kanitz, PhD, (I) Saline, MI

Craig Lemmen, MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE

To study the effectiveness of DBT in an inpatient forensic population.

SUMMARY

The current study tracks treatment outcome data for ten months of a Dialectical Behavior Therapy (DBT) program at a forensic inpatient facility in Michigan. To date, the program has served 61 male and female patients in both acute and long-term inpatient units. All patients received skills training and a subset received individual DBT therapy. Empirical data concerning incident reports and PRN medications was gathered, and additional outcome measures assessing behavioral symptoms (via the Borderline Symptom Checklist), resources (via the Modified Recovery Scale), interpersonal effectiveness (via the Inventory of Interpersonal Problems) and knowledge base (via pre and post test measures for each skills training module) were completed by patients. Treating clinicians also completed a measure assessing the patients' interpersonal problems (via the Inventory of Interpersonal Problems). Results indicate that the number of incident reports for behavioral dyscontrol and PRN use for agitation were significantly

lower when comparing the three months prior to entering DBT treatment with the most recent three months. Despite these empirical measures of patient improvement, patients self-reported increased behavioral symptoms and interpersonal problems, and clinician-completed measures did not reflect significant improvement in patient functioning over time.

REFERENCES

Linehan MM: Cognitive behavioral treatment of borderline personality disorder. New York, NY: Guilford Press, 1993
Swenson CR, Witterholt S, Bohus M: Dialectical Behavior Therapy on Inpatient Units. In Kimeff, L.A., Koerner, K. (eds). Dialectical Behavior Therapy in Clinical Practice New York, NY: Guildford Press, 2007

SELF ASSESSMENT QUESTIONS

1. Challenges implementing a DBT group in a forensic setting include:

- a. Motivation for change for long-term chronic forensic patients.
- b. Challenges training a variety of security and nursing staff over different units and different shifts.
- c. Adapting the model to meet the needs of antisocial individuals.
- d. All of the above.

ANSWER: d

2. The outcome of DBT treatment in a forensic setting is more likely to be:

- a. Improved medication compliance.
- b. Patients reporting reduction in their symptoms.
- c. Clinicians noting reduction in symptoms.
- d. Reduction in aggressive behavior.

ANSWER: d

F37

TRAUMA, PTSD, AND SELF-INJURIOUS BEHAVIOR IN TWO CORRECTIONS SAMPLES

Tracy Gunter, MD, St. Louis, MO
Sandra Antoniak, MD, Iowa City, IA

EDUCATIONAL OBJECTIVE

To understand the frequencies and types of traumatic events reported by individuals in institutional and community corrections, and appreciate the relationship of these to substance use disorders and suicidal behaviors.

SUMMARY

Lifetime trauma is frequently reported by people who have served in correctional settings, and more commonly reported by corrections-involved women than similarly situated men. Traumatic life experience has been implicated in the etiology of a number of adverse health outcomes including impulsivity, emotional lability, internalizing and externalizing disorders, and self-harm in both correctional and noncorrectional samples. Particularly common and problematic among traumatized people are the substance use disorders, which then elevate the risk of other adverse outcomes such as criminal behavior, poor health, depression and anxiety, and death by suicide. In the current study we investigate the frequencies and types of trauma experienced by individuals in two corrections samples, one drawn from community corrections (n=411) and the other from a prison (n=322). We were particularly interested in the rates of posttraumatic stress disorder and self-injurious behaviors among traumatized individuals in each of these settings, which also have high frequencies of antisocial personality and substance use disorders.

REFERENCES

Baillargeon J, Penn JV, Thomas CR, et al: Psychiatric disorders and suicide in the nation's largest state prison system. *J Am Acad Psychiatry Law* 37(2): 188-19, 2009
Clements-Nolle K, Wolden M, Bargmann-Losche J: Childhood trauma and risk for past and future suicide attempts among women in prison. *Womens Health Issues* 19(3): 185-192, 2009

SELF ASSESSMENT QUESTIONS

1. Traumatic life experience is:

- a. frequently reported by subjects in correctional settings and associated with poor health outcomes.
- b. more rare in incarcerated offenders than in community dwellers.
- c. generally single episode and benign.
- d. invariably associated with posttraumatic stress disorder and suicides.
- e. freely reported by corrections clients and easily treated.

ANSWER: a

2. Which of the following statements is true concerning gender differences in correctional populations?
 - a. Women in correctional settings tend to be better educated and more affluent than similarly situated men.
 - b. Incarceration rates for women continue outstripping rates for men.
 - c. Suicidal ideation and behavior are more common among women.
 - d. Traumatic life experience, post traumatic stress disorder, and borderline personality disorder occur more frequently in corrections involved women than men.
 - e. There is no differences in age, race, or ethnicity between women and men in correctional settings.
- ANSWER: d

F38

WOMEN'S MENTAL HEALTH IN CORRECTIONAL SETTINGS

Anna Glezer, MD, Boston, MA

Rebecca Brendel, MD, JD, Boston, MA

EDUCATIONAL OBJECTIVE

To characterize current trends in reproductive mental health, understand the effects of incarceration on peripartum women's mental health and identify areas for continued research, education, and treatment in this area.

SUMMARY

Reproductive mental health has received substantial attention in recent years, with research suggesting that depression during pregnancy and postpartum mood disorder may have lasting effects on child development. For women who are incarcerated and already have multiple stressors and risk factors for mental illness, pregnancy constitutes yet another powerful biopsychosocial stressor. Notwithstanding the significant potential impact of peripartum mood disorder in incarcerated women, there are little data characterizing the mental health needs and treatment of pregnant or postpartum incarcerated women. This descriptive pilot investigation aims to fill that void by characterizing the present landscape in order to set the stage for further study of potential opportunities for intervention for this high-risk population, with a focus on the benefits effective treatment could have for this vulnerable population of women and their children. The proposed method, currently in IRB review in the Massachusetts Department of Correction (MDOC), is completion of the Edinburgh Depression Scale by women incarcerated in the MDOC. We will then review the medical charts of the women to determine how their mental health needs were assessed and what treatment, if any, they received or are engaged in at the time of the study.

REFERENCES

- Faust E, Magaletta PR: Factors predicting levels of female inmates' use of psychological services. *Psychological Services* 7(1): 1-10, 2010
- Jordan B, Schlenger WE, Fairbank JA, et al: Prevalence of psychiatric disorders among incarcerated women. *Archives of General Psychiatry* 53: 513-519, 1996

SELF ASSESSMENT QUESTIONS

1. What are current rates of mental health services use by incarcerated women?
 - a. less than 10%
 - b. 25%
 - c. 50-75%
 - d. greater than 90%

ANSWER: c

2. What is not a known predictor of mental health service use while incarcerated for women?
 - a. prior mental health history
 - b. suicide attempt history
 - c. being a US citizen
 - d. substance abuse
 - e. all of the above
 - f. none of the above

ANSWER: e

EDUCATIONAL OBJECTIVE

To inform participants of the psycho-cultural foundations of political terrorism, torture and genocide and crimes against humanity. Participants will learn how political violence arises from man's need for enemies and the psychopolitics of hatred.

SUMMARY

Emphasizing that as individuals terrorists are "normal," the presentation stresses the determining role of group psychology and collective identity. Emphasizing that "hatred is bred in the bone," nationalist-separatist terrorists are characterized as carrying on the mission of their parents who are disloyal to, and damaged by, the regime. This contrasts with social revolutionary terrorists who are rebelling against the generation of their family which is loyal to the régime. For religious extremist terrorism, "killing in the name of God" is conveyed as the basis for suicide terrorism which has been reframed as martyrdom operations. Implications of these understandings for counter-terrorism will be discussed as will the challenges of serving as expert witness. Drawing on man's need for enemies and the psychopolitics of hatred, the basis for man's inhumanity to man is discussed, clarifying how normal people can be led to righteously kill the innocent, including the extremity of genocide and ethnic cleansing. The torturer is discussed as dutifully compliant to the system, with consideration of Abu Ghraib.

REFERENCES

- Post J: The Mind of the Terrorist: The Psychology of Terrorism from the IRA to al Qaeda. New York, NY: Palgrave-Macmillan, 2008
Robins R, Post J: Political Paranoia: The Psychopolitics of Hatred. New Haven, CT: Yale University Press, 1997

SELF ASSESSMENT QUESTIONS

1. Nationalist separatist terrorists are:

- carrying on the mission of their parents
- loyal to parents who are damaged by the regime, dissident to the regime
- their hatred has been "bred in the bone," and their need for vengeance has been generationally transmitted
- all of the above

ANSWER: d

2. In considering the mass psychology of hate movements and genocide:

- hate-mongering leaders "manipulate the slime of discontented souls"
- the psychological foundation of the enemy is stranger anxiety
- the psychological foundation of nationalism is comfort with familiar
- all of the above

ANSWER: d

Mark Hauser, MD, Newton, MA
Alan Newman, MD, Washington, DC
Tyler Jones, MD, Washington, DC
Andrew Nanton, MD, Orlando, FL

EDUCATIONAL OBJECTIVE

Participants will learn ways to improve forensic psychiatry practice utilizing the latest technology, will become familiar with the benefits of computer hardware, software and peripheral devices, will gain a basic understanding of resources useful for teaching, learning and practicing forensic psychiatry, and will become aware of various useful websites.

SUMMARY

The Computers and Forensic Psychiatry Committee hosts an annual workshop for participants to learn about the use of computer hardware and software, and connected gadgets, that can enhance training in, and the practice of, forensic psychiatry. Presenters will be available with internet connected laptop computers and an array of gadgets to demonstrate selected software applications and discuss their usefulness. For the beginner, there will be a review of some computer basics, including the importance of backup strategies. The presenters will review various internet based tools, some that can be useful for teaching and learning forensic psychiatry, others being used for collaboration with colleagues, for example to facilitate committee work as an alternative to live meetings. The presenters will demonstrate the use of text expanders to aid report writing, the use of web-based research to enhance forensic psychiatry practice, and a review of resources of interest to the forensic psychiatrist. We will discuss the experience

of using on-line collaboration software, pro and con, by the members of the Computers and Forensic Psychiatry Committee, as an example for other AAPL committees. The audience is encouraged to bring questions and share their relevant experience to enable dialogue with the workshop participants.

REFERENCES

<http://lifelifehacker.com/#!238306/lifelifehacker-code-texter-windows> (Accessed 3/10/2011)

<http://www.aapl.org> (Accessed 7/21/2011)

SELF ASSESSMENT QUESTIONS

1. Which of the following statements is most accurate regarding the use of text expanders?

- a. They require too much effort to set up and use.
- b. The software is not ready for prime time.
- c. The cost is prohibitive.
- d. The software is readily available, easy to use, and provides dramatic time efficiency.

ANSWER: d

2. Over the last several years, which of the following statements is true about cloud computing?

- a. Cloud computing has remained difficult to access.
- b. Cloud computing is too expensive.
- c. Cloud computing requires obscure prerequisites.
- d. Cloud computing has become readily accessible, inexpensive, and virtually indispensable.

ANSWER: d

F41

SERIOUSLY MENTALLY ILL PERSONS IN US IMMIGRATION DETENTION

Kristen Ochoa, MD, Los Angeles, CA

Joseph Penn, MD, Huntsville, TX

Homer Venters, MD, (I) New York, NY

Erin Hustings, Esq., (I) Washington, DC

Sarah Mehta, Esq., (I) New York, NY

Laura Belous, Esq., (I) Florence, AZ

EDUCATIONAL OBJECTIVE

To examine legal and ethical issues surrounding the psychiatric care, representation and forensic evaluation of seriously mentally ill persons in removal proceedings who are detained within the US Immigration Detention system. Medical and legal experts working on these issues will seek to improve overall knowledge of this hidden population.

SUMMARY

Immigration law, due process requirements and access to care for immigration detainees are new and evolving areas of concern for forensic and correctional psychiatry. This presentation will build on a previous panel describing psychiatric services within Immigration and Customs Enforcement (ICE) detention facilities. Attorneys who represent seriously mentally ill persons will discuss the lack of legal safeguards for this population, such as no right to appointed legal counsel and a lack of developed regulations to protect immigrants with serious mental illnesses who appear in immigration court. Ethical issues surrounding competency evaluations for persons who have no attorney will be discussed, as well as efforts to ensure incompetent persons are identified, represented and evaluated. Physicians in correctional settings will discuss the problematic diversion of seriously mentally ill inmates from criminal court-ordered psychiatric treatment into immigration detention. We will discuss the need to develop policies and programs that meet national standards for the provision of mental health services to ICE detainees. Finally, we will receive an update of the work of the ICE/NGO Advisory Group on Detention and Medical Care. Counsel from ACLU, Physicians for Human Rights, a representative of NCCHC and members of the ICE Medical Advisory group will present.

REFERENCES

Ochoa K, Pleasants GL, Penn JV, et al: Disparities in justice and care: persons with severe mental illnesses in the U.S. immigration detention system. *J Am Acad Psychiatry Law* 38(3): 392-399, 2010

Mehta S: *Deportation by Default: Mental Disability, Unfair Hearings, and Indefinite Detention in the US Immigration System*. New York, NY: Human Rights Watch/ACLU ISBN: 1-56432-665-9, 2010

SELF ASSESSMENT QUESTIONS

1. According to AAPL Ethics Guidelines for the Practice of Forensic Psychiatry, which of the following statements is true?
 - a. Psychiatrists should not perform forensic evaluations on persons in removal proceedings.
 - b. Absent a court order, psychiatrists should not perform forensic evaluations on persons charged with immigration violations who have not consulted with legal counsel.
 - c. Psychiatrists should provide forensic evaluations only to the court (immigration judge) and not to the government (ICE attorney).

ANSWER: b

2. Most seriously mentally ill persons in removal proceedings in the United States:
 - a. have no legal counsel and must proceed pro se.
 - b. are detained by ICE after serving time in criminal correctional settings for minor crimes.
 - c. are detained in facilities without mental health housing and/or an on-site psychiatrist.
 - d. All of the above

ANSWER: d

F42

COMPLICATED CHILD CUSTODY ISSUES: WHAT EVALUATORS SHOULD KNOW ABOUT AUTISTIC CHILDREN, HOMOSEXUAL PARENTS, AND NATIVE AMERICANS

Jesse Raley, MD, Columbia, SC
Alicia Hall, PhD, (I) Columbia, SC
Crystal Bullard, MD, (I) Columbia, SC

EDUCATIONAL OBJECTIVE

To enhance the audience's knowledge about literature directly and indirectly related to child custody evaluations involving autistic children, homosexual parents, and Native Americans.

SUMMARY

It is a misnomer to say that any child custody evaluation is uncomplicated, but there certainly are issues which could make an evaluation more complicated. There has been growing literature on parental alienation dynamics, relocation evaluations, and domestic violence, but other complicated issues have received less attention in the literature. This panel has chosen three particular areas on which to focus: autistic children, homosexual parents, and Native American issues. Autistic children have a unique set of deficits that may directly relate to parenting plan recommendations as well as conducting the evaluation itself. The panel will address these issues. Homosexual adoption, parenting, and marriage have received significant press over the past decade. While literature has been emerging since the 1980s there have been few studies directly addressing child custody, and the issue is growing. Finally, Native American culture has multiple intricacies as they relate to families and parenting. When child custody is involved, evaluators need to be knowledgeable about Native American culture as well as laws relating to custody, adoption, and termination of parental rights.

REFERENCES

Raley JA: Factors to explore in doing child custody evaluations involving gay and lesbian parents. *Journal of Child Custody* 7: 176-191, 2010
Jones LR, Holmes DL: Autism and divorce guidelines for family court practice. *New Jersey Lawyer* 7-17, 2009

SELF ASSESSMENT QUESTIONS

1. Which of the following factors has been shown to predict fewer behavioral problems in children of lesbian mothers?
 - a. Presence of a male role model
 - b. Home schooling
 - c. Involvement in parenting by both mothers
 - d. Exposing the child to other children of homosexual parents

ANSWER: c

2. Which of the following traits of children with autism could impact a parenting plan?
 - a. Impaired adaptability to changes in routine
 - b. Limited ability to communicate effectively
 - c. Specific psycho-educational needs
 - d. a and b
 - e. All of the above

ANSWER: e

SATURDAY, OCTOBER 29, 2011

POSTER SESSION C

7:15AM - 10:15AM

MEZZANINE FOYER

- S1** **Rolling Up Your Sleeves...Involving Patients in the Audit of Community Meetings**
Callum Ross, MBChB, (I) Crowthorne, United Kingdom
- S2** **Neuropsychiatric Issues of Caffeine Use**
Christopher Davidson, MD, Sioux Falls, SD
James Reynolds, MD, St. Joseph, MO
Sylvester Smarty, MD, Broadview Heights, OH
Brooke Beckham, MSW, (I) Sioux Falls, SD
Michael Harlow, MD, St. Peter, MN
- S3** **Criminal Responsibility of the Noncompliant Mentally Ill Offender**
Zachary Torry, MD, San Mateo, CA
Kenneth Weiss, MD, Bala Cynwyd, PA
- S4** **Community Correctional Conditions Imposed on Sex Offenders in Canada: Is More Always Better?**
Samantha Rice, MA, (I) Ottawa, ON, Canada
John Paul Fedoroff, MD, Ottawa, ON, Canada
Lisa Murphy, MA, (I) Ottawa, ON, Canada
- S5** **The Other Risk Assessment - The Science of Suicide Risk Assessment**
Victoria Roth, MD, Victoria, BC, Canada
Anthony Dugbartey, PhD, (I) Victoria, BC, Canada
- S6** **Predictors of Custody and Visitation Recommendations**
Jonathan Raub, MD, MPH, Cambridge, MA
Nicholas Carson, MD, (I) Cambridge, MA
Benjamin Cook, PhD, (I) Cambridge, MA
Grace Wyshak, PhD, (I) Boston, MA
Barbara Hauser, LICSW, (I) Cambridge, MA
- S7** **Forensic Practice and Professionalism: Is Facebook a Friend or Foe?**
Helen M. Farrell, MD, Boston, MA
- S8** **When Rights Collide: Right to a Speedy Arraignment vs. Right to Treatment**
Susan Gray, MD, New York, NY
Elizabeth Ford, MD, New York, NY
Christopher Racine, MD, (I) New York, NY
- S9** **Approaching Sex Offender Treatment "Mindfully"**
Tammy Benoit, MA, (I) Worcester, MA
Fabian Saleh, MD, Boston, MA
- S10** **Serious Mental Health Issues Among Incarcerated Individuals**
Georgia Stathopoulou, PhD, (I) Boston, MA
Kristen Czarnecki, BA, (I) Boston, MA
Fabian Saleh, MD, Boston, MA
- S11** **The Uniform Commercial Code in Criminal Proceedings**
Salvatore Savatta, MD, Pittsburgh, PA
Brett DiGiovanna, MD, Hershey, PA
Christine Martone, MD, Pittsburgh, PA
- S12** **WITHDRAWN**
- S13** **Recidivism of Participants in a Pretrial Mental Health Diversion Program**
Peter Ash, MD, Atlanta, GA
Amy Simon, JD, (I) Decatur, GA
Funmilayo Rachal, MD, Houston, TX
Susan Berberian, LCSW, (I) Decatur, GA
Winston Bethel, JD, (I) Decatur, GA
Rhathelia Stroud, JD, (I) Decatur, GA
Berryl Anderson, JD, (I) Decatur, GA

SATURDAY

S14	Comparing Processes of Adult and Juvenile Diversion Treatment Courts	Funmilayo Rachal, MD Houston, TX Beth Higgins-Brooks, JD, (I) Decatur, GA Amy Simon, JD, (I) Decatur, GA Peter Ash, MD, Atlanta, GA
S15	Drug Court: "Working The System"	Kristen Czarnecki, BA, (I) Boston, MA Fabian Saleh, MD, Boston, MA Georgia Stathopoulou, PhD, (I) Boston, MA
S16	The COVR: Civil Actuarial Violence Risk Assessment in Canada	Jeff McMaster, MD Toronto, ON, Canada
S17	Crime Scene Analysis: What Psychiatrists and Psychologists Should Know	Samuel Leistedt, MD, PhD, Brussels, Belgium Paul Linkowski, MD, PhD, (I) Brussels, Belgium
BUSINESS MEETING		8:00AM - 9:30AM IMPERIAL BALLROOM
COFFEE BREAK		10:00AM - 10:15AM MEZZANINE FOYER
WORKSHOP		10:00AM - 12:00 NOON IMPERIAL BALLROOM
S18	The Forensic Assessment	Graham Glancy, MB, Toronto, ON, Canada Michael Norko, MD, New Haven, CT Debra Pinals, MD, Worcester, MA Alec Buchanan, MD, New Haven, CT
COURSE (TICKET REQUIRED)		10:00AM - 12:00 NOON GEORGIAN
S19	Child Murder by Parents and Insanity	Phillip Resnick, MD, Cleveland, OH
	SA	
PANEL		10:00AM - 12:00 NOON STATLER
S20	Prescription Opioid Abuse: When are Pain Doctors Drug Dealers? Addiction Psychiatry Committee	Gregory Sokolov, MD, Davis, CA Ajay Wasan, MD, (I) Chestnut Hill, MA Scott Fishman, MD, (I) Sacramento, CA
PANEL		10:00AM - 12:00 NOON BERKELEY/CLARENDON
S21	Madness and Badness: A Statewide Program for Aggression Reduction	Barbara McDermott, PhD, (I) Sacramento, CA Katherine Warburton, DO, Napa, CA Chad Woofter, MD, Napa, CA Joel Dvoskin, PhD, (I) Tucson, AZ
PANEL		10:00AM - 12:00 NOON ARLINGTON
S22	How I Became a Researcher: Career Trajectories Research Committee	Suzanne Yang, MD, Pittsburgh, PA Phillip Candilis, MD, Worcester, MA Susan Hatters Friedman, MD, Cleveland Heights, OH Douglas Mossman, MD, Cincinnati, OH Robert Trestman, PhD, MD, Farmington, CT
LUNCH (TICKET REQUIRED)		12 NOON - 2:00PM PLAZA BALLROOM
S23	Counseling Innocent Prisoners: An Exoneree's Perspective	Dennis Maher, (I) Boston, MA

A/V SESSION	2:15PM - 4:00PM	IMPERIAL BALLROOM
S24 <i>Assessment of Causation and Damages Years After Sexual Abuse</i> <i>Peer Review Committee</i>	David Rosmarin, MD, Newton, MA Renée Binder, MD, San Francisco, CA Graham Glancy, MB, Toronto, ON, Canada Howard Zonana, MD, New Haven, CT	
PANEL	2:15PM - 4:00PM	STATLER
S25 <i>Traumatic Brain Injury and Sociopathy: How, What and Where?</i> <i>Forensic Neuropsychiatry Committee</i>	Manish Fozdar, MD, Wake Forest, NC Timothy Allen, MD, Lexington, KY Hal Wortzel, MD, Denver, CO Robert Granacher, MD, Lexington, KY Jacob Holzer, MD, Pocasset, MA	
PANEL	2:15PM - 4:00PM	GEORGIAN
S26 <i>Hate Crimes: Psychiatric and Sociological Perspectives</i> SA	Gregory Sokolov, MD, Davis, CA Jack Levin, PhD, (I) Boston, MA Annie Steinberg, MD, Narberth, PA	
PANEL	2:15PM - 4:00PM	BERKELEY/CLARENDON
S27 <i>Beyond Dangerous and Severe PD: British Experience</i> <i>International Relations Committee</i>	Kenneth Busch, MD, Chicago, IL Gill McGauley, MD, (I) London, United Kingdom Richard Taylor, MD, Enlfield, United Kingdom Andrew Williams, MD, (I) London, United Kingdom Jessica Yakeley, MD, London, United Kingdom	
RESEARCH IN PROGRESS #5	2:15PM - 4:00PM	ARLINGTON
S28 <i>Early Outcomes of Court-Based Jail Diversion for Veterans</i>	Stephanie Hartwell, PhD, (I) Boston, MA Paul Christopher, MD, Rumford, RI William Fisher, PhD, (I) Worcester, MA Carl Fulwiler, MD, PhD, (I) Worcester, MA Debra Pinals, MD, Worcester, MA David Smelson, PsyD, (I) Worcester, MA	
S29 <i>Criminogenic Factors and Recidivism in a NYC Mental Health Court</i>	Katya Frischer, MD, JD, New York, NY Merrill Rotter, MD, Bronx, NY Charles Amrhein, PsyD, (I) Bronx, NY Virginia Barber Rioja, PhD, (I) New York, NY	
S30 <i>MISSION Community Re-Entry for Women (MISSION CREW): Program Development and Implementation</i>	Laura Guy, PhD, (I) Worcester, MA Andrea Leverentz, PhD, (I) Boston, MA Carl Fulwiler, MD, PhD, (I) Worcester, MA Elizabeth Aaker, BA, (I) Worcester, MA Stephanie Hartwell, PhD, (I) Boston, MA Ken Nelson, MS, (I) Boston, MA David Smelson, PsyD, (I) Worcester, MA Debra Pinals, MD, Worcester, MA	
COFFEE BREAK	4:00PM - 4:15PM	MEZZANINE FOYER

SATURDAY

PANEL S31	<i>Kings in Court: Sovereigns in the Criminal Justice System</i>	4:15PM - 6:15PM	IMPERIAL BALLROOM
		KyleeAnn Stevens, MD, Arlington, VA Alan Newman, MD, Washington, DC Humaira Siddiqi, MD, (I) Washington, DC Steven Snyder, JD, (I) Washington, DC	
WORKSHOP S32	<i>Difficult Forensic Cases Private Practice Committee</i>	4:15PM - 6:15PM	GEORGIAN
		Carla Rodgers, MD, Wynnewood, PA Celestine DeTrana, MD, Indianapolis, IN Robert Granacher, MD, Lexington, KY Trent Holmberg, MD, Draper, UT Brian Crowley, MD, Washington, DC	
WORKSHOP S33	<i>Forensic Psychiatrists in the Immigration Process</i>	4:15PM - 6:15PM	STATLER
		Maya Prabhu, MD, New Haven, CT Madelon Baranoski, PhD, (I) New Haven, CT Howard Zonana, MD, New Haven, CT Becca Heller, JD, (I) New York, NY	
WORKSHOP S34	<i>Thinking Outside the Witness Box: Novel Training Strategies</i>	4:15PM - 6:15PM	BERKELEY/CLARENDON
		Brian Cooke, MD, Gainesville, FL Patrick Fox, MD, New Haven, CT Reena Kapoor, MD, New Haven, CT	
WORKSHOP S35	<i>Management of Deliberate Self-Harming Inmates: Novel Uses of Dialectical Behavior Therapy (DBT) in Jail and Prison</i>	4:15PM - 6:15PM	ARLINGTON
		Camille LaCroix, MD, Boise, ID Gregory Sokolov, MD, Davis, CA Scott Eliason, MD, Eagle, ID	

S1

ROLLING UP YOUR SLEEVES...INVOLVING PATIENTS IN THE AUDIT OF COMMUNITY MEETINGS

Callum Ross, MBChB, (I) Crowthorne, United Kingdom

EDUCATIONAL OBJECTIVE

Broadmoor Hospital is one of three English hospitals that provides specialist mental health care in high secure conditions. Doctors and audit department colleagues provide training to our patients to equip them with the skills to undertake clinical audit. This poster demonstrates how we do it, so you can too.

SUMMARY

The Broadmoor Clinical Audit Group membership comprises multi-disciplinary staff from across the hospital who have received formal clinical audit training, as well as up to six patients. The group's remit is to identify audit projects and provide expertise in current projects. It also assists in completing action plans that then go to various committees and management teams for implementation. The Group identified the need to audit community meetings within the wards at Broadmoor Hospital. We were keen to involve patients throughout the audit and the nature of the data meant that they could be involved in its collection. The patients have a unique perspective on the service being delivered, so we value their participation in clinical audit projects within the hospital. The audit was undertaken by three patients, three consultant forensic psychiatrists, two staff nurses, one occupational therapist, one health care assistant, and a clinical audit coordinator. The community meeting minutes were requested from each ward for a period of two months and were collated by the Clinical Effectiveness and Audit Coordinator. The group agreed to standards and devised an audit tool. This poster sets out what happened next.

REFERENCES

Marks I: Overcoming obstacles to routine outcome measurement: the nuts and bolts of implementing clinical audit. *British Journal of Psychiatry* 173: 281 -286, 1998
Adelman S, Ward A, Davidson S: Setting up clinical audit in a psychodynamic psychotherapy service: a pilot study. *Psychiatric Bulletin* 27: 371 -374, 2003

SELF ASSESSMENT QUESTIONS

1. What is meant by "Clinical Governance"? People often describe six key components. Can you name them?
ANSWER: Education and training; clinical audit; clinical effectiveness; research and development; openness; and risk management.
2. Can you define clinical audit?
ANSWER: A clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

S2

NEUROPSYCHIATRIC ISSUES OF CAFFEINE USE

Christopher Davidson, MD, Sioux Falls, SD
James Reynolds, MD, St. Joseph, MO
Sylvester Smarty, MD, Broadview Heights, OH
Brooke Beckham, MSW, (I) Sioux Falls, SD
Michael Harlow, MD, JD, St. Peter, MN

EDUCATIONAL OBJECTIVE

To inform the forensic examiner and correctional clinician of the important neurobehavioral issues associated with caffeine use.

SUMMARY

The use of caffeine in correctional environments may have underappreciated and unintended neuropsychiatric effects. Knowledge of caffeine induced behavioral changes and drug interactions may also play an important part in forensic evaluations. This poster illustrates the relevant effects of caffeine in prisoners for correctional staff, and mental health providers in correctional settings. Important, yet overlooked, happenings associated with correctional caffeine availability and use may include behavioral changes (intoxication and withdrawal), inmate economic issues (gambling or bartering), drug-drug interactions, and unnecessary medical treatment, injury or expense. Case studies will provide clinical examples of affected patients housed in correctional settings and those undergoing forensic evaluation. Identification and monitoring of inmates misusing caffeinated products, or suffering from caffeinism, is outlined. Literature review of the subject will provide neuropharmacological and physiological components of caffeine's effects such as the importance of CYP450 1A2 mediated metabolism. In addition, caffeine's adenosine receptor antagonism may increase activity in dopaminergic circuits potentially exacerbating psychosis. Issues surrounding psychiatric management of the caffeine imbibing patient by the astute correctional psychopharmacologist will be addressed. Strategic details for correctional system policies addressing caffeine use will be highlighted.

SATURDAY

REFERENCES

Armstrong SC, Cozza KL: Consultation-liaison psychiatry: drug-drug interactions update. *Psychosomatics* 41: 76-77, 2000
Winston AP, Hardwick E, Jaber N: Neuropsychiatric effects of caffeine. *Advances in Psychiatric Treatment* 11: 432-439, 2005

SELF ASSESSMENT QUESTIONS

1. What are caffeine's main neuropsychiatric effects thought to be mediated by?

- a. Antagonism of presynaptic serotonergic transporter function.
- b. Direct decrease of postsynaptic membrane potentials.
- c. Alteration of GABA receptor sensitivity.
- d. Neurotoxic effect of basal ganglia and cerebellar structures.

ANSWER: d

2. Metabolism of caffeine is primarily performed by which Cytochrome P450 Isoenzyme?

- a. CYP3A4
- b. CYP2D6
- c. CYP1A2
- d. Renally excreted unchanged
- e. CYP2D4

ANSWER: c

S3

CRIMINAL RESPONSIBILITY OF THE NONCOMPLIANT MENTALLY ILL OFFENDER

Zachary Torry, MD, San Mateo, CA
Kenneth Weiss, MD, Bala Cynwyd, PA

EDUCATIONAL OBJECTIVE

This presentation will examine the dynamics of medication noncompliance; analyze the culpability of treatment noncompliant mentally ill offenders; compare and contrast medication noncompliance to other self-induced incapacities; and analyze whether or not medication noncompliance can bar an insanity defense.

SUMMARY

Noncompliance with medication therapy and mental health care is prevalent among the mentally ill. Its multifactorial dynamics can include aspects of the illness itself, such as anosognosia. Noncompliance with medication can lead to violent or other criminal behavior, but the law currently does not recognize it as a factor in determining culpability. No legal test of insanity focuses on the cause of the "defect of reason" from "disease of the mind." Noncompliance with medication and voluntary intoxication can both be seen as self-induced incapacities, but their adjudication is often quite different. Crimes committed while voluntarily intoxicated are not excused by insanity, unlike psychosis. The distinction is not only the obvious one of acts of omission (medication noncompliance) and acts of commission (voluntary intoxication). There are other complicating factors, such as the knowledge of the effects of noncompliance, the mental state prior to the noncompliance, and the presence of any conditions that would excuse or justify it. These and other considerations render the assignment of criminal responsibility for the noncompliant psychiatric offender complex. A possible solution to this would be the application of therapeutic jurisprudence to the noncompliant mentally ill offender.

REFERENCES

Sherlock R: Compliance and responsibility: new issues for the insanity defense. *J Am Acad Psychiatry Law* 12: 483-505, 1983

Mitchell EW: Madness and meta-responsibility: the culpable causation of mental disorder and the insanity defense. *Journal of Forensic Psychiatry* 10(3): 597-622, 1999

SELF ASSESSMENT QUESTIONS

1. The dynamics of noncompliance psychiatric offender complex includes all of the following factors except:

- a. Primary and secondary gain of illness
- b. Mood or thought congruent ideas
- c. Adverse effects of medications
- d. Anosognosia
- e. None of the above

ANSWER: e

2. A proposed therapeutic jurisprudence approach to some noncompliant psychotic offenders is:
 - a. Abolish the insanity defense
 - b. Treat the culpable behavior as if it were intoxication
 - c. Consider bringing charges of reckless endangerment for disregarding the effects of noncompliance
 - d. Lengthen post-NGRI commitments
- ANSWER: c

S4

COMMUNITY CORRECTIONAL CONDITIONS IMPOSED ON SEX OFFENDERS IN CANADA: IS MORE ALWAYS BETTER?

Samantha Rice, MA, (I) Ottawa, ON, Canada
 John Paul Fedoroff, MD, Ottawa, ON, Canada
 Lisa Murphy, MA, (I) Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

Knowing the number and types of correctional conditions restricting the movement, employability, and internet accessibility of sex offenders in the community will help clinicians better understand the legislative limits imposed on their patients during correctional supervision and improve services to alleviate some of the stress associated with these limits.

SUMMARY

The purpose of this exploratory study was to survey the common and more specialized community conditions placed on sex offenders living in Canada. Although a small amount of research conducted in the United States has attempted to analyze public protection policies that aim to restrict the movement, settlement, and employability of sex offenders, very little research on this topic has been conducted in Canada (see Murphy et al. 2009). Results are drawn from a survey of 23 sex offenders living in the province of Ontario, Canada. Respondents were asked a number of quantitative and qualitative questions related to their experience of community supervision. Significant results corresponding to previous research (Levenson & Cotter 2005) related to barriers in obtaining adequate housing and employment as a consequence of the conditions placed on participants as well as a perception that conditions restricting internet use are not at all effective in preventing reoffending or reducing risk.

REFERENCES

Levenson JS, Cotter LP: The impact of sex offender residence restrictions: 1,000 feet from danger or one step from absurd? *International Journal of Offender Therapy and Comparative Criminology* 49(2): 168-178, 2005
 Murphy L, Brodsky JD, Brakel SJ, et al: *Community-Based Management of Sex Offenders: An Examination of Sex Offender Registries and Community Notification in the United States and Canada*. New York, NY: Oxford University Press, 2009

SELF ASSESSMENT QUESTIONS

1. What are the most common conditions imposed on sex offenders living under community supervision in Canada?
 - a. Avoid certain places where children frequent, including but not limited to: playgrounds, school yards, arcades, sports complexes, swimming pools, recreation centers.
 - b. Report annually your address to the National Offender Registry for a specified number of years.
 - c. Obey the law and keep the peace.
- ANSWER: a

2. What condition was consistently ranked lowest by participants in terms of effectiveness in helping to reduce recidivism?
 - a. Obey the law and keep the peace.
 - b. Abstain from accessing the internet (except in the work place for employment purposes.)
 - c. Abstain from the use of drugs and/or alcohol except medications prescribed by your medical doctor.
- ANSWER: a

S5

THE OTHER RISK ASSESSMENT - THE SCIENCE OF SUICIDE RISK ASSESSMENT

Victoria Roth, MD, Victoria, BC, Canada
 Anthony Dugbartey, PhD, (I) Victoria, BC, Canada

EDUCATIONAL OBJECTIVE

A review of the current evidence around suicide risk assessment and the use of suicide risk assessment tools, highlighting new evidence around relative risks associated with specific psychiatric diagnosis and specific past methods of self-harm.

SATURDAY

SUMMARY

The use of suicide risk assessment tools has been increasing as different health care organizations require a standardized approach to the assessment and documentation of suicide risk, with the goals of improving quality of the assessment and reducing medicolegal risk. The rationale for the choice of certain assessment tools by management is not always made clear. This paper reviews the current available evidence for the use of suicide risk assessment tools, and takes a wider look at recent research exploring risk factors linked to completed suicide.

REFERENCES

Runeson B, Tidelmalm D, Dahlin M, *et al*: Method of attempted suicide as predictor of subsequent successful suicide: national long term cohort study. *British Medical Journal* 340: 3222, 2010
Wortzel H, Gutierrez P, Homaifar B, *et al*: Surrogate endpoints in suicide research. *Suicide and Life Threatening Behaviour* 40(5), 2010

SELF ASSESSMENT QUESTIONS

1. What diagnostic category has recently been demonstrated to have the highest correlation with completed suicide?
ANSWER: psychotic disorders

2. What are some predictors of completed suicide within one year of discharge from a psychiatric admission?
ANSWER: Self-harm/suicide attempts during admission; noncompliance with treatment; unplanned discharge; discontinuity of care.

S6

PREDICTORS OF CUSTODY AND VISITATION RECOMMENDATIONS

Jonathan Raub, MD, MPH, Cambridge, MA
Nicholas Carson, MD, (I) Cambridge, MA
Benjamin Cook, PhD, (I) Cambridge, MA
Grace Wyshak, PhD, (I) Boston, MA
Barbara Hauser, LICSW, (I) Cambridge, MA

EDUCATIONAL OBJECTIVE

There have been limited studies looking at how parent and child factors influence custody and visitation; this study investigates which parental and child characteristics influence custody and visitation. The goal is to provoke thought on whether custody and visitation arrangements are based on factors that serve the child's best interests.

SUMMARY

This is a chart review of the Middlesex County Family Court Clinic records. Intake questionnaires were coded for several independent variables. Parent characteristics included income, education, ethnicity, history of psychiatric treatment, substance use, history of arrests, and involvement of family protective services. Child characteristics included psychiatric and medical history. Outcomes of current custody, recommended custody and visitation were investigated in relation to these characteristics. Communication and hostility between parents were also investigated, but in relation to an outcome of joint custody. Results reveal that mothers receive custody unless they have a low income or history of psychiatric hospitalizations, substance use, arrests, or other legal involvement. Mothers are more likely to be awarded custody if their child has a history of mental health treatment, if they lack higher educational attainment, and if there is a history of arrests of the father. A lower maternal income predicted a greater likelihood of a father being awarded visitation. A low degree of inter-parental communication and histories of arrests for both mother and father all predicted a lower likelihood of joint custody. Under consideration is whether the aforementioned predictors of custody and visitation outcomes are relevant in serving the best interest of the child.

REFERENCES

Fox G, Kelly R: Determinants of child custody arrangement at divorce. *J Marriage and the Family* 57: 693-708, 1995
Ackerman M: Custody evaluation practice; a survey of experienced professionals. *Professional Psychology* 28:137-145, 1997

SELF ASSESSMENT QUESTIONS

1. Which of the following was not found to predict a lower likelihood of a mother being awarded custody (either joint or sole)?
a. A history of psychiatric hospitalizations
b. A history of substance abuse
c. A history of arrests
d. An income of less than \$20,000
e. A history of involvement of family protective services (child protective services and/or a history of a restraining order)
ANSWER: c

2. Which of the following maternal factors was found to predict a greater likelihood of a father being awarded visitation?
- An income of less than \$20,000
 - A history of arrests
 - A history of mental health treatment, excluding psychiatric hospitalizations
 - A history of psychiatric hospitalizations
 - A history of substance use
- ANSWER: a

S7

**FORENSIC PRACTICE AND PROFESSIONALISM:
IS FACEBOOK A FRIEND OR FOE?**

Helen M. Farrell, MD, Boston, MA

EDUCATIONAL OBJECTIVE

To know the principles that guide medical ethics and professionalism, understand how social networking sites such as Facebook impact professional standards, to learn about multiple studies that reveal how doctors use Facebook and appreciate the need to integrate specific guidelines for Facebook use into medical ethics and professional standards.

SUMMARY

The rise of social media and popularity of Facebook have led to the emergence of an “e-professionalism” concept in medicine. Social networking sites allow for the rapid dissemination of information to its users. For many physicians, applying principles for medical professionalism to the online environment is challenging. This literature review of Facebook use among healthcare providers, finds that professional truancy is problematic. The result is that attention must be paid to privacy settings, content of posts, communication with patients, faculty, and colleagues. Guidelines for Facebook use among forensic psychiatrists are proposed in accordance with the Accreditation Council for Graduate Medical Education and the American Academy of Psychiatry and Law professionalism mandates. By acknowledging this need and by following these guidelines, forensic psychiatrists will continue to define and uphold ethical boundaries and thus demonstrate a commitment to the highest levels of professionalism.

REFERENCES

- Guseh JS, Brendel RW, Brendel DH: Medical professionalism in the age of online social networking. *J Med Ethics* 35(9): 584-6, 2009
- MacDonald J, Sohn S, Ellis P: Privacy, professionalism and Facebook: a dilemma for young doctors. *Medical Education* 44(8): 805-13, 2010

SELF ASSESSMENT QUESTIONS

1. What are the most common examples of unprofessional online content posted by healthcare professional?
ANSWER: Sexual-relational content, affiliation with institution/organization, i.e. disparaging remarks about colleagues, institutions, courses, faculty, rotations, or facilities; intoxication or substance abuse; threats to patient confidentiality, i.e. describing clinical experiences in enough detail that patients could be identified.
2. What are some actions that medical schools, institutions, and the AAPL could undertake to address social networking professionalism?
ANSWER: Introduce a formal professional curriculum, incorporate instruction on relevant laws such as Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA), assess professional competence on a regular basis, model appropriate web behavior through faculty, implement professional guidelines for social networking sites into institutional policies and AAPL ethics guidelines.

S8

WHEN RIGHTS COLLIDE: RIGHT TO A SPEEDY ARRAIGNMENT V. RIGHT TO TREATMENT

Susan Gray, MD, New York, NY
Elizabeth Ford, MD, New York, NY
Christopher Racine, MD, (I) New York, NY

EDUCATIONAL OBJECTIVE

To qualitatively and quantitatively describe the tension between pre-arraignment prisoners’ rights to a speedy arraignment and their rights to psychiatric treatment by examining the delay in arraignment caused by psychiatric hospitalization and exploring the conflict psychiatrists experience between providing needed psychiatric care and considering patients’ legal situations.

SUMMARY

Every person has a right to a speedy trial under the Sixth Amendment of the United States Constitution. In New York City, and some other jurisdictions, psychiatric hospitalization necessarily involves a delay in arraignment,

SATURDAY

thus delaying, among other things, first contact with an attorney and an opportunity for release. However, while a psychiatric admission delays criminal proceedings, it fulfills the individual's right to medical treatment while in custody. This study describes a population of NYPD detainees who are seen in the Bellevue Hospital psychiatric emergency room and who are then admitted to an inpatient jail unit at Bellevue prior to arraignment. In addition to identifying a statistically significant delay in arraignment that comes with hospitalization, this study also explores the impact of borough of arrest, top charge and discharge diagnosis on arraignment delay. A case review will help illustrate what is considered a significant enough psychiatric emergency to warrant a delayed arraignment. Relevant landmark cases will also be reviewed. We hope that the discussion will focus on possible system changes so that the right to a speedy arraignment and the right to psychiatric treatment do not preclude each other.

REFERENCES

Mack A, Alter C, Newman A: The interface of mental illness and the criminal justice system in the District of Columbia: Analysis and Recommendations. A report submitted to the Criminal Justice Coordinating Council by the Department of Psychiatry, Georgetown University Hospital: Washington, DC, 2007
Steadman H, Cocozza J, Veysey B: Comparing outcomes for diverted and nondiverted jail detainees with mental illnesses. *Law and Human Behavior* 23(6): 615-627, 1999

SELF ASSESSMENT QUESTIONS

1. Which of the following cases was a landmark case that established prisoners' right to medical treatment?

- a. Estelle v. Smith
- b. Washington v. Harper
- c. Godinez v. Moran
- d. Estelle v. Gamble

ANSWER: d

2. What are the consequences for a pre-arraignment detainee who is psychiatrically hospitalized?

- a. Delayed access to legal counsel
- b. Potential for greater time in custody
- c. Psychiatric treatment
- d. All of the above

ANSWER: d

S9

APPROACHING SEX OFFENDER TREATMENT "MINDFULLY"

Tammy Benoit, MA, (I) Worcester, MA
Fabian Saleh, MD, (I) Boston, MA

EDUCATIONAL OBJECTIVE

At the end of this presentation, participants will be able to: discuss current evidence related to Mindfulness, and describe ways in which this evidence is relevant to sex offender treatment.

SUMMARY

This poster will review data pertaining to Mindfulness, which as a mental state is characterized by attention to and awareness of present events and experiences. Incorporating Mindfulness into sex offender therapy could be beneficial to both the offender and the community at large. Mindfulness emphasizes the importance of being in the present and acceptance of the current situation. Mindfulness encourages participants to observe and accept their thoughts and feelings rather than react automatically and habitually. This state of self-observation can bring insight and improved self-control. Teaching Mindfulness techniques to offenders may help them better regulate their emotions, especially negative affects which may indeed lead to impulsive sexual behavior. Mindfulness may also address empathy deficits and thus help cultivate empathy. Other positive by-products of Mindfulness that may prove useful to this population include an improvement in both, mental, and physical health.

REFERENCES

Howells K, Tennant A, Day A, Elmer R: Mindfulness in forensic mental health: does it have a role? *Mindfulness* 1:4-9, 2010
Kabat-Zinn J: *Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness*. New York, NY: Delacorte Press, 1990

SELF ASSESSMENT QUESTIONS

1. Why incorporate Mindfulness into sex offender treatment?
 - a. Improves offenders ability to cope with stress.
 - b. Teaches offenders self-regulation.
 - c. Provides insight into behaviors.
 - d. All of the above.

ANSWER: d

2. Mindfulness techniques can help offenders with which of the following?
 - a. Find housing
 - b. Improve self-control
 - c. Reach vocational goals
 - d. Choose the proper pharmacological treatment

ANSWER: b

S10

SERIOUS MENTAL HEALTH ISSUES AMONG INCARCERATED INDIVIDUALS

Georgia Stathopoulou, PhD, (I) Boston, MA
Kristen Czarecki, BA, (I) Boston, MA
Fabian Saleh, MD, (I) Boston, MA

EDUCATIONAL OBJECTIVE

To review the literature on the prevalence of serious mental health issues among adult inmates, to identify specific sociodemographic and clinical characteristics of the above population, to examine how these characteristics predict the severity of their legal issues, and finally, to examine the implications for the correctional mental health system.

SUMMARY

Approximately one million individuals with serious mental health issues are estimated to be incarcerated every year, and the number keeps growing with serious implications such as longer length of jail stay. We will examine the prevalence of serious mental issues among incarcerated individuals, and the specific socio-demographic and clinical characteristics of the above population, especially as they relate to the severity of their legal issues. Finally, we will examine the current status of correctional mental health care and identify barriers to its access as they are perceived by inmates with serious mental health issues.

REFERENCES

- Steadman H, Osher F, Clark Robbins P, *et al*: Prevalence of serious mental illness among jail inmates. *Psychiatric Services* 60(6): 761-765, 2009
- Constantine R, Andel R, Petrila J, *et al*: Characteristics and experiences of adults with a serious mental illness who were involved in the criminal justice system. *Psychiatric Services* 61(5): 451-457, 2010

SELF ASSESSMENT QUESTIONS

1. What does a substance use disorder diagnosis increase the risk of?
 - a. Felony arrests and longer stays in jail.
 - b. Misdemeanor arrests and longer stay in jail.
 - c. Felony arrests and shorter stays in jail.
 - d. Misdemeanor arrests and shorter stay in jail.

ANSWER: a

2. Arrests and re-arrests of adults with serious mental health conditions have been associated with:
 - a. Non-white race and substance dependence.
 - b. White race and substance abuse.
 - c. White race and impulse control disorders.
 - d. White race and borderline personality disorder.

ANSWER: a

Salvatore Savatta, MD, Pittsburgh, PA
Brett DiGiovanna, MD, Hershey, PA
Christine Martone, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE

To examine the use of the Uniform Commercial Code (UCC) as a criminal defense strategy and describe the implications of this phenomenon for psychiatric examiners who are asked to assess competence to stand trial in these cases.

SUMMARY

The Uniform Commercial Code (UCC) is a Federal act intended to integrate laws governing interstate trade, but it has been seized upon by libertarian groups in order to subvert the legitimacy of federal and state agencies. These strategies are variably called the "UCC," "Common Law," or "Flesh and Blood" defense. In recent years, the UCC has made its way into the criminal courts by defendants attempting to find loopholes in legal jurisdiction. Competence to stand trial is often questioned in these cases due to the unusual behavior and bizarre beliefs typically demonstrated by defendants employing this strategy. The goal of the poster will be to clarify the role of the forensic examiner in these cases. The poster will describe the historical background of the UCC, its use as a criminal defense, and the common legal course and outcome of trials where the UCC defense was initially employed. It will then illustrate these principals in greater detail through discussing two cases where the UCC defense was raised by psychotic and nonpsychotic defendants in Alleghany County, PA. The poster will conclude with general guidelines for competency evaluations in defendants who utilize these types of legal strategies.

REFERENCES

Carey, K: Too weird for The Wire: How black Baltimore drug dealers are using white supremacist legal theories to confound the Feds. Washington Monthly www.washingtonmonthly.com/features/2008/0805.carey.html (Accessed 7/21/2011)
Guerrero v. Texas, 4th Court of Appeals, Nos. 04-07-00583-CR & 04-07-00584-CR <http://www.4thcoa.courts.state.tx.us/opinions/PDFOpinion.asp?OpinionId=21346> (Accessed 8/2/2008)

SELF ASSESSMENT QUESTIONS

1. The Uniform Commercial Code (UCC):

- a. has been deemed unconstitutional by the U.S. Supreme Court.
- b. governs the use of the U.S. flag in government offices.
- c. was intended to facilitate interstate trade.
- d. establishes insanity criteria for civil proceedings.

ANSWER: c

2. In Guerrero v. Texas, a Texas Appellate Court held that Guerrero's use of the UCC in his defense:

- a. qualified him as legally insane.
- b. did not suggest incompetence to stand trial.
- c. was unusual but legally sound.
- d. was evidence of incompetence to stand trial.

ANSWER: b

RECIDIVISM OF PARTICIPANTS IN A PRETRIAL MENTAL HEALTH DIVERSION PROGRAM

Peter Ash, MD, Atlanta, GA
Amy Simon, JD, (I) Decatur, GA
Funmilayo Rachal, MD, Houston, TX
Susan Berberian, LCSW, (I) Decatur, GA
Winston Bethel, JD, (I) Decatur, GA
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Berryl Anderson, JD, (I) Decatur, GA

EDUCATIONAL OBJECTIVE

To educate about outcomes of mental health diversion program.

SUMMARY

Mental health court diversion programs are focused on decreasing recidivism and improving mental health outcomes of participants. This study of one pretrial diversion program compares recidivism outcomes with those who completed the program, those who dropped out, and an age and crime matched sample of prisoners not identified as having mental health needs. In addition, there are comparisons from groups who served at two different time periods separated by several years to test whether the program experience and evaluation has improved outcomes.

REFERENCES

Steadman HJ, Redlich A, Callahan L, *et al*: Effect of mental health courts on arrests and jail days: a multisite study. *Arch Gen Psychiatry* 68(2):167-172, 2011
Steadman HJ, Naples M: Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. *Behav Sci Law* 23(2):163-70, 2005

SELF ASSESSMENT QUESTIONS

1. Research has shown that jail diversion of mentally ill offenders:
- a. is more effective for misdemeanor offenders than felony offenders.
 - b. is more effective if implemented post-conviction than before trial.
 - c. reduces recidivism
 - d. decreases the need for housing placement services.
 - e. is more effective for offenders who have comorbid substance abuse.

ANSWER: c

2. Jail diversion of mentally ill offenders may be implemented:

- a. Pre-arrest
- b. Post-arrest but prior to trial
- c. Post-conviction
- d. All of the above

ANSWER: d

**COMPARING PROCESSES OF ADULT AND JUVENILE
DIVERSION TREATMENT**

Funmilayo Rachal, MD, Houston, TX
 Beth Higgins-Brooks, JD, (I) Decatur, GA
 Amy Simon, JD, (I) Decatur, GA
 Peter Ash, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE

Participants will become familiar with the structure of an adult and juvenile jail diversion program within the same county and will understand barriers to jail diversion cross program comparisons.

SUMMARY

Jail diversion services for mentally ill offenders vary widely in structure. For example, the point of diversion may be at time of arrest, between arrest and trial, or post-adjudication. Diversion services also vary in the type of services provided and program philosophy. Because of this heterogeneity, cross-program comparisons are difficult, and this difficulty may account for varying findings about program efficacy. Nevertheless, jail diversion services for adults have gained increasing acceptance. Diversion services for youth in juvenile court are relatively new. This poster will address how lessons learned from a longstanding adult diversion program have been carried over into the establishment of a juvenile court diversion program that was recently started in the same county.

REFERENCES

Sirotych F: The criminal justice outcomes of jail diversion programs for persons with mental illness: a review of the evidence. *J Am Acad Psychiatry Law* 37(4): 461-472, 2009
 Steadman HJ, Redlich A, Callahan L, *et al*: Effect of mental health courts on arrests and jail days: a multi-site study. *Archives of General Psychiatry* 68(2): 167-172, 2011

SELF ASSESSMENT QUESTIONS

1. Jail diversion programs are structured to intervene at:

- a. Pre-booking
- b. Post-booking
- c. All of the above
- d. None of the above

ANSWER: c

2. Common outcome measures in assessing the effectiveness and public safety of a mental health court include:

- a. measuring arrest rates
- b. measuring the remission of psychiatric illness
- c. measuring days in jail time
- d. all of the above
- e. a and c

ANSWER: e

DRUG COURT: "WORKING THE SYSTEM"

Kristen Czarnecki, BA, (I) Boston, MA
 Fabian Saleh, MD, (I) Boston, MA
 Georgia Stathopoulou, PhD, (I) Boston, MA

EDUCATIONAL OBJECTIVE

To review the literature regarding the effectiveness of court mandated treatment, as well as the Standards on Substance Abuse as they have been defined by the Supreme Judicial Court in Massachusetts. Also, to compare the standards in Massachusetts to others across the nation.

SUMMARY

There is a significant need for increased and updated research regarding the effectiveness of mandated treatment for offenders. It is important to identify barriers to treatment and possible discrepancies between the standards on substance abuse of Massachusetts and the reality of available treatment options. We will also compare the drug court and mental health services in Massachusetts with those available throughout the country.

REFERENCES

Taxman F, Bouffard J: Treatment as part of drug court: the impact on graduation rates. *Journal of Offender Rehabilitation* 42 (1): 23-50, 2005
 Morrissey J, Fagan J, Cocozza J: New models of collaboration between criminal justice and mental health systems. *American Journal of Psychiatry* 166 (11): 1211-1214, 2009

SELF ASSESSMENT QUESTIONS

1. What is the recidivism rate for offenders with mental illness compared to those in the general prison population?
- Nearly twice as high
 - Almost the same rate
 - Nearly three times as high

ANSWER: a

2. In one study of drug court treatment services, government-run programs:

- tended to increase the likelihood of graduation.
- tended to decrease the likelihood of graduation.
- did not make any difference.

ANSWER: b

S16

THE COVR: CIVIL ACTUARIAL VIOLENCE RISK ASSESSMENT IN CANADA

Jeff McMaster, MD, Toronto, ON, Canada

EDUCATIONAL OBJECTIVE

To review whether the COVR (Classification of Violence Risk) actuarial risk assessment is valid in Canada. To review the practice of violence risk assessments in civil (non-forensic) settings.

SUMMARY

The standard of care regarding violence risk assessments in general psychiatric settings is clinical judgment. Actuarial risk assessments are often superior to clinical judgments. In the United States, an actuarial model, the COVR, was developed to assess risk of violence in recently discharged psychiatric patients. To determine whether the COVR is valid in Canada, and to what extent it should be used in violence risk assessments in a civil setting. The COVR was administered to 239 inpatients at CAMH, a psychiatric hospital in Toronto. Patients classified by the COVR as high or low risk were followed up in the community for 20 weeks after discharge to determine actual rates of violence. Results Of the 239 patients, 22(9%) were classified as high risk. Three of 12(25%) high risk, and none of 75 low risk patients ($p=0.002$) contacted after discharge, committed violence. The respective rates, using a more inclusive definition of violence, were 50% and 12% ($p=0.005$). The COVR may be helpful to clinicians who are faced with making decisions about discharge planning for hospitalized civil patients in Canada, but does not replace clinical judgment.

REFERENCES

- Monahan J, Steadman HJ, Robbins PC, *et al*: An actuarial model of violence risk assessment for persons with mental disorders. *Psychiatric Services* 56(7), 2005
- Mossman D: Assessing predictions of violence: being accurate about accuracy. *Journal of Consulting and Clinical Psychology* 62(4): 783-792, 1994

SELF ASSESSMENT QUESTIONS

1. Actuarial violence risk assessments in general psychiatric settings:
- may be inferior to clinical judgment
 - should replace a clinical judgment
 - use formula derived from empirically demonstrated relationships between data and outcome
 - are sensitive to patients' clinical changes that guide treatment interventions or gauge the impact of treatment
 - represent the standard of care

ANSWER: c

2. Mental health clinicians who use clinical judgment in violence risk assessment:

- are unable to predict violence
- will be committing malpractice unless actuarial methods are used
- may also use actuarial methods to assist with decision making
- cannot assess dangerousness with better than chance accuracy

ANSWER: c

S17

CRIME SCENE ANALYSIS: WHAT PSYCHIATRISTS AND PSYCHOLOGISTS SHOULD KNOW

Samuel Leistedt, MD, PhD, Brussels, Belgium
Paul Linkowski, MD, PhD, (I) Brussels, Belgium

EDUCATIONAL OBJECTIVE

To improve knowledge about criminal scene analysis among mental health professionals.

SUMMARY

Forensic psychiatry and psychology involve the application of the behavioral sciences to legal questions. Common psycholegal questions that forensic mental health professionals answer involve risk for future sexual offense recidivism, competency to stand trial, and criminal responsibility/sanity at the time of the offense. In addition, forensic psychiatrists and psychologists, with their knowledge of human behavior, can add a unique perspective to ongoing investigations in the form of offender profiling. The authors propose an overview of the crime scene characteristics (such as Modus Operandi, Signature Behavior, Victim Selection, etc.) that can be used by mental health professionals during murder investigations to offer informed assessments, i.e., criminal profile. In a second part, scientific methods, ethics limits and guidelines are also discussed.

REFERENCES

Brussels JA: Casebook of a Crime Psychiatrist. New York, NY: Bernard Geis Associates, 1968
Burgess A. Hazelwood R: Practical Aspects of Rape Investigation, 4nd Edition. Boca Raton, FL: Taylor & Francis Group, CRC Press, 2009

SELF ASSESSMENT QUESTIONS

1. Related to a specific offender, what are ligatures, weapons, and verbal forces?

ANSWER: methods of control

2. What are three examples of precautionary acts?

ANSWER: clothing and disguise, alteration of voice, use of blindfold

S18

THE FORENSIC ASSESSMENT

Graham Glancy, MB, Toronto, ON, Canada
Michael Norko, MD, New Haven, CT
Debra Pinals, MD, Worcester, MA
Alec Buchanan, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will be able to describe the purpose and design of this guidelines project, become familiar with major elements of the current draft of the proposed guidelines and understand areas of consensus as well as continued debate in the construction of the guidelines.

SUMMARY

The purpose of the proposed guidelines is to provide practical guidance and assistance in the performance of forensic psychiatric evaluations. Forensic assessment is one of the core competencies in the practice of psychiatry and the law, along with report writing and testimony. The integrity of forensic psychiatry depends upon how well each of these competencies is practiced in conjunction with the others. No matter how good the practitioner's skills in report writing are, the quality of the final product depends on the excellence of the initial assessment. While many texts have emerged describing and refining general psychiatric assessment, the special skills and techniques of a forensic assessment are not well explored. The panelists will describe the purpose and structure of the proposed guidelines, major elements of the current draft, areas of significant consensus, and areas of continued debate and development. Participants will be invited to discuss the guidelines and provide input that may be incorporated into the final versions. It is hoped that the experiences of a broad sample of the membership will inform the final published guidelines. This panel is offered as an early opportunity for all AAPL members to review and comment upon the development of the guidelines.

REFERENCES

Melton GB, Petrilla J, Poythress NG, *et al*: Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers, 2nd Edition. New York, NY: Guilford Press, 1997
Wettstein RM: Quality and quality improvement in forensic mental health evaluations. *J Am Acad Psychiatry Law* 33:158-75, 2005

SELF ASSESSMENT QUESTIONS

1. Guidelines for the forensic assessment are intended for each of the following purposes except:

- To provide information and direction to clinicians and trainees
- To improve resources for teaching and training purposes
- To establish a legal standard of practice for malpractice determinations
- To create a template to improve the consistency of assessments

e. ANSWER: c

2. These guidelines will be applicable to each of the following types of assessment, except:
 - a. Civil commitment
 - b. Criminal responsibility
 - c. Risk assessment
 - d. Disability
- ANSWER: a

S19

CHILD MURDER BY PARENTS AND INSANITY

Phillip Resnick, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

Participants will learn how to apply insanity criteria to defendants charged with neonaticide and five categories of filicide.

SUMMARY

About 3% of American homicides involve parents killing their own child (filicide). A much higher proportion of defendants charged with filicide raise an insanity defense than those charged with other crimes. This course will review approaches to analyzing an insanity defense in each category of filicide: (1) altruistic, (2) acutely psychotic, (3) unwanted child, (4) fatal maltreatment, and (5) spouse revenge. Special attention will be given to women with post-partum depression who kill their child as an extended suicide or kill their child to relieve delusionally perceived suffering. Public attitudes towards mothers who kill their children will be illustrated by the cases of Susan Smith and Andrea Yates. Mothers are far more likely to be forgiven than fathers. Fathers are more likely to commit familicide than mothers. Strategies will be discussed for conveying a defendant 's psychotic thinking to juries, such as making a videotape shortly after the crime. Videotapes of women discussing their thinking at the time of their filicides will allow the audience to practice their insanity formulations. Finally, strategies for prevention will be discussed.

REFERENCES

- Resnick, PJ: The Andrea Yates Case: Insanity on Trial, The 2006 Friedman & Gilbert Criminal Justice Forum, 55 Clev. St. L. Rev. 147, 2007
 Shelton JL, Muirhead Y, Canning KE: Ambivalence toward mothers who kill: an examination of 45 U.S. cases of maternal neonaticide. Behav Sci Law 28: 812-831, 2010

SELF ASSESSMENT QUESTIONS

1. What is the most common motive for neonaticide?
 - a. Altruistic
 - b. Unwanted child
 - c. Spouse revenge
 - d. Loss of temper
 - e. Confusion

ANSWER: b
2. A woman who commits an altruistic filicide is most likely to succeed with an insanity defense under which test?
 - a. Wild Beast Test
 - b. McNaughton
 - c. Federal test
 - d. *Mens rea*
 - e. Model Penal Code

ANSWER: e

S20

PRESCRIPTION OPIOID ABUSE: WHEN ARE PAIN DOCTORS DRUG DEALERS?

Gregory Sokolov, MD, Davis, CA
 Ajay Wasan, MD, (I) Chestnut Hill, MA
 Scott Fishman, MD, (I) Sacramento, CA

EDUCATIONAL OBJECTIVE

The objective of this panel presentation is to provide updates regarding both clinical and medicolegal issues in the area of opioid prescribing, so that participants will have a better understanding of standard of care issues in the area.

SUMMARY

Dr. Sokolov, chair of the AAPL Addiction Psychiatry Committee, will introduce the panel and present the case of Dr. Ronald McIver, who was criminally prosecuted and convicted of misprescribing opioids, as a primer for the panel discussion. Dr. Wasan, board certified in psychiatry and pain medicine, will present the current clinical guidelines for

SATURDAY

the use of chronic opioid treatment in non-cancer pain patients, and discuss the role psychiatrists may play in chronic pain management. Lastly, Dr. Fishman, Past President of the American Academy of Pain Medicine, will discuss medicolegal issues in opioid prescribing, including informed consent and agreements, documentation, and compliance with relevant state and federal laws and regulations, and Risk Evaluation and Management Strategies (REMS), which are requirements mandated by the Food and Drug Administration (FDA) for patients and healthcare providers to minimize risks associated with certain medications. Opioid REMS programs have the potential to lower public health risks of overdose, misuse, abuse, and addiction. Dr. Fishman will also present specific case examples, including the criminal cases against the physicians involved in the treatment of Anna Nicole Smith, to illustrate key medicolegal points.

REFERENCES

Chapman CR, Lipschitz D, Angst M, *et al*: Opioid pharmacotherapy for chronic non-cancer pain in the United States: a research guideline for developing an evidence base. *J Pain* 11(9):807-29, 2010
Fishman SM: *Responsible Opioid Prescribing: A Physician's Guide*. Washington, DC: Waterford Life Sciences, 2007

SELF ASSESSMENT QUESTIONS

1. Physicians may consider a trial of chronic opioid treatment as an option in chronic non-cancer pain if:
 - a. pain is moderate or severe
 - b. pain is having an adverse impact on function or quality of life
 - c. potential therapeutic benefits outweigh potential harms
 - d. opioids are the patient's preference
 - e. a, b and cANSWER: e

2. Some states have legal language in their professional or business codes that:
 - a. limit the amount of opioids that can be prescribed
 - b. require special government-issued prescription forms
 - c. restrict access to opioids in patients with a history of substance abuse
 - d. require opioids to be only a treatment of last resort
 - e. All of the aboveANSWER: e

S21

MADNESS AND BADNESS: A STATEWIDE PROGRAM FOR AGGRESSION REDUCTION

Barbara McDermott, PhD, (I) Sacramento, CA
Katherine Warburton, DO, Napa, CA
Chad Woofter, MD, Napa, CA
Joel Dvoskin, PhD, (I) Tucson, AZ

EDUCATIONAL OBJECTIVE

The attendee will develop an understanding of the multi-systemic issues related to aggression reduction in a large forensic system.

SUMMARY

California is the most populous state in the US, with over 12% of the US population. It also boasts one of the largest prison systems and one of the nation's toughest three-strikes law, perhaps not unrelated matters. In California, a third strike can be any felony, including petty theft with a prior. The sentence is a mandatory 25 years to life. As a consequence, many offenders are attempting to serve "easier time" in one of California's five state forensic facilities. Our data indicate that a significant number of patients malingering their way into forensic facilities, either through the IST or NGI finding. Malingers, whose primary diagnosis is often ASPD, account for a substantial portion of aggression exhibited in these facilities. This panel will discuss the efforts initiated to decrease aggression in all facilities through a variety of efforts. Dr. Warburton will discuss the system-wide issues related to aggression reduction, including reforms to the criminal justice system; Dr. Woofter will discuss the programmatic changes implemented in one of the facilities; Dr. McDermott will present a summary of all aggression data from each facility; Dr. Dvoskin will discuss the implications for these programmatic changes from both the staff and patient perspective.

REFERENCES

Martin T, Daffern M: Clinician perceptions of personal safety and confidence to manage inpatient aggression in a forensic psychiatric setting. *Journal of Psychiatric and Mental Health Nursing* 13: 90-99, 2006
Maden T: *Treating Violence: A Guide to Risk Management in Mental Health*. New York, NY: Oxford University Press, 2007

SELF ASSESSMENT QUESTIONS

1. Which factor is not related to forensic staff feeling safe in their work environment?

- a. colleagues' knowledge, experience and skill
- b. management of aggression training
- c. use of prevention strategies
- d. length of mental health practice

ANSWER: d

2. What type of intervention is most effective for individuals committing planned/predatory assaults?

- a. no intervention is effective
- b. therapeutic community
- c. behavioral interventions
- d. psychoanalytic psychotherapy

ANSWER: c

S22

HOW I BECAME A RESEARCHER: CAREER TRAJECTORIES

Suzanne Yang, MD, Pittsburgh, PA

Phillip Candilis, MD, Worcester, MA

Susan Hatters Friedman, MD, Cleveland Heights, OH

Douglas Mossman, MD, Cincinnati, OH

Robert Trestman, PhD, MD, Farmington, CT

EDUCATIONAL OBJECTIVE

To describe the variety of research careers that are possible within forensic psychiatry, to respond to questions from the audience regarding ways to prepare for and organize an effective research program, and to discuss ways that AAPL can support the research efforts of its members.

SUMMARY

Scarcity of physician researchers is a feature of many psychiatric subspecialties, and forensic psychiatry is no exception. A large proportion of research in forensic mental health is conducted by psychologists and other non-physicians. Active participation of forensic psychiatrists in research would likely enhance the applicability of findings to expert practice. Clarifying key aspects of a researcher's career development may help encourage psychiatrists to participate in collaborative projects with other mental health professionals. The panel features academic psychiatrists who have conducted and published key research studies while devoting most of their professional time to clinical duties and psychiatrists who have conducted research for which they received federal grants to support more than 75% of their salary. Panel participants will describe their research career trajectories, responding to these questions: When did you know that you wanted to pursue a research career? How did you define a research focus and long-term goals? What training did you need, and how did you get it? What obstacles did you encounter? What, if anything, would you do differently? The presentation will conclude with discussion of ways that AAPL can further support research and foster cross-disciplinary collaboration.

REFERENCES

Kahn CR: Picking a research problem: the critical decision. *New Engl J Med* 330 (21): 1530-1533, 1994

Kupfer DJ, Hyman SE, Schatzberg AF, *et al*: Recruiting and retaining future generations of physician scientists in mental health. *Arch Gen Psychiatry* 59 (7): 657-660, 2002

SELF ASSESSMENT QUESTIONS

1. Which of the following statements is not true?

- a. The NIH provides student loan repayment programs for clinicians who devote over 50% of their professional time to research.
- b. In some circumstances, it is feasible to conduct meaningful research with less than 50% protected research time.
- c. Becoming a researcher requires sacrificing one's career as a forensic expert.

ANSWER: c

2. Which of the following statements is true?

- a. In order to pursue a research career, a psychiatrist must choose a specific research focus early, during medical school, and continue working on the same content area throughout medical training.
- b. Research fellowship training can be an extremely valuable step in research career development.
- c. Independent investigator means that the scientist is able to complete and publish statistical analyses without asking for help.
- d. In the future, forensic psychiatrists will likely need to develop separate research programs that are distinct from those of psychologists, in order to compete effectively for limited funding resources.

ANSWER: b

SATURDAY

EDUCATIONAL OBJECTIVE

To provide some insight into how innocent prisoners cope with wrongful incarceration and to inform practitioners about some of the factors to consider when counseling/ representing prisoners who claim innocence.

SUMMARY

Dennis Maher was wrongfully incarcerated for 19 years before DNA testing exonerated and freed him in 2003. During his years of incarceration, he went to therapy twice a week, and he also took courses in stress management, communicating without violence, and more. Dennis will speak about how he benefitted from these courses and counseling and will introduce his own counselor from the treatment center who was a wonderful advocate for him.

REFERENCES

Scheck B, Neufeld P, Dwyer J: *Actual Innocence: When Justice Goes Wrong and How to Make it Right*. New York, NY: Signet, 2001
Sanders J, Simon, M: *After Innocence*. http://www.afterinnocence.net/main_press.html (Accessed August 8, 2011)

SELF ASSESSMENT QUESTIONS

1. According to Innocence Project researchers, approximately what percentage of overturned convictions (based on DNA testing) were originally based on eyewitness testimony?:

- a. 5%
- b. 25%
- c. 50%
- d. 75%
- e. 95%

ANSWER: d

2. Which of the following is generally not considered a key element of a good DNA access law?

- a. Include a reasonable standard to establish proof of innocence at the stage where an individual is petitioning for post-conviction DNA testing.
- b. Allow access to post-conviction DNA testing wherever it can establish innocence, even if the petitioner is no longer incarcerated, and including cases where the petitioner pled guilty or provided a confession or admission to the crime.
- c. Give state officials discretion and autonomy in handling evidence in their custody.
- d. Exclude "sunset provisions," or absolute deadlines, for when access to post-conviction DNA evidence will expire.
- e. Disallow procedural hurdles that stymie DNA testing petitions and proceedings that govern other forms of post-conviction relief.

ANSWER: c

David Rosmarin, MD, Newton, MA
Renée Binder, MD, San Francisco, CA
Graham Glancy, MB, Toronto, ON, Canada
Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

Attendees will be able to improve their analysis of sexual abuse victims for causation, damages, and treatment. Attendees will be able to improve their testimony under expert cross exam.

SUMMARY

This case involves the evaluation of a young adult who had been sexually abused in a foster home for several years in latency and early teens. Video testimony by Dr. Binder under cross examination will be reviewed. Because the case is presented by the Committee on Peer Review of Psychiatric Testimony, only AAPL members will be admitted.

REFERENCES

Chen L, Murad M, Paras M, Colbenson K, Sattler A, Goranson E, Elamin M, Seime R, Shinoza G: Sexual abuse and lifetime diagnosis of psychiatric disorders: systematic review and meta-analysis. *Mayo Clin Proc* 85(7): 618-29, 2010
Koch W, O'Neill M, Douglas K: Empirical limits for the forensic assessment of PTSD litigants. *Law Human Behav* 29(1): 121-149, 2005

SELF ASSESSMENT QUESTIONS

1. In civil trials, what is the law concerning facts deriving from criminal trials on the same matter?

ANSWER: Facts found in criminal trials, such as whether an abuser victimized a particular victim, are considered to be true because the fact was found beyond a reasonable doubt and the civil standard is preponderance.

2. According to the first reference, a large meta-analysis, which of the following disorders were not associated with a history of childhood sexual abuse?

- a. anxiety disorder
- b. depression
- c. eating disorder
- d. PTSD
- e. sleep disorder
- f. suicide attempts
- g. schizophrenia and somatoform disorders

ANSWER: g

S25

TRAUMATIC BRAIN INJURY AND SOCIOPATHY: HOW, WHAT AND WHERE?

Manish Fozdar, MD, Wake Forest, NC
Timothy Allen, MD, Lexington, KY
Hal Wortzel, MD, Denver, CO
Robert Granacher, MD, Lexington, KY
Jacob Holzer, MD, Pocasset, MA

EDUCATIONAL OBJECTIVE

This presentation is intended to illustrate the relationship between Traumatic Brain Injury and acquired sociopathy. Panel members will discuss various aspects of this relationship and highlight the important areas for evaluation of such a case for a forensic psychiatrist.

SUMMARY

Traumatic Brain Injury is known to cause behavioral, cognitive and psychological dysfunction. Damage to frontal lobes, ventromedial prefrontal cortex in particular, can lead to significant behavioral disinhibition and unintended psychosocial consequences. Frontal lobe dysfunction is associated with aggressive-impulsive behaviors, impaired insight, poor social comportment, emotional dysregulation and impaired ability to learn from social/environmental clues. Such cases are frequently encountered by a forensic psychiatrist and other mental health providers. However, the attribution of aggressive behaviors to traumatic brain injury should be undertaken with caution, and only after careful consideration of the totality of the circumstances surrounding any given act of violence. Such consideration includes (but is not limited to) specific details of the traumatic brain injury, pre-and post psychosocial factors, the context in which the particular act occurred, and any potential precipitants and objectives related to the behavior at issue. Presenters will discuss the basic neuroscience of this association between brain injury and sociopathy. Case presentations will highlight real life practical issues encountered in such cases. This will be followed by discussion of the guidelines for the evaluation of cases. Lastly, controversial issues such as criminal responsibility, sentencing and mitigating factors will be discussed.

REFERENCES

Granacher R, Fozdar M: Acquired Psychopathy and the Assessment of Traumatic Brain Injury: The International Handbook of Psychopathic Disorders and the Law. Hoboken, NJ: John Wiley & Sons Ltd., 2007
Barzman D, Kennedy J, Fozdar M: Does traumatic brain injury cause violence? *Current Psychiatry* 1(4): 49-55, 2002

SELF ASSESSMENT QUESTIONS

1. Pathology of which part of the brain is often associated with disinhibition syndrome?

ANSWER: Frontal lobes, especially Ventromedial Prefrontal cortex.

2. Which comorbid psychiatric disorders greatly increase the risk of violence in patients with traumatic brain injury?

ANSWER: Substance abuse disorders.

Gregory Sokolov, MD, Davis, CA
 Jack Levin, PhD, (I) Boston, MA
 Annie Steinberg, MD, Narberth, PA

EDUCATIONAL OBJECTIVE

The objective of this presentation is to present an overview of hate crimes, from both psychiatric and sociological perspectives, so that participants may develop a better understanding of this phenomenon.

SUMMARY

Hate crimes occur when a perpetrator targets a victim because of his or her perceived membership in a certain social group, usually defined by racial group, religion, sexual orientation, disability, class, ethnicity, nationality, age, gender, gender identity, social status or political affiliation. Incidents may involve physical assault, damage to property, bullying, harassment, verbal abuse or insults, or offensive graffiti or letters/e-mail (hate mail). Forty-five states and the District of Columbia have statutes criminalizing various types of hate crimes. Thirty-one states and the District of Columbia have statutes creating a civil cause of action in addition to the criminal penalty for similar acts. Dr. Sokolov will provide an introductory overview of FBI statistics of hate crimes, and will present recent criminal cases which highlight forensic psychiatric issues, including the insanity defense. Dr. Levin, will discuss motives for hate crimes, which can be categorized as thrill, defensive, retaliatory, and mission. Lastly, Dr. Steinberg, a child and adolescent forensic psychiatrist will provide an overview of youth hate crimes, including a discussion about the association with school bullying behaviors.

REFERENCES

Levin J, Nolan J: The Violence of Hate. Boston, MA: Allyn and Bacon, 2010
 Steinberg A, *et al*: Youth hate crimes: identification, prevention, and intervention. J Am Acad Psychiatry Law 16(5):979-89, 2003

SELF ASSESSMENT QUESTIONS

1. Hate crimes occur when a perpetrator targets a victim because of his or her perceived membership in a certain social group, usually defined by:

- a. race
- b. religion
- c. sexual orientation
- d. disability
- e. all of the above

ANSWER: e

2. Youths who perpetrate hate crimes demonstrate:

- a. impulse control problems
- b. "thrill-seeking" behavior
- c. bullying
- d. conduct or aggression problems
- e. all of the above

ANSWER: e

Kenneth Busch, MD, Chicago, IL
 Gill McGauley, MD, (I) London, United Kingdom
 Richard Taylor, MD, Enfield, United Kingdom
 Andrew Williams, MD, (I) London, United Kingdom
 Jessica Yakeley, MD, London, United Kingdom

EDUCATIONAL OBJECTIVE

To describe UK legislation and policy initiatives in managing personality disordered offenders, highlighting tensions between public protection and rehabilitation/treatment. Improve understanding of multi-agency risk management and potential ethics conflicts. Review research evidence base for etiology and treatment of antisocial personality disorder and understand principles of mentalization-based treatment.

SUMMARY

This panel will review UK government policy over the last decade in managing high-risk personality disordered offenders, highlighting the tensions between initiatives driven by public protection versus those based on principles of rehabilitation and treatment. Law enforcement, correctional and health agencies are now legally required to cooper-

ate in the management of high-risk offenders (multi-agency public protection arrangements, or MAPPA), raising ethics dilemmas regarding confidentiality and disclosure. At the same time the UK government has prioritized the treatment of those offenders perceived to be of highest risk, setting up special units for so-called "Dangerous and Severe Personality Disorder" (DSPD). The panel will summarize the main findings from the results of the DSPD treatment pilots, and outline the UK government's new strategy for personality disordered offenders, which emphasises the need for evidenced-based treatments for offenders, as well as increasing education and supervision for staff. We will discuss our experience as psychiatrists working on both sides of the divide: in the service of public protection in working with MAPPA, and in the treatment of antisocial patients in both high security settings and the community. We will conclude by presenting preliminary results from an outcome research pilot of mentalization-based treatment for ASPD.

REFERENCES

- Yakeley J, Taylor R: Multi-Agency Public Protection Arrangements: can we work with them?, in Thinking about Antisocial Behaviour and Mental Health in the Community. Edited by Reiss, D, Rubitel, A, London, Karnac, pp 161-185, 2011
- Bateman A, Fonagy P: Co-morbid antisocial and borderline personality disorders: mentalization-based treatment. J of Clinical Psychology 64(2): 181-194, 2008

SELF ASSESSMENT QUESTIONS

1. Which of the following situations would justify disclosure of mental health data to law enforcement agencies in the UK?
 - a. A written request from a police officer investigating a serious crime.
 - b. A request for a list of inpatients to rule out suspects in a homicide investigation.
 - c. An offender convicted of a sexual homicide absconds from a high security hospital.
 - d. Escorted visit by sex offender patient in medium secure forensic hospital to general hospital for medical treatment.

ANSWER: c

2. Which of the following statements regarding mentalization-based treatment (MBT) is not true?
 - a. Personality disordered individuals are unable to mentalize.
 - b. MBT arose from an attachment-based model of personality disorder.
 - c. MBT is primarily a treatment for borderline personality disorder.
 - d. Psychopaths demonstrate areas of selectively enhanced mentalization.

ANSWER: a

S28

EARLY OUTCOMES OF COURT-BASED JAIL DIVERSION FOR VETERANS

Stephanie Hartwell, PhD, (I) Boston, MA
Paul Christopher, MD, Rumford, RI
William Fisher, PhD, (I) Worcester, MA
Carl Fulwiler, MD, PhD, (I) Worcester, 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 characteristics of participants in this program, as well as important early clinical and criminal justice outcomes of those participants who have completed the program.

SUMMARY

High rates of post-deployment mental health and substance use problems among U.S. military service members raise concern for veterans' becoming involved in the criminal justice system on return from service. MISSION – Diversion & Recovery for Traumatized Veterans (MISSION DIRECT VET) is a post-adjudication, pre-sentencing court-based jail diversion program that was developed for veterans with mental illness, histories of trauma and problematic substance use. Participants receive one year of veteran-focused wraparound services including mental health and substance abuse treatment, specialized case management, trauma-informed care, and peer support. Early planning and baseline participant data was presented at the 2010 AAPL meeting. This year's presentation will further characterize participants' demographic, military, criminal justice, mental health, and substance use histories, their treatment motivations, and their perceptions of coercion during the diversion process. We will also provide early data on criminal justice, mental health, and substance use outcomes for program participants thus far. Finally, we will discuss the implications of these findings with regard to jail diversion efforts for military service members with mental health and/or substance abuse problems in general.

SATURDAY

REFERENCES

CMHS National GAINS Center. (2008). 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
Stecker T, Fortney J, Owen R, *et al*: Co-occurring medical, psychiatric, and alcohol-related disorders among veterans returning from Iraq and Afghanistan. *Psychosomatics* 51(6):503-7, 2010

SELF ASSESSMENT QUESTIONS

1. Veterans participating in the MISSION DIRECT VET program have experienced which of the following types of trauma?
 - a. Combat trauma
 - b. Pre-deployment trauma as an adult
 - c. Pre-deployment trauma as a minor (under 18 years of age)
 - d. All of the above

ANSWER: d

2. Which of the following were the two most common diagnostic categories among Iraq/Afghanistan veterans who presented for care at the VA between 2001 and 2006?

- a. Pain and depression
- b. Depression and PTSD
- c. Pain and PTSD
- d. PTSD and substance use disorder
- e. Pain and substance use disorder

ANSWER: a

S29

CRIMINOGENIC FACTORS AND RECIDIVISM IN A NYC MENTAL HEALTH COURT

Katya Frischer, MD, JD, New York, NY
Merrill Rotter, MD, Bronx, NY
Charles Amrhein, PsyD, (I) Bronx, NY
Virginia Barber Rioja, PhD, (I) New York, NY

EDUCATIONAL OBJECTIVE

To show that criminal thinking patterns are a better predictors of recidivism among mentally ill offenders in an NYC mental health court than stabilization of psychiatric illness.

SUMMARY

Recent studies indicate that among mentally ill defendants psychiatric symptom reduction is unrelated to criminal justice recidivism reduction. Criminogenic factors such as criminal thinking, hostility and criminogenic peers are more relevant to the likelihood of recidivism. COMPAS (Correctional Offender Management Profiling for Alternative Sanctions) is a risk and needs assessment tool for criminal justice practitioners to assist them in the placement, supervision, and case management of offenders in community and secure settings. COMPAS helps identify criminogenic factors for treatment planning. Its use in a mental health population and in a mental health diversion setting is novel. The NYC TASC Mental Health Diversion programs identify mentally ill defendants who are diverted from the correctional setting for treatment of psychiatric symptoms and substance dependence. COMPAS data including criminal history, history of substance dependence, criminal attitudes, social isolation and family criminality will be analyzed in this population of diverted mental health defendants with particular attention to description of criminogenic factors and predictors of success.

REFERENCES

Peterson J, Skeen J, Hart E, Vidal S, Keith F: Analyzing offense patterns as a function of mental illness to test the criminalization hypothesis. *Psychiatr Serv* 61:1217-1222, 2010
Case B, Steadman H, Dupuis S, *et al*: Who succeeds in jail diversion programs for persons with mental illness? A multi-site study. *Behav Sci Law* 27: 661-674, 2009

SELF ASSESSMENT QUESTIONS

1. Which of the following substantially increases the risk for recidivism in a mental health court defendant?
 - a. History of untreated mental illness
 - b. Limit of mental health resources in the community
 - c. Limited insight into the need for treatment
 - d. A family history of incarceration among parents and siblings

ANSWER: d

2. Which of the following is the biggest risk factor for recidism among mentally ill defendants?

- a. Antisocial personality
- b. Mental illness
- c. Availability of mental health services
- d. Psychosis

ANSWER: a

S30

MISSION COMMUNITY RE-ENTRY FOR WOMEN (MISSION CREW): PROGRAM DEVELOPMENT AND IMPLEMENTATION

Laura Guy, PhD, (I) Worcester, MA
Andrea Leverentz, PhD, (I) Boston, MA
Carl Fulwiler, MD, PhD, (I) Worcester, MA
Elizabeth Aaker, BA, (I) Worcester, MA
Stephanie Hartwell, PhD, (I) Boston, MA
Ken Nelson, MS, (I) Boston, MA
David Smelson, PsyD, (I) Worcester, MA
Debra Pinals, MD, Worcester, MA

EDUCATIONAL OBJECTIVE

At the end of this workshop, participants will be able to discuss a novel approach to community re-entry for non-violent female offenders with co-occurring disorders and trauma histories and describe the significance of inter-agency partnership, in-reach and outreach, peer involvement, and a trauma-focused model for re-entry services.

SUMMARY

The effectiveness of a new intervention for women released from incarceration who have a mental illness and substance use problem (co-occurring disorders: CODs) was examined. The treatment, Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking – Community Re-Entry for Women (MISSION-CREW), was adapted from the original MISSION program that aimed to help formerly homeless veterans with CODs to re-establish their lives in the community. MISSION-CREW seeks to reduce criminal justice involvement of women with CODs vis-à-vis a model of evidence-based practices that includes trauma-sensitive treatment, care coordination and peer support. MISSION-CREW comprises (a) a clinical services component that is an augmentation to treatment as usual and (b) a research project that evaluates service effectiveness. The research compares one-year rearrest rates of women receiving treatment as usual to women receiving MISSION-CREW services. The MISSION-CREW group is evaluated at release from incarceration and then six months later at service completion. Additional outcome variables among this group include change in medical, substance abuse, and psychiatric symptoms; perceptions/satisfaction with services; and service referral/completion. Presently, 18 women are receiving MISSION-CREW services; 8 are in the research evaluation. By the time of the conference, we anticipate having baseline evaluation data and preliminary follow-up results.

REFERENCES

Hartwell S: Female mentally ill offenders and their community reintegration needs. *Int J Law Psychiatry* 24:1-11, 2001
Lewis C: Treating incarcerated women: gender matters. *Psychiatr Clin North Am* 39:773-789, 2006

SELF ASSESSMENT QUESTIONS

1. Female offenders differ from male offenders in that they have:

- a. A higher proportion of trauma histories
- b. Higher rates of depression and anxiety disorders
- c. Higher rates of substance use
- d. All of the above

ANSWER: c

2. Re-entry research demonstrates that offenders with co-occurring disorders:

- a. Have a high risk of rearrest and clinical relapse post-release.
- b. Have fewer service needs due to time spent incarcerated and opportunity for addiction recovery.
- c. Face challenges in reconnecting to treatment and reacquiring benefits.
- d. None of the above
- e. a and c

ANSWER: e

KyleeAnn Stevens, MD, Arlington, VA
 Alan Newman, MD, Washington, DC
 Steven Snyder, JD, (I) Washington, DC

EDUCATIONAL OBJECTIVE

In recent years there has been a dramatic increase in the numbers of individuals claiming to be sovereign citizens, exempt from all laws in the United States. The panel will examine issues related to the involvement of defendants claiming sovereign citizen status in criminal courts.

SUMMARY

There are an estimated 300,000 people in the United States who identify themselves as “sovereign citizens.” The principle behind sovereignty hails from the 1970s, though in the 1990s the concept took flight. In its most recent iteration, sovereigns claim that the United States government is illegitimate. Sovereigns have most frequently been involved in civil litigation, such as taxation disputes. However, there have been a number of high profile criminal cases of those claiming sovereignty, including that of Jared Lee Loughner in Arizona. The criminal judiciary has been inundated with self-proclaimed sovereigns and at times has been at a loss as to how to proceed with adjudication of those refusing to cooperate with legal procedures. The panel will discuss the association of mental illness with those claiming sovereignty and how it may influence the adjudication of their cases. Evaluations of competency to stand trial and represent oneself in criminal procedures are issues raised by the courts, particularly in the context of a defendant’s refusal to participate. The panel will discuss how competency determinations are to be made in these situations. The discussion will also include an attorney’s perspective as to how defendants claiming sovereignty are advanced in the judicial process.

REFERENCES

Henderickson P: Cracking the Code: Third Edition. Tarzana, CA: Better Book and Cassette of America Publishers, 2002
 Fleishman D: Paper terrorism: the impact of the sovereign citizen on local government. Public Law Journal 27(2), 2004

SELF ASSESSMENT QUESTIONS

1. Sovereign citizens believe which of the following?
 - a. Municipal, State, and Federal governments are fraudulent.
 - b. They are required to pay both income and property taxes.
 - c. Violence is not an acceptable method of self expression.
 - d. All of the above

ANSWER: a

2. Assessing competency in sovereign citizens must include:
 - a. Careful examination of their beliefs
 - b. Discussion with their attorney
 - c. Assessment of mental illness
 - d. All of the above

ANSWER: d

Carla Rodgers, MD, Wynnewood, PA
 Celestine DeTrana, MD, Indianapolis, IN
 Robert Granacher, MD, Lexington, KY
 Trent Holmberg, MD, Draper, UT
 Brian Crowley, MD, Washington, DC

EDUCATIONAL OBJECTIVE

The Private Practice Committee will present actual case material from their own files to engage the panel members and the audience in a dialog on how to resolve difficult forensic issues, such as conflict of interest, working with demanding attorneys, and interviewing hostile evaluatees.

SUMMARY

The presentation will consist of forensic case vignettes. Each vignette, which will consist of approximately 1-2 paragraph summary of the case content will illustrate a particular issue. Examples of the problems include the following:

1. The expert has been retained by a defense attorney in a malpractice case, and proceeds up to and including the

report, having forgotten that she or he was the certifying expert for the plaintiff's attorney for this very malpractice action. What does the expert do? 2. In a criminal case, the expert's review supports mitigation at sentencing, but not a criminally not responsible plea. The attorney tells the expert, "Doctor, I'm afraid I'm going to have to ask you for a flat-out statement that my client was insane at the time of the offense." What does the expert do? During the workshop, panel members will give brief commentary on cases, but the focus will be on encouraging the audience members to comment on the cases and engage in a dialog with each other and with panel members in trying to solve the problems presented in an ethical and practical manner. The highlight of the workshop will be this dialog.

REFERENCES

Sadoff RL: Ethical issues in Forensic Psychiatry-Minimizing Harm, Chichester, West Sussex: John A. Wiley & Sons, 2011
Appelbaum PS, Gutheil TG: Clinical Handbook of Psychiatry & the Law (ed 4), Philadelphia, PA: Walters Kluwer/
Lippincott Williams & Wilkins, 2007

SELF ASSESSMENT QUESTIONS

1. In a civil case you send your report to the retaining attorney, who asks you to make some changes in light of new information and law, on which you had not focused. You do which of the following?
 - a. Decline, telling him/her that your reports cannot be changed once submitted.
 - b. Offer to make any requested changes without further discussion.
 - c. Discuss the matter with the attorney, then make changes which reflect your valid opinion.
 - d. Refuse to make changes, but refer the attorney to a colleague for a second opinion.

ANSWER: c

2. AAPL guidelines note that absent a court order, psychiatrists should not perform forensic evaluations for the prosecution or the government on persons who have not consulted with legal counsel when such persons:

- a. are known to be charged with criminal acts.
- b. need medical care or treatment.
- c. are being evaluated for civil commitment.
- d. are being evaluated for risk assessment.

ANSWER: a

S33

FORENSIC PSYCHIATRISTS IN THE IMMIGRATION PROCESS

Maya Prabhu, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Howard Zonana, MD, New Haven, CT
Becca Heller, JD, (I) New York, NY

EDUCATIONAL OBJECTIVE

Participants will learn potential roles for forensic psychiatrists in the refugee and asylum application processes; differences between the refugee and asylum procedures of relevance to psychiatrists; ethical, cultural and logistical limitations of these evaluations.

SUMMARY

The need for forensic psychiatric consultations is increasing in refugee and asylum cases. The complexity of the law, cultural and language barriers, increased concerns about malingering, and "security risks," have all resulted in referrals to psychiatrists for assessments, consultation, and training. The unique characteristics of the legal context and refugee and asylum seekers themselves, require a creative but disciplined and ethical forensic approach. In this workshop, we will explore the challenges of asylum and refugee law and the role for forensic psychiatrists, based on collaboration between the Yale Law and Psychiatry Program, the Yale Immigration Legal Services and the Iraq Refugees Assistance Project. We will present the demographic and diagnostic profile of both asylum and refugee seekers and the ethical and clinical issues that emerged in the cohort. Finally, we will present a model for legal-psychiatric collaboration, identifying necessary resources and the barriers and challenges in this work.

REFERENCES

Meffert SM, Musalo K, McNiel DC *et al*: The role of mental health professionals in political asylum processing. *J Am Acad Psychiatry Law* 38(4), 2010
Herlihy J, Turner S: Asylum claims and memory of trauma: sharing our knowledge. *British Journal of Psychiatry* 191: 3-4, 2007

SELF ASSESSMENT QUESTIONS

1. What does the granting of asylum or refugee status require?
 - a. persecution based on political dissent
 - b. the absence of all physical and mental diagnoses
 - c. a nexus between persecution and a select set of reasons
 - d. severe PTSD or physical injury with long-term sequelae

ANSWER: c

2. The role for forensic psychiatrists in asylum or refugee cases:

- a. is limited to the diagnosis of severe mental illness
- b. is best realized in a psychiatric-legal collaboration
- c. requires specialized training in understanding country conditions and asylum laws
- d. is no different from civil forensic cases

ANSWER: b

S34

THINKING OUTSIDE THE WITNESS BOX: NOVEL TRAINING STRATEGIES

Brian Cooke, MD, Gainesville, FL
Patrick Fox, MD, New Haven, CT
Reena Kapoor, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

At the conclusion of the workshop, participants will be prepared to incorporate new techniques into the education of forensic psychiatry trainees.

SUMMARY

Although the Accreditation Council of Graduate Medical Education (ACGME) has established core competencies that aim to standardize forensic psychiatry education, fellowship programs continue to offer variable experiences to trainees. In this workshop, we first review briefly the ACGME requirements and discuss the results of our recent survey, which demonstrates the variability between fellowship programs. We then highlight several innovative strategies to teach forensic psychiatry to forensic fellows and general psychiatry residents. With a focus on audience participation, we illustrate the use of technology, unique clinical experiences, writing exercises (other than forensic reports), public policy involvement, and other creative techniques to augment the ACGME educational requirements. Our goal is to think beyond the traditional focus on report writing and expert witness testimony in forensic training. Participants are encouraged to discuss their own challenges and dilemmas with learning and teaching forensic psychiatry and to share potential solutions.

REFERENCES

- Pinals D: Forensic psychiatry fellowship training: developmental stages as an educational framework. *J Am Acad Psychiatry Law* 33:317-23, 2005
Lewis CF: Teaching forensic psychiatry to general psychiatry residents. *Acad Psychiatry* 28:40-6, 2004

SELF ASSESSMENT QUESTIONS

1. Which of the following is not one of the expected developmental stages of a forensic psychiatry fellow?
 - a. Transformation
 - b. Growth of confidence and adaptation
 - c. Identification and realization
 - d. Intellectualization and isolation of affect

ANSWER: d

2. Which of the following are potential obstacles to updating the educational methods used in forensic psychiatry training?

- a. Adherence to tradition
- b. Lack of resources (time, departmental support, available faculty)
- c. Unfamiliarity with technological opportunities
- d. Competing interests
- e. All of the above

ANSWER: e

**MANAGEMENT OF DELIBERATE SELF-HARMING INMATES:
NOVEL USES OF DIALECTICAL BEHAVIOR THERAPY (DBT) IN
JAIL AND PRISON**

Camille LaCroix, MD, Boise, ID
Gregory Sokolov, MD, Davis, CA
Scott Eliason, MD, Eagle, ID

EDUCATIONAL OBJECTIVE

Review of the assessment and management of deliberate self-harm in correctional settings, including novel applications of DBT in jail and prison settings.

SUMMARY

Estimates of deliberate self-harm (DSH) in correctional settings range from 2 to 53%. Various psychiatric and non-psychiatric diagnoses can be related to increased risk of DSH, including personality disorders. Complete assessment of suicide risk is also important as individuals with DSH are at increased risk for suicide as well. Management of inmates with DSH in correctional settings presents unique challenges to both correctional staff and clinicians. Interventions may include psychotropic medications, segregation, use of a safety suit or even transfer to psychiatric inpatient care. Correctional mental health programs should consider use of DBT in management of these individuals. DBT is empirically supported and has been shown to reduce the incidence of self-harm and number of days of psychiatric hospitalization in treated individuals. It has been modified successfully for use in correctional settings, including use in antisocial personality disorder. This workshop will provide information on demographics of individuals who use DSH, assessment and management strategies including use of modified DBT. Case examples will be presented and audience members will participate in discussion of assessment of risk, management and use of DBT in various correctional settings. Participants are asked to bring clinical cases from correctional/forensic settings to discuss management and treatment strategies for patients with deliberate self harm.

REFERENCES

Berzins L, Trestman R: The development and implementation of dialectical behavior therapy in forensic settings. *International Journal of Forensic Mental Health* 3(1): 93-103, 2004
McCann R, Ball E: DBT with an inpatient forensic population: the CMHIP forensic model. *Cognitive and Behavioral Practice* 7: 447-456, 2000

SELF ASSESSMENT QUESTIONS

1. Examples of deliberate self-harm (DSH) include which of the following:

- a. Cutting
- b. Burning
- c. Head banging
- d. Opening wounds
- e. Genital mutilation
- f. All of the above

ANSWER: f

2. Which five factors support the use of DBT in forensic settings?

- a. The high incidence of personality disorders in this population
- b. DBT is a cognitive-behavioral treatment with clear behavioral targets
- c. Managing aggressive or life-threatening patient behaviors in forensic units is a critical need
- d. staff burnout and treatment interfering behaviors addressed
- e. Accreditation bodies support use of systemic and empirically validated treatments
- f. All of the above

ANSWER: f

SUNDAY, OCTOBER 30, 2011

<hr/> WORKSHOP Z1 <i>Testamentary Capacity and Guardianship Case Conference</i>	8:00AM - 10:00AM	STATLER Debra Pinals, MD, Worcester, MA David Siegel, JD, (I) Boston, MA Marilyn Price, MD, CM, Malden, MA Thomas Gutheil, MD, Brookline, MA
<hr/> WORKSHOP Z2 <i>Ethical Issues Arising in the Treatment of Sex Offenders Sexual Offender Committee</i>	8:00AM - 10:00AM	GEORGIAN Albert Grudzinskas Jr., JD, (I) Worcester, MA Abigail Judge, PhD, (I) Boston, MA John Paul Fedoroff, MD, Ottawa, ON, Canada Fabian Saleh, MD, Boston, MA Lisa Murphy, MA, (I) Ottawa, ON, Canada
<hr/> WORKSHOP Z3 <i>Wild Child? Assessing Risk of Pediatric Inpatient Aggression</i>	8:00AM - 10:00AM	BERKELEY/CLARENDON Drew Barzman, MD, Cincinnati, OH Douglas Mossman, MD, Cincinnati, OH
<hr/> PANEL Z4 <i>Neurolaw: Approaching Uses of Neuroimaging Evidence of PTSD (Advanced) Trauma & Stress Committee</i>	8:00AM - 10:00AM	ARLINGTON Stuart Kleinman, MD, New York, NY Francis Shen, JD, PhD, (I) Nashville, TN Nathan Kolla, MA, MSc, New York, NY Jonathan Brodie, PhD, MD, Old Greenwich, CT
<hr/> WORKSHOP Z5 <i>Hard Time: Coping with the Risks of Correctional Practice Institutional & Correctional Committee</i>	8:00AM - 10:00AM	WHITE HILL Annette Hanson, MD, Baltimore, MD Ana Cervantes, MD, E. Amherst, NY Stephen Goldberg, MD, Hanover, MD Erik Roskes, MD, Baltimore, MD Samantha Rice, MA, (I) Ottawa, ON, Canada
<hr/> COFFEE BREAK	10:00AM - 10:15AM	MEZZANINE FOYER
<hr/> WORKSHOP Z6 <i>Competency and Criminal Responsibility (706) Boards on Detainees at GIMO</i>	10:15AM - 12:15PM	STATLER Edward Simmer, MD, Beaufort, SC
<hr/> PANEL Z7 <i>Forensic Sampler: Sexual Assault Liason with Forensic Sciences Committee</i>	10:15AM - 12:15PM	GEORGIAN Alan Felthous, MD, St. Louis, MO Robert Weinstock, MD, Los Angeles, CA Constance Hoyt, MD, (I) Merrimac, MA Albert Elian, MS, (I) Sudbury, MA Dean De Crisce, MD, Brooklyn, NY

SUNDAY

WORKSHOP
Z8 ***Restraint and Seclusion Reform: Implications and Outcomes*** 10:15AM - 12:15PM **BERKELEY/CLARENDON**
Patrick Fox, MD, New Haven, CT
Paul Whitehead, MD, Provo, UT
Traci Cipriano, PhD, (I) New Haven, CT
Charles Dike, MD, Middletown, CT

PANEL
Z9 ***New York State's SVP Law: Program Development and Implementation*** 10:15AM - 12:15PM **ARLINGTON**
Sexual Offenders Committee
Li-Wen Lee, MD, New York, NY
Richard Krueger, MD, New York, NY
Richard Miraglia, LCSW, (I) Albany, NY
Naomi Freeman, PhD, (I) Albany, NY

Debra Pinals, MD, Worcester, MA
 David Siegel, JD, (I) Boston, MA
 Marilyn Price, MD, CM, Malden, MA
 Thomas Gutheil, MD, Brookline, MA

EDUCATIONAL OBJECTIVE

At the end of this workshop, participants will be able to 1) discuss a guardianship and testamentary capacity case and attempt to form opinions and defend them under cross examination and 2) describe how a standardized approach to teaching using a case-based DVD portfolio might be utilized across training programs.

SUMMARY

Case-based learning is an excellent method to enhance medical knowledge and practice-based learning and improvement. Forensic psychiatry requires the development of core competencies, yet “standardized patients,” common in medical training, are rarely used and more complex in forensic contexts. Utilizing this concept, with support of an educational grant from the AAPL Institute of Education and Research, a DVD was developed that provides a case file raising issues of guardianship and testamentary capacity. This case file can serve as the basis for a clinical case conference and didactic training across specialty programs. Included in the DVD are Instructions for Educators, Case Background Information related to the legal issues discussed, a chapterized Interview of a Hypothetical Evaluatee, and Additional Case and Teaching Materials. In this workshop, general issues related to guardianship and testamentary capacity will be reviewed. Participants will be presented with case background and will view the DVD interview. This will be followed by an opportunity to discuss forensic opinions and pitfalls. An experienced trial lawyer will lead participants in direct and cross examination. The DVD is the second in a series, and the prior DVD was well-received in an earlier AAPL workshop.

REFERENCES

Gutheil TG: Common pitfalls in the evaluation of testamentary capacity. *J Am Acad Psychiatry Law* 35:514–17, 2007
 Moye J, Wood S, Edelstein B, et al: Clinical evidence in guardianship of older adults is inadequate: findings from a tri-state study. *Gerontologist* 47:604-612, 2007

SELF ASSESSMENT QUESTIONS

1. Guardianship determinations have increasingly scrutinized:

- individual areas of functional deficits
- the person's ability to execute a will
- guardian conduct toward treatment providers
- none of the above
- all of the above

ANSWER: a

2. Testamentary capacity usually comprises an ability to:

- know the natural heirs of one's bounty
- know what a will is
- know the extent of one's property
- avoid influences that would undermine one's independent decisions
- a, b, and c

ANSWER: e

Albert Grudzinskas, Jr., JD, (I) Worcester, MA
 Abigail Judge, PhD, (I) Boston, MA
 John Paul Fedoroff, MD, Ottawa, ON, Canada
 Fabian Saleh, MD, (I) Boston, MA
 Lisa Murphy, MA, (I) Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

This workshop will concentrate on the interplay between politics, morals, and values and their combination that creates a difficult climate for practice for forensic psychiatrists trying to maintain the integrity of themselves and the field while treating patients. The workshop will focus on ethical decision making and risk management strategies.

SUMMARY

The discussion beginning with brief introductions to the ethics dilemmas presented in the practice of sex offender assessment and treatment. The following topics will be addressed: informed consent and limits of confidentiality in both

forensic assessment and in treatment settings with a discussion of recent case law, expert testimony, including issues of how far the evaluator can go in aiding the preparation of the case and preparing for the cross examining of opposing experts, strategies for dealing with requests to change reports or testimony, and guidance regarding ultimate issue questions and management of sex offenders in community settings, including a discussion of recent changes regarding sex offender registries in the U.S. and Canada. Attendees will be required to submit a question for panel discussion as the “price” of admission. The panel and the audience will then participate in a discussion of questions selected by the panel. The focus of the discussion will be on decision making strategies and on risk management approaches.

REFERENCES

Murphy L, Brodsky DJ, Brakel SJ, et al: Community based management of sex offenders: an examination of sex offender registries and community notification in the United States and Canada. In Saleh F: Sex Offenders: Identification, Risk Assessment, Treatment, and Legal Issues. New York, NY: Oxford University Press, 2009
Grudzinskas AJ, Brodsky DJ, Fedoroff JP, et al: Sexual predator laws and their history. In Saleh F: Sex Offenders: Identification, Risk Assessment, Treatment, and Legal Issues. New York, NY: Oxford University Press, 2009

SELF ASSESSMENT QUESTIONS

1. Do all U.S. states and Canadian Provinces have sex offender commitment statutes and registration requirements for convicted sex offenders and do they apply to juveniles?
 - a. All states and provinces have sex offender registry requirements for convicted sex offenders.
 - b. All states and provinces have similar requirements regarding sex offender commitment provisions.
 - c. All sex offender registry requirements apply to juveniles.
 - d. No states or provinces require adjudicated juveniles to register as convicted sex offenders.

ANSWER: a

2. Can an evaluator change his/her report in response to a request from an attorney in a sex offender commitment case?
 - a. It depends on the nature and substance of the request.
 - b. Requests to clarify information should always be entertained.
 - c. An evaluator should never change his/her report once submitted.
 - d. An evaluator should always change his/her report if it helps the attorney with the case.

e. a and b

ANSWER: e

Z3

WILD CHILD? ASSESSING RISK OF PEDIATRIC INPATIENT AGGRESSION

Drew Barzman, MD, Cincinnati, OH

Douglas Mossman, MD, Cincinnati, OH

EDUCATIONAL OBJECTIVE

At the conclusion, participants will summarize steps in and principles of developing a valid risk assessment tool; report increased awareness of rates of and risk factors for inpatient aggression; have gained hands-on experience in procedures for using and testing a risk assessment measure.

SUMMARY

Violence by psychiatrically hospitalized minors is a common phenomenon that can cause emotional and/or physical injury to patients and staff members. This workshop will give attendees a hands-on demonstration of the Brief Rating of Aggression in Children and Adolescents (BRACHA), a new, 14-item instrument for quickly assessing short-term risk of aggression by minors admitted to psychiatric units. The workshop will feature actual video vignettes used in a reliability study (funded by the AAPL Foundation) to evaluate the reliability of BRACHA assessments. The workshop will begin with an introduction to the BRACHA, including steps in creating the instrument, contexts for its use, validation and accuracy data available to date, and analyses of reliability. Next, audience members will participate in interactive demonstrations that simulate recent reliability studies of the BRACHA. Participants will view teaching videos for learning about the instrument's scoring, followed by additional videos for which audience members will anonymously rate “patient's” risk of aggression. Presenters will encourage audience members to comment on the instrument and presenters' testing methods, to provide suggestions for improvements in future studies, and to suggest alternative areas of potential application. Participants will gain access to new scientific data as well as improved data in an area that forms the basis for practice of the discipline.

REFERENCES

Barzman D, Brackenbury L, Sonnier L, et al: Brief rating of aggression by children and adolescents (BRACHA): development of a tool to assess risk of inpatients' aggressive behavior. J Am Acad Psychiatry Law (in press)
Meyers J, Schmidt F: Predictive validity of the structured assessment for violence risk in youth (SAVRY) with juvenile offenders. Criminal Justice and Behavior 35:344-355, 2008

SELF ASSESSMENT QUESTIONS

1. What is the strongest risk factor for future inpatient aggression in children?

- a. Body Mass Index
- b. Living situation
- c. Income level
- d. Young age

ANSWER: d

2. What two types of emergency department observations appear associated with future inpatient aggression in children?

- e. Dysphoria and irritability
- f. Impulsiveness and intrusiveness
- g. Thought disorganization and psychosis
- h. Oppositional behavior and defiant attitude

ANSWER: b

Z4

NEUROLAW: APPROACHING USES OF NEUROIMAGING EVIDENCE OF PTSD

Stuart Kleinman, MD, New York, NY

Francis Shen, JD, PhD, (I) Nashville, TN

Nathan Kolla, MD, New York, NY

Jonathan Brodie, PhD, MD, Old Greenwich, CT

EDUCATIONAL OBJECTIVE

To learn: 1) What neuroimaging techniques reveal about the neuroanatomy of PTSD; 2) The strengths and susceptibility to technical manipulation of each of these techniques; 3) Anticipated legal applications of these techniques; 4) How courts have regarded admissibility of neuroimaging data regarding neuropsychiatric entities, generally, and PTSD, specifically.

SUMMARY

Neuroscientific evidence is increasingly introduced in courtrooms. In the past year, a court, for the first time, held argument regarding the admissibility of fMRI for purposes of lie detection, and qEEG evidence was admitted for the first time to support sentence reduction in a homicide case. Also, in 2010, the Michigan Supreme Court agreed to hear a case (which then settled) in which PET findings were to be employed to argue that PTSD represented a “bodily” injury, exempting it from governmental immunity for recovery for non-economic damages. This panel will address: 1) relevant evidentiary standards, 2) effects of neuroscience on juror decision making, and 3) specific psychiatric-legal questions which neuroimaging data might be utilized to address. These, for example, include: 1) whether claimed damage of PTSD is present, 2) whether PTSD is being malingered (akin, but not identical to using fMRI for lie detection), 3) whether, for worker’s compensation purposes, PTSD is a “physical” entity, and 4) to determine an appropriate sentence, for example, do data support arousal induced dissociation? The panel will additionally help attendees appreciate the strengths and weaknesses of imaging technologies, particularly, common errors of data interpretation and presentation.

REFERENCES

Shen F: Monetizing Memory Science: Neuroscience and the Future of PTSD Litigation (book chapter edited volume on Memory and the Law, forthcoming in 2012).

Hughes KC, Shin LM: Functional neuroimaging studies of post-traumatic stress disorder. Expert Review of Neurotherapeutics 11(2): 275-285, 2011

SELF ASSESSMENT QUESTIONS

1. In order to be admitted into evidence in a federal court in the United States, fMRI imaging data:

- a. will always be admitted if the images come from a published, peer-reviewed paper
- b. will not be admitted if its probative value is substantially outweighed by the danger of unfair prejudice
- c. will not be admitted if there is a “reasonable doubt” about the inferences made from the data
- d. will be admitted only if it is shown that the study producing the image had a “reasonable and sufficient” sample size

ANSWER: b

2. Regarding the seminal neuroimaging twin study of Vietnam veterans and PTSD, which of the following statements is true?
 - a. The largest hippocampal volumes were seen in trauma-exposed veterans with unremitting PTSD.
 - b. The civilian identical twins of trauma-exposed veterans with PTSD had smaller hippocampal volumes than unrelated combat veterans without PTSD.
 - c. An inverse correlation was observed between the hippocampal volumes of combat-exposed co-twins and the PTSD severity of their combat-exposed brothers.
 - d. Study data supported the hypothesis that smaller hippocampi in PTSD is a neurotoxic by-product of trauma.

ANSWER: b

Z5

HARD TIME: COPING WITH THE RISKS OF CORRECTIONAL PRACTICE

Annette Hanson, MD, Baltimore, MD

Ana Cervantes, MD, E. Amherst, NY

Stephen Goldberg, MD, Hanover, MD

Erik Roskes, MD, Baltimore, MD

EDUCATIONAL OBJECTIVE

Participants will learn: 1) to identify risk factors for professional liability in correctional practice; 2) the collateral impact of those factors on clinical and administrative practice; and 3) effective risk management strategies that protect patients and providers by improving clinical and institutional responses to commonly encountered challenging situations.

SUMMARY

The correctional environment presents many challenges to the provision of adequate patient care, including low professional staffing levels, the need to rely on correctional and paraprofessional staff for observational data, an environment particularly stressful to individuals with psychiatric disorders, and the difficulties of arranging adequate mental health care for re-entry into the community. The four presenters, all members of the Institutional and Correctional Psychiatry committee, have extensive experience in jails and prisons of all security levels. They will address identification of high risk situations and effective collaborative risk management strategies involving both custody and civilian staff. Dr. Annette Hanson, a fellowship training director and correctional educator, will discuss existing correctional healthcare guidelines and the clinician's ethical duty to improve correctional services. Dr. Ana Natasha Cervantes, a treating psychiatrist, will discuss the environmental and staffing issues which pose a risk to the frontline clinician. Dr. Stephen Goldberg, Executive Vice President of Clinical Affairs for Conmed Healthcare Management, Inc, will present development of a suicide risk identification program. Dr. Erik Roskes, an experienced court-appointed monitor, will discuss risks presented by release planning for mentally ill inmates and detainees. Each presenter will offer practical suggestions to improve responses to these challenges, in active discussion with participants.

REFERENCES

Simon R, Shuman D: Therapeutic risk management of clinical-legal dilemmas: should it be a core competency? *J Am Acad Psychiatry Law* 37:155-61, 2009

Fazel S, Cartwright J, Norman-Nott A, et al: Suicide in prisoners: a systemic review of risk factors. *J Clin Psychiatry* 69:1721-31, 2008

SELF ASSESSMENT QUESTIONS

1. Ethics conflicts in the correctional setting may arise as a result of:
 - a. the prisoner's misunderstanding of the role of the correctional physician
 - b. the correctional physician's duty to maintain institutional security
 - c. external demands for confidential treatment information
 - d. evaluations requested for purposes other than clinical care
 - e. deviation from practice standards due to limited resources

ANSWER: e

2. Elements of a constitutionally adequate correctional mental health system include:
 - a. maintenance of complete and confidential treatment records
 - b. systematic screening to identify prisoners requiring treatment
 - c. participation of trained mental health professionals
 - d. identification and treatment of suicidal inmates
 - e. all of the above

ANSWER: e

Edward Simmer, MD, Beaufort, SC

EDUCATIONAL OBJECTIVE

1. To learn how to do a competency assessment on a detainee. 2. Understand the challenges of doing such evaluations, to include language, culture, religion, correctional setting, and issues about coercion and possible abuse.

SUMMARY

The Uniform Code of Military Justice establishes the procedures for doing competency and criminal responsibility evaluations, commonly known as a "706 Board" or "Sanity Board." Procedures for sanity boards are very similar to civilian forensic evaluations. In the fall of 2008, the authors performed sanity boards on several detainees at Guantanamo Bay (GTMO). These proceedings ended as the new administration took office and the legal proceedings essentially ceased at GTMO. These evaluations of detainees introduced a host of issues to include: 1) language; 2) culture; 3) possible effects of prior mistreatment; 4) questions of influence from other detainees; and 5) strongly-held religious convictions. Doing these evaluations in the context of the heavily charged politics of the time was also a challenge. The talk will discuss some of these considerations and challenges in general. Specific details of cases will not be discussed and no classified information will be presented. Dr. Simmer is recently retired from the Army. The opinions expressed are his alone and do not represent those of the Army, Navy or DoD.

REFERENCES

Uniform Code of Military Justice (UCMJ), 64 Stat. 109, 10 U.S.C. Chapter 47)
Ritchie EC, Benedek D, Malone R, et al: Military psychiatry: an update. *Psychiatric Clinics of North America* 29(3): 695-707, 2006

SELF ASSESSMENT QUESTIONS

1. What is the accepted procedure for performing competency and criminal responsibility evaluations on detainees?
ANSWER: 706 Boards

2. What are some of the challenges in doing 706 boards on detainees?
ANSWER: Culture, language, and issues about coercion and possible history of abuse.

Alan Felthous, MD, St. Louis, MO
Robert Weinstock, MD, Los Angeles, CA
Constance Hoyt, MD, (I) Merrimac, MA
Albert Elian, MS, (I) Sudbury, MA
Dean De Crisce, MD, Brooklyn, NY

EDUCATIONAL OBJECTIVE

The participant will learn about the functions of rape nurse examiners and toxicologists in investigating allegations of sexual assault as well as the potential forensic relevance of the psychopathology of sexual offenders.

SUMMARY

Sexual assault is an offense that impacts victims but also perpetrators, and society in general. The solutions, i.e. investigation, prosecution and legal defense, criminal punishment, treatment and rehabilitation, involve a variety of scientific, social and clinical disciplines. The sexual assault exam should be conducted by a qualified forensic examiner, on the victim, and on the suspected perpetrator. The examiner collects evidentiary specimens, sets in motion the Sexual Assault Response Team (SART), arranges for a medical follow-up check, assesses how the victim is coping and makes appropriate referrals to trauma counseling specialists. The toxicological challenges associated with drug-facilitated sexual assault (DFSA) cases center upon the various drugs used to commit a DFSA, as well as how they impact reporting the crime. Additional challenges include proper evidence collection and laboratory methodologies used to detect the over 50 different drugs that have been used to commit DFSA. The forensic psychiatrist should meticulously investigate evidence and discriminate between true paraphilia and other potential causes for sexual misconduct. A growing body of sex offender literature indicates clues that can be used as guidelines to differentiate various types of paraphilic offenders. Expert witness conclusions and testimony should demonstrate consideration of alternative explanations for misconduct.

REFERENCES

LeBeau M, Andollo W, Hearn WL, et al: Recommendations for toxicological investigations of drug-facilitated sexual assaults. *J Forensic Sci* 44(1): 227-230, 1999
D. Doren: *Evaluating Sex Offenders; A Manual for Sex Offenders and Beyond*, Thousand Oaks, CA: Sage Publications, 2002

SELF ASSESSMENT QUESTIONS

1. What are the challenges associated with DFSA investigations?
 - a. Early reporting, underreporting, evidence collection, and laboratory methodologies.
 - b. Delayed reporting, underreporting, drug dosage, pharmacokinetics, pharmacodynamics, evidence collection and laboratory methodologies.
 - c. Delayed reporting, overreporting, drug dosage, pharmacokinetics, evidence collection.
 - d. Early reporting, underreporting, drug dosage, pharmaceutical formulation, pharmacokinetics laboratory methodologies.
 - e. Delayed reporting, overreporting, drug dosage, chain-of-custody.

ANSWER: b

2. The collection of evidentiary specimens in the forensic exam of the female victim of sexual assault can be done up to what time frame?

- a. Within 1 hour
- b. Within 5 days
- c. Within 3 days
- d. Within 1 day

ANSWER: b

Z8

RESTRAINT AND SECLUSION REFORM: IMPLICATIONS AND OUTCOMES

Patrick Fox, MD, New Haven, CT
Paul Whitehead, MD, Provo, UT
Traci Cipriano, PhD, (I) New Haven, CT
Charles Dike, MD, Middletown, CT

EDUCATIONAL OBJECTIVE

This workshop addresses the core competencies of systems based practice and medical knowledge in the practice of forensic psychiatry. Participants will learn about recent trends in restraint and seclusion use at forensic psychiatric hospitals, factors that affect restraint and seclusion use, and methodological approaches to reduce restraint and seclusion.

SUMMARY

In recent years, and in the wake of highly publicized restraint-related deaths, heightened scrutiny regarding seclusion and restraint use has led to sweeping reforms. Most approaches to restraint and seclusion reduction have focused on changing the culture within hospitals to one less reliant on these modalities for behavioral management. This is typically achieved through changes in hospital policy and administrative oversight. As the rates of seclusion and restraint decline, base rate variability becomes less dependent on staff training and education, and more focused on the particular characteristics of individual patients. This requires a change in strategy to a more patient-centered approach to restraint and seclusion reduction; one in which patients who had historically comprised outliers now become the majority. Below this very low rate of restraint and seclusion use, further efforts at reduction are prone to produce unintended consequences with implications for the entire mental health delivery system. This workshop will detail the steps taken by several forensic hospitals to drastically reduce restraint and seclusion. Attendees will participate in discussion regarding the challenges that forensic facilities face in implementing restraint reform, and will be provided with reference materials to assist them with this task.

REFERENCES

Smith G, Davis R, Bixler E, et al: Special section on seclusion and restraint: Pennsylvania State Hospital System's seclusion and restraint reduction program. *Psychiatric Services* 56:1115-1122, 2005
Hellerstein D, Staub A, Lequesne E : Decreasing the use of restraint and seclusion among psychiatric inpatients. *J Psychiatric Practice* 13:308-317, 2007

SELF ASSESSMENT QUESTIONS

1. Which of the following organizations has policies or regulations governing restraint and seclusion use at psychiatric facilities?
 - a. The Joint Commission (TJC)
 - b. The Substance Abuse and Mental Health Services Administration (SAMHSA)
 - c. The Centers for Medicare and Medicaid Services (CMS)
 - d. All of the above

ANSWER: d

2. Which of the following is correct regarding restraint and seclusion use in the United States during the past decade?
- The rate of seclusion and restraint use has increased.
 - The rate of seclusion and restraint use has decreased.
 - The rate of seclusion and restraint use has remained unchanged.
 - Seclusion and restraint use has been eliminated.

ANSWER: b

Z9

NEW YORK STATE'S SVP LAW: PROGRAM DEVELOPMENT AND IMPLEMENTATION

Li-Wen Lee, MD, New York, NY
Richard Krueger, MD, New York, NY
Richard Miraglia, LCSW, (I) Albany, NY
Naomi Freeman, PhD, (I) Albany, NY

EDUCATIONAL OBJECTIVE

Participants will be able to 1) describe the 2007 statute passed in NYS regarding the civil management of sexual offenders; 2) describe the development of state mental health services to evaluate and treat sexual offenders; and 3) discuss challenges to balancing individual clinical needs with public safety demands.

SUMMARY

In 2007, New York State joined nineteen other states in passing a statute for the civil management of sexual offenders. New York's statute, the Sex Offender Management and Treatment Act (SOMTA), represents an effort to identify and treat recidivist sex offenders with a mental abnormality that predisposes them to engage in repeated sex offenses. The New York State Office of Mental Health (OMH) was charged with the evaluation of sex offenders who potentially qualify for civil management and the subsequent provision of appropriate treatment. One feature distinguishing the New York statute is the provision for civil management of sex offenders in both secure treatment facilities and community placement. During this presentation, the statute and historical precedents will be reviewed, followed by a description of the process implemented to evaluate sex offenders, and the programs and strategies developed to treat them, which include therapeutic groups, plethysmography, and pharmacologic considerations. The challenges of treatment and management within this context will be discussed.

REFERENCES

2009 Annual Report on the Implementation of MHL Article 10. Albany, NY: New York State Office of Mental Health, 2010
Involuntary Commitment of Sexually Violent Predators: Comparing State Laws. Olympia, WA: Washington State Institute for Public Policy, 2005

SELF ASSESSMENT QUESTIONS

1. The New York SVP statute provides for:
- Involuntary civil commitment
 - Mandated medications
 - Supervision on outpatient status
 - a and c
 - All of the above

ANSWER: d

2. SOMTA specifies that sex offenders requiring civil management:
- are diagnosed with a serious mental illness causing sexually aggressive behaviors.
 - have a mental abnormality predisposing them to engage in repeated sex offenses.
 - are entitled to biennial review of their status.
 - are automatically returned to prison if conditions of outpatient status are violated.
 - all of the above

ANSWER: b

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