

AMERICAN ACADEMY
OF
PSYCHIATRY AND THE LAW

44TH ANNUAL MEETING

October 24-27, 2013
San Diego, California



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-fourth Annual Meeting
American Academy of Psychiatry and the Law
October 24-27, 2013
San Diego, California**

OFFICERS OF THE ACADEMY

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PAST PRESIDENTS

Charles Scott, MD	2011-12	Howard V. Zonana, MD	1992-93
Peter Ash, MD	2010-11	Kathleen M. Quinn, MD	1991-92
Stephen B. Billick, MD	2009-10	Richard T. Rada, MD	1990-91
Patricia R. Recupero, MD, JD	2008-09	Joseph D. Bloom, MD	1989-90
Jeffrey S. Janofsky, MD	2007-08	William H. Reid, MD, MPH	1988-89
Alan R. Felthous, MD	2006-07	Richard Rosner, MD	1987-88
Robert I. Simon, MD	2005-06	J. Richard Ciccone, MD	1986-87
Robert T.M. Phillips, MD, PhD	2004-05	Selwyn M. Smith, MD	1985-86
Robert Wettstein, MD	2003-04	Phillip J. Resnick, MD	1984-85
Roy J. O'Shaughnessy, MD	2002-03	Loren H. Roth, MD	1983-84
Larry H. Strasburger, MD	2001-02	Abraham L. Halpern, MD	1982-83
Jefrey L. Metzner, MD	2000-01	Stanley L. Portnow, MD	1981-82
Thomas G. Gutheil, MD	1999-00	Herbert E. Thomas, MD	1980-81
Larry R. Faulkner, M.D	1998-99	Nathan T. Sidley, MD	1979-80
Renée L. Binder, MD	1997-98	Irwin N. Perr, MD	1977-79
Ezra E. H. Griffith, MD	1996-97	G. Sarwer-Foner, MD	1975-77
Paul S. Appelbaum, MD	1995-96	Seymour Pollack, MD	1973-75
Park E. Dietz, MD, PhD, MPH	1994-95	Robert L. Sadoff, MD	1971-73
John M. Bradford, MB	1993-94	Jonas R. Rappeport, MD	1969-71

2013 ANNUAL MEETING CO-CHAIRS

Stuart Anfang, MD and Barry Wall, 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 2014

The 45th Annual Meeting of the
American Academy of Psychiatry and the Law will be held in
Chicago, IL October 23-26, 2014

Inquiries may be directed to,
Christopher Thompson, MD and Gregory Sokolov, MD, Program Co-Chairs.

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

The deadline for abstract submission is March 1, 2014



FUTURE ANNUAL MEETING DATES and LOCATIONS

46th Annual Meeting
October 22-25, 2015

Marriott Harbor Beach Resort, Ft. Lauderdale, Florida

47th Annual Meeting
October 27-30, 2016

Hilton Portland & Executive Tower, Portland, OR

GENERAL INFORMATION

Table of Contents

Awardees	2
CME Information	122
Call for Papers - 2014	ii
Evaluation Form	124
Future Meeting Dates	ii
AAPL Policies	v
Financial Disclosures	viii
Index of Authors	132
Invited Speakers	5
Meeting Facilities	x
Opening Ceremony	1
Program	7
Special Events	ix

REGISTRATION DESK

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. - 12:30 p.m.

AAPL BOOKSTORE

**Crystal/Continental Room
Victorian Building**

MONDO DIGITAL SOLUTIONS, INC.

Victorian Building

COURSE CODES

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

DESIGNATIONS USED IN THIS PROGRAM

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



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

The AIER was developed to stimulate educational and research activities, provide educational resources and activities, and to aid education and research by encouraging tax-exempt donations to forensic education and research programs. The RFP for educational and research grant proposals is available at the registration desk.

Support the AIER

AAPL Logo Shirt *	\$35.00
AAPL Logo Hats	\$20.00
AAPL Shirt and Hat *	\$50.00
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The American Academy of Psychiatry and the Law's Institute for Education and Research, Inc., is exempt from federal income taxes as a public charity under IRS Section 501 (c) (3).



A MESSAGE TO PHYSICIAN ATTENDEES CONTINUING MEDICAL EDUCATION CHANGES

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

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

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

1. Not practicing forensic psychiatry at the highest level attainable based on current knowledge of the fundamentals of the field.
Need: Improvement in knowledge of civil, criminal, and correctional forensic psychiatry.
2. Lacking the knowledge of content or technique to teach psychiatrists the fundamentals of forensic psychiatry in the most effective ways.
Need: Knowing new content and effective ways to teach forensic psychiatry.
3. Lacking the ability to conduct or assess research in forensic psychiatry.
Needs: 1. Knowing how to do research or 2. Knowing the outcomes of research in forensic psychiatry and how to apply those outcomes to forensic practice.

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

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

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

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

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

Thank you in advance.

Richard Frierson, MD, and Elizabeth Ford, 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:

Abel, G.; Adelaja, A.; Adler, J.; Agraharkar, S.; Ahearn, E.; Ahmed, A.; Alam, M.; Allen, J.; Allen, T.; Anderson, M.; Anfang, S.; Annas, G.; Antoniak, S.; Appelbaum, K.; Appelbaum, P.; Arroyo-Carrero, D.; Ash, P.; Bailey-Smith, K.; Bajgier, J.; Bales, A.; Baranoski, M.; Barba, V.; Barker, J.; Bazzi, L.; Beauregard, E.; Beck, B.; Belfi, B.; Benedek, E.; Benoit, T.; Bielska, W.; Billick, S.; Binder, R.; Blair, G.; Bogoy, M.; Booth, B.; Bradford, J.; Brenner, L.; Bromley, R.; Buchanan, J.; Buchi, H.; Bursztajn, H.; Candilis, P.; Carabellese, F.; Catanesi, R.; Cerny, C.; Cervantes, A.; Chandra, S.; Chang, Y.; Chien, J.; Chlebowski, S.; Christopher, P.; Ciccone, J.; Ciric, S.; Clarke, J.; Clift, R.; Cohen, M.; Cohen, Z.; Curry, S.; Davis, B.; De Crisce, D.; DeLand, S.; D'Eon, M.; DeYoung, N.; Dietz, P.; Dike, C.; Dorio, N.; Dwyer, R.G.; Eappen, S.; Egan, G.; El Shayeb, N.; Eno Loudon, J.; Erwin, K.; Falls, A.; Falls, B.; Fedoroff, J.P.; Feinberg, K.; Felthous, A.; Fields, C.; Fisher, K.; Foellmi, M.; Ford, E.; Forman, H.; Fowler, C.; Frierson, R.; Frischer, K.; Funkenstein, A.; Gaskins, M.; Gerring, J.; Ghinassi, F.; Gillis, A.; Glancy, G.; Gold, J.; Gold, L.; Gomez, A.; Gopal, A.; Gosein, V.; Graham, D.; Graham, N.; Granacher, R.; Gray, J.; Green, D.; Greenspan, M.; Gulrajani, C.; Gutheil, T.; Hall, R.; Hatters Friedman, S.; Hauser, M.; Hazelwood, R.; Hemphill, J.; Holmberg, T.; Holmes, D.; Holoyda, B.; Hsu, D.; Inlender, T.; Janofsky, J.; Jeste, D.; Johnson, C.; Johnson, R.S.; Johnson, R.; Jones, T.; Kaempf, A.; Kambam, P.; Kaplan, J.; Kapoor, R.; Kathpal, A.; Kaufman, A.; Kellaheer, D.; Kelly, B.; Kenedi, C.; Khadivi, A.; Khin Khin, E.; Klein, C.; Kleinman, S.; Knack, N.; Knapp, S.; Knight, S.; Knoll, J.; Kolla, N.; Komarovskaya, I.; Korenisi, P.; Krueger, R.; Kumar, T.; Kunz, M.; Kushnier, A.; La Tegola, D.; LaCroix, C.; LeBlanc, V.; Lee, B.; Lee, E.; Lee, L.; Leo, A.; Leonard, C.; Levin, A.; Lilly, S.; Lockey, C.; Logroscino, G.; Lopez, T.; Lopez, N.; Lopez-Leon, M.; Loza, W.; Luther, G.; Manguno-Mire, G.; Margery Bertoglia, S.; Martin, P.; Martinez, G.; Martinez, R.; Martinez Lopez, N.; Martone, L.; Maskel, L.; Matto, M.; McBride, A.; McDermott, B.; McIntyre, I.; McKenny, J.; McNiel, D.; McQuirt, B.; Mehta, A.; Mela, M.; Menard, W.; Metzner, J.; Miceli, J.; Moreira, E.; Morris, D.; Mossman, D.; Mukherjee, M.; Mulbry, L.; Mulvey, E.; Mundy, D.; Murphy, L.; Murray, S.; Musalo, K.; Myers, W.; Nanton, A.; Nelsen, A.; Neltner, M.; Newman, A.; Newman, W.; Noffsinger, S.; Norko, M.; Noroian, P.; Ochoa, K.; Ogundipe, T.; Oldham, J.; O'Leary, P.; O'Shaughnessy, R.; Osterhout, C.; Ostermeyer, B.; Ourada, J.; Parker, G.; Paterson, J.; Paul, R.; Pequeno, G.; Perlo, S.; Peykanu, J.; Piel, J.; Pinals, D.; Poa, E.; Prabhu, M.; Price, M.; Rachal, F.; Rai, S.; Raley, J.; Ramshaw, L.; Ranger, R.; Ravven, S.; Read, S.; Reardon, C.; Recupero, P.; Reeves, R.; Regehr, C.; Resnick, P.; Reynolds, A.; Riar, K.; Roberts, V.; Rodgers, C.; Rodrigues, N.; Roof, J.; Rosenbaum, K.; Rosenfeld, B.; Roskes, E.; Rosmarin, D.; Roth, L.; Rotter, M.; Saleh, F.; Salem, A.; Saltis, M.; Savage, S.; Schreiber, J.; Schwenke, T.; Schubert, C.; Scott, C.; Selhi, Z.; Seto, M.; Sexton, S.; Shah, S.; Shand, J.P.; Sikes, K.; Silverman, M.; Silverman, S.; Simpson, J.; Smith, C.; Smith, D.D.; Smith, D.M.; Sokolov, G.; Soliman, S.; Soloway, S.; Sorrentino, R.; Spanggaard, M.; Stafford, M.; Stankowski, J.; Steinberg, A.; Stiffler, D.; Stolar, A.; Stoneking, L.; Stongarone, S.; Streed, T.; Sullivan, P.; Tamburello, A.; Tanaka, G.; Taylor, K.; Thompson, C.; Thompson, Jr., J.; Thrasher, T.; Torrissen, T.; Trestman, R.; Trinder, K.; Tsai, G.; Tucker, D.; Vanderpool, D.; Vermette, H.; Vitko, C.; Wagoner, R.; Watson, C.; Weiner, K.; Weinstock, R.; Weiss, K.; West, S.; Westmoreland, P.; Westphal, A.; Whalen, J.; Whitehead, P.; Wilk, C.; Wortzel, H.; Wright, A.; Xiong, G.; Yahr Nelson, L.; Zonana, H.

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.

Anfang, A.; Ash, P.; Benedek, E.; Billick, S.; Christopher, Coleman, J.; P.; Ford, E.; Fozdar, M.; Frierson, R.; Gold, L.; Greiner, C.; Halavonich, R.; Hegarty, A.; Henry, S.; Holzer, J.; Johnson, N.; Kaempf, A.; Knoll, J.; Krueger, R.; Kunz, M.; Lei, L.; Lewis, C.; Newman, A.; Newman, W.; Noffsinger, S.; Ostermeyer, B.; Parker, G.; Pearlson, S.; Pinals, D.; Pozios, V.; Price, M.; Preven, D.; Rai, S.; Resnick, P.; Rosmarin, D.; Ryan, E.; Schiffman, E.; Scott, C.; Silberberg, J.; 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 Sunovion Pharmaceuticals, Inc.

Emily Keram, MD: Stockholder – Merck

Gregory Sokolov, MD: Received speaker honoraria from Astra Zeneca and Janssen



SPECIAL EVENTS

THURSDAY, OCTOBER 24

Past Presidents' Breakfast	7:00 a.m. - 8:00 a.m.	Stuart Room Victorian Building
Opening Ceremony - President's Address (open to all attendees)	8:00 a.m. - 10:00 a.m.	Ballroom Victorian Building
Association of Directors of Forensic Psychiatry Fellowships Reception (for fellowship program faculty, fellows, and potential applicants)	6:00 p.m. - 7:00 p.m.	Sun Deck Outdoor Venue

FRIDAY, OCTOBER 25

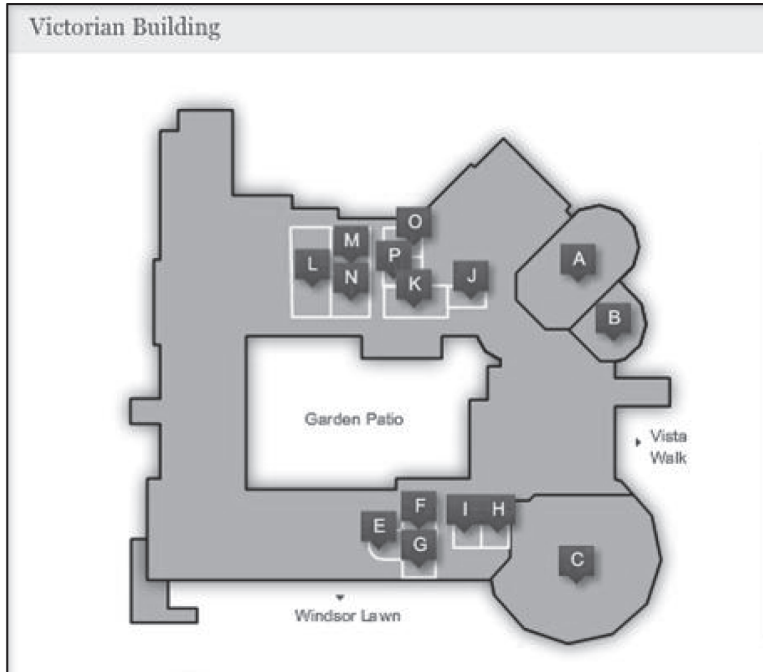
Rappeport Fellows Breakfast (Rappeport Fellows and Committee)	7:00 a.m. - 8:00 a.m.	Stuart Room Victorian Building
Reception (for all meeting attendees)	6:00 p.m. - 7:30 p.m.	Windsor Lawn Outdoor Venue

SATURDAY, OCTOBER 26

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.	Stuart Room Victorian Building
AAPL Business Meeting (members only)	8:00 a.m. - 9:30 a.m.	Ballroom Victorian Building
Mid-west AAPL Chapter Meeting (Chapter Meetings by request only, please contact AAPL Staff)	6:15 p.m. - 7:30 p.m.	Seabreeze California Cabanas Building

COFFEE BREAKS WILL BE HELD IN THE CROWN ROOM, VICTORIAN BUILDING

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

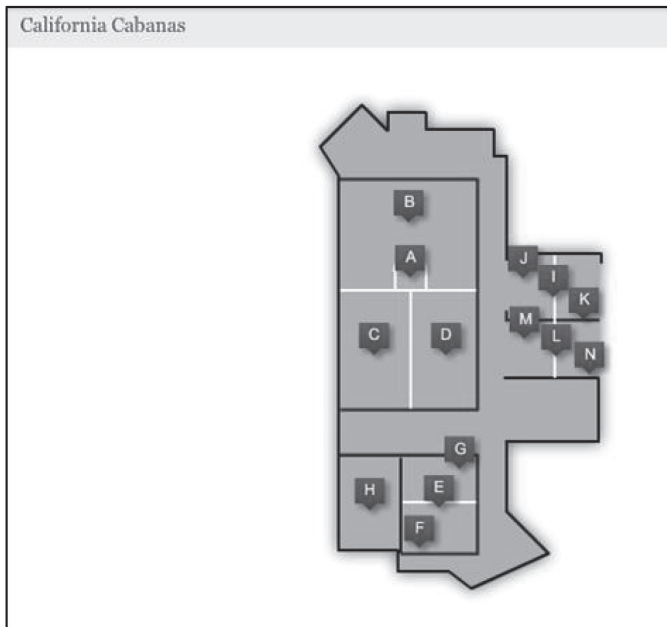


**Victorian Building
Room Key**

Ballroom	C
Continental Room	I
Coronet Room	B
Crown Room	A
Crystal Room	H
Embassy Room	G
Executive Room	J
Garden Room	K
Hanover Room	L
Kent Room	O
Stuart Room	M
Tudor Room	N
Windsor Room	E/F
York Room	P

**California Cabanas
Room Key**

Bayside Room	F
Coastal Room	M
Pacifica Room	J
Palm/Sunset Room	C/D
Pointe Room	H
Seabreeze Room	B
Surf Room	N
Strand Room	G
Tropics Room	A



PLEASE

**BE COURTEOUS TO
YOUR FELLOW ATTENDEES.**

**TURN CELL PHONES OFF OR
SET THEM TO VIBRATE.**

**HOLD YOUR PHONE CONVERSATIONS
OUTSIDE THE MEETING ROOM.**

**IF YOU ARE PARTICIPATING IN A
PRESENTATION UTILIZING THE
AUDIENCE RESPONSE SYSTEM (ARS)
REMEMBER TO RETURN YOUR CLICKER.**

(SESSION MODERATORS HAVE BEEN ASKED TO ENFORCE THESE POLICIES)

**American Academy of Psychiatry and the Law
Forty-fourth Annual Meeting**



OPENING CEREMONY

Thursday, October 24, 2013

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

WELCOME, INTRODUCTIONS	Debra Pinals, MD <i>President</i>
PRESENTATION OF RAPPEPORT FELLOWS	Susan Hatters Friedman, MD Britta Ostermeyer, MD <i>Co-Chairs, Rappeport Fellowship Committee</i>
Caitlin Dufault, MD <i>University of New Mexico</i>	Eric Huttenbach, MD, JD <i>University of Massachusetts Memorial Medical Center</i>
Jacqueline Landess, MD, JD <i>McGaw Medical Center of Northwestern University</i>	Anne McBride, MD <i>University of California, Davis Medical Center</i>
Michael Seyffert, MD <i>University of Michigan</i>	Amanda Square, MD <i>Yale University School of Medicine</i>
AWARD PRESENTATIONS	Renée L. Binder, MD <i>Chair, Awards Committee</i>
Golden Apple Award Paul Appelbaum, MD	
Seymour Pollack Award Robert Weinstock, MD	
Red Apple Award Kenneth Busch, MD	
Award for Outstanding Teaching in a Forensic Fellowship Program Richard Martinez, MD	
Young Investigator Award Jennifer Piel, MD, JD	Andrew Kaufman, MD <i>Chair, Research Committee</i>
2012 Poster Award Bryan Shelby, MD, JD	
INTRODUCTION OF GRANTEES AAPL INSTITUTE FOR EDUCATION AND RESEARCH	Larry Faulkner, MD <i>President, AAPL Institute</i>
OVERVIEW OF THE PROGRAM	Stuart Anfang, MD Barry Wall, MD <i>Co-Chairs, Program Committee</i>
INTRODUCTION OF THE PRESIDENT	Charles Scott, MD
PRESIDENT'S ADDRESS	Debra Pinals, MD
ADJOURNMENT	Stuart Anfang, MD Barry Wall, MD <i>Co-Chairs, Program Committee</i>

AWARD RECIPIENTS

RED AAPL OUTSTANDING SERVICE AWARD

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

KENNETH G. BUSCH, MD

Dr. Busch received his medical degree from Indiana University School of Medicine and completed his psychiatric residency at Northwestern University Feinberg School of Medicine in Chicago. He has been in private practice since 1975 and has consulted nationally to the U.S. State Department and the US Department of Health and Human services. His areas of research and publication have focused on medical professionalism and ethics, youth violence, terrorism, and national security issues. Dr. Busch has served as President of the Illinois Psychiatric Society and representative to the APA Assembly. He currently serves as the Vice-Chair of the APA Board of Trustees Work Group on International Psychiatry. He also serves as Chair of the Health Care Advisory Council for Congressman Mike Quigley and Chair of the Mental Health Advisory Committee for Congressman Danny K. Davis.

Dr. Busch has been an active member of AAPL for many years and has made extensive contributions to the organization. He has participated on the Child and Adolescent Committee, Public Information Committee and International Relations Committee serving as Chair for the last 10 years. Dr. Busch has arranged many site visits on the Wednesday at the Annual Meeting. These have included visits to FBI district offices, law enforcement agencies, forensic hospitals, correctional facilities, military bases, and courts. He has organized numerous panels at the Annual Meeting and engaged colleagues from other countries to take part on the program. He has contributed various articles to the AAPL newsletter including topics from the United Kingdom, Argentina, and Chile. Following a panel discussion at the 2008 annual meeting on the international relevance of AAPL's ethics guidelines, Dr. Busch published a manuscript with colleagues on *Contemplating Common Ground in Professional Ethics in Forensic Psychiatry* in a British forensic journal. One of our international colleagues wrote in his nomination letter: "Dr. Busch has 'done an immense amount to create and sustain professional friendships, collaborations, cross-national education, affection and respect for AAPL in the international context.'"

For his many years of service to AAPL and especially his work promoting international connections and site visits, the American Academy of Psychiatry and the Law presents the 2013 Outstanding Service Award (the Red AAPL) to Dr. Ken Busch.

GOLDEN AAPL AWARD

This award is presented in recognition of AAPL members who are over 60 and who have made significant contributions to the field of forensic psychiatry.

PAUL S. APPELBAUM, MD

Dr. Appelbaum attended Harvard Medical School and completed his residency in psychiatry at the Massachusetts Mental Health Center in Boston. From 1992-2005, he served as the Chair of Psychiatry at the University of Massachusetts Medical School. Since 2006, he has been the Elizabeth K. Dollard Professor of Psychiatry, Medicine, and Law and the Director of the Division of Law, Ethics and Psychiatry in the Department of Psychiatry at Columbia University College of Physicians and Surgeons.

Dr. Appelbaum is the author of over 250 articles and multiple books on law in clinical practice, including four that were awarded the Manfred S. Guttmacher Award from the American Psychiatric Association and the American Academy of Psychiatry and the Law: *The Clinical Handbook of Psychiatry and the Law*, *Almost a Revolution: Mental Health Law and the Limits of Change*, *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Healthcare Professionals*, and *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence*. Dr. Appelbaum is Past President of the American Psychiatric Association, Past President of the American Academy of Psychiatry and the Law, and Past President of the Massachusetts Psychiatric Society. He has served as Chair of the Council on Psychiatry and the Law and is the current Chair of the Commission on Judicial Action for the American Psychiatric Association, and also has been a member of the MacArthur Foundation Research Network on Mental Health and the Law. He has received the Seymour Pollack Award of AAPL and the Isaac Ray Award of the American Psychiatric Association for "outstanding contributions to forensic psychiatry and the psychiatric aspects of jurisprudence." He also has been elected to the Institute of Medicine of the National Academy of Sciences.

For his distinguished contributions to the field of forensic psychiatry and especially his significant accomplishments in integrating forensic psychiatry into the mainstream of the American Psychiatric Association, and his embodiment of the highest ethical, clinical, research, educational, and administrative standards, the American Academy of Psychiatry and the Law presents the 2013 Golden AAPL Award to Paul Appelbaum, M.

AWARD FOR OUTSTANDING TEACHING IN A FORENSIC FELLOWSHIP PROGRAM

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

RICHARD P. MARTINEZ, MD, MPH

Dr. Richard Martinez received his M.D. from LSU Medical School in New Orleans. After eight years in private practice in psychiatry, he went to Boston, where he completed a Fellowship at Harvard Medical School, Division of Medical Ethics in 1994-95, followed by a Fellowship at the Edward J. Safra Center for Ethics at the JFK School of Government at Harvard University in 1995-96 and then a forensic fellowship at the University of Colorado. Dr. Martinez is currently Professor of Psychiatry at the University of Colorado, Denver, Adjunct Professor at the Denver University Sturm School of Law and Director of Psychiatric Forensic Services at Denver Health Medical Center. He is the Robert D. Miller Professor of Psychiatry and Law at the University of Colorado, Denver and Director of the Fellowship Program in Forensic Psychiatry. He consults in civil and criminal forensic psychiatry and teaches forensic psychiatry and professional ethics to residents and fellows. Dr. Martinez has written numerous articles, book chapters, and a book on topics related to professional ethics and social responsibility, organizational healthcare ethics, medical undergraduate education, boundaries in the patient-professional relationship, and forensic psychiatry.

Dr. Martinez is an excellent educator. Here are some of the comments about him from his fellows: "What makes Dr. Richard Martinez an outstanding teacher, first and foremost, is his genuine and warm curiosity about each trainee as a person. He develops long lasting mentoring relationships with his students, and these relationships extend beyond the year of fellowship training. He is always willing to help his fellows (and former fellows) find their path as forensic psychiatrists. Dr. Martinez also inspires his trainees to think outside the box. His background in the humanities and narrative ethics encourages a model of thoughtfulness. He approaches his evaluations with an open mind and renders an opinion only after thorough and rigorous analysis. His passion for teaching and mentoring, as well as his thoughtfulness and dedication, create an atmosphere of openness, trust and robust dialogue."

In recognition of his outstanding teaching, the American Academy of Psychiatry and the Law presents the 2013 Best Teacher in Forensic Fellowship Award to Dr. Richard Martinez.

SEYMOUR POLLACK AWARD

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

ROBERT WEINSTOCK, MD

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

Dr. Weinstock was the founding Chair of the AAPL Addiction and Geriatric Committees. He served as Chair of the AAPL Program Committee and was Chair of the AAPL Committee on Ethics for 8 years. As Chair of the Ethics Committee, he revised the ethics guidelines for AAPL. He also has served as Councilor and Secretary of AAPL and is the incoming President. He has been President of the Association of Directors of Forensic Psychiatry Fellowships and President of the former Accreditation Council on Fellowship in Forensic Psychiatry. Dr. Weinstock has also been an Associate Editor of the Journal of AAPL. In addition, he has contributed to forensic psychiatry through his service to the American Psychiatric Association (APA) and the California Psychiatric Association (CPA). He has been a member and consultant to the APA Committee on Judicial Action and a member of the Corresponding Committee on Confidentiality. At the CPA, he was Chair of the Committee on Judicial Action and was instrumental in getting California law changed in 2007 to deal with Tarasoff duties and to clarify and revise the official jury instructions. Dr. Weinstock has written more than 100 book chapters and peer-reviewed papers and is the co-author of a recent book on *Forensic Ethics*. He also is section editor for two sections in Richard Rosner's textbook *Principles and Practice of Forensic Psychiatry*.

For his distinguished contributions to the teaching and educational functions of forensic psychiatry, the American Academy of Psychiatry and the Law presents the 2013 Seymour Pollack Award to Dr. Robert Weinstock.

DISTINGUISHED LECTURERS

Thursday, October 24

KENNETH FEINBURG

Unconventional Responses to Unique Catastrophes: Tailoring the Law to Meet the Challenges

Kenneth Feinberg is a Washington, D.C. attorney specializing in mediation and alternative dispute resolution who was appointed Special Master of the U.S. Government's September 11th Victim Compensation Fund. He received a Bachelor of Arts from the University of Massachusetts in 1967 and a law degree from the New York University School of Law in 1970. He worked for five years as an administrative assistant and chief of staff for U.S. Senator Ted Kennedy, and as a prosecutor for the U.S. Attorney General. He has served as Court-Appointed Special Settlement Master in cases including Agent Orange product liability litigation and Asbestos Personal Injury Litigations. He was one of three arbitrators who determined the fair market value of the Zapruder film of the Kennedy assassination. He was one of two arbitrators who determined the allocation of legal fees in the Holocaust slave labor litigation. He is Lecturer-in-Law at the University of Pennsylvania Law School, the Georgetown Law Center, and the University of Virginia School of Law. He taught a course at NYU entitled "The 9/11 Victim Compensation Fund: Alternatives to the Civil Justice System." Mr. Feinberg is administrator of the One Fund Boston Victim Compensation Fund arising out of the Boston Marathon bombings.

Friday, October 25

HOWARD ZONANA, MD

Reflections of a Medical Director

Howard Zonana, MD has been Medical Director of AAPL since 1995. He is only the second Medical director in AAPL's history and has seen many changes in his 18 years of service to AAPL. Since 1968 he has been on the faculty at Yale University School of Medicine and is a Professor of Psychiatry and an Adjunct Clinical Professor of Law at the Yale Law School. Since 1969 he has been the forensic psychiatry residency-training director at Yale with approximately 75 graduates from the program. He has also been active in the American Psychiatric Association as Chair of the Committee on Judicial Action and Chair of the Council of Psychiatry and Law. He also has served as a federal court monitor at the York prison for women in CT, regarding standards of mental health care from 1987 to the present. He was a member of the APBN group writing the Board exam for Forensic Psychiatry for 15 years, including services as Chair. He is a recipient of AAPL's Golden Apple, Red Apple and Seymour Pollack Awards. In 2012 he won the Isaac Ray award of the APA-AAPL.

Saturday, October 26

JUDY CLARKE, ESQ.

Capital Defense and Forensic Psychiatry: One Capital Defender's View

Judy Clarke is in private practice in San Diego, California, serves as one of the national Federal Death Penalty Resource Counsel and is also adjunct faculty at Washington and Lee University School of Law. She has served as the Executive Director of Federal Defenders of Eastern Washington and Idaho and Federal Defenders of San Diego, Inc., argued twice before the U.S. Supreme Court, and represented defendants in a number of high profile capital cases, including Susan Smith in Union, South Carolina, Theodore Kaczynski, charges as the "Unabomber," Eric Robert Rudolph, charged with an abortion clinic bombing in Birmingham, Alabama and Jared Loughner, charged in the January 2011 shootings in Tucson, Arizona. She is currently one of the lawyers for Dzhokhar Tsarnaev, charged in the 2013 Boston Marathon bombing. Ms. Clarke is a 1974 graduate of Furman University, and a 1977 graduate of the University of South Carolina, School of Law. She is a Past President of the National Association of Criminal Defense Lawyers, a Fellow in the American College of Trial Lawyers, and was selected by the National Law Journal in 1998 as one of the top women litigators in the United States. She was selected by the Daily Journal as one of the top 100 lawyers in California in 2011 and 2012, and was recently selected for inclusion in the 20th edition of "The Best Lawyers in America."

THURSDAY, OCTOBER 24, 2013

THURSDAY

POSTER SESSION A	7:00 AM – 8:00 AM/ 9:30 AM – 10:15 AM	CROWN ROOM, VICTORIAN BUILDING
T1	<i>And Then I Woke Up In Jail: Amnesia Claims in Evaluations</i>	John Shand, MD, (I) Cleveland, OH Susan Hatters Friedman, MD, Cleveland Heights, OH Renée Sorrentino, MD, Quincy, MA
T2	<i>Trial Competency Restoration Thru Music</i>	Andrew Sammons, MA, (I) Napa, CA
T3	<i>Prevalence of Delusional Disorder in Prison</i>	Joanna Bajgier, DO, Collingswood, NJ Rusty Reeves, MD, Piscataway, NJ Anthony Tamburello, MD, Glassboro, NJ
T4	<i>Challenges in Female Juvenile Detention Facilities (Core)</i>	Susan Chlebowski, MD, Syracuse, NY Joan Gerring, MD, (I) Syracuse, NY
T5	<i>Allostatic Load and Outcomes in Child Maltreatment Cases (Core)</i>	Annette Reynolds, MD, Lexington, KY
T6	<i>Child and Adolescent Forensic Consultation in a Class Action</i>	Annie Steinberg, MD, Narberth, PA
T7	<i>Veteran Status of Prison Suicides in New York State</i>	Ziv Cohen, MD, New York, NY Paul Appelbaum, MD, New York, NY Hal Wortzel, MD, Denver, CO
T8	<i>Juvenile Probation, Offending, and Psychopathy</i>	Ryan Wagoner, MD, Sacramento, CA Edward Mulvey, PhD, (I) Pittsburgh, PA Carol Schubert, MPH, (I) Pittsburgh, PA
T9	<i>Group Therapy: Locked Up, Therapy in a Correctional Setting</i>	Anne McBride, MD, Orangevale, CA Christine Osterhout, MD, (I) Roseville, CA Jason Roof, MD, (I) Sacramento, CA
T10	<i>Trauma and PTSD Among Forensic Psychiatric Inpatients</i>	Varendra Gosein, MD, Brooklyn, NY Elizabeth Ford, MD, New York, NY Irina Komarovskaya, PhD, (I) New York, NY J. David Stiffler, MD, (I) New York, NY
T11	<i>WITHDRAWN</i>	
T12	<i>Parity: A Pair of Conundrums?</i>	Carolina Klein, MD, Alexandria, VA Marie Rosa Alam, MD, Washington, DC
T13	<i>Competence to Give Consent of Patients with Chronic Diseases</i>	Felice Francesco Carabellese, (I) Bari, Italy Roberto Catanesi, (I) Bari, Italy Donatella La Tegola, (I) Bari, Italy Antonio Leo, MD, (I) Bari, Italy Giancarlo Logroscino, (I) Bari, Italy
T14	<i>Fitness for Duty Evaluations of Licensed Professionals</i>	Richard Frierson, MD, Columbia, SC

T15	<i>Violence in the Systems: A Literature Review</i>	Matthew Gaskins, MD, Columbia, SC
T16	<i>The Sadistic Symbiosis of Sadist and Spouse</i>	Melissa Spanggaard, DO, Sioux Falls, SD Sandra Antoniak, MD, Syracuse, NY Robert Hazelwood, MS, (I) Manassas, VA Archana Kathpal, MD, Liverpool, NY Tarun Kumar, MD, (I) Liverpool, NY James Knoll, IV, MD, Syracuse, NY
T17	<i>Psychiatric Comorbidity in Sexually Offending Youth</i>	Shane Savage, MD, Newnan, GA
T18	<i>The Standardized Risk Assessment in US Residency Programs</i>	Howard Forman, MD, New York, NY Merrill Rotter, MD, White Plains, NY
T19	<i>Dangerous Offender Designations and Psychiatric Evaluations</i>	Rebekah Ranger, BSocS, BA, (I) Ottawa, ON, Canada Paul Fedoroff, MD, Ottawa, ON, Canada
T20	<i>Mock Trial: Rationale and Practice</i>	Graham Glancy, MB, Toronto, ON, Canada Lisa Ramshaw, MD, FRCPC, Toronto, ON, Canada
T21	<i>Creation of a Geriatric Forensic/Correctional Rotation</i>	Jason Roof, MD, (I) Sacramento, CA David Hsu, MD, (I) Sacramento, CA
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	OPENING CEREMONY	8:00 AM – 10:00 AM BALLROOM, VICTORIAN BUILDING
T22	<i>Forensic Prevention through Policy and Financing: A Birdseye View</i>	Debra Pinals, MD, Boston, MA
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	COFFEE BREAK	10:00 AM – 10:15 AM CROWN ROOM, VICTORIAN BUILDING
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	AV SESSION	10:15 AM – 12:00 PM BALLROOM, VICTORIAN BUILDING
T23	<i>Interviewing the I-5 Strangler (Advanced)</i>	Park Dietz, MD, Newport Beach, CA
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	PANEL	10:15 AM – 12:00 PM PALM/SUNSET ROOM, CALIFORNIA CABANAS
T24	<i>SVP Programs: Who Gets Released Sexual Offenders Committee</i>	R. Gregg Dwyer, MD, Charleston, SC Dean De Crisce, MD, Jersey City, NJ John Paul Fedoroff, MD, Ottawa, ON, Canada Li-Wen Lee, MD, New York, NY Leonard Mulbry, Jr., MD, Charleston, SC Lisa Murphy, MCA, (I) Ottawa, ON, Canada
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	PANEL	10:15 AM – 12:00 PM GARDEN ROOM, VICTORIAN BUILDING
T25	<i>Forensic Psychiatry and Immigration: Cross Cultural Complexity Cross Cultural Committee</i>	Karen Musalo, JD, (I) San Francisco, CA Maya Prabhu, MD, LLB, New Haven, CT Bandy Lee, MD, (I) New Haven, CT Solange Margery Bertoglia, MD, Philadelphia, PA

WORKSHOP	10:15 AM – 12:00 PM	SEABREEZE ROOM, CALIFORNIA CABANAS
T26	<i>Child/Adolescent Tracks in Adult Forensic Psychiatric Program</i> <i>Child and Adolescent Committee</i>	Annie Steinberg, MD, Narberth, PA Abiola Adelaja, MBBS, Rochester, NY Peter Ash, MD, Atlanta, GA J. Richard Ciccone, MD, Rochester, NY Peter Martin, MD, (I) Rochester, NY
WORKSHOP	10:15 AM – 12:00 PM	CORONET ROOM, VICTORIAN BUILDING
T27	<i>10 Reasons Why Psychiatrists Should Do Their Own Psychometric Testing</i>	Wade Myers, MD, Providence, RI Ryan Hall, MD, Lake Mary, FL Charles Scott, MD, Sacramento, CA
LUNCH (TICKET REQUIRED)	12 NOON – 2:00 PM	CROWN ROOM, VICTORIAN BUILDING
T28	<i>Unconventional Responses to Unique Catastrophes: Tailoring the Law to Meet the Challenges</i>	Kenneth Feinberg, (I) Washington, DC
DEBATE	2:15 PM – 4:00 PM	SEABREEZE ROOM, CALIFORNIA CABANAS
T29	<i>Mass Murder and Mental Illness</i>	Jonathan Barker, MD, Cambridge, MA Lama Bazzi, MD, Brooklyn, NY Renée Binder, MD, San Francisco, CA Kayla Fisher, MD, Memphis, TN Belinda Kelly, MD, San Antonio, TX James Knoll, MD, Syracuse, NY Stephen Noffsinger, MD, Hudson, OH
WORKSHOP	2:15 PM – 4:00 PM	GARDEN ROOM, VICTORIAN BUILDING
T30	<i>Wise Beyond Their Years? Juvenile Competence to Stand Trial</i>	Joseph Chien, DO, New Haven, CT Taiye Ogundipe, MD, (I) New Haven, CT Howard Zonana, MD, New Haven, CT
WORKSHOP	2:15 PM – 4:00 PM	PALM/SUNSET ROOM, CALIFORNIA CABANAS
T31	<i>A Fluid Goldwater Rule: Grasping the Brass Ring of Publicity</i> <i>Private Practice and Peer Review Committees</i>	Trent Holmberg, MD, Draper, UT Charles Dike, MD, Cheshire, CT David Rosmarin, MD, Newton, MA
COURSE (TICKET REQUIRED)	2:15 PM – 6:15 PM	CORONET ROOM, VICTORIAN BUILDING
T32	<i>Psychological Testing of Feigned Psychosis: Test and Testify</i>	Charles Scott, MD, Sacramento, CA Barbara McDermott, PhD, (I) Sacramento, CA
WORKSHOP	2:15 PM – 4:00 PM	BALLROOM, VICTORIAN BUILDING
T33	<i>Do's and Don'ts of Discovery Depositions</i>	Phillip Resnick, MD, Cleveland, OH
COFFEE BREAK	4:00 PM – 4:15 PM	CROWN ROOM, VICTORIAN BUILDING

WORKSHOP	4:15 PM – 6:15 PM	BALLROOM, VICTORIAN BUILDING
T34 <i>Inpatient Violence: Risk Mitigation Strategies</i>	Jeffrey Janofsky, MD, Timonium, MD Kenneth Appelbaum, MD, Shrewsbury, MA Erik Roskes, MD, Baltimore, MD Patricia Sullivan, MS, RN, (I) Baltimore, MD Karin Taylor, PMH, CNS, BC, (I) Timonium, MD	
SCIENTIFIC PAPER SESSION #1	4:15 PM – 6:15 PM	GARDEN ROOM, VICTORIAN BUILDING
T35 <i>Long-Term Competence Restoration</i>	Douglas Morris, MD, Logansport, IN Nathaniel DeYoung, MS, (I) Catawba, VA	
T36 <i>Involuntary Intoxication by Prescribed Medications</i>	Jennifer Piel, MD, JD, Seattle, WA	
T37 <i>Asperger's Disorder and the Criminal Courts: U.S. Case Law</i>	Yufang Chang, MD, MPH, San Francisco, CA Renée Binder, MD, San Francisco, CA Dale McNiel, PhD, (I) San Francisco, CA	
T38 <i>Clozapine's Effect on Institutional Violence and Recidivism</i>	Mansfield Mela, MBBS, FRCP, Saskawon, SK, Canada	
WORKSHOP	4:15 PM – 6:15 PM	SEABREEZE ROOM, CALIFORNIA CABANAS
T39 <i>Forensic Scientists' Challenges and Successes in San Diego Liaison with Forensic Sciences Committee</i>	Manuel Lopez-Leon, MD, New York, NY Ronn Johnson, PhD, (I) San Diego, CA Iain McIntyre, PhD, (I) San Diego, CA Karen Rosenbaum, MD, New York, NY Thomas Streed, PhD, (I) San Diego, CA	
AAPL GOES TO THE MOVIES	7:00 PM – 9:00 PM	BALLROOM, VICTORIAN BUILDING
T40 <i>AAPL Goes to the Movies</i>	Thomas Gutheil, MD, Brookline, MA Lisa Gold, MD, Arlington, VA Stuart Anfang, MD, Longmeadow, MA Barry Wall, MD, Providence, RI	

T1

AND THEN I WOKE UP IN JAIL: AMNESIA CLAIMS IN EVALUATIONS

John Shand, MD, (I) Cleveland, OH
Susan Hatters Friedman, MD, Cleveland Heights, OH
Renée Sorrentino, MD, Quincy, MA

EDUCATIONAL OBJECTIVE

At the end of this session, the attendee will be able to describe the common characteristics of defendants who claimed amnesia for a felony and were referred for forensic psychiatric evaluation, and compare characteristics of those opined incompetent versus those found competent.

SUMMARY

There are many defendants who claim interrupted memory which overlaps all or parts of an alleged crime. This descriptive pilot study seeks to examine the characteristics of defendants who claim amnesia for all or part of an alleged crime. Data was obtained from (n=147) court cases from the Cuyahoga County Court Clinic in Cleveland, Ohio for which amnesia was claimed for all or part of an alleged crime. Data about the defendant was extracted from sanity and competency reports from the years 2001-2011 including: age; sex; crime; Axis I and II diagnoses; substance use; type of amnesia claimed; legal history; history of traumatic brain injury; relationship to victim and psychological testing. Defendants claiming amnesia had a mean age of 36 years and were primarily male. The majority were facing charges for violent felonies, the most common being aggravated assault. The majority of defendants claimed either full amnesia or alcohol induced blackout, had a legal history and had substance dependence disorders. 78.2% of the defendants had more than one Axis I diagnosis while only 5.4% had none. Most were opined to be competent to stand trial and sane at the time of the act.

REFERENCES

Bourget D, Whitehurst L: Amnesia and Crime. *J Am Acad Psychiatry Law* 35:4:469-480, 2007
Zuchowski SJ, Friedman SH, Sorrentino RM, et al: Traumatic Brain Injury, Amnesia and Competency to Stand Trial. *Newsl Am Acad Psychiatry Law* 37:2:1-4,31, 2012

QUESTIONS AND ANSWERS

- 1. What are common characteristics of a defendant claiming amnesia who was referred for psychiatric evaluation?
ANSWER: Commonly a male in his mid-30s, charged with a violent felony against a stranger, along with another crime; with one or more Axis I diagnoses, including a substance dependence diagnosis. Full amnesia for the offense is claimed, including a lack of recollection of the offense.
- 2. What was the rate at which a defendant's amnesia was opined to be a formal diagnosis of malingering?
ANSWER: 2/147 (1.3%)

T2

TRIAL COMPETENCY RESTORATION THRU MUSIC

Andrew Sammons, MA, (I) Napa CA

EDUCATIONAL OBJECTIVE

Audience members will be able to describe the music therapy method Competency Through Music (CTM). Audience members will gain knowledge about the benefit of CTM such as decreased aggression on psychiatric units and decreased length of stay for defendants admitted to trial competency restoration programs.

SUMMARY

Competence to stand trial is a 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). The majority of defendants are committed to an inpatient facility for restoration. Although psychopharmacological intervention is a critical component of restoration, as most defendants are found incompetent for a psychotic disorder, many other modalities of intervention are utilized. Traditional treatment methods include the use of standardized testing and psycho educational group sessions. This research evaluated an innovative intervention using music therapy. Music as the catalyst provides a forum in which psychiatric patients are engaged and observed within a structured environment designed to address both their factual and rational knowledge set as well as abilities to assist their attorney in their defense. Trial competency training through a specific music therapy method called Competency Through Music (CTM) will be presented, including examples of the music used and how music can be used to educate patients and assess competence. The efficacy of this intervention approach will be examined by evaluating changes in length of stay and decreases in aggression for individuals participating in these groups.

REFERENCES

Bertman L: Effect of an Individualized Treatment Protocol on Restoration of Competency in Pretrial Forensic Inpatients. *J Am Acad Psychiatry Law* 31:27-35
Bonnie RJ, Grisso T: Adjudicative competency and youthful offenders in T. Grisso & R.G. Schwartz(Eds.), *Youth on Trial: A developmental perspective of juvenile justice*. Edited by T. Grisso & R.G. Scharz Chicago: University of Chicago Press, 2003, pp 73-103

QUESTIONS AND ANSWERS

1. Traditionally the majority of defendants are treated as inpatients in trial competency programs through what means?
ANSWER: Traditional treatment methods include the use of psychopharmacological intervention, standardized testing and psycho educational group sessions.
2. What is the purpose of using the method Competency Through Music with the incompetent to stand trial population?
ANSWER: Music as the catalyst provides a forum in which psychiatric patients are engaged and observed within a structured environment designed to address both their factual and rational knowledge set as well as abilities to assist their attorney in their defense.

T3

PREVALENCE OF DELUSIONAL DISORDER IN PRISON

Joanna Bajgier, DO, Collingswood, NJ
Rusty Reeves, MD, Piscataway, NJ
Anthony Tamburello, MD, Glassboro, NJ

EDUCATIONAL OBJECTIVE

To discuss the relationship between delusions and violence. To present evidence from the literature and new data suggesting a greater prevalence of delusional disorder in correctional settings than in the community. To identify future opportunities for research on delusional disorder in the field of forensic psychiatry.

SUMMARY

Delusional disorder has important implications for forensic psychiatrists, as delusions are not infrequently related to criminal behavior. The study of delusional disorder has been limited due to its infrequent occurrence (estimated at 0.03% in the general population). Some delusions, especially those of persecution, jealousy, and erotomania, have the potential to lead to criminal activity. Incarceration may be the first opportunity for treatment, as those with delusional disorder are not expected to readily seek attention for their symptoms from community mental health providers. We hypothesize that delusional disorder is over-represented in correctional populations. We are conducting a retrospective chart review of the electronic medical records from 2000 to 2012 of New Jersey Department of Corrections inmates who were currently incarcerated as of March 2012. Potential cases of delusional disorder were initially identified using a search for current or past diagnoses of delusional disorder or other diagnoses that could potentially be misdiagnosed cases of delusional disorder. After an initial chart review identifies a case as "probable delusional disorder" it will be confirmed by at least one concurring independent review. Using prison census data, the number of confirmed cases will be used to estimate a point prevalence for delusional disorder in prison.

REFERENCES

Sarlou E, Duburcq A, Neveu X, et al: Imprisonment, alcohol dependence and risk of delusional disorder: a cross-sectional study. *Revue d'Epidemiologie et de Santé Publique*. 60(3):197-203, 2012
Swanson JW, Swartz M, Van Dorn RA: A national study of violent behavior in persons with schizophrenia. *Arch Gen Psychiatry* 63:490-491, 2006

QUESTIONS AND ANSWERS

1. What is the estimated prevalence of delusional disorder in the general population?
a: 0.001%
b: 0.03%
c: 1%
d: 10%
ANSWER: b
2. According to the CATIE study, which symptom was associated with the greatest risk of serious violence?
a: Persecutory delusions
b: Social withdrawal
c: Poor rapport
d: Problems with abstract thinking
ANSWER: a

T4

CHALLENGES IN FEMALE JUVENILE DETENTION FACILITIES

Susan Chlebowski, MD, Syracuse, NY
Joan Gerring, MD, (I) Syracuse, NY

EDUCATIONAL OBJECTIVE

Increasing the awareness of an increase in female delinquency cases entering detention centers and the reasons for their detention.

SUMMARY

Working with female juvenile offenders poses unique challenges including 1) pharmacologic side effects; 2) chaotic mother daughter relationships; 3) male staff issues; 4) cross gender relationships; 5) sexual identity issues; 6) body image concerns; 7) gang mentality/affiliation; 8) history of sexual trauma and 9) borderline intellectual functioning. 2 to 10% of the offender population has intellectual disabilities which impact treatment and compliance. The youth often have characteristics of borderline, narcissistic and histrionic personality disorders. Externalizing behaviors such as splitting, self harm, staff injury and destruction of property are frequent. Suicidal ideation is common.

REFERENCES

Fazel S, Doll H, Långström N: Mental disorders among adolescents in juvenile detention and correctional facilities: a systematic review and meta-regression analysis of 25 surveys. *J Am Acad Child Adolesc Psychiatry* 47(9):1010-9, 2008
Wasserman G, McReynolds L, Ko S, et al: Gender differences in psychiatric disorders at juvenile probation intake. *Am J of Public Health* 95: 131-137, 2005

QUESTIONS AND ANSWERS

1. In a large psychiatric review, what percent of female juvenile offenders suffered from depression?
 - a. 2%
 - b. 10%
 - c. 29%
 - d. 70%
 - e. 90%ANSWER: c

2. Challenges facing the psychiatrist working with female juvenile offenders include which of the following?
 - a. Galactorrhea with risperidone
 - b. Transient homosexual relationships
 - c. Splitting among staff
 - d. Gang hostility amongst the girls
 - e. Medication refusal and noncompliance
 - f. All of the aboveANSWER: f

T5

ALLOSTATIC LOAD AND OUTCOMES IN CHILD MALTREATMENT CASES

Annette Reynolds, MD, Lexington KY

EDUCATIONAL OBJECTIVE

To define and raise awareness of the effects of allostatic load in child maltreatment cases. To investigate which historical factors are associated with the highest rates of persistent medical, emotional, and behavioral difficulties in abused and neglected children.

SUMMARY

Allostatic load refers to the chronic dysregulation in the hypothalamic-pituitary-adrenal axis that occurs in response to chronic or severe stress and neglect. Severe maltreatment and disrupted attachment have been shown to have negative long-term effects on neuroendocrine, cardiovascular, and immune function. Exposure to persistent trauma and neglect has been linked to poor physical health as well as premature death in the most severe cases. Children in the child welfare system are at particular risk of compounded trauma due to iatrogenic harm from frequently disrupted placements and multiple placements over time which worsens already tenuous attachments. This study seeks to increase awareness of the concept of allostatic load and to determine which factors are associated with the highest rates of persistent medical, emotional, and behavioral difficulties in child maltreatment cases.

REFERENCES

- Clark MS, Bond MJ, Hecker JR: Environmental stress, psychological stress, and allostatic load. *Psychology, Health & Medicine* 12:18-30, 2007
- Sprang G, Katz D, Cooke C: Allostatic load: Considering the burden of cumulative trauma on children in foster care. *J of Child & Adolescent Trauma* 2:242-252, 2009

QUESTIONS AND ANSWERS

1. The effects of severe and cumulative early adverse life experiences have been shown to increase the rates of which of the following conditions in all age groups?
- Obesity
 - Diabetes
 - Atherosclerosis
 - All of the above

ANSWER: d

2. Of the 800,000 children living in foster care in the United States, what percentage have chronic medical conditions?
- 10-30%
 - 30-60%
 - 60-80%
 - > 80%

ANSWER: b

T6

CHILD AND ADOLESCENT FORENSIC CONSULTATION IN A CLASS ACTION

Annie Steinberg, MD, Narberth, PA

EDUCATIONAL OBJECTIVE

This poster describes a psychiatric consultation within three phases of a lawsuit against a pedophilic pediatrician and others: 1) assessing the nature and extent of damages; 2) facilitating a codified solution; and 3) implementing a remedy. The challenge of changing roles and corresponding ethics of the forensic consultant are reviewed.

SUMMARY

Over 1000 alleged victims, most of them very young children (and their families), claimed abuse at the hand of a pediatrician in Lewes, Delaware between 1994 and 2009. Videotaped materials and other evidence were overwhelming. The doctor was convicted of multiple criminal offenses, including rape and sexual exploitation of children, and sentenced to 14 consecutive life terms plus 164 years. A year later, 40 separate lawsuits emerged, asserting additional claims against a hospital and the Medical Society of Delaware. A proposed class action suit was certified (*Jane Doe 30 v. Bradley et al*). Afterwards, hundreds of additional alleged victims were included. Shortly thereafter, the hospital initiated settlement discussions and a retired Delaware Supreme Court Justice became the mediator. This poster will outline the author's involvement: with defense counsel in assessment of the data, with the plaintiffs' counsel regarding the categorization of plaintiffs, and with the attorney assigned to oversee administrative disbursement of the settlement.

REFERENCES

- Hoge MA, Tebes JK, Davidson L, et al: The roles of behavioral health professionals in class action litigation. *Am Acad Psychiatry Law* 30:1:49-58, 2002
- Applebaum P: A theory of ethics for forensic psychiatry. *Am Acad Psychiatry Law* 25:233-47, 1998

QUESTIONS AND ANSWERS

1. When is it appropriate for professionals to change roles during a class action?
- When asked to do so by the mediator
 - After completing all of the medical examinations
 - If he is made an informal member of the trial team
 - When they carefully define the role that they are playing and function in only one role at a time
 - Never

ANSWER: d

2. To avoid problems, a forensic psychiatrist should clarify:

- Functional responsibilities of the role assigned
- Legal parameters for this role
- Ethical principles that should guide behavior
- All of the above

ANSWER: d

Ziv Cohen, MD, New York, NY
 Paul Appelbaum, MD, New York, NY
 Hal Wortzel, MD, Denver, CO

EDUCATIONAL OBJECTIVE

To describe a study of suicide by veterans in a correctional system, highlighting an innovative model of research that utilizes correctional data made publically available through the Freedom of Information Act (FOIA) in combination with the Veterans Benefits Administration (VBA) database.

SUMMARY

Both incarcerated persons and military veterans are known to have elevated rates of suicide compared to the general population. Yet no published studies have reported the proportion of veterans among completed suicides in a prison system. Given high rates of veteran incarceration and mental illness, this is a timely and pressing issue. Through the New York State Freedom of Information Act, the names of the 255 individuals who completed suicide in the New York State Corrections system from 1989 to 2011 have come into the public domain. We have used the publically available Inmate Lookup on the New York Department of Corrections website to characterize these individuals with regard to demographic, criminal, and correctional data. We are now collaborating with the Department of Veterans Affairs (VA) to check the publically available identifying information on these deceased persons against the Veterans Benefits Administration (VBA) database to establish veteran status. The study will report the proportion of completed suicides in New York State Corrections from 1989 to 2011 that were veterans, something which has not been reported for any state. Our research model utilizes publically available information on deceased persons to conduct innovative research in collaboration with the VA.

REFERENCES

Wortzel HS, Binswanger IA, Anderson CA, et al: Suicide among incarcerated veterans. *J Am Academy Psychiatry Law* 37:82-91, 2009
 Wortzel HS, Blatchford P, Connor L, et al: Risk of death for veterans on release from prison. *J Am Academy Psychiatry Law* 40:348-54, 2012

QUESTIONS AND ANSWERS

1. What reasons do we have to suspect that veteran prisoner suicide rates may be particularly high?
 - a. Suicide amongst incarcerated populations is known to be elevated as compared to the general population.
 - b. Studies of veterans in the United States have estimated that veteran suicide rates are approximately 2-3 times that of the general population's suicide rate.
 - c. a and b
 - d. None of the above

ANSWER: c

2. What reasons are there to consider the correctional mental health of veterans a public health concern?

- a. According to the Bureau of Justice Statistics, veterans constitute approximately 10 percent of the US prison population.
- b. Incarcerated veterans are more likely to have serious mental illness as compared to other prisoners.
- c. a and b
- d. None of the above

ANSWER: a

Ryan Wagoner, MD, Sacramento, CA
 Edward Mulvey, PhD, (I) Pittsburgh, PA
 Carol Schubert, MPH, (I) Pittsburgh, PA

EDUCATIONAL OBJECTIVE

This poster will examine the relationships among intensity of juvenile probation services, offender characteristics, and self-reported offending in a large sample of serious juvenile offenders from two different sites. It will also present an analysis of psychopathy's role as a moderating variable in these relationships.

SUMMARY

It is important to understand both the factors which affect apportionment of services and the effectiveness of those services in reducing recidivism in the juvenile justice system. A subset of 1,354 juveniles from Philadelphia County, PA and Maricopa County, AZ in the Pathways to Desistance Study was used for our analysis. These individuals were juveniles sentenced to probation for serious (almost exclusively felony level) crimes. Age and the total risk

score were significantly related to self-reported offending, but the intensity of probation services was not. Self-reported offending was significantly related to subsequent intensity of probation in year 1, but not in the two years following. Age was most consistently related to number of probation sessions across multiple years. The presence of high levels of psychopathic traits, defined as a Youth Psychopathy Checklist Score greater than or equal to 25, did not interact significantly with the variables assessed. In the group with high psychopathy scores, the only variable predictive of self-reported offending was total risk score, and this only occurred in year 1. The predictive value of age and self-reported offending on probation intensity was also lost across all years.

REFERENCES

Murrie DC, Cornell DG, McCoy WK: Psychopathy, conduct disorder, and stigma: Does diagnostic labeling influence juvenile probation officer recommendations. *Law & Human Behavior* 29(3):323-342, 2005
Vidal S, Skeem JL: Effect of psychopathy, abuse, and ethnicity on juvenile probation officers' decision-making and supervision strategies. *Law & Human Behavior* 31:379-498, 2007

QUESTIONS AND ANSWERS

1. Intensity of probation services predicted self-reported offending in which of the following years?

- a. Year 1
- b. Year 2
- c. Year 3
- d. All of the above
- e. None of the above

ANSWER: e

2. High levels of psychopathy interacted with self-reported offending in which of the following ways?

- a. Improved predictive value of total risk score.
- b. Improved predictive value of probation intensity.
- c. Decreased predictive value of total risk score.

ANSWER: c

T9

GROUP THERAPY: LOCKED UP, THERAPY IN A CORRECTIONAL SETTING

Anne McBride, MD, Orangevale, CA
Christine Osterhout, MD, (I) Roseville, CA
Jason Roof, MD, (I) Sacramento, CA

EDUCATIONAL OBJECTIVE

To teach about an innovative forensic experience during residency training. To increase knowledge about the unique characteristics and findings of a group therapy experience in a correctional setting. To teach methods to expand services for a mentally ill incarcerated population.

SUMMARY

In our PGY-3 year of general psychiatry residency at the University of California, Davis, we created a year-long group therapy for women with mood disorders at the Sacramento County Jail. Our motivations for creating the group included early interest in forensic psychiatry, enhancing our knowledge of group therapy, and expanding care for an underserved population. Referrals were accepted from Jail Psychiatric Services throughout the year for a group size of 5-10 women with mood disorders, and we implemented a structure that blended a therapeutic supportive and psychodynamic model. Initial challenges included managing disruptions to the frame and confidentiality in a correctional setting. Group dynamics emerged surrounding subgrouping, transference, and termination. Unique characteristics of group therapy amongst incarcerated women include focus on trauma, substance abuse, instability, family estrangement, and legal issues. Several case examples will be explored to highlight individual group members and overall group dynamics. Outcomes for group members included improved supportive network, increased empathy, and interpersonal growth. Our learning included increased empathy and understanding of incarcerated women with mental illness, expanded knowledge of implementing group therapy in a correctional setting, and appreciation for the need for group therapy both in this underserved population and within residency training.

REFERENCES

Yalom, ID: *The Theory and Practice of Group Psychotherapy*. New York, NY: Basic Books, 1970
Montgomery, C: Role of dynamic group therapy in psychiatry. *Advances in Psychiatric Treatment* 8:34-41, 2002

QUESTIONS AND ANSWERS

- 1. In a study of mental illness in incarcerated women, what did Teplin et al (1996) find that the lifetime prevalence of PTSD was?
 - a. 7%
 - b. 10%
 - c. 22%
 - d. 33%
 - e. 70%

ANSWER: d

- 2. What advantage does utilizing a psychodynamic model for group therapy have?
 - a. Forming a supportive network
 - b. Ability to explore and process unconscious dynamics
 - c. Structured group learning
 - d. Supporting members who attend infrequently
 - e. Dealing with patients in acute crises

ANSWER: b

T10

TRAUMA AND PTSD AMONG FORENSIC PSYCHIATRIC INPATIENTS

Varendra Gosein, MD, Brooklyn, NY
Elizabeth Ford, MD, New York, NY
Irina Komarovskaya, PhD, (I) New York, NY
J. David Stiffler, MD, (I) New York, NY

EDUCATIONAL OBJECTIVE

To understand the rates of traumatic exposure and PTSD in inmates receiving acute psychiatric inpatient treatment. This will aid in developing improved diagnostic and screening procedures, as well as treatment paradigms.

SUMMARY

Inmates represent a vulnerable population with increased rates of trauma and PTSD. Untreated PTSD may have important clinical implications, such as increased comorbidity of other disorders, longer hospital stays, greater healthcare costs, and complicated discharge planning. Little is known about the rates of trauma and PTSD among male forensic psychiatric inpatients. A preliminary chart review revealed only 31% of patients with a history of trauma and only 1% was diagnosed with PTSD. This rate is likely a gross underestimate and suggests that accurate diagnosis of trauma and PTSD can be often overlooked in the context of treatment. The current study aims to assess the rates of trauma and PTSD in this population so as to better guide treatment. Up to 200 randomly selected patients admitted to a hospital jail psychiatry service were assessed using the Life Stressor Checklist-Revised and the Structured Clinical Interview for DSM-IV-TR Disorders, PTSD Module. Demographic information and psychiatric diagnoses were obtained from medical records. The data will be analyzed for rates and types of trauma, age of occurrence, and posttraumatic sequelae. The results of this study will be used to better understand and diagnose trauma in this population and guide effective treatment.

REFERENCES

Gariballa SS, Schauer M, Neuner F, et al: Traumatic events, PTSD, and psychiatric comorbidity in forensic patients – assessed by questionnaires and diagnostic interview. *Clinical Practice and Epidemiology in Mental Health* 2:7, 2006
Gibson LE, Holt JC, Fondacaro KM, et al: An examination of antecedent traumas and psychiatric comorbidity among male inmates with PTSD. *Journal of Traumatic Stress* 12:473-484, 1999

QUESTIONS AND ANSWERS

- 1. According to recent studies, what percentage of individuals admitted to forensic hospitals for long-term psychiatric treatment met lifetime criteria for PTSD?
 - a. 10%
 - b. 15%
 - c. 56%
 - d. 89%

ANSWER: c

- 2. According to recent studies, untreated PTSD can lead to which of the following?
 - a. Exacerbation of other comorbid psychiatric illnesses
 - b. Medical problems such as hypertension and cardiovascular diseases
 - c. Reduced quality of life
 - d. All of the above

ANSWER: d

Carolina Klein, MD, Alexandria VA
Marie Rose Alam, MD, Washington, DC

EDUCATIONAL OBJECTIVE

To compare the legal premises underlying continued hospitalization between medical and psychiatric settings across the states.

SUMMARY

Discharge against medical advice is a common occurrence in general hospitals, often preceded by a psychiatric evaluation of decisional capacity to do so. As part of the evaluation, the level of capacity will bear proportionate relevance to the potential health consequences associated with a departure from hospital care sooner than is medically recommended. In the psychiatric setting, however, a patient's petition to be discharged is preceded by an evaluation of risk or dangerousness, and not an evaluation of decisional capacity to consent or refuse inpatient care. This premise translates into a situation whereby a patient who is not considered to be an imminent danger to self or others, may not have the decisional capacity to consent or refuse hospitalization. Our purpose is to explore state legislation regarding civil commitment, specifically in regards to how it differs in application from psychiatric and medical settings. States vary in their legislature with regard to details of involuntary commitment, and in their parity laws. Given the recent interest in parity between psychiatric and general medical conditions, and the increasing blur between somatic and psychiatric paradigms, laws may require close analysis and understanding for adequate implementation.

REFERENCES

MD. CODE ANN., HEALTH-GEN. § 10-622(a) (2008)
Rosner, R: Principles and Practice of Forensic Psychiatry (2nd ed.). London, UK: Hodder Arnold, 2003

QUESTIONS AND ANSWERS

1. What are two means of involuntary hospitalization available in most states and what are their characteristics?
ANSWER: 1. emergency certification - can be initiated by a number of people and does not require court review, but often accompanied by time-limits on involuntary hospitalization before requiring a hearing. 2. petition for commitment - involve court ordered review and hearing, usually longer than emergency certification, but also time-limited.
2. How is lack of capacity to consent to treatment reconciled with legal criteria for involuntary psychiatric hospitalization?
ANSWER: Oftentimes, it is not. Patients who lack capacity to consent to treatment are allowed to agree to voluntary hospitalization and allowed discharge if dangerousness criteria are not met.

Felice Francesco Carabellese, (I) Bari, Italy
Roberto Catanesi, (I) Bari, Italy
Donatella La Tegola, (I) Bari, Italy
Antonio Leo, MD, (I) Bari, Italy
Giancarlo Logroscino, (I) Bari, Italy

EDUCATIONAL OBJECTIVE

The aim of our study is to assess the competence of patients affected by chronic degenerative diseases of various natures, neuropsychological and organic, to understand their medical condition, need for treatment, and the effects of the drugs and non pharmacological treatments.

SUMMARY

Obtaining informed consent is essential before performing any diagnostic or therapeutic procedure and, in general, is a fundamental element in the doctor-patient relationship. It is clear that for the patient to be competent to give valid consent, s/he must first be properly informed about her/his health condition/s, understand the risks and benefits of the therapy, be aware of the alternative treatments, and be capable of making a decision. Tools have been developed to help assess the levels of competence to give consent. Among these, the best known is the semi-structured interview, the MacCAT-T (Grisso et al., 1997) or the matched version for research protocols (MacCAT-CR) (Appelbaum & Grisso, 2001). The problem of correctly informing and obtaining valid informed consent from patients with neurocognitive diseases and patients with severe diseases in the terminal stage is a hot topic at the present time. To assess the specific degree of impairment induced by different chronic diseases, and of the cognitive and affective capacities involved in the decision process, we investigated the degree of impairment induced by different chronic degenerative diseases (systemic diseases in terminal stage patients; Alzheimer patients; patients with chronic psychotic diseases).

REFERENCES

Paterick TJ, Carson GV, Allen MC, et al: Medical informed consent: general considerations for physicians. *Mayo Clin Proc* 83:313-9, 2008
Marsh FH: Informed consent and the elderly patient. *Clin Geriatr Med* 2:501-10, 1986

QUESTIONS AND ANSWERS

1. What is MacCAT-T?

ANSWER: The MacCAT-T is a semi-structured interview to assess the levels of competence to give consent.

2. What kind of patients value our research?

ANSWER: The research project aims to assess competence to give valid consent to treatment of patients affected by chronic degenerative diseases of various natures: systemic diseases in terminal stages (hospice for terminal patients), Alzheimer's patients, and patients with chronic psychotic disease.

T14

FITNESS FOR DUTY EVALUATIONS OF LICENSED PROFESSIONALS

Richard Frierson, MD, Columbia, SC

EDUCATIONAL OBJECTIVE

This poster will summarize the development of a professionals wellness program that provides fitness for duty evaluations of non-substance impaired medical professionals (physicians, nurses, etc.) for a state licensing board. The types of evaluations requested and summarized outcomes will be presented.

SUMMARY

Most state medical licensing boards have programs that evaluate and manage physicians and other medical professionals who are impaired by substance use. However, there are few organized programs that assess impairment due to mental illness, disruptive behavior in the workplace, dementia, or other causes. Evaluations by this program were requested for a variety of reasons: professional involved in criminal activity (arson, pointing a firearm, impersonating a physician), concerns about potential mental illness or dementia, disruptive behavior in the workplace, or sexual misconduct in the workplace. This poster presents an overview of the development of such a program, the types of referrals received over the first few years and the summarized clinical outcomes of the evaluations. Recommendations for the development of similar programs, fee structures for the evaluations, and opportunity for revenue generation will also be presented.

REFERENCES

Anfang SA, Wall BW: Psychiatric Fitness for Duty Evaluation. *Psychiatric Clin No Am* 29(3): 675-93, 2006
Meyer DJ, Price M: Peer review and psychiatric physician fitness for duty evaluations: analyzing the past and forecasting the future. *Int J Law Psychiatry* 35(5-6):445-51, 2012

QUESTIONS AND ANSWERS

1. Which of the following disorders is most prevalent in physicians referred for fitness for duty evaluation?

- a. Anxiety Disorder
- b. Depressive Disorder
- c. Bipolar Disorder
- d. Dementia
- e. Personality Disorder

ANSWER: b

2. Which of the following health organization characteristics was most associated with disruptive clinician behavior in the workplace?

- a. High census, volume, and patient flow
- b. Low administrative costs
- c. Salary dissatisfaction among employees
- d. Longer shift hours
- e. Lack of continuing education opportunities

ANSWER: a

EDUCATIONAL OBJECTIVE

The purpose of this poster is to review the available medical literature to determine what correlations have been made between violent video game exposure and violent behavior.

SUMMARY

Recently, there have been many news stories of violent incidents wherein children, public safety workers, political figures, or seemingly average Americans are hurt or killed for no apparent reason. Society responds by asking questions about the perpetrators in an attempt to understand possible causes of otherwise unexplainable violence. The perpetrator's recreational habits and personal histories are analyzed for anything that could make someone act out violently. When violent video game play is discovered, the media will often show undeniably graphic images from video games that are designed to be provocative for the viewers linking the games to the violent act being reported on. The connection between video game play and human behavior has been debated since the existence of the electronic media. Do violent video games make a person more likely to be violent? One difficulty answering this question is the vast number of video game players who do not have violent tendencies. The question becomes does exposure to violent video games help create a perpetrator of violence, or because of the prevalence of electronic media, is it a statistical coincidence that a growing majority of people, including perpetrators of violence, have played video games at some point in their life?

REFERENCES

Anderson C, Bushman B: Effects of violent video games on aggressive behavior, aggressive cognition, aggressive affect, physiological arousal, and prosocial behavior: a meta-analytic review of the scientific literature.

Psychological Science 12(5): 353-359, 2001

Ferguson, CJ: The good, the bad and the ugly: a meta-analytic review of positive and negative effects of violent video games. The Psychiatric Quarterly 78(4): 309-316, 2007

QUESTIONS AND ANSWERS

1. When was the Entertainment Software Rating Board established?

- a. 1979
- b. 1984
- c. 1989
- d. 1994
- e. 1999

ANSWER: d

2. Which category of video game players has the highest sales of the past 5 years?

- a. Everyone
- b. Everyone 10 +
- c. Teen
- d. Mature

ANSWER: a

Melissa Spanggaard, DO, Sioux Falls, SD

Sandra Antoniak, MD, Syracuse, NY

Robert Hazelwood, MS, (I) Manassas, VA

Archana Kathpal, MD, Liverpool, NY

Tarun Kumar, MD, (I) Liverpool, NY

James Knoll IV, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

Understand the psychological and relational factors that cause certain women to develop and maintain intimate relationships with men who are highly sadistic sexual offenders.

SUMMARY

The type of sadism demonstrated by sadistic sexual murderers lies at the extreme end of the sexual sadism spectrum. It is not uncommon for this type of offender to have a relatively long-term relationship with a female spouse. There are only two previous studies of spouses of sexually sadistic men. The studies suggest that spouses were subjected to chronic physical, psychological, and sexual torture. The present study builds upon previous research, and involved 7 spouses of sadistic sexual murderers who were interviewed by an FBI Special Agent in the Behavioral Sciences Unit. Not only did these women stay in the relationship, but they voluntarily engaged in dangerous forms

of sexual and criminal behavior. An interview protocol consisting of 453 questions was administered to each spouse to more fully explore the interpersonal factors of their intimate relationships. This study explores important nuances of the relationships, including substance use habits, methods of psychological control and diagnostic findings. The findings are discussed in light of the extant research on female sexual co-offenders, as well as psychological control in abusive relationships.

REFERENCES

Hazelwood R, Warren J, Dietz P: Compliant victims of the sexual sadist. *Australian Fam Physician* 22(4): 10.1-10.5, 1993
Warren J, Hazelwood R: Relational factors associated with sexual sadism: a study of 20 wives and girlfriends. *J Fam Violence* 17(1): 75-89, 2002

QUESTIONS AND ANSWERS

- 1. Most women who become involved with sexual sadists
 - a. Come from single parent homes
 - b. Were physically abused as children
 - c. Were sexually abused as children
 - d. Were emotionally abused as children

ANSWER: d

- 2. Most women who were involved with sexual sadists say that they stayed with them for:

- a. Love
- b. Fear
- c. They believed he would get better
- d. Financial or emotional dependence

ANSWER: c

T17

PSYCHIATRIC COMORBIDITY IN SEXUALLY OFFENDING YOUTH

Shane Savage, MD, Newnan, GA

EDUCATIONAL OBJECTIVE

This poster will examine the diagnoses and prescribed medications on admission of sexually offending youth presenting for treatment at a residential treatment center. Participants will better understand the prevalence of common psychiatric co-morbidities in this population, as salient offender characteristics help to guide understanding, evaluation, and treatment.

SUMMARY

Adolescents commit approximately 30% - 50% of all child molestations in the United States and 20% of rapes. The criminal justice system relies on mental health providers for treatment interventions and solutions to the growing problem of youth-perpetrating sexual offending. Psychiatric comorbidity has been found in approximately 60% to 90% of adolescent sexual abusers. The most prevalent comorbid psychiatric disorders are conduct disorder, mood disorders, anxiety disorders, substance use disorders, and attention-deficit hyperactivity disorder. Younger sexual offenders have a higher number of coexisting psychiatric diagnoses. Adolescent sex offenders are often referred for residential treatment and are prescribed multiple psychotropic medications, targeting a variety of symptom clusters. This poster presentation will report on a systematic review of admission records of sexually offending youth to a residential treatment center, focusing on psychiatric diagnoses and psychotropic medication regimens. The findings illustrate the mental health needs of this population and underscore the need for immediate mental health evaluation and treatment of these youth as they enter the judicial system, as they are often detained in correctional facilities following arrest.

REFERENCES

Bukstein O, Walter H: AACAP Practice Parameter for the Assessment and Treatment of Children and Adolescents Who Are Sexually Abusive of Others, *Journal of the American Academy of Child & Adolescent Psychiatry*. 38:12 Supplement, 1999.
Moore T, Franey K, Geffner R: Introduction: Assessment and Treatment of Youth Who Sexually Offend: An Overview, *J of Child Sexual Abuse*, 13:3-4, 1-13, 2005

QUESTIONS AND ANSWERS

- 1. Which of the following psychiatric disorders are prevalent in sexual offending youth?

- a. Conduct disorder
- b. Mood disorder
- c. Anxiety disorder
- d. ADHD
- e. All of the above

ANSWER: e

2. Psychiatric comorbidity has been found in approximately what % of adolescent sexual abusers?
- a. < 5%
 - b. 10%
 - c. 30%
 - d. > 50%

ANSWER: d

T18

THE STANDARDIZED RISK ASSESSMENT IN US RESIDENCY PROGRAMS

Howard Forman, MD, New York NY
Merrill Rotter, MD, White Plains, NY

EDUCATIONAL OBJECTIVE

To determine if US psychiatric residents are being trained in standardized structured assessments as part of developing competency in violence risk assessment.

SUMMARY

Standardized structured assessment has long been accepted as the gold-standard in violence risk evaluation. While risk assessment is a core competency that must be demonstrated to complete psychiatric residency, it is unclear how widely the use of structured tools is being taught. One recent study showed that even in a residency based in a major research center where many researchers rely on standardized assessments for research, they are not being routinely taught to residents for clinical use. The objective of this study is to determine how widely structured violence risk assessment tools are being taught to psychiatry residents at US Programs. Additionally, the study will assess whether teaching in this area is affected by affiliation with a forensic psychiatry fellowship and/or general attitudes towards teaching standardized clinical assessment tools. A web-based survey has been created and an email with an invitation to complete the survey will be sent to every adult psychiatry residency program in the United States.

REFERENCES

Arbuckle MR, Weinberg M, Harding KJK, et al: The feasibility of standardized patient assessments as a best practice in an academic training program, *Psychiatric Services*, 64:209-211, 2013
Trivedi MH, Rush AJ, Crismon ML, et al: The Texas medication algorithm project (TMAP): clinical results for patients with major depressive disorder. *Archives of General Psychiatry* 61(7): 669-680, 2004

QUESTIONS AND ANSWERS

1. According to APA Guidelines, the use of structured professional judgment in the evaluation of an adult
- a. Is recommended against.
 - b. Is considered something useful for less experienced clinicians.
 - c. Can be an important part of a comprehensive evaluation.
 - d. Is not useful, but is useful in the evaluation of a child.
 - e. Is not mentioned in APA Guidelines.

ANSWER: c

2. Validated Structural Professional Assessments exist for the following

- a. Major Depression
- b. Generalized Anxiety
- c. PTSD
- d. Sexual Offender Recidivism
- e. All of the Above

ANSWER: e

T19

DANGEROUS OFFENDER DESIGNATIONS AND PSYCHIATRIC EVALUATIONS

Rebekah Ranger, BSocS, BA, (I) Ottawa, ON Canada
Paul Fedoroff, MD, Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

The objective is to become aware of the relationship between judicial outcomes in dangerous offender applications and psychiatric evaluations of dangerousness.

SUMMARY

This study investigates the relationship between psychiatric evaluations of dangerousness and judicial outcomes in dangerous and long-term offender applications. Retrospectively, files of 50 men assessed at the Sexual Behaviours Clinic of the Royal Ottawa Mental Health Centre for dangerous offender designations were used. The psychiatric evaluations of dangerousness were compared with trial outcomes to determine their concordance. Results on risk assessments were also compared to judicial outcomes, with the idea that higher risk assessment scores would result

in indeterminate sentencing (dangerous offender status) rather than determinate sentencing (long-term offender status). Lastly, the legal outcomes were studied in order to determine whether judges cited psychiatric evaluations of dangerousness in their final decisions.

REFERENCES

Bonta J, Zinger I, Harris A, et al: The Crown Files Research Project: A Study of Dangerous Offenders. Ottawa, ON: Solicitor General Canada, 1996
Lloyd C, Clark H, Forth A: Psychopathy, expert testimony, and indeterminate sentences: exploring the relationship between psychopathy checklist revised testimony and trial outcome in Canada. *Legal and Criminological Psychology* 15:323-33, 2010

QUESTIONS AND ANSWERS

- 1. What must judges consider before designating an offender a dangerous offender?
ANSWER: A long-term offender status.
- 2. What is the most commonly used risk assessment measure in evaluations of dangerousness in dangerous offender applications?
ANSWER: The psychopathy checklist revised.

T20 **MOCK TRIAL: RATIONALE AND PRACTICE**
Graham Glancy, MB, Toronto, ON, Canada
Lisa Ramshaw, MD, FRCPC, Toronto, ON, Canada

EDUCATIONAL OBJECTIVE

Attendees will be alerted to the efficacy of the mock trial format and understand the rationale for this format. Additionally they will receive practical tips on setting up a mock trial and giving feedback.

SUMMARY

Simulation has been recognized as an effective teaching tool in medical training for some time. Giving testimony in court is the end product of forensic psychiatry and the face of our subspecialty shown to the world. Although teachers impart knowledge well, training a student to perform actions requires different teaching methods. The mock trial format is an example of simulation and this poster outlines the advantages and disadvantages of this format. We also give some practical advice for setting up a mock trial and for giving feedback.

REFERENCES

McGaghie W, Issenberg SB, Cohen ER, et al: Does simulation-based medical education with deliberate practice yield better results than traditional clinical education? A meta-analytic comparative review of the evidence. *Acad Med* 86:706-711, 2011
Alinier G: A typology of educationally focused medical simulation tools. *Med Teach* 29(8): e243-e250, 2007

QUESTIONS AND ANSWERS

- 1. All of the following are advantages of simulation in medical training except:
 - a. It is realistic
 - b. It teaches broad skills
 - c. There is no preparation needed
 - d. There are opportunities for feedbackANSWER: c
- 2. Which of the following is true of the mock trial format:
 - a. There is no context to learning
 - b. Trainees do not like it
 - c. The format increases anxiety like real testimony
 - d. There is no opportunity for feedbackANSWER: c

T21 **CREATION OF A GERIATRIC FORENSIC/CORRECTIONAL ROTATION**
Jason Roof, MD, (I) Sacramento CA
David Hsu, MD, (I) Sacramento, CA

EDUCATIONAL OBJECTIVE

To present innovative forensic/correctional training experience during residency training. To increase knowledge about the unique characteristics of geriatric offenders. To increase knowledge of geriatric psychiatric assessment and treatment in correctional settings. To increase knowledge about instruments of assessment utilized in geriatric populations.

SUMMARY

Training opportunities to specifically work with geriatric offenders in correctional settings afford several educational, research and clinical opportunities benefitting forensic psychiatric residents, geriatric psychiatric residents, general psychiatric residents and medical students. Such an elective was created by David Hsu, MD and Jason Roof, MD at the University of California, Davis in 2012. Motivation for creating this rotation included: a desire to better manage psychiatric conditions of the geriatric offender; exploration of the psychosocial context of the geriatric offender with regard to ancillary staff, social support, and access to durable medical equipment; an opportunity to review the literature on dementia case law and epidemiology of dementia in the correctional setting and to seek out new avenues of research in the geriatric offender population, such as cohort studies on the incidence of falls. No other such training opportunity existed at the University of California, Davis prior to the creation of this elective. Methods and resources for creation of a specific Geriatric Correctional/Forensic elective will be reviewed including methods of screening patients for clinics, resources and screening tools to be introduced to the trainee and techniques of customizing the elective to meet the needs of specific trainees including facilitation of research projects.

REFERENCES

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Lewis CF, Fields C, Rainey E: A study of geriatric forensic evaluatees: who are the violent elderly? J Am Acad Psychiatry Law 34: 324-32, 2006

QUESTIONS AND ANSWERS

1. Management of mental health and medical costs of geriatric patients are estimated to be how many times greater than of younger inmates?

ANSWER: 5 times

2. What age is typically considered to be "geriatric" in incarcerated populations?

ANSWER: 55 years old

T22

FORENSIC PREVENTION THROUGH POLICY AND FINANCING: A BIRDSEYE VIEW

Debra Pinals, MD, Boston, MA

EDUCATIONAL OBJECTIVE

At the end of this presentation, participants will be able to describe national statutory and administrative infrastructure that helps shape programming related to individuals with mental illness in the criminal justice system; and describe directions for forensic mental health professionals to enhance public mental health systems and individual case analyses.

SUMMARY

Given the revolving door of the criminal justice and healthcare systems, individuals who receive care across civil, forensic, and correctional systems are at especially increased risk of disrupted healthcare access and coverage. This results in challenges to individual recovery goals and has led to system-wide analyses to try to improve identification of individuals in need of treatment and their linkage to services. With healthcare reform on the horizon in the United States, and disparate reform approaches being considered across jurisdictions, it is increasingly important to understand public policy and financing and their impact on these connections to forensic services. This presentation reviews overarching administrative and legislative infrastructure that helps shape public programs for justice-involved individuals with behavioral health needs. Information will be provided related to public mental health funding focused on Medicaid and other federal resources, the movement toward community based services, and the impact of these areas on forensic practice and forensic systems. This presentation will review the important role of well-informed and uniquely skilled forensic practitioners can play to enhance individual forensic case analyses and to contribute to the evolution of the forensic mental health system. Through enhanced exposure of forensic trainees and clinicians to these areas, care that individuals receive across the boundaries of correctional and community health services has the potential for further improvement.

REFERENCES

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Baillargeon J, Binswanger IA, Penn JV, et al: Psychiatric disorders and repeat incarcerations: the revolving prison door. Am J Psychiatry 166:103-109, 2009

QUESTIONS AND ANSWERS

- 1. Risk factors for individuals being released from jails and prisons include:
 - a. Higher risk of multiple incarcerations for persons with psychiatric disorders
 - b. Higher risk of death
 - c. Racial and ethnic disparities
 - d. Disruption in health care
 - e. All of the above

ANSWER: e

- 2. The following represents one of the most major shifts in public mental health financing in the last 50 years that impacts justice involved individuals:

- a. The budget of the Substance Abuse and Mental Health Services Administration has contributed to state block grant funding
- b. Medicaid funding has exceeded state public mental health funding
- c. Medicare has expanded reimbursements and included more coverage related to prescriptions
- d. The Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) of 2004 provided a major infrastructure of funding mental health services for offenders with mental illness
- e. Prison budgets have shifted significant funds from correctional facility costs to cover community based services as a strategy to avoid re-incarceration expenses

ANSWER: b

T23

INTERVIEWING THE I-5 STRANGLER

Park Dietz, MD, Newport Beach, CA

EDUCATIONAL OBJECTIVE

This presentation is designed to teach forensic psychiatrists about a novel use of psychiatric interviewing as part of a plea agreement, to demonstrate effective interviewing technique, to teach the benefits of sharing one's findings directly with the defendant, and to teach the pros and cons of participating in television documentaries.

SUMMARY

Prosecutors approached the author while deciding whether to pursue the death penalty for an already incarcerated defendant, dubbed by the media "The I-5 Strangler," for whom sufficient evidence was available to secure conviction on six untried homicides. Ultimately, the decision was made to accept a plea to life without possibility of parole if the defendant agreed to be interviewed by both detectives and the author. Prior to the latter interviews, and with the knowledge of both prosecutors and defense counsel, the defendant agreed to have these interviews filmed for a television documentary. That documentary, given the misleading title "Profiling Evil: The I-5 Strangler" by the network, was aired on MSNBC. The documentary will be played in this session, and the author will describe the experience of conducting the interview, searching for a missing victim, and dealing with the production company and networks in developing the documentary for broadcast. The techniques used to prepare for the interview, conduct the interview, and share the results of the interview with the defendant will be illustrated, discussed, and illuminated.

REFERENCES

Dietz PE: The quest for excellence in forensic psychiatry. Bull Am Acad Psychiatry Law 24:153-163, 1996.
Warren J, Hazelwood RR, Dietz PE: The sexually sadistic serial killer. Journal of Forensic Sciences 41:970-974, 1996.

QUESTIONS AND ANSWERS

- 1. Interviewing techniques that are most effective include:
 - a. Multiple choice questions
 - b. Suggestive questions
 - c. Leading questions
 - d. Avoiding awkward periods of silence
 - e. None of the above

ANSWER: e

- 2. Advantages of participating in documentaries as opposed to news shows include:

- a. No urgency, allowing time for preparation
- b. More thoughtful context
- c. Unlikely to affect ongoing investigation
- d. Likely to air repeatedly
- e. All of the above

ANSWER: e

R. Gregg Dwyer, MD, Charleston SC
 Dean De Crisce, MD, Jersey City, NJ
 John Paul Fedoroff, MD, Ottawa, ON, Canada
 Li-Wen Lee, MD, New York, NY
 Leonard Mulbry, Jr., MD, Charleston, SC
 Lisa Murphy, MCA, (I) Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

This presentation will provide descriptive and comparison data on sexually violent predator treatment programs that have unconditionally discharged committed persons and those that have not. Such information will be of practical value to those who consult with SVP programs and those who conduct commitment and release evaluations.

SUMMARY

How do the state inpatient civil commitment sexual violent predator treatment programs that have released persons back into the community with treatment team endorsement differ from those with no releases and for releases without program endorsement? Are their treatment modalities, criteria for commitment, criteria for release, or clientele significantly different? What about programs that manage offenders with the same type of offense histories but without a civil commitment model such as those in Canada? This panel will present data addressing these questions. A review of states' and federal programs along with the Canadian approach to the same criminal behaviors will provide a picture of who receives treatment and who is identified as safe to be at large in the community and under what circumstances. The evidence-based support or lack thereof will also be presented for each of the aforementioned questions.

REFERENCES

D'Orazio D, Jackson R, Schneider J: SOCCPN Annual Survey of Sex Offender Civil Commitment Programs 2012. Paper presented at the Annual Conference for the Sex Offender Civil Commitment Programs Network, Denver, Colorado, October 2012
 Jumper S, Babula M, Casbon T: Diagnostic profiles of civilly committed sexual offenders in Illinois and other reporting jurisdictions: what we know so far. *International Journal of Offender Therapy and Comparative Criminology* 56(6): 838-8, 2012

QUESTIONS AND ANSWERS

1. What is the most common psychiatric diagnosis among civilly committed persons?

- a. Pedophilia
- b. Sexual Sadism
- c. Paraphilia, NOS with an unnamed paraphilia
- d. Antisocial Personality Disorder
- e. Paraphilia, NOS identified as Coercive Type or Biastophilia (rape)

ANSWER: a

2. What is the most common general treatment modality targeting sexual problem behavior across programs?

- a. Individual therapy
- b. Group therapy
- c. Medication therapy
- d. Aversion therapy

ANSWER: b

Karen Musalo, JD, (I) San Francisco, CA
 Maya Prabhu, MD, LLB, New Haven, CT
 Bandy Lee, MD, (I) New Haven, CT
 Solange Margery Bertoglia, MD, Philadelphia, PA

EDUCATIONAL OBJECTIVE

Participants will learn about the potential cultural challenges for forensic psychiatrists in immigration cases including cross-cultural differences, language barriers, socioeconomic disparities and approaches to mitigating them during the evaluation.

SUMMARY

The need for forensic psychiatrists in immigration cases has been growing. The United Nations High Commissioner for Refugees reports ever increasing numbers of refugees as a result of persistent and new conflict in parts of the world; and the United States and Canada continue to be the two largest recipient countries. Forensic psychiatrists

are frequently called upon to evaluate asylum seekers as well as immigrants in many contexts raising numerous challenges and opportunities for practitioners. This panel will consider the nature of some of those challenges focusing on racial and cultural differences, cultural idioms of distress, shifting cultural identities, biases arising from language barriers, socioeconomic disparities between evaluator and applicant, and countertransference and transference. Perspectives will be provided by both evaluating psychiatrists and immigration attorneys. Focus will also be paid to judicial misunderstandings of cultural differences and ways to convey narrative complexity to skeptical adjudicators.

REFERENCES

Kirmayer L: Failures of imagination: the refugee's narrative in psychiatry. *Anthropology & Medicine* 10:2:167-185, 2003
 Bertoglia SM: Immigrants: A Vulnerable Population, in *Ethical Issues in Forensic Psychiatry: Minimizing Harm*. Chichester, UK: John Wiley & Sons, Ltd, 2010

QUESTIONS AND ANSWERS

1. Immigration adjudication boards such as the Canadian Immigration and Refugee Boards may consider which of the following factors in assessing the credibility of an applicant?
 - a. Nervousness caused by testifying before a tribunal
 - b. The trauma associated with testifying about a trying event such as an arrest or torture
 - c. Cultural differences such as the claimant's experiences with officials of the home country
 - d. Cultural differences such as the claimant's cultural and educational background
 - e. All of the above

ANSWER: e

2. What are the only 5 grounds upon which a refugee claimant may base a claim of persecution under the 1951 United Nations Convention Relating to the Status of Refugees (the Refugee Convention)?

ANSWER: Race, religion, nationality, membership of a particular social group or political opinion.

T26

CHILD/ADOLESCENT TRACKS IN ADULT FORENSIC PSYCHIATRY PROGRAM

Annie Steinberg, MD, Narberth, PA
 Abiola Adelaja, MBBS, Rochester, NY
 Peter Ash, MD, Atlanta, GA
 J. Richard Ciccone, MD, Rochester, NY
 Peter Martin, MD, (I) Rochester, NY

EDUCATIONAL OBJECTIVE

This workshop will provide an overview of the training of child and adolescent forensic psychiatrists in three forensic psychiatry fellowship programs (Emory University, University of Pennsylvania and University of Rochester), with represented programs ranging from those long established to recently begun.

SUMMARY

Despite the acknowledgement that expertise is needed, there remains no formal fellowship to train individuals in the subspecialty of child forensic psychiatry. A small number of adult forensic psychiatry programs in the country have developed a track or specific training with a focus on child and adolescent issues. This workshop will present forensic psychiatry programs that have long developed "tracks" for child and adolescent psychiatrists, along with a more recent programmatic endeavor. Recruitment of child and adolescent fellows, the provision of training that meets ACGME program requirements in forensic psychiatry relevant to children and adolescents, approaches to improving the forensic experience for child and adolescent psychiatry residents, the development of child-focused learning sites and didactic curricular materials will be outlined. A cadre of child and adolescent forensic psychiatrists is needed to address youths involved in the child welfare and juvenile justice system as well as civil litigation. Models of sustainable training initiatives that help the child and adolescent expert competently testify and develop expertise relevant to public policy for children and adolescents involved in the court can be replicated to address this underserved area of forensic psychiatry.

REFERENCES

Scott C: The child and adolescent track in the forensic fellowship. *Child Adolescent Psychiatric Clinics of North America* 20:565-575, 2011
 ACGME Program Requirements for Graduate Medical Education in Forensic Psychiatry. Available at: http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/406pr703_u105.pdf. Accessed February 20, 2013.

QUESTIONS AND ANSWERS

1. Child and adolescent psychiatry residents may seek to pursue forensic training so that they can:
 - a. Evaluate adults with developmental disorders
 - b. Develop expertise in public policy and advocacy
 - c. Work closely with adolescents who have been adjudicated delinquent
 - d. More competently assess those children who have alleged abuse.
 - e. All of the above

ANSWER: e

2. Currently, there is an ACGME-approved Graduate Medical Education Program for
 - a. Child and adolescent psychiatry
 - b. Child forensic psychiatry
 - c. Forensic psychiatry
 - d. Adolescent forensic psychiatry
 - e. a and c

ANSWER: e

T27

10 REASONS WHY PSYCHIATRISTS SHOULD DO THEIR OWN PSYCHOMETRIC TESTING

Wade Myers, MD, Providence, RI
Ryan Hall, MD, Lake Mary, FL
Charles Scott, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

To be able to discuss the advantages gained by psychiatric physicians who independently conduct psychometric testing as a standard part of their forensic consultation practices.

SUMMARY

Psychometrics, the study of variations in human capabilities and traits, dates back to ancient times. Psychiatry has played an important role in the development of modern psychometric tests. For example, Swiss psychiatrist Hermann Rorschach created the Rorschach test and psychiatrist J.C. McKinley co-created the MMPI. Psychometrics has expanded over time and hundreds of testing instruments are now available. Measures are available to assess intelligence, cognition, development, achievement, emotions, attitudes, behaviors, personality, psychopathology, violence risk, malingering, competency, etc. Presently, professionals from myriad backgrounds perform psychometric testing, including but not limited to mental health counselors, social workers, psychologists, psychiatrists, family practitioners, internists, pediatricians, neurologists, guidance counselors, and undergraduates in research labs. Forensic consultants are increasingly expected to perform psychometric testing as part of their evaluative methodology. In some jurisdictions testing is mandated for certain classes of evaluatees. This workshop will address 10 reasons why psychiatrists should do their own psychometric testing. Examples are: (1) performing comprehensive evaluations using state-of-the-art assessment techniques augments the quality and validity of forensic consultation, (2) physicians are uniquely qualified to observe and assess the influence of medical conditions on psychometric testing outcomes, and (3) increasing economic restraints can necessitate forensic evaluations be completed by one professional.

REFERENCES

Schiffer RB, Rao SM, Fogel BS: *Neuropsychiatry* (2nd Edition). Philadelphia, PA: Lippincott, Williams and Wilkins, 2003
Simon RI, Gold LH: *The Textbook of Forensic Psychiatry* (2nd Edition). Washington, DC: American Psychiatric Publishing, 2010

QUESTIONS AND ANSWERS

1. Which of the following psychometric tests might be appropriate to use as part of a comprehensive forensic psychiatry evaluation?
 - a. Static-99
 - b. Mini-mental State Examination
 - c. Test of Memory Malingering
 - d. Positive and Negative Syndrome Scale for Schizophrenia
 - e. All of the above

ANSWER: e

- 2. Psychometric tests are reasonably objective in all of the following areas except for:
 - a. Evaluatee responses
 - b. Scoring protocols
 - c. Question content
 - d. Sensitivity
 - e. Negative predictive power
- ANSWER: a

T28

**UNCONVENTIONAL RESPONSES TO UNIQUE CATASTROPHES:
TAILORING THE LAW TO MEET THE CHALLENGES**

Kenneth Feinberg, (I) Washington, DC

EDUCATIONAL OBJECTIVE

At the conclusion of this presentation, forensic psychiatrists will be able to discuss how the legal system can offer novel approaches to address the practical and philosophical problems of using money as a way to address wrongs and reflect individual worth.

SUMMARY

This talk will focus on how, and under what circumstances, policymakers (e.g. judges, legislators, executive officials) decide to create unique compensation programs to compensate the victims of national tragedies (e.g. the September 11 Terrorist Attacks, the BP Gulf Oil Spill Fund, the Aurora Colorado and Virginia Tech Shootings, etc.). Usually, the American legal system provides court procedures to vindicate the rights of innocent victims; but occasionally, policymakers decide there should be a more efficient, speedy method to compensate victims. The talk will also focus on how victims react to such compensation, and how these special compensation programs provide victims with an opportunity to be heard, to voice their concerns and express their outrage at life's unfairness.

REFERENCES

Feinberg, K: Who Gets What? Fair Compensation After Tragedy and Financial Upheaval. Public Affairs Press, 2012
Feinberg, K: What is Life Worth? The Unprecedented Effort to Compensate the Victims of 9/11. Public Affairs Press, 2005

QUESTIONS AND ANSWERS

- 1. Vietnam Veteran's Agent Orange Litigation Settlement did not achieve the following:
 - a. Acknowledgement that scientific data available made it highly unlikely that any plaintiffs, except perhaps those exposed to chloracne, could legally prove any causal relationship between Agent Orange and any other injury.
 - b. Acknowledgement that any action would almost certainly result in repeated trials and appeals, with likely no resulting ultimate recovery by the plaintiffs.
 - c. The settlement size increased awareness of the general plight of the veteran community.
 - d. Specific guidance on distributing the proceeds among the plaintiffs.
- ANSWER: d

- 2. Compensation and human nature interact based on the following conditions:
 - a. An understanding of how people react to tragedy.
 - b. An understanding of how people view compensation.
 - c. Understanding what people expect in receiving a check.
 - d. All of the above.
- ANSWER: d

T29

MASS MURDER AND MENTAL ILLNESS

Jonathan Barker, MD, Cambridge, MA
 Lama Bazzi, MD, Brooklyn, NY
 Renée Binder, MD, San Francisco, CA
 Kayla Fisher, MD, Memphis, TN
 Belinda Kelly, MD, San Antonio, TX
 James Knoll IV, MD, Syracuse, NY
 Stephen Noffsinger, MD, Hudson, OH

EDUCATIONAL OBJECTIVE

To review the current data concerning mental illness and risk of violence. To review the current legislation regarding patients with mental illness and access to firearms. To understand various models for reducing risk of violence, and mass murder specifically, perpetrated by people with mental illness.

SUMMARY

The position statement to be debated: Gun restriction laws placed on people who suffer from mental illness protects the public and is worth the additional stigma these laws would have on individuals diagnosed with mental illness. Participants will form their own opinions on this position and participate in the discussion after the debate. Debate participants will be Renée Binder, MD, James Knoll, MD, and the following Case Western University forensic fellows: Lama Bazzi, MD, Kayla Fisher, MD, and Belinda Kelly, MD.

REFERENCES

American Psychiatric Association, Position Statement on Access to Firearms by People with Mental Illness. 2009
Knoll, J: Mass shootings and the ethic of the open heart. Medscape Dec 20, 2012.

QUESTIONS AND ANSWERS

1. What was the first federal legislation passed to prevent mentally ill people from buying guns?

- a. The 1968 Gun Control Act
- b. The 1993 Brady Handgun Violence Protection Act
- c. The Firearm Owners Protection Act
- d. The National Firearm Act
- e. Omnibus Crime Control and Safe Streets Act of 1968

ANSWER: a

2. What is the definition of Mass Murder according to the FBI?

- a. Four or more murders occurring during a particular event with no cooling-off period between the murders
- b. A series of two or more murders, committed as separate events, usually, but not always, by one offender acting alone
- c. Killings at two or more locations with almost no time break between murders
- d. An individual kills one or more other persons before, or at the same time as, killing him- or herself
- e. Two or more murders occurring during a single event by a single perpetrator

ANSWER: a

T30

WISE BEYOND THEIR YEARS? JUVENILE COMPETENCE TO STAND TRIAL

Joseph Chien, DO, New Haven, CT

Taiye Ogundipe, MD, (I) New Haven, CT

Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

To review the history of juvenile justice in the United States and the evolving standards in the evaluation and treatment of juvenile competence to stand trial (CST).

SUMMARY

American juvenile courts were created at the turn of the century with the goal of rehabilitating deviant youths. Under the *parens patriae* philosophy, these courts were non-adversarial and focused on the well-being and rehabilitation of youth, with little consideration given to the due process rights of children. However, in the 1960s, the Supreme Court cases *Kent vs. United States* and *In re Gault* raised the issue of whether juveniles should be entitled to the same constitutional due process protections as adults. The 1980s saw an explosion of juvenile arrests for violent crimes, leading to the “criminalization” of juvenile court. With these changes, the competence of juveniles to stand trial has emerged as an issue for legislators as well as clinicians. The workshop will outline the evolution of juvenile adjudicative competency and explore the challenges inherent in conducting competency evaluations of minors. A case study will highlight the complexity of these evaluations, emphasizing the role of developmental theory, and examining the State’s diverse interests in risk management, criminal adjudication, and service provision. Finally, trends in treatment of juveniles found incompetent to stand trial will be explored, and results from research on Connecticut youth undergoing competency remediation will be presented.

REFERENCES

Soulier MF, Scott CL: Juveniles in court. *Harv Rev Psychiatry* 18(6): 217-325, 2010

Kruh I, Grisso T: *Evaluation of Juveniles’ Competence to Stand Trial*. New York, NY: Oxford University Press, 2009

QUESTIONS AND ANSWERS

1. When was the first juvenile court created?

- a. In 1967 in response to *In re Gault*
- b. In 1982 by Ronald Reagan.
- c. In 1899 by the Illinois Juvenile Court Act
- d. In 1825 by the New York Society for Prevention of Juvenile Delinquency

ANSWER: c

2. In a 2001 study by McGaha et al., what was the Axis I diagnosis most represented in a sample of juvenile defendants referred for CST remediation?
- Psychotic Disorder NOS
 - Mood Disorder NOS
 - ADHD
 - Conduct Disorder
 - Adjustment Disorder
- ANSWER: d

T31

A FLUID GOLDWATER RULE: GRASPING THE BRASS RING OF PUBLICITY

Trent Holmberg, MD, Draper UT
 Charles Dike, MD, Cheshire, CT
 David Rosmarin, MD, Newton, MA

EDUCATIONAL OBJECTIVE

Service: To improve knowledge of existing standards regarding ethical interactions with the media. Teaching: To develop and improve skill in educating the public regarding forensic psychiatric issues via ethical interaction with the media.

SUMMARY

This workshop will explore ethical issues relating to the interaction between forensic psychiatrists and the media. Dr. Holmberg, Chair of the Private Practice Committee, Dr. Rosmarin, Chair of the Peer Review Committee, and Dr. Dike, Chair of the Ethics Committee, will review the history of the APA as it relates to the advent of the "Goldwater Rule," an ethical standard published by the APA in 1973 and thought to have been written in response to Barry Goldwater's successful libel suit against Fact magazine. Arguments for and against a strict application of the Goldwater Rule will be discussed. Audience commentary will be encouraged. Following the presentation of the historical context and a discussion of the ethical issues in general, an audiovisual training session will follow. In this training, Drs. Holmberg, Rosmarin and Dike will show clips illustrating both laudable and questionable comments made by various mental health professionals to media outlets regarding various public figures. Exercises will be conducted in which audience members will be asked to attempt to formulate an ethically defensible response to actual questions that have been posed by media representatives to mental health professionals in actual cases. Audience participation will be encouraged.

REFERENCES

American Psychiatric Association. The Principles of Medical Ethics: Principles With Annotations Especially Applicable to Psychiatry. Arlington, VA: American Psychiatric Press Inc, 2010
 Post JM: Ethical considerations in psychiatric profiling of political figures. Psychiatr Clin North Am 25(3):635-646, 2002

QUESTIONS AND ANSWERS

- According to the "Goldwater Rule," Section 7.3 of The APA's Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, a psychiatrist may ethically take which of the following actions when asked to comment about a public figure?
 - Offer a professional opinion regarding what diagnosis s/he would assign if the public figure were a patient
 - Offer a professional opinion that the public figure does not have a psychiatric disorder
 - Offer a legal conclusion about the public figure - i.e. that s/he is "sane," "competent" or "fit" for public office
 - Share with the public his or her expertise about psychiatric issues in general
 - None of the above - the psychiatrist should decline to discuss the public figure

ANSWER: d
- A few years ago, an APA task force discussed a revision of the Goldwater Rule that would allow an exception to the rule in certain circumstances. In which of the following circumstances could such an exception be ethically justifiable?
 - A living individual voluntarily publishes extensive information about him/herself, such that a psychiatrist believes s/he can review such information and formulate a diagnosis.
 - The public figure being discussed is a deceased individual of historical importance and the psychiatrist's opinion is part of a scholarly project.
 - An analysis of the public figure could provide information that would promote a compelling national security interest and the psychiatrist's opinions are provided to the relevant government officials at their request.
 - b & c
 - All of the above

ANSWER: d

EDUCATIONAL OBJECTIVE

This course will provide hands-on training on the use of two structured assessments to assess malingering of psychosis: the M-FAST and the SIRS. The audience participant will learn how to administer and score each instrument, how to summarize findings and how to testify on their use.

SUMMARY

The assessment of malingering is a critical component of a comprehensive forensic assessment. In order to accurately diagnose malingering, an evaluation is required to verify that feigning is occurring and an external incentive exists. This evaluation should consist of extensive interviewing, contact with collateral informants, and adjunctive psychological testing. Experienced clinicians often rely too heavily on clinical opinion alone without systematically assessing for malingering. In criminal forensic assessments, estimates of malingering are approximately 15 to 20 percent. Since successful malingerers are not included in these figures, the actual numbers may be higher. This course will describe the structured assessment strategies that are useful in evaluating the possibility of malingering of psychiatric symptoms. Two assessments will be described in detail: the Miller Forensic Assessment of Symptoms Test (M-FAST) and the Structured Interview of Reported Symptoms (SIRS). Relevant scale development information will be presented for each assessment, including validity, reliability and details of the normative samples. The administration of each instrument will be demonstrated with opportunities for attendees to receive supervised administration experience. Role playing of common types of evaluatees will be demonstrated, as well as pitfalls in courtroom testimony when these instruments are used.

REFERENCES

Jackson RL, Rogers R, Sewell KW: Forensic applications of the Miller Forensic Assessment of Symptoms Test (MFAST): screening for feigned disorders in competency to stand trial evaluations. *Law and Human Behavior* 29: 199-210, 2005
 Scott CL, McDermott BE: Malingering and mental health disability evaluations, in *Clinical Guide to Mental Disability Evaluations*. Edited by Gold LH, Vanderpool D. New York, NY: Springer Science and Business Media, 2013

QUESTIONS AND ANSWERS

1. What is the cutoff score for suspecting malingering on the M-FAST?
 - a. Greater than 6
 - b. Greater than 10
 - c. Greater than or equal to 6
 - d. Greater than or equal to 10

ANSWER: c

2. What is the cut-off score for malingering on the SIRS-2?
 - a. Three (or more) primary scales in the definite range
 - b. Three (or more) primary scales in the probable range
 - c. One primary scale in the definite range and three primary scales in the probable range
 - d. None of the above

ANSWER: d

EDUCATIONAL OBJECTIVE

To increase skills in being deposed by understanding attorneys' goals and avoiding common pitfalls.

SUMMARY

Since over 90% of civil cases settle before trial, the expert's deposition often has substantial impact on the amount of settlement. The goals of deposing attorneys are to learn your opinions, assess you as a witness and gather ammunition to impeach you at trial. Preparation should include thorough knowledge of facts, being appropriately dressed, and being well rested. The expert deponent should listen carefully to each question and pause before answering. Information beyond the question should not be volunteered because it will open up new areas for questioning, provide ammunition for attacks, eliminate the opportunity for surprise, and the information fails to get to the jury. Roles sometimes played by deposing attorneys include: Mr. Friendly; Ms. Silent; Eager student; and Mr. Unpredictable. The workshop will cover the deponent's rights, the meaning of objections, and how to answer questions about documents. Deponents should not answer compound questions, certain types of hypothetical questions, and should not speculate. Some attorney ploys will be identified. Ten video clips will illustrate deposition issues and provide the audience an opportunity to interact by volunteering their answers to specific questions. Ample time will be left for questions and comments about deposition issues encountered by participants.

REFERENCES

Gutheil TG: Deposition Do's and Don'ts: Strategies for the Expert Witness in Forensic Psychiatry, Psychiatric Clinics of North America, Clinics Review Articles. Edited by Scott CL. Philadelphia, PA: Elsevier, 2012.
 Knoll J, Resnick PJ: Do's and don'ts for depositions: how to answer 8 tricky questions. Current Psychiatry 7:25-28, 36, 39-4, 2008

QUESTIONS AND ANSWERS

1. The expert witness deponent should do all the following EXCEPT:
 a. Be well rested.
 b. Bring up-to-date CV.
 c. Dress professionally.
 d. Discard interview notes from your examination.
 e. Avoid appearing arrogant.
 ANSWER: d

2. Volunteering information in a discovery deposition does all of the following EXCEPT:
 a. Open up new areas for questioning.
 b. Provide potential ammunition to the deposing attorney.
 c. Educate the deposing attorney.
 d. Convey information to the jury.
 e. Eliminate opportunities for surprise at trial.
 ANSWER: d

T34

INPATIENT VIOLENCE: RISK MITIGATION STRATEGIES

Jeffrey Janofsky, MD, Timonium MD
 Kenneth Appelbaum, MD, Shrewsbury, MA
 Erik Roskes, MD, Baltimore, MD
 Patricia Sullivan, MS, RN, (I) Baltimore, MD
 Karin Taylor, PMH, CNS, BC, (I) Timonium, MD

EDUCATIONAL OBJECTIVE

Participants will understand: types of violence in health care settings; typologies and prevalence of violence from patients to staff on inpatient psychiatric units; and best practices for managing violence risk on inpatient psychiatric units.

SUMMARY

In its June 2010 Sentinel Event Alert, the Joint Commission focused on assault, rape or homicide of patients and visitors perpetrated by staff, visitors, other patients, and intruders at health care institutions. The Joint Commission noted a significant increase in such sentinel events since 2004. The Commission made several general recommendations for improvement. Unfortunately the document did not focus on patient on staff violence, which has become a growing problem in health care facilities. In contrast, The Occupational Health and Safety Administration (OSHA) collects data and has issued guidance to help measure and reduce patient on staff violence in health care facilities. OSHA has found that 48 percent of all non-fatal injuries from occupational assaults and violent acts occurred in health care and social services. Health care and social service workers are at high risk of violent assault at work. Motivation for inpatient violence is typically categorized as either reactive, instrumental, or psychotic. Workshop members are experienced psychiatrists and senior psychiatric nurses who have dealt with inpatient violence mitigation in a variety of civil and forensic hospital settings. Workshop members will discuss how to identify patients who are at high risk for inpatient violence and violence mitigation strategies.

REFERENCES

Preventing Violence in the Health Care Setting. Available at http://www.jointcommission.org/assets/1/18/SEA_45.PDF. Accessed February 26, 2013
 OSHA Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers Available at <http://www.osha.gov/Publications/osh3148.pdf>. Accessed February 26, 2013

QUESTIONS AND ANSWERS

1. What does the Clinical Violence triad include?
 ANSWER: Histories of violence toward others; History of personal victimization; substance use disorder
2. What are the most common precipitants of inpatient violence?
 ANSWER: Denial of service; Acute psychosis; Excess sensory stimulation

Douglas Morris, MD, Logansport, IN
Nathaniel DeYoung, MS, (I) Catawba, VA

EDUCATIONAL OBJECTIVE

Upon completion of this activity, participants should be able to discuss factors associated with successful long-term competence restoration and evidence regarding reasonable periods of time for restoration efforts.

SUMMARY

While the United States Supreme Court's *Jackson v. Indiana* decision and most state statutes mandate determinations of incompetent defendants' restoration probabilities, courts and forensic clinicians continue to lack empirical evidence to guide these determinations and do not yet have a consensus regarding whether and under what circumstances incompetent defendants are restorable. The evidence base concerning the restoration likelihood of those defendants who fail initial restoration efforts is even further diminished and has largely gone unstudied. With this study, we report the disposition of a cohort of defendants who underwent long-term competence restoration efforts (greater than six months) and identify factors related to whether these defendants were able to attain restoration and adjudicative success. Approximately two-thirds ($n = 52$) of the 81 individuals undergoing extended restoration efforts were eventually opined restored to competence. Lengths of hospitalization to restoration success are presented with implications for the reasonable length of time restoration efforts should persist. Older individuals were less likely to be restored and successfully adjudicated, and individuals with more severe charges and greater factual legal understanding were more likely to be restored and adjudicated. The significance of these findings for courts and forensic clinicians is discussed.

REFERENCES

Morris DR, DeYoung MS: Psycholegal abilities and restoration of competence to stand trial. *Behav Sci Law* 30:710-28, 2012
Kaufman AR, Bruce BW, Suardi E: Forty years after *Jackson v. Indiana*: States' compliance with "reasonable period of time" ruling. *J Am Acad Psychiatry Law* 40:261-5, 2012

QUESTIONS AND ANSWERS

1. Which of the following describes states' responses to the *Jackson v. Indiana* mandate that criminal defendants may be confined for only the reasonable period of time necessary to determine whether there is a substantial probability of restoration in the foreseeable future?
 - a. Many states specify a restoration period of one year or less.
 - b. Many states link restoration limits to the criminal penalty for the alleged offense.
 - c. Many states continue to set no limits on confinement for restoration efforts.
 - d. There remains a great deal of heterogeneity regarding states' responses to this mandate.
 - e. All of the above.

ANSWER: e

2. Which of the following statements regarding the United States Supreme Court's *Jackson v. Indiana* decision is false?
 - a. The Court ruled that Jackson's due process rights had been violated.
 - b. The Court ruled that Jackson's equal protection rights had been violated.
 - c. The Court opined that a defendant committed solely on the basis of his incompetency to proceed to trial cannot be held more than the reasonable period of time to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future.
 - d. The Court ruled that due process required that Jackson's charges be dismissed.

ANSWER: Answer: D

Jennifer Piel, MD, JD, Seattle, WA

EDUCATIONAL OBJECTIVE

Subtitled "Take Two Pills and Blame Me in the Morning: The Defense of Involuntary Intoxication by Prescribed Medications," this presentation will review the criminal defense of involuntary intoxication when a defendant claims intoxication from prescribed medication. The legal standards as well as practice pointers for the forensic assessment will be discussed.

SUMMARY

The defense of involuntary intoxication has long been an exception to the general notion that intoxication is not a defense to criminal liability. The consumption of medications prescribed by a physician can form the basis of an involuntary intoxication defense. Reviewed here are legal cases where defendants relied on the use of prescribed medications for their involuntary intoxication defense. Trends identified in the cases will be discussed, including the types of medications most frequently "blamed" by defendants for their aberrant behavior and concomitant use of medication with alcohol or illicit drugs. Common pitfalls and practice pointers for the forensic evaluator will also be reviewed.

REFERENCES

Perkins v. United States, 228 F. 208 (1915)
 Daley C, McNeil D, Binder R: "I did what?" Zolpidem and the courts. J Am Acad Psychiatry Law 39:535-42, 2011

QUESTIONS AND ANSWERS

1. Which is the seminal case that discussed the defense of involuntary intoxication when a defendant claimed that his criminal act was caused by ingested medication?
 - a. Model Penal Code
 - b. Perkins v. United States, 228 F. 208 (1915)
 - c. People v. Murray, 247 Cal. App. 730 (1967)
 - d. M’Naghten’s Case, 101 Cl. & F. 200, 8 Eng. Rep. 718 (H.L 1843)

ANSWER: b

2. From a review of appellate legal cases, which class of psychotropic medication do criminal defendants most frequently claim in their defense of involuntary intoxication?
 - a. Stimulants
 - b. Sedative hypnotics
 - c. SSRIs
 - d. Mood stabilizers

ANSWER: b

T37

ASPERGER’S DISORDER AND THE CRIMINAL COURTS: U.S. CASE LAW

YuFang Chang, MD, MPH, San Francisco CA
 Renée Binder, MD, San Francisco, CA
 Dale McNeil, PhD, (I) San Francisco, CA

EDUCATIONAL OBJECTIVE

To discuss the circumstances under which individuals with Asperger’s Disorder are likely to come into contact as offenders within the criminal justice system and the use of Asperger’s Disorder as a defense in U.S. case law.

SUMMARY

Asperger’s Disorder (AD) has been offered as a basis for multiple criminal defenses within the United States legal system. These include issues of trial competency and self-representation, refutation of mens rea, diminished capacity, and sentencing mitigation. We examine the admissibility of expert testimony that was offered for each issue. Examination of case law involving AD reveals that AD has received mixed treatment by the criminal courts. An accurate and reliable diagnosis is fundamental in the acceptance of expert testimony regarding AD. In successful defenses, the diagnosis of AD was consistent across expert witnesses, and behaviors associated with this disorder were also revealed in lay witness testimony. The mere presence of this disorder, however, is not adequate. It is important to relate a defendant’s specific deficits to the components of competency and/or the crime committed. Expert testimony regarding AD has been excluded or deemed irrelevant for failure to link the specific deficits to competency and/or the criminal act. Recommendations for the forensic expert will be discussed as well as implications of the change in diagnostic criteria in DSM-V.

REFERENCES

Haskins BG, Silva JA: AD and criminal behavior: forensic psychiatric considerations. J Am Acad Psychiatry Law 34:374-84, 2006
 Schwartz-Watts DM: Asperger’s disorder and murder. J Am Acad Psychiatry Law 33(3): 390-393, 2005

QUESTIONS AND ANSWERS

1. For which of the following criminal defenses has the diagnosis of Asperger’s Disorder been used?
 - a. Competency to Stand Trial
 - b. Competency to Self-Represent
 - c. Refutation of mens rea
 - d. Diminished Capacity
 - e. All of the above

ANSWER: e

2. A forensic evaluation of a defendant with Asperger’s Disorder should include:
 - a. Collateral information from sources such as family, peers, teachers and employers
 - b. A developmental history
 - c. An interview informed by DSM criteria
 - d. A determination of the relationship between the deficits and the legal issue
 - e. All of the above

ANSWER: e

EDUCATIONAL OBJECTIVE

1. Become aware of the impact of clozapine's anti-aggressive properties on risk factors of recidivism among psychotic mentally disordered offenders.
2. Learn about clozapine's effectiveness in reducing institutional violent incidents among mentally disordered offenders.
3. Learn about effectiveness in reducing recidivism among high risk mentally disordered offenders released in the community.

SUMMARY

Among treatment-resistant psychotic and mentally retarded patients, clozapine's role as an anti-aggressive agent beyond its antipsychotic effect is already known. Clozapine reduces self-directed aggression directed towards others. The study was completed among mentally disordered offenders at the Regional Psychiatric Centre Saskatoon, a multilevel secure forensic psychiatry facility. Patients on clozapine (65) were matched to a comparison group of 33 patients admitted during the same period. This comparison group had never been on clozapine but were required to have been on any other antipsychotic medication for at least six weeks. After two years in the community, the rates of recidivism (total, non-violent, violent and sexual) were compared. Two years after the initiation of the psychotropic medications, those on clozapine had significantly lower rates of institutional violent incidents. Among the 62 released offenders, there was no statistically significant difference in rates of offending but the mean length of time from release to offending on clozapine was significantly longer than those not on clozapine. These results suggest that clozapine improves clinical and institutional adjustment outcomes as well as recidivism lowering effects. Clozapine thus adds positive effects on functional and correctional variables among mentally disordered offenders with high risk of offending.

REFERENCES

- Buckley P, Bartell J, Donenwirth K, et al: Violence and schizophrenia: Clozapine as a specific antiaggressive agent. *Bull Am Acad Psychiatry Law* 23:607-611, 1995
- Balbuena L, Mela MA, Tempier R, et al: Does Clozapine promote employability and reduce offending among mentally disordered offenders. *Canadian Journal of Psychiatry* 55(1):50-56, 2010

QUESTIONS AND ANSWERS

1. The following have been described on clozapine's use among mentally disordered offenders except
 - a. decrease rates of agranulocytosis
 - b. reduction of BPRS scores
 - c. reduction of aggressive scores without reduction in psychotic symptoms
 - d. a significant effective response within six months of therapy
 - e. improved employability
 ANSWER: a

2. The following are important side effects of clozapine to watch specifically when using doses over 900 milligrams
 - a. Agranulocytosis
 - b. Cardiomyopathy
 - c. Constipation
 - d. Epileptic seizures
 - e. Myocarditis
 ANSWER: d

Manuel Lopez-Leon, MD, New York, NY
 Ronn Johnson, PhD, (I) San Diego, CA
 Iain McIntyre, PhD, (I) San Diego, CA
 Karen Rosenbaum, MD, New York, NY
 Thomas Streed, PhD, (I) San Diego, CA

EDUCATIONAL OBJECTIVE

The attendees will learn about the challenges and successes of forensic sciences that overlap with forensic psychiatry, including the role of forensic science in coerced false statements during police interrogation, the challenges of forensic toxicology in postmortem analysis, and mental health evaluations of officers at the San Diego PD.

SUMMARY

The Liaison with Forensic Sciences Committee has a traditional forensic sampler each year, bringing forensic experts from different fields to discuss issues of interest and relevance to forensic psychiatrists, and creating awareness of the American Academy of Forensic Sciences (AAFS). This prestigious organization, which is the largest forensic sciences professional organization in the US, represents the following sections: Psychiatry & Behavioral Sciences, Pathology/Biology, Criminalistics, Toxicology, Physical Anthropology, Odontology, Questioned Documents, Jurisprudence, Digital & Multimedia, Engineering Science, and a General Section. The forensic experts bring a wealth of knowledge, some of which is extremely pertinent to forensic psychiatrists. This year, the forensic sampler's guests will discuss the evaluation and analysis of police interrogation which has, in some cases, led to coerced false confessions and statements. The panel will also explore some general principles of forensic toxicology and issues related to the postmortem analysis. The discussion will include case presentations which may overlap with psychiatric issues. The panel will also discuss the challenges working with the San Diego Police Department in the identification and treatment of officers who may have mental health issues.

REFERENCES

McIntyre IM, Meyer Escott C: Editorial: postmortem drug redistribution. *J Forensic Research* 3:e108. doi:10.4172/2157-7145.1000e108, 2012.
 Streed T: Complex Issues of Proof and the Use of Forensic Experts ~ Use and Recognition of Torture in Coerced Confessions in the World's Judicial Systems , in *Central Asia Regional Criminal Law Program*. Almaty, Kazakhstan: 2011

QUESTIONS AND ANSWERS

1. Do coerced false confessions or false statements frequently lead to the conviction of innocent defendants?
 ANSWER: A false confession is an admission of guilt in a crime in which the confessor is not responsible for the crime. False confessions can be induced through coercion or by the mental disorder or incompetency of the accused. Even though false confessions might appear to be an exceptional and unlikely event, they occur on a regular basis in case law, which is one of the reasons why jurisprudence has established a series of rules to detect, and subsequently reject, false confessions. These are called the "confession rules." Plea agreements typically require the defendant to stipulate to a set of facts establishing he/she is guilty of the offense; in the United States federal system, before entering judgment on a guilty plea, the court must determine that there is a factual basis for the plea.

2. Why is postmortem forensic toxicological analysis crucial in elucidating the role of psychoactive agents in individuals who perpetrate violent acts towards themselves and others?
 ANSWER: Psychoactive legal and illegal drugs may induce mania, hostility, violence and even homicidal ideation. Dozens of high profile shootings/killings tied to their use are linked to senseless acts of senseless violence.

T40

AAPL GOES TO THE MOVIES

Thomas Gutheil, MD, Brookline, MA
 Lisa Gold, MD, Arlington, VA
 Stuart Anfang, MD, Longmeadow, MA
 Barry Wall, MD, Providence, RI

EDUCATIONAL OBJECTIVE

At the end of this program, participants will be able to discuss typologies of forensic experts that the lay public encounters in media and understand how movies can contribute to teaching particular aspects of forensic psychiatry.

SUMMARY:

Media portrayals of forensic psychiatrists often give the public an inaccurate and negative perception of the field. Nevertheless, stereotypes of forensic psychiatrists portrayed in the popular media provoke interest in forensic psychiatry and can provide lessons on what not to do when serving in a forensic role. Avoiding the use of jargon, awareness of criticism of experts as hired guns, the dangers of losing objectivity, and not acting for personal reasons or feelings is amply illustrated in a showing of the 1938 film *The Amazing Dr. Clitterhouse*. Edward G. Robinson plays Dr. Clitterhouse, a brilliant physician obsessed with understanding the criminal mind. After thieves interrupt his 'medical experiment' of robbing a safe, he decides to infiltrate a gang led by Rocks Valentine (Humphrey Bogart). Come on out to see how far Dr. Clitterhouse will go for the sake of his research.

REFERENCES

Hatters Friedman S: Reel forensic experts: forensic psychiatrists as portrayed on screen. *J Am Acad Psychiatry Law* 39:412-417, 2011
 Gutheil T: Teaching movies for the American Academy of Psychiatry and the Law. *American Academy of Psychiatry and the Law Newsletter* 37(2): 25-26, 2012

QUESTIONS AND ANSWERS

1. Which of the following films do not include a forensic psychiatric character(s)?

- a. Primal Fear
- b. Mr. Deeds Goes to Town
- c. The Verdict
- d. Psycho
- e. Basic Instinct 2

ANSWER: c

2. From the viewpoint of training young forensic psychiatrists what is the most relevant risk faced by Dr. Clitterhouse?

- a. going to jail
- b. continuing a career in crime
- c. acting unethically
- d. loss of objectivity
- e. all of the above

ANSWER: e

FRIDAY, OCTOBER 25, 2013

POSTER SESSION B	7:00 AM – 8:00 AM/ 9:30 AM – 10:15 AM	CROWN ROOM, VICTORIAN BUILDING
F1	<i>Joint Law and Psychiatry Seminar Improves Relationship</i>	Mansfield Mela, MBBS, FRCP, Saskawon, SK, Canada Glen Edward Luther, JD, (I) Saskawon, SK, Canada Krista Trinder, MSC, (I) Saskawon, SK, Canada Marcel D'Eon, PhD, (I) Saskawon, SK, Canada
F2	<i>Child Pornography Sentencing and Treatment</i>	Seth Silverman, MD, Houston, TX Jerry McKenney, JD, (I) Houston, TX
F3	<i>Self-Reported Measures for Mentally Disordered Offenders</i>	A.G. Ahmed, MBBS, Brockville, ON, Canada Nicole Rodrigues, BA, (I) Brockville, ON, Canada Wagay Loza, CPsych, (I) Brockville, ON, Canada Michael Seto, CPsych, (I) Brockville, ON, Canada
F4	<i>Cybersexual Harassment and Adolescents</i>	Simha Ravven, MD, Somerville, MA Amy Funkenstein, MD, (I) Providence, RI Fabian Saleh, MD, Boston, MA
F5	<i>The Impact of Race on Filicide</i>	Nicole Graham, MD, Gainesville, FL
F6	<i>Sex Offenders, Empathy Deficits, and Oxytocin (Core)</i>	Alicia Bales, MD, Marina Del Ray, CA
F7	<i>Involuntary Medication, Inpatient Days and Offenses in Prison</i>	Anasuya Salem, MD, Basking Ridge, NJ Nicole Dorio, DO, Stewartsville, NJ Rusty Reeves, MD, South Orange, NJ Alexander Kushnier, MD, (I) Highland Park, NJ
F8	<i>Competency to Stand Trial in the Context of Fahr's Disease</i>	Ana Gomez, MD, Charleston, SC L. William Mulbry, Jr., MD, Charleston, SC Christopher Fields, MD, Charleston, SC
F9	<i>Expert Testimony and Imperfect Self Defense</i>	Clarence Watson, MD, JD, Bala Cynwyd, PA Kenneth Weiss, MD, Bala Cynwyd, PA
F10	<i>Forensic Psychiatrists' Experience with PTSD: Criminal Cases</i>	Ziv Cohen, MD, New York, NY Paul Appelbaum, MD, New York, NY
F11	<i>Different Patterns of Civil Commitment in Wisconsin</i>	Elliot Lee, MD, PhD, Madison, WI Eileen Ahearn, MD, PhD, (I) Madison, WI Claudia Reardon, MD, (I) Madison, WI Tony Thrasher, DO, (I) Madison, WI
F12	<i>Involuntary Hospitalization Laws and Trainee Views of Court (Core)</i>	Laura Yahr Nelson, MD, Pawtucket, RI Paul Christopher, MD, Providence, RI
F13	<i>Informed Consent: Complexities, Criteria and Caveats (Core)</i>	Andrea Wright, MD, Austin, TX

F14	<i>Is it Time for a Federally Mandated AOT Program?</i>	Subhash Chandra, MD, Brooklyn, NY Chinmoy Gulrajani, MD, Brooklyn, NY Sasha Rai, MD, Brooklyn, NY
F15	<i>Firearm Legislation: The Good, The Bad, and The Ugly</i>	Eindra Khin Khin, MD, Washington, DC Jesse Raley, MD, Columbia, SC Stephanie Knapp, MS, (I) Washington, DC Scott Sexton, MS, (I) Washington, DC
F16	<i>Mindfulness and Sex Offender Treatment</i>	Tammy Benoit, MA, (I) Worcester, MA Fabian Saleh, MD, Boston, MA
F17	<i>The Effect of Substance Use on Outpatient Commitment</i>	Louis Martone, MD, New York, NY Panagiota Korenis, MD, Eastchester, NY Christopher Smith, PhD, (I) New York, NY Scott Soloway, MD, Long Island City, NY
F18	<i>Informant Memory in the Mass Murder Psychological Autopsy (Core)</i>	Brian Falls, MD, Sacramento, CA Harold Bursztajn, MD, (I) Cambridge, MA
F19	<i>Assessing Disruptive Behavior: Lessons Learned from VHA</i>	Jennifer Piel, MD, JD, Seattle, WA
F20	<i>Recommitment of Insanity Acquittes</i>	Michal Kunz, MD, New York, NY Brian Belfi, PsyD, (I) New York, NY Debbie Green, PhD, (I) Teaneck, NJ Jeremy Schreiber, MA, (I) New York, NY
F21	<i>Cognitive Remediation for In-Jail Competency Restoration</i>	Peter Ash, MD, Atlanta, GA Ryan Bromley, PsyD, (I) Atlanta, GA Glenn Egan, PhD, (I) Atlanta, GA Bryon McQuirt, MD, Atlanta, GA Vicki Roberts, MEd, Atlanta, GA Tomina Schwenke, PhD, (I) Atlanta, GA Sanjay Shah, PhD, JD, (I) Atlanta, GA
PANEL		8:00 AM – 10:00 AM SEABREEZE ROOM, CALIFORNIA CABANAS
F22	<i>Landmark Case Updates: The Supremes' Recent Rulings (Core)</i>	William Newman, MD, Sacramento, CA Brian Falls, MD, Sacramento, CA Charles Scott, MD, Sacramento, CA Ryan Wagoner, MD, Sacramento, CA
PANEL		8:00 AM – 10:00 AM BALLROOM, VICTORIAN BUILDING
F23	<i>DSM-5: Forensic Psychiatric Implications</i>	Robert Weinstock, MD, Los Angeles, CA Dilip Jeste, MD, (I) La Jolla, CA Debra Pinals, MD, Boston, MA Patricia Recupero, MD, JD, Providence, RI Howard Zonana, MD, New Haven, CT
RESEARCH IN PROGRESS #1		8:00 AM – 10:00 AM GARDEN ROOM, VICTORIAN BUILDING
F24	<i>Bayesian Evaluation of Measures for Faked Memory Impairment (Advanced)</i>	Douglas Mossman, MD, Cincinnati, OH

F25	Arresting Civil Patients, Quantifying the Justifications	Daniel Mundy, MD, New York, NY Shilpa Agraharkar, BS, (I) New York, NY Elizabeth Ford, MD, New York, NY
F26	Change and Effect: The New Orleans Forensic Aftercare Clinic	Kelly Erwin, MD, MPH, New Orleans, LA Gina Manguno-Mire, PhD, (I) New Orleans, LA Sarah DeLand, MD, New Orleans, LA John Thompson, Jr., MD, New Orleans, LA
F27	Restoration of Competency to Stand Trial in Misdemeanants	Artha Gillis, MD, PhD, (I) Sacramento, CA Brian Holoyda, MD, MPH, Sacramento, CA William Newman, MD, Sacramento, CA Glen Xiong, MD, (I) Sacramento, CA
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WORKSHOP	8:00 AM – 10:00 AM	PALM/SUNSET ROOM, CALIFORNIA CABANAS
F28	Ethics of Sex Offender Management: Is There a Right Answer? Sexual Offenders Committee	Li-Wen Lee, MD, New York, NY Natasha Knack, BA, (I) Ottawa, ON, Canada Richard Krueger, MD, New York, NY Lynn Maskel, MD, Madison, WI Lisa Murphy, MCA, (I) Ottawa, ON, Canada
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COURSE (TICKET REQUIRED)	8:00 AM – 12:00 PM	CORONET ROOM, VICTORIAN BUILDING
F29	Applying Risk Assessment in Psychiatry	Michael Norko, MD, New Haven, CT Madelon Baranoski, PhD, (I) New Haven, CT
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COFFEE BREAK	10:00 AM – 10:15 AM	CROWN ROOM, VICTORIAN BUILDING
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WORKSHOP	10:15 AM – 12:00 PM	GARDEN ROOM, VICTORIAN BUILDING
F30	In-Jail Competency Restoration	Peter Ash, MD, Atlanta, GA Karen Bailey-Smith, PhD, (I) Atlanta, GA Aimee Kaempf, MD, Tucson, AZ Reena Kapoor, MD, New Haven, CT
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AV SESSION	10:15 AM – 12:00 PM	SEABREEZE ROOM, CALIFORNIA CABANAS
F31	Crazy Ladies: Female Psychopathic Traits in Recent Popular Culture (Core)	Cathleen Cerny, MD, Seven Hills, OH Susan Hatters Friedman, MD, Cleveland Heights, OH Delaney Smith, MD, Columbus, OH Sherif Soliman, MD, Northfield, OH
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PANEL	10:15 AM – 12:00 PM	PALM/SUNSET ROOM, CALIFORNIA CABANAS
F32	Mental Competency in Immigration Removal Proceedings Law Enforcement Liason and International Human Rights and Human Law Committees	Kristen Ochoa, MD, MPH, Sylmar, CA Veronica Barba, JD, (I) San Diego, CA Talia Inlender, JD, (I) Los Angeles, CA Graciela Martinez, JD, (I) Los Angeles, CA Stacey Stongarone, JD, (I) Los Angeles, CA

PANEL	10:15 AM – 12:00 PM	BALLROOM, VICTORIAN BUILDING
F33 <i>Breivik – Extreme Ideologist or Mentally Deranged International Relations Committee</i>	Cecilia Leonard, MD, Manlius, NY David Annas, MD, Syracuse, NY James Knoll, IV, MD, Syracuse, NY Terje Torrissen, MD, (I) Ottestad, Norway	
LUNCH (TICKET REQUIRED)	12 NOON – 2:00 PM	CROWN ROOM, VICTORIAN BUILDING
F34 <i>Reflections of a Medical Director</i>	Howard Zonana, MD, New Haven, CT	
PANEL	2:15 PM – 4:00 PM	BALLROOM, VICTORIAN BUILDING
F35 <i>Breivik Rempage: All-Consuming Hatred Approaching Psychosis? Peer Review Committee (Members Only)</i>	David Rosmarin, MD, Newton, MA James Knoll, IV, MD, Syracuse, NY Terje Torrissen, MD, (I) Ottestad, Norway	
PANEL	2:15 PM – 4:00 PM	SEABREEZE ROOM, CALIFORNIA CABANAS
F36 <i>Up in Smoke? Legal and Forensic Issues of Medical Marijuana Addiction Psychiatry Committee</i>	Gregory Sokolov, MD, Davis, CA Mikel Matto, MD, San Francisco, CA Douglas Tucker, MD, Berkeley, CA	
PANEL	2:15 PM – 4:00 PM	PALM/SUNSET ROOM, CALIFORNIA CABANAS
F37 <i>School Mass Shootings Child and Adolescent Committee</i>	Leanne Stoneking, MD, (I) Los Angeles, CA Park Dietz, MD, PhD, Newport Beach, CA Praveen Kambam, MD, Los Angeles, CA Christopher Thompson, MD, Los Angeles, CA	
WORKSHOP	2:15 PM – 4:00 PM	GARDEN ROOM, VICTORIAN BUILDING
F38 <i>Computers and Technology in Forensic Psychiatry Computer Committee</i>	Mark Hauser, MD, Newton, MA Tyler Jones, MD, Arlington, VA Andrew Nanton, MD, Orlando, FL Alan Newman, MD, Washington, DC Paul O'Leary, MD, Birmingham, AL	
COURSE (TICKET REQUIRED)	2:15 PM – 6:15 PM	CORONET ROOM, VICTORIAN BUILDING
F39 <i>Can't Work or Won't Work? Psychiatric Disability Evaluations</i>	Liza Gold, MD, Arlington, VA Marilyn Price, MD, Malden, MA Donna Vanderpool, MBA, JD, (I) Arlington, VA	
COFFEE BREAK	4:00 PM – 4:15 PM	CROWN ROOM, VICTORIAN BUILDING

PANEL	4:15 PM – 6:15 PM	PALM/SUNSET ROOM, CALIFORNIA CABANAS
F40 <i>ICD-11: A Work in Progress Sexual Offenders Committee</i>	Richard Krueger, MD, New York, NY Nicolas Martinez Lopez, MD (I) San Lorenzo, Mexico	
SCIENTIFIC PAPER SESSION #2	4:15 PM – 6:15 PM	GARDEN ROOM, VICTORIAN BUILDING
F41 <i>Court-Ordered Treatment of Severe Eating Disorders</i>	Patricia Westmoreland, MD, Denver, CO Craig Johnson, PhD, (I) Denver, CO Richard Martinez, MD, Denver, CO Michael Stafford, JD, (I) Denver, CO	
F42 <i>Assisted Outpatient Treatment in California</i>	Gary Tsai, MD, (I) San Diego, CA	
F43 <i>PAS: Considering Evidence and an Emerging Role for Psychiatry</i>	Abilash Gopal, MD, San Francisco, CA	
WORKSHOP	4:15 PM – 6:15 PM	BALLROOM, VICTORIAN BUILDING
F44 <i>Correctional Psychiatry: Evolving and Recommended Standards</i>	Kenneth Appelbaum, MD, Shrewsbury, MA Jeffrey Metzner, MD, Denver, CO Robert Trestman, MD, PhD, Farmington, CT Jason Ourada, MD, Worcester, MA	
WORKSHOP	4:15 PM – 6:15 PM	SEABREEZE ROOM, CALIFORNIA CABANAS
F45 <i>Preparedness When Disaster Strikes a Forensic System</i>	Debra Pinals, MD, Boston, MA Elizabeth Ford, MD, New York, NY Panagiota Korenis, MD, Eastchester, NY Alan Newman, MD, Washington, DC	

FRIDAY

Mansfield Mela, MBBS, FRCP, Saskawon, SK, Canada
 Glen Edward Luther, JD, (I) Saskawon, SK, Canada
 Krista Trinder, MSC, (I) Saskawon, SK, Canada
 Marcel D'Eon, PhD, (I) Saskawon, SK, Canada

EDUCATIONAL OBJECTIVE

1. Become aware of the different models of interprofessional education involving lawyers and psychiatrists.
2. Learn about the effectiveness of an innovative seminar involving law students and psychiatric residents in improving attitudinal relationships.

SUMMARY

The relationship between psychiatrists and lawyers, sometimes antagonistic, does not serve the patient or society well. This may stem from differences in pedagogical constructs and related historical factors. The resulting characteristic problem of miscommunication presents an opportunity for intervention at the pre-licensure educational stage with the hope of positively shaping future practice. Using the Law and Psychiatry interprofessional seminar in which protégées of the two professions (39 law students and 9 psychiatric residents) are brought together to interact with each other and instructors from the two fields, we examined the attitudes and perceived cooperation in comparison to a control group of 25 law students (Human Rights class) without such interaction. Those with the interactive component revealed statistically significant positive attitudes towards members of the other profession. Interactive seminar law students also showed before and after positive changes in the level of perception of and actual cooperation with the psychiatric residents with higher satisfaction. Such avenues where positive interactions in learning occur and understanding of each other is fostered can be a model for improving relations and collaboration in interprofessional education. The impact and potential benefits for the patient and the system are worthwhile.

REFERENCES

Aggarwal NK, Rohrbaugh RM: Teaching cultural competency through an experiential seminar on anthropology and psychiatry. *Academic Psychiatry* 35(5):331-4, 2011
 McBain SM, Hinton JA, Thrush CR, et al: The effect of a forensic fellowship program on general psychiatry residents' in-training examination outcomes. *J Am Acad Psychiatry and the Law*: 38(2):223-8, 2010

QUESTIONS AND ANSWERS

1. Which of the following have been used to explain the communication differences that exist between psychiatrists and lawyers?
 - a. Differential pay rates
 - b. Educational methods
 - c. Differences in personality
 - d. Selection bias for more women
 - e. Neuropsychological dysfunction
 ANSWER: b

2. The following are both core competencies of the Canadian medical education system and can be enhanced through interprofessional education except
 - a. Collaboration
 - b. Communication
 - c. Health advocacy
 - d. Expert witness
 - e. Medical Expert
 ANSWER: d

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

EDUCATIONAL OBJECTIVE

The audience will become familiar with trends and logic in child pornography (CP) sentencing in selected states and federal districts. The audience will become more familiar with the current literature that focuses on the characteristics of child pornographers, predictors of their recidivism, progression to predators, and CP response to treatment.

SUMMARY

Child pornography availability and consumption has increased dramatically in the past ten years with the internet being the number one offender. Despite the fact that great majority of CP offenders do not reoffend or progress to hands-on offenders, the severity of their sentencing appears to be disproportionate to the offense. In a study of

over 2,600 convicted CP offenders found that 2% committed a new contact sexual offense and 3.4% recidivated to view child pornography. The 2012 amendments to the federal sentencing guidelines increased the upper ranges of certain sentences and increased the pressure on judges to impose harsher sentences regardless of their judicial discretion. This legislative mandate has eroded judicial discretion. Social factors might be driving an unusual legislative intrusion into judiciary sentencing in part because it appears as if convicted child pornographers are used as a proxy for punishment for child pornographers who are not caught. Treatment options, their effectiveness and availability, do not appear to play a role in sentencing. A more rational approach to sentencing might be to include an objective assessment of the relevant data available as well as with considerations for the cost and effectiveness of incarceration for punishment.

REFERENCES

Temporini H: Child pornography and the internet. *Psychiatric Clinics of North America* 35(4):821-835, 2012
Seto MC, Hanson RK, Babchishin KM: Contact sexual offending by men with online sexual offenses. *Sexual Abuse J of Research and Treatment* 23(1): 124-145, 2011

QUESTIONS AND ANSWERS

1. According to Seto, in a study of over 2,600 child pornographers, what per cent progressed to hands-on offenders?
ANSWER: 2%

2. What is a possible reason that child pornographers appear to be sentenced harshly?

ANSWER: They may be punished by the courts by proxy for the child pornographers that are not caught.

F3

SELF-REPORTED MEASURES FOR MENTALLY DISORDERED OFFENDERS

A.G. Ahmed, MBBS, Brockville, ON, Canada
Nicole Rodrigues, BA, (I) Brockville, ON, Canada
Wagay Loza, CPsych, (I) Brockville, ON, Canada
Michael Seto, CPsych, (I) Brockville, ON, Canada

EDUCATIONAL OBJECTIVE

The audience will become familiar with (1) self-reported measures of risk (Self-Appraisal Questionnaire and Measures of Criminal Attitudes and Associates) used in forensic/correctional populations and (2) the results of a new study examining their utility with mentally disordered offenders.

SUMMARY

This study examined the utility of two self-report risk measures, the Self-Appraisal Questionnaire (SAQ) and the Measures of Criminal Attitudes and Associations (MCAA), in a sample of 162 mentally disordered offenders. Results suggest concurrent validity for the two self-report measures with each other and with two clinician rated risk measures, the HCR-20 and the Psychopathy Checklist-Revised (PCL-R). As expected, scores on the two self-report measures were highly and positively correlated with each other, $r(158) = .79$, $p < .001$, as well as positively and significantly correlated with the HCR-20 and PCL-R, as predicted (.40 and .54, respectively, for the SAQ, and .39 and .47 for the MCAA). In terms of predictive validity, 41% of the sample had at least one aggressive incident while in custody; the number of incidents ranged from 1 to 9, but the model number of incidents was 1. The HCR-20 (AUC=.74) and the PCL-R (AUC=.79) predicted having any aggressive incidents, whereas the SAQ (AUC=.60) and MCAA (AUC=.58) did not. We also hope to report results for prediction of recidivism (defined as new criminal charges or convictions) at the time of the conference.

REFERENCES

Loza W, Loza-Fanous A: Predictive validity of the Self-Appraisal Questionnaire (SAQ): A tool for assessing violent and non-violent release failures. *J of Interpersonal Violence* 15:1183-1191, 2000
Mills JF, Loza W, Kroner DG: Predictive validity despite social desirability: evidence for the robustness of self-report among offenders. *Criminal Behaviour and Mental Health* 13:140-150, 2003

QUESTIONS AND ANSWERS

1. The Self-Appraisal Questionnaire is _____ correlated with another self-report risk measure, the Measures of Criminal Attitudes and Associates, in this study.

- Not significantly
- Weakly (correlation $< .25$)
- Moderately (correlation $.25$ to $.50$)
- Strongly (correlation $> .50$)

ANSWER: d

2. What were the relative predictive accuracies in predicting institutional aggression for the risk measures examined in this study?
 - a. Self-report = clinician-rated
 - b. Self-report < clinician-rated
 - c. Self-report > clinician-rated
 - d. None were significantly predictive
- ANSWER: b

F4

CYBERSEXUAL HARASSMENT AND ADOLESCENTS

Simha Ravven, MD, Somerville, MA
 Amy Funkenstein, MD, (I) Providence, RI
 Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE

1. Understand definitions of cybersexual harassment.
2. Learn the prevalence of adolescent internet usage and online media as well as prevalence and effects of cybersexual harassment on adolescents.
3. Become familiar with methods of risk assessment and intervention strategies to reduce cybersexual harassment among adolescents.

SUMMARY

Cybersexual harassment is a widespread problem among youth. Adolescents have wide access to the internet: 93% of teens have access to the internet and 75% have their own cell phone. According to a recent survey of internet-using 10-15 year olds, 33% reported online sexual harassment in the prior year and 15% reported an unwanted sexual solicitation online in the same time period. Cyberbullying, generally, and cybersexual harassment, have profound negative effects on both victims and bullies. Involved youth are more likely to perform poorly in school and suffer psychological distress. Adolescents involved in cyberbullying are more likely to experience depressive symptoms, and to self-injure and contemplate and attempt suicide. Both victimhood and perpetration were associated with criminal behavior as well. Definitions of cybersexual harassment, prevalence data and comparison with offline bullying will be discussed. Similarities and differences between offline bullying and sexual harassment and its cyber counterpart will be considered, including whether the latter may be considered a category of sexual offending. An overview of offline sexual harassment, including landmark legal cases will be given. There will also be a discussion of assessment of risk and intervention strategies.

REFERENCES

Schneider KS, O'Donnell L, Stueve A, et al: Cyberbullying, school bullying, and psychological distress: a regional census of high school students. *Am J Public Health* 102(1):171-77, 2012
 Ybarra ML, Mitchell KJ: How risky are social networking sites? a comparison of places online where youth sexual solicitation and harassment occurs. *Pediatrics* 121:e350, 2008

QUESTIONS AND ANSWERS

1. Both adolescent victims and perpetrators of cyber-harassment are at greater risk of the following:
 - a. Poor school performance
 - b. Psychological distress
 - c. Criminal activity
 - d. All of the above

ANSWER: d
2. Research indicates that the following intervention is most helpful when counseling children who have been victims of cyber harassment
 - a. Advising the child to ignore the harassment
 - b. Advising the child to "Tell the bully how you feel."
 - c. Listening closely to the child and validating their sense of unfairness
 - d. Taking away the child's computer and internet access

ANSWER: c

F5

THE IMPACT OF RACE ON FILICIDE

Nicole Graham, MD, Gainesville, FL

EDUCATIONAL OBJECTIVE

At the end of this session attendees will be able to identify gaps in the literature related to race and filicide.

SUMMARY

Filicide is a form of family violence in which a child is killed by his or her own parent. While filicide-suicide rates are higher in Caucasians in the United States, the rate of simple filicide is considerably higher in African Americans. Researchers have been able to identify five reasons filicide occurs, including fatal maltreatment, altruistic, acutely psychotic, unwanted child, and spouse revenge. While some of these factors might be driven by poverty, little research has been conducted to identify what role culture and race may have. The purpose of this study was to determine what impact a perpetrator's race may have in filicide cases. A systematic review of the literature was performed in which we identified 134 articles over a 50 year period. Race was rarely reported in the filicide cases; however, when recorded, African American perpetrators made up a substantial percentage. However, the majority of the articles did not address the impact of race/culture in filicide cases. Few articles specifically addressed the racial status of the perpetrators and even fewer delineated what role race/culture played. Identifying such influences might allow for more culturally tailored preventive measures.

REFERENCES

Resnick PJ: Child murder by parents: a psychiatric review of filicide. *Am J Psychiatry* 126:325-334, 1969
 Goetting A: Child victims of homicide: a portrait of their killers and the circumstances of their deaths. *Violence Vict* 5:287-296, 1990

QUESTIONS AND ANSWERS

1. Within the United States, in what racial group is filicide-suicide the highest? In what racial group is simple filicide the highest?

ANSWER: 1. Caucasians. 2. African Americans.

2. What are five factors that drive filicide?

ANSWER: Fatal maltreatment, altruistic, acutely psychotic, unwanted child, and spouse revenge.

F6**SEX OFFENDERS, EMPATHY DEFICITS, AND OXYTOCIN**

Alicia Bales, MD, Marina Del Ray, CA

EDUCATIONAL OBJECTIVE

The poster will review the basic deficits in empathy commonly seen in sex offenders. Readers will gain a basic knowledge of the current state of research examining effects of oxytocin on empathy and will consider the potential avenues of future research with oxytocin and sex offenders.

SUMMARY

As a group, sex offenders show deficits in both cognitive and emotional aspects of empathy. In addition, sex offenders often demonstrate cognitive distortions that contribute to offending. It is generally believed that if sex offenders' empathy can be improved, they are less likely to reoffend. However, there are several challenges to increasing empathy in sex offenders through therapy. Exploring alternative ways to increase empathy in this population is warranted. Oxytocin is a neuropeptide that is receiving much attention from the psychiatric community for its pro-social effects. Several studies have found oxytocin can increase both cognitive and emotional aspects of empathy. There is also some evidence that oxytocin enhances cognitive processing of neutral social cues in a way that increases the degree social information is appraised in a positive manner. By allocating more attention toward positive information, oxytocin may help offenders with cognitive distortions "learn" new ways of interpreting social interactions, which may help change negative cognitive distortions, which in turn might help the development of empathy. Since oxytocin appears to act on some of the core elements believed to be problematic in sex offenders, it would be of interest to see if oxytocin can help cultivate empathy in this group.

REFERENCES

Barnett GD, Mann RE: Cognition, empathy, and sex offending. *Trauma Violence Abuse* 14(1):22-33, 2013
 Hurlemann R, et al: Oxytocin enhances amygdala-dependent, socially reinforced learning and emotional empathy in humans. *J of Neuroscience* 30(14): 4999-5007, 2010

QUESTIONS AND ANSWERS

1. Which of the following regarding oxytocin's effects is false?

- There is evidence to show that oxytocin is an important modulator of aggression.
- Mice in which the oxytocin gene is absent from the time of conception have shown higher levels of aggressive behavior compared to normal mice.
- In humans, the levels of oxytocin in cerebrospinal fluid tends to be directly correlated with a life history of aggression.
- Compared to control subjects, prisoners with a history of violence have higher levels of autoantibodies directed against oxytocin.

ANSWER: c

2. Which of the following statements regarding empathy in sex offenders is false?
 - a. As a group, sex offenders are more accurate than the general population in recognizing facial expressions of anger, disgust, surprise and fear.
 - b. Interviews with rapists and sexual murderers have found that a common, pervasive cognitive pattern in this group is a general sense of grievance, anger, and resentment.
 - c. When sex offenders are given feedback surveys regarding their experiences in treatment, they rate victim empathy as one of the most important components to their treatment and recovery.
 - d. As a group, sex offenders tend to rate themselves as having less distress or anxiety when witnessing negative emotions in other people.

ANSWER: a

F7

INVOLUNTARY MEDICATION, INPATIENT DAYS AND OFFENSES IN PRISON

Anasuya Salem, MD, Basking Ridge, NJ
 Nicole Dorio, DO, Stewartsville, NJ
 Rusty Reeves, MD, South Orange, NJ
 Alexander Kushnier, MD, (I) Highland Park, NJ

EDUCATIONAL OBJECTIVE

To examine whether placement of mentally ill inmates on nonemergency involuntary medication reduces the number of prison inpatient days and the number of inmates who receive disciplinary charges.

SUMMARY

The hypothesis of this study was that placement of mentally ill inmates on involuntary antipsychotic medication will reduce the number of prison inpatient days and the number of inmates who receive disciplinary charges. For the years 2005-2009, we studied 134 mentally ill inmates who were placed on the NJ Department of Corrections (NJ DOC) Non-Emergency Involuntary Medication Protocol and received antipsychotic medication for at least one year. No statistically significant difference was noted in an inmate's mean number of prison inpatient days in the year before vs. the year during involuntary medication. Fewer inmates received any serious disciplinary charges during the year of involuntary medication relative to the year prior. This finding was statistically significant. The mean numbers of inpatient days while on involuntary medication were not statistically different between the inmates who had no charges and the inmates who had any charges, demonstrating that increased numbers of inpatient days does not explain the inmates who received no charges during the period of involuntary medication. Involuntary medication reduced the number of inmates with disciplinary charges but did not reduce prison inpatient days among mentally ill inmates in the NJ DOC.

REFERENCES

Swanson JW, Swartz MS, Wagner HR, et al: Involuntary outpatient commitment and reduction of violent behaviour in persons with severe mental illness. *BPJ* 176:324-331, 2001
 Torrey EF, Zdanowicz, M: Outpatient commitment: what, why, and for whom. *Psychiatric Services* 52(3):337-341, 2001

QUESTIONS AND ANSWERS

1. Has the effect of nonemergency involuntary medication in corrections ever been published in the scientific literature?
ANSWER: No
2. What is the principal methodological limitation to studying the effect of medication on inmates?
ANSWER: The prohibition against experimentation upon inmates.

F8

COMPETENCY TO STAND TRIAL IN THE CONTEXT OF FAHR'S DISEASE

Ana Gomez, MD, Charleston, SC
 L. William Mulbry, Jr., MD, Charleston, SC
 Christopher Fields, MD, Charleston, SC

EDUCATIONAL OBJECTIVE

To review the psychiatric manifestations of Fahr's Disease, an uncommon disorder that may present in a forensic setting with psychiatric symptoms alone. We will discuss a Competency to Stand Trial Evaluation in which the psychiatric symptoms due to Fahr's Disease played a prominent role in the competency opinion.

SUMMARY

Fahr's Disease is a rare, sporadic, familial condition characterized by radiographically evident, bilateral basal ganglia calcifications and associated with many neurologic and psychiatric abnormalities. It must be distinguished from Fahr's Syndrome and incidental basal ganglia calcification. About 40% of the patients with Fahr's Disease

present initially with psychiatric features including cognitive impairment, psychotic and mood disorders and anxiety disorders. Neurologic symptoms of the disorder may include deterioration of motor function, dementia, seizures, headache, dysarthria and spasticity. It is the psychiatric symptoms that had a significant impact on a Competency to Stand Trial Evaluation of Mr. A, who was diagnosed with Fahr's Disease and presented in a manic and psychotic state. It was these severe psychiatric symptoms that led to the incompetency opinion. A literature review revealed minimal information on Fahr's Disease in a forensic setting. It did, however, suggest that Fahr's Disease and Syndrome often present with disruptive behaviors. Therefore, this poster seeks to alert the audience to this rare but important neurological disorder that can affect a defendant's competency to stand trial through psychiatric manifestations and might appear in a variety of forensic settings.

REFERENCES

Scott JG, Hoffman RL, Tremont G, Adams RL: Diagnosing early onset Fahr's disease (idiopathic basal ganglia calcifications) in a criminal forensic population. *Archives of Clinical Neuropsychology*, 12(4), 401, 1997
 Lauterbach EC, Cummings JL, Duffy J, et al: Neuropsychiatric correlates and treatment of lenticulostratial diseases: a review of the literature and overview of research opportunities in Huntington's, Wilson's and Fahr's diseases. *J Neuropsychiatry Clin Neurosci* 10(3): 249-66, 1998

QUESTIONS AND ANSWERS

1. All of the following are common manifestations of Fahr's Disease except:

- a. Mania
- b. Cognitive impairment
- c. Motor abnormalities
- d. Substance abuse

ANSWER: d

2. Basal ganglia calcifications always reflect:

- a. A pathologic situation
- b. Fahr's Disease
- c. Fahr's Syndrome
- d. None of the above

ANSWER: d

F9

EXPERT TESTIMONY AND IMPERFECT SELF DEFENSE

Clarence Watson, MD, JD, Bala Cynwyd, PA
 Kenneth Weiss, MD, Bala Cynwyd, PA

EDUCATIONAL OBJECTIVE

This presentation will examine the Imperfect Self Defense doctrine in the context of the mentally ill criminal offender; analyze the limitations of admissibility of psychiatric testimony in imperfect self defense cases; and provide an algorithm for the introduction of psychiatric testimony in these cases.

SUMMARY

What are a mentally ill murder defendant's options when an insanity defense is not available? Faced with certain conviction and unwilling to plead to a life sentence, some defendants may claim that their belief in the necessity of homicide was colored by unreasonable perceptions or judgment. When permitted, such individuals may attempt to reduce culpability by claiming an Imperfect self defense. It can be used if the facts support that a defendant was under a genuine but unreasonable belief that the killing was justifiable. In those jurisdictions, a defendant may argue a genuine belief that self defense was needed when the killing occurred, but the underlying belief was unreasonable, based on psychiatric factors. Though psychiatric testimony on justifiable homicide may not be necessary due to an objective test, here there may be subjective factors requiring expert opinions. Psychiatric testimony proffered in those cases has faced judicial scrutiny for admissibility. Limitations of psychiatric testimony to support imperfect self defense arguments have been outlined in the case law, which we will cite. In this presentation, we outline the differential possibilities for introduction of psychiatric testimony in these unusual cases, using an algorithm based on recent decisions.

REFERENCES

Commonwealth v. Sepulveda, 55 A.3d 1108 (Pa. 2012)
 Byers E: Mentally ill criminal offenders and the strict liability effect: is there hope for a just jurisprudence in an era of responsibility/consequences talk? *Arkansas Law Review* 57:447, 2004

QUESTIONS AND ANSWERS

1. Which best distinguishes justified homicide from “imperfect” self defense?
 - a. Proportionality of threat to response
 - b. Presence or absence of a delusion
 - c. The factor of imminence
 - d. Correct versus incorrect perception of threat

ANSWER: d

2. Which is true about psychiatric testimony in an imperfect self defense?
 - a. It includes both subjective and objective factors
 - b. It requires scientific evidence of an actual threat to the defendant
 - c. It can be excluded due to a reasonable-person standard
 - d. It must include a diagnosis of serious mental illness
 - e. All of the above

ANSWER: c

F10

FORENSIC PSYCHIATRISTS' EXPERIENCE WITH PTSD: CRIMINAL CASES

Ziv Cohen, MD, New York, NY

Paul Appelbaum, MD, New York, NY

EDUCATIONAL OBJECTIVE

To characterize the knowledge, experience, and opinions of forensic psychiatrists with regard to post traumatic stress disorder (PTSD) in the criminal forensic setting, using a Web-based survey of members of the American Academy of Psychiatry and the Law (AAPL).

SUMMARY

By the end of 2014, 1.5 million veterans of the Second Iraq and Afghan wars will have returned home, up to 35% suffering from PTSD. The appropriateness of the use of PTSD as the basis for legal claims in criminal defense is therefore a pressing issue. Using a Web-based survey, this study examines the experiences and attitudes of AAPL members towards PTSD in the criminal forensic setting. Of 161 respondents, 50% have been involved in a criminal case involving PTSD, 40% in the previous year. Eighty-six percent of cases involved violent crime and 40% homicides. Forty-three percent of defendants were soldiers in active service or veterans, and all had combat exposure, mostly in the Second Iraq and Afghan wars. Outcomes reported were not guilty by reason of insanity (NGRI) (8%), guilty on the original charge (45%), and plea bargaining to a lesser charge (23%). The findings suggest that forensic psychiatrists are likely to be asked to evaluate PTSD in the criminal setting, with a growing number of cases related to combat exposure in recent veterans. The implications of these findings for the practice of forensic psychiatry will be discussed.

REFERENCES

- Friel A, White T, Hull A: Posttraumatic stress disorder and criminal responsibility. *J of Forensic Psychiatry and Psychology* 19(1): 64-85, 2008
- Appelbaum PS, Zoltek Jick R, Grisso T, et al: Use of posttraumatic stress disorder to support an insanity defense. *Am J Psychiatry* 150:229-234, 1993

QUESTIONS AND ANSWERS

1. PTSD as a legal argument for the defense in the criminal legal context is a pressing issue for which of the following reasons?
 - a. There are anecdotal reports of increased veteran involvement in the criminal justice system due to violence and substance abuse.
 - b. PTSD is rarely invoked in the criminal forensic setting.
 - c. Since the Second Iraq war the number of new veterans has swelled by 1.5 million
 - d. a and c

ANSWER: d

2. Forensic psychiatrists are likely to be asked to evaluate PTSD in the criminal forensic setting for which of the following reasons?
 - a. In a recent survey-based study, fifty percent of forensic psychiatrists reported involvement with a criminal case where PTSD was an issue, with 40 percent of cases in the past year.
 - b. In a recent survey-based study, in 43 percent of criminal cases involving PTSD the defendant was an active duty soldier or veteran.
 - c. a and b
 - d. PTSD is rarely relevant in plea bargaining or mitigation in sentencing.

ANSWER: c

Elliot Lee, MD, PhD, Madison, WI
 Eileen Ahearn, MD, PhD, (I) Madison, WI
 Claudia Reardon, MD, (I) Madison, WI
 Tony Thrasher, DO, (I) Madison, WI

EDUCATIONAL OBJECTIVE

Examine the process of involuntary hospitalization in a system involving multiple decision makers. This can lead to disagreement and inconsistent practice of care. Both cases and a retrospective review will be used to illustrate these differences.

SUMMARY

In Wisconsin, an individual may be involuntarily hospitalized to a psychiatric facility by police for a period of 72 business hours, followed by an initial court hearing. This action must be authorized by the county mental health crisis unit. In contrast, physicians are not authorized to involuntarily hospitalize a patient unilaterally. This difference in legal authority can lead to disagreements between county crisis staff, law enforcement, and health care providers about which subjects need hospitalization. We first describe three cases in neighboring counties which illustrate differences in the practice of involuntary hospitalization. We also examine differences in involuntary hospitalization rates and criteria between two counties during 2011. In Dane County, 41% of those involuntarily hospitalized had suicidal behavior, and 43% had aggressive or homicidal behavior. Eighty-three percent of these hospitalizations led to subsequent commitment or court ordered treatment. In Rock County, 74% of the involuntary hospitalizations had suicidal behavior, while 26% were aggressive or homicidal. Less than half (46%) of the suicidal hospitalizations resulted in commitment or court ordered treatment. These results show that even with the same commitment laws, the process can be very different even in neighboring areas.

REFERENCES

Erickson S, Vitacco M, Van Rybroek G: Beyond overt violence: Wisconsin's progressive civil commitment statute as a marker of a new era in mental health law. *Marquette Law Review* 89: 359-405, 2005
 Wisconsin Statutes § 51.15(1-5) (2011-2012)

QUESTIONS AND ANSWERS

1. In Wisconsin, an individual may be involuntary hospitalized by police in psychiatric facility if authorized by:
 - a. One physician
 - b. Two physicians
 - c. County mental health crisis (department of community programs)
 - d. Only police authorization needed
- ANSWER: c

2. An initial probable cause mental health hearing is held how long after initiation of detention?
 - a. 24 hours
 - b. 72 hours
 - c. 90 days
 - d. 72 business hours
- ANSWER: d

Laura Yahr Nelson, MD, Pawtucket, RI
 Paul Christopher, MD, Providence, RI

EDUCATIONAL OBJECTIVE

Participants will be able to describe state-to-state variations in the maximum permitted duration of temporary detention of psychiatric patients prior to court ordered civil commitment and the extent to which these differences may relate to psychiatry resident training experiences and comfort with court proceedings.

SUMMARY

Statutes for involuntary hospitalization vary greatly between states. For example, Virginia requires a civil commitment hearing within 48 hours of emergency detention, while other states allow for much longer holding periods. A recent study found that longer periods of detention were correlated with fewer involuntary court-ordered civil commitments, which could suggest lower frequency of court appearances. Not surprisingly, there is considerable variability among psychiatrists in the frequency of involvement in involuntary hospitalization, although notably 31% of psychiatrists in one study reported having been involved in at least three cases in the preceding year. Residents who train in states in which longer periods of involuntary hospitalization are permitted may have less exposure to court proceedings and testimony compared with those in states with shorter detention periods. This study will

present the results of a survey of psychiatry residents from different geographic regions that examines the extent to which the variability in maximum periods of involuntary hospitalization relate to residents' exposure, comfort level, and overall attitudes toward court. The implications of these findings will be discussed.

REFERENCES

Wanchek TN, Bonnie RJ: Use of longer periods of temporary detention to reduce mental health civil commitments. *Psychiatric Services* 63(7):643-8, 2012
Luchins D, Cooper A, Hanrahan P, et al: Psychiatrists' attitudes toward involuntary hospitalization. *Psychiatric Services* 55(9):1058-60, 2004

QUESTIONS AND ANSWERS

1. Has any relationship been found between length of temporary detention of psychiatric patients and frequency of involuntary hospitalizations?

- a. No, the length of temporary detention does not impact frequency of involuntary hospitalizations.
- b. Yes, longer temporary detention periods lead to more frequent involuntary hospitalizations.
- c. Yes, longer temporary detention periods were found in one study to correlate with fewer involuntary hospitalizations.
- d. Yes, longer temporary detention periods were found in one study to lead to fewer involuntary hospitalizations.

ANSWER: c

2. What percentage of psychiatrists in a recent study had three or more involuntary hospitalization court cases in the past year?

- a. 23%
- b. 31%
- c. 35%
- d. 39%

ANSWER: b

F13

INFORMED CONSENT: COMPLEXITIES, CRITERIA AND CAVEATS

Andrea Wright, MD, Austin, TX

EDUCATIONAL OBJECTIVE

To improve knowledge of criteria for obtaining informed consent for the treatment of special populations. Specific populations covered will include minors, severely mentally disabled individuals and prisoners and research on these special populations.

SUMMARY

This poster will review variations among states of the criteria for obtaining informed consent for the treatment of special populations including minors, severely mentally disabled individuals and prisoners and for research on these special populations. The variations are extensive. For example, one state has no general requirement for informed consent, some states allow treatment of "mature minors" without parental consent, and some require assent of the child for all research that will not benefit the child. Variations are also present depending on the particular treatment being offered, such as special rules that apply to contraception, abortion, substance abuse treatment, and mental health care. The forensic psychiatrist needs to be familiar with these laws as he or she may be requested to give education to the court system on the decision-making process for members of these special populations.

REFERENCES

American Psychiatric Association Resources Document on Principles of Informed Consent in Psychiatry. *J Am Acad Psychiatry Law*, 23:121-125, 1997
Schuman D: *Law and Mental Health Professionals*. Washington, DC: American Psychological Association, 1997 pp 184-185

QUESTIONS AND ANSWERS

1. How many states plainly allow minors to consent to contraceptive services?

- a. 15
- b. 21
- c. 30

ANSWER: b

2. Which state does not have general requirements for informed consent?

- a. Georgia
- b. Texas
- c. Florida

ANSWER: a

Subhash Chandra, MD, Brooklyn, NY
 Chinmoy Gulrajani, MD, Brooklyn, NY
 Sasha Rai, MD, Brooklyn, NY

EDUCATIONAL OBJECTIVE

To familiarize mental health practitioners with the concept and advantages of a federally run AOT program and to make them aware how this model serves the purpose of providing consistent, superior and cost effective mental health care across states.

SUMMARY

44 U.S. states authorize some form of AOT (assisted outpatient treatment) program. In New York, AOT has been shown to reduce re-incarceration, re-hospitalization and homelessness. Involuntary outpatient commitment laws are state specific; serious and persistent mentally ill (SPMI) individuals under state mandated AOT can lose care if they choose to leave the state, leading to a decline in their overall functioning. This study was conducted to look into the advantages of having a federally mandated AOT program with a unified policy across the nation. Review of AOT statutes of all 50 states of the US was done; similarities and differences between these statutes were compared and contrasted. The definition of mental illness, grave disability and the criteria for mandating AOT in different states shows a wide range of variation. The federal mental health court program is an innovative and successful approach in diverting offenders into treatment programs and easing the burden on criminal justice system. Similarly with a federally-run AOT program there will be a coordinated delivery of services across states with no lapse in the treatment, thus decreasing the overall cost and providing continuity of mental health care across states.

REFERENCES

Swartz MS, Swanson JW, Steadman HJ, et al: New York State Assisted Outpatient Treatment Program Evaluation. Durham, NC: Duke University School of Medicine, 2009.
 Council of State Governments Justice Center, United States, Mental Health Courts: A Primer for Policymakers and Practitioners. Available at <https://www.ncjrs.gov/App/abstractdb/AbstractDBDetails.aspx?id=248016>. Accessed Feb 2013.

QUESTIONS AND ANSWERS

1. What could be the main objection to such a model?

ANSWER: States will object to federal encroachment on states' rights in health care. Moreover consumer organizations will take a stand against perceived violation of the civil rights of mentally ill individuals.

2. Will it make the utilization of mental health services more effective?

ANSWER: Reduction in re-hospitalization and re-incarceration will definitely decrease the cost of providing mental health care and the funds can be channeled into strengthening existing community treatment programs.

Eindra Khin Khin, MD, Washington, DC
 Jesse Raley, MD, Columbia, SC
 Stephanie Knapp, MS, (I) Washington, DC
 Scott Sexton, MS, (I) Washington, DC

EDUCATIONAL OBJECTIVE

The purpose of our inquiry is to challenge some of the fundamental assumptions inherent in the current and recently proposed firearm laws as they pertain to the mentally ill population, using the current body of evidence-based literature. In addition, we highlight the limitations and negative implications associated with these laws.

SUMMARY

Amidst recent high-profile mass shootings involving persons who are suspected of being mentally ill, lawmakers are poised to pass new firearm restrictions, with special attention focused on the mentally ill population. This phenomenon appears to be built on the premise that there is an established, significant link between firearm-related violence and mental illness. In this study, we conduct a critical analysis of evidence-based literature to determine whether such a link exists. We then explore current and recently proposed firearm laws and highlight inherent limitations associated with them when addressing firearm related violence, specifically in the context of mental illness. Finally, we discuss negative implications that these laws can have on the mental health care system, both from the consumers' and the providers' perspectives.

REFERENCES

Gostin LO, Record KL: Dangerous people or dangerous weapons: access to firearms for persons with mental illness. JAMA 305(20):2108-9, 2011

QUESTIONS AND ANSWERS

1. According to federal statutes such as the Gun Control Act of 1968, the following persons are banned from firearm purchases or possession:
- Those who are addicted to controlled substances
 - Those who have been involuntarily committed to a mental institution or adjudicated as incompetent or dangerous
 - Those who have received a verdict of not guilty by reason of insanity
 - All of the above
 - None of the above
- ANSWER: d

2. The 2013 Secure Ammunition and Firearms Security (SAFE) Act of New York includes provisions mandating that, if they conclude in their reasonable professional judgment that a patient “is likely to engage in conduct that would result in serious harm to self or others,” certain health care professionals report to:
- The potential victim
 - Law enforcement
 - A local director of community services
 - All of the above
 - None of the above
- ANSWER: c

F16

MINDFULNESS AND SEX OFFENDER TREATMENT

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

EDUCATIONAL OBJECTIVE

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

SUMMARY

This poster will review the usefulness of incorporating mindfulness into sex offender treatment. Mindfulness, which is a mental state, is characterized by attention to and awareness of present events and experiences. Approaching sex offender treatment mindfully may have a positive impact on the offender and enhance sex offender treatment. Mindfulness emphasizes the importance of being in the present moment and acceptance of the current situation. Mindfulness encourages participants to observe and accept their thoughts, feelings, and bodily sensations rather than react automatically and habitually. This state of self-observation can bring insight and improve self control. Teaching mindfulness techniques to offenders may help them better regulate their emotions, especially negative affects that may lead to impulsive sexual behavior. Mindfulness may also address empathy deficits and thus help cultivate empathy. Mindfulness may also improve offender's ability to cope with stress.

REFERENCES

- Kabat-Zinn J: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness. New York, NY: Delacorte Press, 1990
- Saleh F M, Grudzinskas AJ, Bradford JM, et al: Sex Offenders: Identification, Risk Assessment, Treatment, and Legal Issues. New York, NY: Oxford Press, 2009

QUESTIONS AND ANSWERS

1. Mindfulness can help offenders with which of the following:
- Empathy deficits
 - Vocational goals
 - Find stable housing
 - Med compliance
- ANSWER: a
2. How can mindfulness enhance current sex offender treatment?
- Teach offenders self-regulation
 - Provide insight into behaviors
 - Improve self control
 - Cultivate empathy
 - All of the above
- ANSWER: e

Louis Martone, MD, New York, NY
 Panagiota Korenis, MD, Eastchester, NY
 Christopher Smith, PhD, (I) New York, NY
 Scott Soloway, MD, Long Island City, NY

EDUCATIONAL OBJECTIVE

To identify the role that substance use has on effective implementation of involuntary outpatient civil commitment and to alert the forensic community about the implications of co-occurring substance use for those who are court ordered to an outpatient civil commitment program.

SUMMARY

Effective implementation of Assisted Outpatient Treatment (AOT), (court ordered involuntary outpatient civil commitment in New York State) remains a concern for both policy makers and mental health professionals. Many studies have investigated the effectiveness of involuntary outpatient commitment. However, few have focused on the role that substance use plays on the length of AOT. Identifying factors that can lengthen AOT can result in a better targeted and more effective course of treatment. We hypothesize that length of stay for AOT clients with a serious mental illness and co-occurring substance use will be longer. This retrospective case-controlled study will investigate length of stay of clients on AOT who were diagnosed with a serious mental illness and co-occurring substance use problem compared with those with only a diagnosis of a serious mental illness. In addition, demographic and treatment information will be collected and analyzed for their impact on the length of AOT and compared for both groups. We will also further analyze length of stay by examining the reason for case closure. We hope to better understand the effects that substance use has on the implementation of AOT so as to more appropriately tailor care for this vulnerable population.

REFERENCES

Swartz MS, Steadman HJ, Wilder CM, et al: Assessing outcomes for consumers in New York's assisted outpatient treatment program. *Psychiatric Services* 61(10):976-981, 2010
 Drake RE, Mueser KT, Brunette MF, et al: A review of treatments for people with severe mental illness and co-occurring substance use disorders. *Psychiatry Rehabilitation Journal* 27(4):360-374, 2004

QUESTIONS AND ANSWERS

1. What percentage of people who have a serious mental illness have a lifetime risk of substance abuse disorder?
 - a. 0-5%
 - b. 10-15%
 - c. 20-25%
 - d. >25%

ANSWER: d

2. How many US states currently have laws mandating a form of involuntary outpatient civil commitment?
 - a. None
 - b. 10
 - c. 25
 - d. 44
 - e. All of them

ANSWER: d

Brian Falls, MD, Sacramento, CA
 Harold Bursztajn, MD, (I) Cambridge, MA

EDUCATIONAL OBJECTIVE

Participants will be able to illustrate examples of cognitive and emotional influences on informants' memory that can decrease objectivity of the psychological autopsy (PA). Furthermore, when subsequently performing PAs, participants will be able to apply their knowledge of these factors to improve the quality of their PA reports.

SUMMARY

Almost two thirds of mass murder incidents in the United States result in the murderer's immediate demise. When a mass murderer dies at the scene, the public is left to speculate regarding his intentions and psychological state leading up to the rampage. Professionals can help society more fully understand these issues by performing psychological autopsies (PAs). Personal interviews with those who knew the decedent are a particularly important

source of information in mass murder PAs. In this poster, we detail a number of emotional and cognitive influences on memory that can significantly decrease objectivity of informants' accounts of those who died shortly after committing mass murder. Influences discussed include misattribution, suggestibility, transience, persistence, and a number of cognitive biases. To date, very little research has examined the impact of informants' emotions and cognitions on PA quality, especially within the emotionally charged context of mass murder. Mental health professionals should be familiar with impediments to obtaining objective data from PA interviews. Specifically, they should be mindful of these factors when gauging accuracy of informants' recollections and note their potential presence throughout the written PA report. Likewise, the final opinions of the PA report should reflect the author's consideration of such subjectivity.

REFERENCES

Duwe G: Mass Murder in the United States: A History. Jefferson, NC: McFarland and Company, 2007.
Schacter DL: The Seven Sins of Memory. New York, NY: Houghton Mifflin Company, 2001

QUESTIONS AND ANSWERS

1. Which of the following cognitive biases, by definition, may act to enhance or minimize foreseeability of mass murders?

- a. Consistency bias
- b. Egocentric bias
- c. Hindsight bias
- d. Stereotypical bias

ANSWER: c

2. Which of the following sources of data distortion happen primarily during the interview process (choose all that apply)?

- a. Persistence
- b. Suggestibility
- c. Transference
- d. Transience

ANSWER: b & c

F19

ASSESSING DISRUPTIVE BEHAVIOR: LESSONS LEARNED FROM VHA

Jennifer Piel, MD, JD, Seattle, WA

EDUCATIONAL OBJECTIVE

This poster will summarize existing literature on violence in the hospital setting; procedures for assessing disruptive behavior at one VA hospital utilizing a forensic clinical assessment; and lessons learned from the program.

SUMMARY

More than 10% of hospital employees report at least one workplace assault per year. Patients are the most common assaulters. The VHA (Veterans Health Administration) has directed its hospitals to create a Disruptive Behavior Committee (DBC) to identify patients who pose elevated risk for violence at their facilities. Among its tasks, the DBC initiates and reviews Patient Record Flags (PRF), which are behavioral flags in the patient's medical chart that identifies patients who are at increased risk for disruptive behavior. At the VA-Puget Sound, Seattle, clinical forensic assessments are being utilized to aid the DBC in its determinations and provide risk reduction recommendations. Patients with disruptive PRFs may voluntarily participate in the disruptive behavior assessments. Presented in this poster are the lessons learned from the first year of this pilot program.

REFERENCES

Hodgson MJ, Reed R, Craig T, et al: Violence in healthcare facilities: lessons from VHA. J Occup Environ Med 46:1158-1165, 2004
38 C.F.R section 17.106 - VA response to disruptive behavior of patients

QUESTIONS AND ANSWERS

1. Working in which area of health care presents an elevated risk for assault as compared to baseline in a hospital setting?

- a. Geriatrics
- b. Mental health
- c. Rehabilitation
- d. Nursing
- e. All of the above

ANSWER: e

2. In response to disruptive behavior at VHA facilities, which of the following must be considered by the Chief of Staff or designee in assessing a patient's risk for violence?
 - a. Pertinent facts
 - b. Prior counseling regarding disruptive behavior
 - c. Pattern of disruptive behavior
 - d. Whether behavior is a result of individual fears, preference, or perceived needs
 - e. All of the above

ANSWER: e

F20

RECOMMITMENT OF INSANITY ACQUITTEES

Michal Kunz, MD, New York, NY
 Brian Belfi, PsyD, (I) New York, NY
 Debbie Green, PhD, (I) Teaneck, NJ
 Jeremy Schreiber, MA, (I) New York, NY

EDUCATIONAL OBJECTIVE

To outline the risk factors associated with the recommitment of insanity acquittees previously designated as having "Dangerous Mental Disorder" and transferred to a civil state psychiatric facility.

SUMMARY

Following an acquittal pursuant to an insanity defense, an acquittee is committed to one of the NYS Office of Mental Health Forensic facilities for the determination of whether he/she suffers from a "Dangerous Mental Disorder" (DMD). Periodic evaluations of clinical and historical criteria are used to assess whether the risk continues to meet the threshold for the DMD. Those acquittees no longer deemed to suffer from a DMD are transferred to a civil (non-secure) facility. A minority of acquittees are subsequently recommitted to a forensic facility. Several static factors, including substance abuse, prior criminal history, male gender, younger age when released, diagnosis of antisocial personality disorder, and prior conditional release failure appear predictive of recommitment (and/or rearrest). We evaluated the use of the Historical, Clinical, Risk-Management 20 (HCR-20) in differentiating acquittees (N=122) who were transferred from a forensic hospital to civil psychiatric hospitals between 1977 and 2010 and were subsequently recommitted from those who were not recommitted. Approximately one third of this group was recommitted. Groups (recommitted vs. not recommitted) were compared on the Historical Items of the HCR-20, as well as on demographic information. Results of this comparison will be presented.

REFERENCES

Manguno-Mire GM, Thompson JW, Bertman-Pate L J, et al: Are release recommendations for NGRI acquittees informed by relevant data? *Behavioral Sciences and the Law* 25: 43-55, doi: 10.1002/bsl.724, 2007
 Gray NS, Taylor J, Snowden RJ: Predicting violent reconvictions using the HCR-20. *The British Journal of Psychiatry*, 192(5), 384-387, 2008

QUESTIONS AND ANSWERS

1. What static risk factors have been associated with decisions to retain or conditionally release acquittees?
 ANSWER: Female gender, diagnoses other than schizophrenia, non-violent offense history, low psychopathy and older age during one's first criminal offense.

2. Name some of the dynamic and protective variables that influence decisions of retention versus release.
 ANSWER: Treatment compliance and responsiveness, substance use, risk of violence, and availability of structured activities in the community.

F21

COGNITIVE REMEDIATION FOR IN-JAIL COMPETENCY RESTORATION

Peter Ash, MD, Atlanta, GA
 Ryan Bromley, PsyD, (I) Atlanta, GA
 Glenn Egan, PhD, (I) Atlanta, GA
 Bryon McQuirt, MD, Atlanta, GA
 Vicki Roberts, MEd, Atlanta, GA
 Tomina Schwenke, PhD, (I) Atlanta, GA
 Sanjay Shah, PhD, JD, (I) Atlanta, GA

EDUCATIONAL OBJECTIVE

Participants will understand the purpose and implications of cognitive remediation training for defendants opined not competent to stand trial, as a means of improving neuropsychological functioning and enhancing treatment outcomes for a jail-based competency restoration program.

FRIDAY

SUMMARY

This study tests the hypothesis that cognitive remediation training will lead to improved cognitive functioning that indirectly enhances the capacity for individuals to assist counsel, understand factual information and rationally understand legal issues. The sample was drawn from pretrial defendants detained in the Fulton County Jail in Atlanta who were opined to be incompetent to stand trial. These defendants were housed in an in-jail competency restoration unit. Upon admission to the competency restoration unit, defendants are cognitively tested to determine overall cognitive functioning and to identify specific individual deficits. In January 2013 a cognitive remediation program was added to the existing competency restoration interventions. The purpose of the remediation program is to target specific cognitive skills including memory, concentration, attention, and executive functioning. Defendants were retested after completion of the program. Preliminary data suggest there is improvement in the underlying cognitive capacity of individuals, the acquisition of domain-specific knowledge essential to competency, as well as an indirect positive effect on general treatment and medication compliance resulting from the increased engagement of the inmates in positive and enjoyable group activities. This poster will discuss outcome data, lessons learned, and future directions for this forensic treatment.

REFERENCES

Hubbard KL, Zapf PA, Ronan KA: Competency restoration: an examination of the differences between defendants predicted restorable and not restorable to competency. *Law Hum Behav* 27: 127-39, 2003.
Schwalbe E, Medalia A. Cognitive dysfunction and competency restoration: Using cognitive remediation to help restore the unrestorable. *J Am Acad Psychiatry Law* 35: 518-525, 2007

QUESTIONS AND ANSWERS

1. When compared to inmates that are competent to stand trial, inmates found incompetent to stand trial show evidence of more severe psychopathology, in all of the following except:

- a. Delusions
- b. Hallucinations
- c. Substance abuse/dependence
- d. Impaired memory
- e. Impaired thought and communication

ANSWER: c

2. Cognitive remediation specifically targets improving cognitive skills including all of the following except:

- a. Domain-specific knowledge
- b. Attention
- c. Memory
- d. Problem solving and reasoning
- e. Executive Functioning

ANSWER: a

F22

LANDMARK CASE UPDATES: THE SUPREMES' RECENT RULINGS

William Newman, MD, Sacramento CA
Brian Falls, MD, Sacramento, CA
Charles Scott, MD, Sacramento, CA
Ryan Wagoner, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

Conference participants will be able to describe landmark cases decided by the U.S. Supreme Court between 2008 and 2013. They will be able to analyze the Court's holdings and reasoning within cases that address a wide variety of mental health issues, and apply them to the practice of forensic psychiatry.

SUMMARY

U.S. Supreme Court cases addressing mental health law are a cornerstone of forensic psychiatry practice and education. This panel will provide a comprehensive review of significant landmark cases decided between 2008 and 2013, with a primary focus on U.S. Supreme Court cases. This panel will also include select lower-court holdings that may become future AAPL landmark cases. Each panelist will provide a description of key facts of each case, the Court's holding and underlying reasoning, and implications for current forensic psychiatric practice. The panel will discuss the most significant mental health law cases in the areas of competency, sanity, execution, child and adolescent psychiatry, correctional psychiatry, and emotional distress claims. The presenters will provide prepared briefs that include the facts of each case and relevant legal issues raised, as well as the Court's decisions and associated rationales. An interactive audience response system will be used to engage participants by assessing their knowledge of cases before and after the presentation, as well as their opinions of case outcomes. Additionally, the presenters will provide sample assessment questions for attendees to utilize in practice-based learning and teaching within forensic psychiatry fellowships.

REFERENCES

Brown v. Plata, 131 S. Ct. 1910 (2011)
Ryan v. Gonzales, 133 S. Ct. 696 (2013)

QUESTIONS AND ANSWERS

1. In Brown v. Plata (2011), the Supreme Court held which of the following:
- An inmate has the right to a full competency evaluation prior to execution.
 - A state can be court ordered to reduce its prison population to help ensure adequate medical and mental health care to inmates.
 - Inmates can be required to submit to a full psychiatric evaluation on initial incarceration.
 - A prison may be utilized in lieu of a psychiatric hospital for involuntary commitment.
- ANSWER: b

2. In Ryan v. Gonzales (2013), the Supreme Court held which of the following:
- NGRI patients who request a writ of habeas corpus may not challenge a court's previously having ruled them insane.
 - The purpose of involuntary commitment is treatment, not punishment.
 - Involuntary commitment represents a need for hospitalization only at the time of commitment, not forever.
 - A prisoner need not be competent for a court to make a habeas corpus decision.
- ANSWER: D

F 23

DSM-5: FORENSIC PSYCHIATRIC IMPLICATIONS

Robert Weinstock, MD, Los Angeles CA
Dilip Jeste, MD, (I) La Jolla, CA
Debra Pinals, MD, Boston, MA
Patricia Recupero, MD, JD, Providence, RI
Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

To become aware of the changes in DSM-5 and their impact on forensic practice. To learn ways of applying DSM-5 in forensic evaluations and to avoid unnecessary problems as a result of the DSM-5 changes.

SUMMARY

The DSM-5 diagnostic changes have effects in the forensic context. There was significant input from forensic psychiatry in the latter stages of development with most major concerns addressed, but there will be effects. Dr. Jeste, President of the APA when DSM-5 was completed, will discuss the rationale for the DSM-5 changes and as a geriatric psychiatrist he will discuss the reasons for making changes in the diagnostic categories that affect geriatric patients. Dr. Recupero is chair of the APA Council on Psychiatry and Law, was a consultant to the DSM-5 workgroup for PTSD and will discuss these changes. She appointed various consultants to other DSM-5 workgroups, some of whom are represented on this panel. Dr. Zonana will discuss the impact of the DSM-5 changes on criminal forensic psychiatry. Dr. Pinals will present information related to the psychotic disorders, the substance use disorders, and the personality disorders with examples of how diagnostic criteria can impact forensic outcomes. Dr. Weinstock consulted with the geriatrics workgroup and will discuss the diagnosis of major neurocognitive disorder (equivalent to dementia) and the receptivity of that DSM-5 workgroup to changes to prevent significant forensic problems. Case examples from the presenters and audience will be encouraged.

REFERENCES

American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders: DSM-5. Arlington, VA: American Psychiatric Press, 2013
Freedman R, Lewis D, Michels R, et al: The initial field trials of DSM-5: new blooms and old thorns. Am J Psychiatry 170:1-5, 2013

QUESTIONS AND ANSWERS

1. Which of the following will be changes in DSM-5 substance use disorders?
- Elimination of substance abuse
 - Elimination of substance dependence
 - Addition of craving
 - Removal of legal consequences as a criterion
 - All of the above
- ANSWER: e

2. Which of the following will be included in DSM-5?
- a. Amnesic disorder
 - b. Major neurocognitive disorder
 - c. Minor neurocognitive disorder
 - d. Two standard deviations from the norm on a standardized test as a requirement for a diagnosis of major neurocognitive disorder
 - e. All of the above
- ANSWER: b

F24

**BAYESIAN EVALUATION OF MEASURES FOR
FAKED MEMORY IMPAIRMENT**

Douglas Mossman, MD, Cincinnati, OH

EDUCATIONAL OBJECTIVE

At the conclusion of this presentation, attendees will: (1) summarize the typical characteristics of neurocognitive effort measures (2) describe the accuracy characteristics of the TOMM (3) explain, in general terms, the difficulties encountered when trying to evaluate neurocognitive effort measures.

SUMMARY

Malingered neurocognitive impairment is a frequent concern for neuropsychologists and forensic psychiatrists, who often encounter individuals with falsely claimed memory deficits—for example, in evaluations of adjudicative competence (10-15% of evaluatees) and disability claims (up to 30%). Establishing the accuracy of neurocognitive effort measures in actual performance situations is problematic because the true status of evaluatees cannot be known for certain. This presentation describes our efforts to quantify the sensitivity and specificity of the Test of Memory Malingering (TOMM). Using the PsycInfo database, we located more than 450 articles that mentioned the TOMM and selected those publications (n=39) that report numerical values for “positive” test results using the standard 90% criterion on TOMM Trial 2. Using the Bayesian estimation program WinBUGS, we implemented an approach proposed by Frederick and Bowden (2009), with modifications that (1) constrain sensitivity and specificity estimates to the range [0,1]; (2) incorporate uncertainty in estimates of malingering rates; and (3) allow hierarchical modeling of study populations (simulators vs. clinical groups), study methods (e.g., coaching about feigning), and bias in estimated malingering rates. Our methods yield results consistent with previous TOMM studies (high specificity, moderate sensitivity) but account explicitly for factors that might affect accuracy estimates.

REFERENCES

Frederick RI, Bowden SC: The Test Validation Summary. *Assessment* 16:215-236, 2009
Mossman D, Wygant DB, Gervais RO: Estimating the accuracy of neurocognitive effort measures in the absence of a “gold standard.” *Psychological Assessment* 24:815-822, 2012

QUESTIONS AND ANSWERS

1. In evaluating middle-aged individuals who respond logically to questions but report memory impairments, which statement about the TOMM is true?
- a. The TOMM often fails to detect honest responders, but it catches almost all malingerers.
 - b. The TOMM often fails to detect malingerers, but it rarely misidentifies an honest responder.
 - c. The TOMM identifies malingerers and honest responders with equally high accuracy.
 - d. The TOMM uses a malingerer-identification strategy that is completely different from other symptom validity tests.
 - e. Most malingerers score below chance on the TOMM.
- ANSWER: b
2. Bayesian methods offer intriguing approaches to problems in forensic psychiatry because:
- a. They never involve making assumptions about background information.
 - b. They always treat probabilities as the direct outcome of objective data.
 - c. They make inferences based on expectations about long-term frequencies.
 - d. They permit inferences about numerical values in situations where one does not know the true status of a matter of interest.
 - e. Bayesian methods are the inferential techniques used most commonly in standard texts on statistics.
- ANSWER: d

F25

ARRESTING CIVIL PATIENTS, QUANTIFYING THE JUSTIFICATIONS

Daniel Mundy, MD, New York, NY
Shilpa Agraharkar, BS, (I) New York, NY
Elizabeth Ford, MD, New York, NY

EDUCATIONAL OBJECTIVE

To learn about the common circumstances leading to arrests of hospitalized psychiatric patients in New York City and the demographic, clinical and legal characteristics of those arrested. Attendees will learn about the recognized goals of incarceration and examine whether these goals are met by the arrest of psychiatric patients.

SUMMARY

This study describes demographic, clinical, and legal characteristics of psychiatric patients who are arrested in civil facilities in New York City and then transferred to the Bellevue Hospital Jail Psychiatry Service. Assessment of motives for prosecution, victim characteristics and criminal case disposition will help to describe the situations in which arrests occur and help provide some estimate of whether any reasons for incarceration are satisfied. This is a cohort study based on a retrospective chart review of each subjects' electronic medical record at Bellevue Hospital and data obtained from the NY Criminal Justice Agency. The primary outcomes are designed to measure justification for punishment. In our sample, 75% had a psychotic disorder, and the most common charge was Assault 3, a misdemeanor (54%). The average length of stay prior to arrest was 42.2 days, comparable to 32.8 days at Bellevue post-arrest. The mean time under legal supervision was 115 days. The mean number of assaults decreased from 2 to 0.5. Sixty-four percent of arrestees were found guilty. Prosecution, regardless of legal outcome, achieved the justice goals of confinement and specific deterrence. Retribution was largely accomplished. There was no clear evidence of a rehabilitative effect.

REFERENCES

Appelbaum KL, Appelbaum PS: A model hospital policy on prosecuting patients for presumptively criminal acts. *Hospital and community psychiatry* 42:1233-1237, 1991
 Noriko M, Zonana H, Phillips R: Prosecuting assaultive psychiatric inpatients. *Hospital and Community Psychiatry* 42:193-195, 1992

QUESTIONS AND ANSWERS

1. Which is NOT a recognized justification for incarceration?
 - a. Deterrence
 - b. Retribution
 - c. Beneficence
 - d. Rehabilitation

ANSWER: c

2. Which of the following statements is FALSE regarding prosecuting patients?
 - a. Staff may be reluctant to press charges due to awareness of transference.
 - b. Committed patients, by definition, are not responsible for their actions.
 - c. Law enforcement may be unwilling to press charges against a patient.
 - d. Confidentiality does not prevent hospitals from pressing charges against a patient.

ANSWER: b

F26

CHANGE AND EFFECT: THE NEW ORLEANS FORENSIC AFTERCARE CLINIC

Kelly Erwin, MD, MPH, New Orleans, LA
 Gina Manguno-Mire, PhD, (I) New Orleans, LA
 Sarah DeLand, MD, New Orleans, LA
 John Thompson, Jr., MD, New Orleans, LA

EDUCATIONAL OBJECTIVE

We plan to use data collected from an outpatient community forensic clinic to inform clinicians and policy-makers about the specific variables that impact success, failure and risk level. We intend to compare jail-diverted/pre-trial clients with hospital-discharged clients to determine which variables are related to re-arrest, hospitalization and new incidents/revocations.

SUMMARY

The New Orleans Forensic Aftercare Clinic is a community-based outpatient forensic clinic that provides clinical, rehabilitative, and supervisory services to individuals found not guilty by reason of insanity (NGRI) or incompetent to stand trial. Data from FAC comparing rehospitalization, rearrest and violent vs. non-violent charges between jail-diverted clients and hospital-discharged clients was published in 2004 (Bertman-Pate). That study demonstrated that clients diverted from jail could be successfully diverted to the community, as recidivism rates and rearrests for new or violent charges were low and roughly equivalent to hospital-discharged clients. Since the initial FAC study in 2004, Louisiana has experienced numerous legal and policy changes (Federal consent decree, case law – Denson v. State of Louisiana (12/01/04), hospital closures) that have impacted community-based forensic treatment services. The purpose of this research study is to examine the impact of state-wide policy changes on the outcome for clients court-mandated to treatment at FAC. Our

specific aim is to evaluate the impact of the increased number of jail-diverted/pre-trial clients on court-mandated treatment, including outcome variables such as rearrest and hospitalization, and other demographic and legal variables. Our goal is to provide systematic data to inform clinical forensic treatment services and guide legal policy.

REFERENCES

Bertman-Pate LJ, Burnett DMR, Thompson JW, et al: The New Orleans Forensic Aftercare Clinic: A seven year review of hospital discharged and jail diverted clients. *Behav Sci Law* 22: 159-169, 2004
State of La. v. Denson, 04-0846, 888 So.2d 805 (La. 12/01/04)

QUESTIONS AND ANSWERS

1. How have the demographic and clinical needs of clients in a community-based outpatient clinic changed in light of legal policy changes mandating outpatient services in lieu of jail-based competency restoration and long-term hospitalization?

ANSWER: Clients receiving mandated outpatient forensic services are predominantly young African-American males with co-occurring disorders, primarily substance use, schizophrenia and mental retardation. Approximately 30% have a current violent charge, and approximately 60% receive social security disability (SSD). Compared to the original study (Bertman-Pate, et al., 2004), in which there were approximately as many clients admitted from long-term forensic hospitalization as from jail, there has been a shift to the majority of clients being diverted directly from the jail setting. Far fewer clients are being admitted from the hospital. Legal status is also significantly changed from the original study in that many more clients are currently in pre-trial status compared to NGRI. The treatment focus for pre-trial clients is on treatment and monitoring that will impact restoration of competency as well as preserve public safety.

2. How does legal status (jail-diverted/pre-trial vs NGRI) impact treatment outcome and risk management in a community-based outpatient forensic clinic?

ANSWER: We have found that jail diverted/pre-trial clients had significantly more incidents (episodes of substance abuse relapse, relapse to psychosis, rule violations, rearrests, etc.) compared to clients admitted from the forensic hospital (predominantly NGRI). Jail-diverted clients also had a significantly shorter period of time between admission to the clinic and first incident. Jail-diverted clients were rated as more impaired using clinician-generated GAF scores than clients discharged from the forensic hospital. Given these findings, this potentially poses a higher risk to the community and may signify a need for more intensive treatment services based on specific incident types.

F27

RESTORATION OF COMPETENCY TO STAND TRIAL IN MISDEMEANANTS

Artha Gillis, MD, PhD, (I) Sacramento, CA
Brian Holoyda, MD, MPH, Sacramento, CA
William Newman, MD, Sacramento, CA
Glen Xiong, MD, (I) Sacramento, CA

EDUCATIONAL OBJECTIVE

To review current knowledge about restoration of competency to stand trial in misdemeanor defendants. To demonstrate the proportion of misdemeanor defendants restored to competency in Sacramento County over an eight year period. To identify variables that predict restorability of competency to stand trial in incompetent misdemeanor defendants.

SUMMARY

In 1960, *Dusky v. US* affirmed a defendant's right to an evaluation of competency to stand trial by a mental health provider. Since that time competency evaluations have become the most common evaluation performed within forensic psychiatry in the United States. Though studies have examined demographic, clinical, and forensic variables that predict the restorability of defendants' competency to stand trial, few have examined the seriousness of the charge as a predictor of restorability. Despite this, most states provide a significantly shorter time period for the assessment and treatment of misdemeanor defendants deemed incompetent to stand trial. In fact, there is evidence that misdemeanor defendants may actually be equally or more difficult to restore to competency than their felony defendant counterparts. The question of what factors predict restoration of competency in misdemeanor defendants remains unanswered. This study presents data from a retrospective review of misdemeanor defendants in Sacramento County sent to a mental health facility for restoration of competency, and identifies the demographic, clinical, and forensic variables that predict restorability in misdemeanor defendants over an eight year period.

REFERENCES

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

QUESTIONS AND ANSWERS

1. Which of the following is true regarding competency to stand trial assessment?
- a. There is a specific set of objective criteria that determine whether or not a defendant is competent to stand trial.
 - b. Every charge dictates a different, defined threshold of competency required.
 - c. Most view competency to stand trial as a sliding scale, the threshold of which varies based on contextual factors.
 - d. Psychiatric evaluations of competency to stand trial typically lack reliability.

ANSWER: c

2. Which of the following is true regarding misdemeanor defendants and competency to stand trial?
- a. Incompetent misdemeanor defendants typically have less severe psychiatric symptoms than incompetent felony defendants.
 - b. In most states misdemeanor defendants receive longer periods of time for assessment and treatment for restoration of competency.
 - c. Incompetent misdemeanor defendants demonstrate less competency than incompetent felony defendants.
 - d. Misdemeanor charges are associated with greater probability of restoration.

ANSWER: c

F28

ETHICS OF SEX OFFENDER MANAGEMENT: IS THERE A RIGHT ANSWER?

- Li-Wen Lee, MD, New York, NY
- Natasha Knack, BA, (I) Ottawa, ON, Canada
- Richard Krueger, MD, New York, NY
- Lynn Maskel, MD, Madison, WI
- Lisa Murphy, MCA, (I) Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

Participants will be able to (1) identify the ethical issues presented by sex offender treatment and management, (2) understand varying perspectives of ethical concerns, and (3) discuss potential means of approaching ethical dilemmas.

SUMMARY

Sexual predator laws have ebbed and flowed in the U.S. since the 1930s. The current generation of laws pertaining to the management of sex offenders typically includes the use of sex offender registries, more stringent sentencing guidelines, provision of sex offender treatment while incarcerated, further treatment in the community, and, in some states, the establishment of inpatient sexually violent predator programs. These measures are theoretically based on both furthering public safety and treating offenders, and the dual purposes lead to a number of ethical issues, including concerns about the potential for these interventions to serve primarily as added punishment, for undue coercion in treatment to occur, and for preventive detention, in and of itself, to become the goal. In this workshop, presenters will discuss ethical aspects of (1) the use and misuse of public notification and sex offender registries, (2) treatment while incarcerated versus treatment in the community, and (3) treatment with hormonal therapies. One of the presenters of the panel will present the defense perspective on each of these areas. Perspectives on ethical issues will be solicited from the audience for discussion.

REFERENCES

- Ward T, Salmon, K: The ethics of care and treatment of sex offenders. *Sexual Abuse: A Journal of Care and Treatment* 23: 397-413, 2011
- Zonana H, Buchanan A: (2009). Ethical issues in the treatment of sexual offenders, in *Sex Offenders: Identification, Risk Assessment, Treatment, and Legal Issues*. Edited by Saleh AJ, et al. New York, NY: Oxford University Press, 2009

QUESTIONS AND ANSWERS

1. Treatment of sexual offenders in correctional settings may be complicated by
- a. Additional limitations to confidentiality
 - b. Coercion to participate
 - c. Stigmatization of participants in treatment
 - d. All of the above

ANSWER: d

2. States that mandate chemical castration prior to return to the community include:
- a. Texas
 - b. New York
 - c. New Jersey
 - d. Oregon
 - e. All of the above

ANSWER: d

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

EDUCATIONAL OBJECTIVE

Participants will understand: 1) how to approach risk assessment tasks utilizing available research data, appropriate actuarial tools, and appropriate clinical methodology; 2) how to apply functional risk assessment techniques; and 3) 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. 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/approaches is essential to this area of forensic practice. This course will present a framework for applying risk assessment in psychiatry, including a review of the APA's new Resource Document on Psychiatric Violence Risk Assessment, published in 2012. We will illustrate the strengths and limitations of various risk-assessment approaches through a review of a case in the public domain, 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 an individual's functional capacities, citing data from an early study of an instrument designed to facilitate such an approach.

REFERENCES

Norko MA, Baranoski MV: The prediction of violence; detection of dangerousness. *Brief Treatment & Crisis Intervention* 8:73-91, 2008
Buchanan A, Binder R, Norko M, et al: Resource Document on Psychiatric Violence Risk Assessment. *Am J Psychiatry* 169:3, March 2012, data supplement

QUESTIONS AND ANSWERS

1. Actuarial measures of risk assessment:

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

ANSWER: b

2. 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 situation
- 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

Peter Ash, MD, Atlanta, GA
Karen Bailey-Smith, PhD, (I) Atlanta, GA
Aimee Kaempf, MD, Tucson, AZ
Reena Kapoor, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will understand the reasons behind the growing trend of jail-based competency restoration, different models of providing services, the pros and cons of this approach, and preliminary outcome data.

SUMMARY

Restoration of competency to stand trial in jails is a new approach that is being practiced in several states but is being considered in many more. The main advantages of utilizing such programs as an adjunct to restoration in forensic units in state mental hospitals are (1) matching the intensity of restoration services to the needs of the defendant, (2) shorter time between evaluation and beginning of restoration, and (3) markedly decreased costs. This workshop will discuss two functioning models of jail-based programs with outcome data, lessons learned in developing these programs, national trends in developing in-jail programs, and potential pragmatic and ethical problems in-jail programs present. Considerable time will be allotted for audience discussion focused on how such programs might be implemented and function under the rules of other jurisdictions.

REFERENCES

Morenz B, Busch K: Pima County jail. AAPL Newsletter 36: 25, 2011
Kapoor R: Jail-based competency restoration. J Am Acad Psychiatry Law 39:311-315, 2011

QUESTIONS AND ANSWERS

1. Potential benefits of jail-based competency restoration include all of the following except:
- a. reduced cost per defendant
 - b. reduced wait times before restoration efforts begin
 - c. reduced incentive for defendants to malingering incompetence
 - d. increased treatment compliance
 - e. increased use of diversion services
- ANSWER: d

2. Jail-based competency restoration programs are best conceptualized as:
- a. An alternative to inpatient restoration
 - b. A replacement for inpatient restoration
 - c. A form of diversion
 - d. One level in a continuum of restoration services
 - e. A trade-off between cost and effectiveness
- ANSWER: d

F31

CRAZY LADIES: FEMALE PSYCHOPATHIC TRAITS IN RECENT POPULAR CULTURE

Cathleen Cerny, MD, Seven Hills, OH
Susan Hatters Friedman, MD, Cleveland Heights, OH
Delaney Smith, MD, Columbus, OH
Sherif Soliman, MD, Northfield, OH

EDUCATIONAL OBJECTIVE

We will use examples from recent popular culture to educate about female psychopathy. Audience members will be better informed with regard to their own forensic evaluations. They will also be able to use our examples to teach trainees about psychopathy.

SUMMARY

In prior presentations, the authors successfully used fictional examples to teach about forensic psychiatry topics. Now, we hope to use the same methods in order to teach about female psychopathy. This is a timely topic because of national focus on violence and deviance in popular culture. Female psychopathy is less prevalent and less researched than male psychopathy. Female psychopaths differ in significant ways from their male counterparts and these differences are not always appreciated by clinicians, expert evaluators or the legal justice system. It is well known that television and cinema impact gender roles, stereotypes and expectations. Popular culture can also impact female deviance. Catherine Tramell in *Basic Instinct* (1992) and Annie Wilkes in *Misery* (1990) are two iconic female characters with prominent psychopathic traits. Although their movies premiered over two decades ago, these fictional women are still referenced today. Characters such as these laid the foundation for deviant women on the ubiquitous procedurals of today such as the CSI franchise and *Criminal Minds*. Versions of Catherine and Annie can also be found on teen-oriented fare such as *Gossip Girl* and *Pretty Little Liars*. These abundant fictional examples of female psychopathic traits can be used as excellent teaching tools.

REFERENCES

Dolan M, Vollm B: Antisocial personality disorder and psychopathy in women: A literature review on the reliability and validity of assessment instruments. *International Journal Law and Psychiatry* 32: 2-9, 2009
Wynn R, Hoiseth MH, Pettersen G: Psychopathy in women: theoretical and clinical perspectives. *International Journal of Women's Health* 4: 257-263, 2012

QUESTIONS AND ANSWERS

1. What percentage of individuals meeting criteria for antisocial personality disorder also meet criteria for psychopathy?
ANSWER: about 30%
2. What are some distinctions about female psychopathy?
ANSWER: unstable emotions, verbal relational aggression and social manipulation, with less criminality and violence than their male counterparts

Kristen Ochoa, MD, MPH, Sylmar, CA
 Veronica Barba, JD, (I) San Diego, CA
 Talia Inlender, JD, (I) Los Angeles, CA
 Graciela Martinez, JD, (I) Los Angeles, CA
 Stacey Stongarone, JD, (I) Los Angeles, CA

EDUCATIONAL OBJECTIVE

To examine problems that non-citizens with serious mental disorders face in criminal proceedings and in immigration proceedings with regard to mental competency. We will explore how persons move from the criminal system to immigration detention and discuss issues surrounding transfers, legal representation and competency examination.

SUMMARY

Mental competency in immigration removal proceedings is a new and evolving area of law and forensic psychiatry. Non-citizens with serious mental disorders and competency issues face many legal challenges, both in the criminal and immigration systems. This presentation will build on a previous panel which discussed the lack of developed regulations to protect immigrants with serious mental disorders who face deportation. We will discuss the responsibility of criminal attorneys to inform their clients of the immigration consequences of conviction and present models for evaluating the competency of non-citizens facing criminal charges that could represent grounds of removal. We will introduce a model for evaluating competency in removal proceedings. Attorneys who represent persons with serious mental disorders in removal proceedings will share case examples and we will receive an update on *Franco-Gonzalez v. Holder*, a class action lawsuit on behalf of hundreds of immigration detainees in California, Arizona and Washington who have mental competency issues, but no legal representation. We will also present pilot efforts to ensure that potentially incompetent persons are properly identified, represented and evaluated. Counsel from Los Angeles Public Defender, Vera Institute of Justice, Public Counsel Law Center and Immigration Justice Project of San Diego will present.

REFERENCES

American Immigration Council Legal Action Center: Representing Clients with Mental Competency Issues Under Matter of M-A-M, Practice Advisory. Available at <http://www.legalactioncenter.org/sites/default/files/docs/lac/Mental-Competency-Issues.pdf>. Accessed on July 24, 2013

Talia Inlender: Immigration detainees: Lost in America, The immigration courts system is failing those detainees who have serious mental disabilities. Los Angeles Times. Available at <http://articles.latimes.com/2011/jul/12/opinion/la-oe-inlender-detainees-20110712>. Accessed on July 24, 2013

QUESTIONS AND ANSWERS

1. The substantial difference between the criminal competency standard set forth in *Dusky v. United States* and the immigration standard set forth in *Matter of M-A-M* is:
 - a. rational as well as a factual understanding of the proceedings.
 - b. reasonable opportunity to examine and present evidence and cross-examine witnesses.
 - c. sufficient present ability to consult with an attorney with a reasonable degree of rational understanding.
 ANSWER: b

2. Which U.S. Supreme Court decision held that counsel that did not “inform a client whether his plea carries a risk of deportation” was “constitutionally deficient”?
 - a. *Chaidez v. United States*
 - b. *Bridges v. Wixon*
 - c. *Padilla v. Kentucky*
 ANSWER: c

Cecilia Leonard, MD, Manlius, NY
 David Annas, MD, Syracuse, NY
 James Knoll, IV, MD, Syracuse, NY
 Terje Tørrissen, MD, (I) Ottestad, Norway

EDUCATIONAL OBJECTIVE

Demonstrate how forensic psycholinguistic analysis can be used to explore the communications of mass murderers to provide enhanced understanding of their motives and psychopathology. Analysis will focus on the case of Anders Breivik, a Norwegian mass murderer, and will receive commentary by a Norwegian psychiatrist who performed Breivik’s forensic evaluation.

SUMMARY

In 2011, Anders Breivik, a 32 year old Norwegian extremist, perpetrated a dual attack in Norway that claimed the lives of 77 innocent victims. He composed a 1,492 page manifesto he published on the Internet hours before his attack. It has been observed that some mass murderers convey a message they hope will serve as a final “living” testament. To date, these communications have received little analysis, despite the fact that the offender’s use of language may provide important data about his motivations and psychopathology. Forensic psycholinguistic analysis seeks to discern subtleties of linguistic style, personality variables, and the presence of certain types of mental illness. This panel will begin with an introduction to basic forensic psycholinguistic analysis, along with brief examples of how it may be applied. Next, the factual and procedural history of the Breivik case will be reviewed. The various themes present in Breivik’s writings will be discussed in detail and in light of psycholinguistic analysis. Finally, Dr. Tørrisen, one of the Norwegian experts involved in the Breivik case, will provide his unique perspective. Dr. Tørrisen will comment on how the psycholinguistic analysis of Breivik’s writings compare to his personal evaluation of Breivik.

REFERENCES

EU’s Eurabia Project – Documenting the EU’s deliberate strategy to gradually Islamise Europe. Available at <http://info.publicintelligence.net/AndersBehringBreivikManifesto.pdf>. Accessed August 13, 2013
 Knoll JL: Mass murder – causes, classification and prevention. *Psychiatr Clin N Am* 35: 757–780, 2012

QUESTIONS AND ANSWERS

1. An offender’s use of language may suggest which of the following?

- a. Schizophrenia
- b. Depression
- c. Personality structure
- d. Conceptual complexity
- e. All of the above

ANSWER: e

2. While significant limitations exist in regard to the research thus far on mass killings, the following appears to be true:

- a. Most mass killers fit a common profile
- b. Pervasive developmental disorder is highly prevalent among perpetrators of mass killings
- c. Perpetrators of mass killings often have experienced significant narcissistic injury
- d. Schizophrenia is the most common Axis I diagnosis among mass killers who have been studied

ANSWER: c

F34**REFLECTIONS OF A MEDICAL DIRECTOR**

Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

At the end of this program, participants will be able to describe the historical development of forensic psychiatry as a subspecialty, discuss AAPL’s relationship to the American Psychiatric Association and American Medical Association, and understand how the professionalization of AAPL helped it become the leading organization of forensic psychiatrists.

SUMMARY

Dr. Zonana has served as AAPL’s Medical Director since 1995. His contributions to the field of forensic psychiatry and to AAPL are legion. In his last meeting as Medical Director, Dr. Zonana will give a personal interview that takes stock of the field of forensic psychiatry over several decades. He will speak of the origins of his involvement in forensic psychiatry and of its development as a subspecialty within psychiatry. He will provide personal reflections on AAPL’s growth and evolution and discuss the history of AAPL’s collaboration with the American Psychiatric Association and American Medical Association.

REFERENCES

Bonnie RJ: Howard Zonana and the transformation of forensic psychiatry. *J Am Acad Psychiatry Law* 38(4):570-6, 2010
 Gold A: On the roots of modern forensic psychiatry: ethics ramifications. *J Am Acad Psychiatry Law* 40(2):246-52, 2012

QUESTIONS AND ANSWERS

1. Dr. Zonana's accomplishments in psychiatry and the law have influenced psychiatry in the following ways:
 - a. the daily application of mental health law in criminal settings
 - b. the daily application of mental health law in civil settings
 - c. the protection of the needs of person with mental illness
 - d. at levels from the grassroots to the United States Supreme Court
 - e. all of the above

ANSWER: e

2. During Dr. Zonana's tenure as Medical Director, AAPL has increased its voice and participation at:

- a. APA Assembly
- b. APA Components
- c. AMA
- d. ABPN
- e. all of the above

ANSWER: e

F35

BREIVIK RAMPAGE: ALL-CONSUMING HATRED APPROACHING PSYCHOSIS?

David Rosmarin, MD, Newton MA
James Knoll, IV, MD, Syracuse, NY
Terje Tørrissen, MD, Ottestad, Norway

EDUCATIONAL OBJECTIVE

Dr. Terje Tørrissen graciously accepted the Peer Review Committee's invitation to discuss his sanity evaluation after an initial team opined Breivik schizophrenic and insane, causing an uproar. By narrative/video clips he will present: world limelight stressors, reviewing hundreds of interview hours and thousands of pages, and struggling with sanity/diminished capacity.

SUMMARY

Acting alone, after years of meticulous planning (renting a farm to obtain fertilizer, international travel to buy guns, weapons training, phony uniforms, spending 130,000 Euros, writing a manifesto that included words of the Unabomber), Breivik struck on July 22, 2011. A massive bomb killed eight and injured hundreds in an explosion that destroyed government offices in Oslo. A diversion, it allowed him to travel to Utøya Island Labor Party Youth Camp where he shot and killed 69 people, mostly children, sparing several and shooting others playing dead. He expected to die but abruptly surrendered when police arrived. The controversy over Breivik's legal insanity involved the questions regarding the extremes of behavior and thoughts that cross the indistinct boundaries between evil and peculiarity into exculpatory psychosis. Did Breivik's extreme grandiosity, life-focused hatred, and false (perhaps fixed) beliefs that he was leading a legion of Knights Templar against Islamic threats to European monoculture constitute psychosis? How should we understand his illogical thinking that killing the children of Norwegian liberals at their summer camp would further his aims by forcing liberal politicians to be less accommodating to Muslims in Norway? Do we term this illogic cognitive distortion or a near-formal thought disorder? We don't consider Hitler, Bin Laden, or Klan lynchings mentally ill. Breivik refused an insanity defense, but in an odd reversal, the prosecution argued for insanity. The maximum sentence for murder in Norway is 21 years, with possible additional preventive detention for dangerousness without mental illness. Insanity acquittees are held for three years initially.

REFERENCES

1. The Court Opinion: Judgment of Anders Behring Breivik 2012-08-24. Available at <https://sites.google.com/site/breivikreport/documents/judgment-of-anders-behring-breivik-2012-08-24>. Accessed on July 24, 2013
2. Breivik saluting and crying in court. Available at: <http://www.youtube.com/watch?v=IGwRKYONzKM>. Accessed on July 24, 2013

QUESTIONS AND ANSWERS

1. What is the insanity standard in Norway?

ANSWER: A person who was psychotic or unconscious at the time of committing the act shall not be liable to a penalty. The same applies to a person who at the time of committing the act was mentally retarded to a high degree.

2. What is the diminished capacity standard in Norway?

ANSWER: A person who was psychotic or unconscious at the time of committing the act shall not be liable to a penalty. The same applies to a person who at the time of committing the act was mentally retarded to a high degree. (NOTE: In Norway there is no nexus to a requirement that the defendant lack legal or moral understand-

ing, lack knowledge of the nature and quality of his act, or lack capacity to conform his behavior to the law. There are merely the three clinical states alone.)

F36

UP IN SMOKE? LEGAL AND FORENSIC ISSUES OF MEDICAL MARIJUANA

Gregory Sokolov, MD, Davis, CA
Mikel Matto, MD, San Francisco, CA
Douglas Tucker, MD, Berkeley, CA

EDUCATIONAL OBJECTIVE

Participants will: (1) know the current US laws legalizing medical marijuana; (2) learn how medical marijuana is distributed, and its current potency; and (3) learn how medical marijuana is legally addressed in courts.

SUMMARY

The use of marijuana for "medical" purposes is a topic of national attention as an increasing number of states have either passed laws or are considering laws regarding its legalization. Dr. Sokolov, Chair of the AAPL Addiction Psychiatry Committee, will present an overview of existing states' laws regarding medical marijuana, and will also present relevant case law regarding the issue. Drs. Matto and Tucker will then present on California's experience with medicinal marijuana, which was legalized by voters' proposition in 1996. They will discuss the role of the medical marijuana card in California, and compare stereotypes with data in terms of who typically gets them, for what indications, and with what ease. They will also describe what medical marijuana actually is in California, comparing the THC content of current medicinal strains to other types of marijuana sold illegally in the 60s and 70s. Lastly, they will review how medicinal marijuana has been treated by the California courts (including the drug court system) in their drug-abusing defendants, including any differences in how the courts treat prescribed medicinal marijuana vs. non-prescribed illicit drugs [e.g. DUI, mental capacity, repeat offenses, etc.].

REFERENCES

The Role of the Physician in "Medical" Marijuana. American Society of Addiction Medicine, September 2010
Cerdá M, Wall M, Keyes KM, et al: Medical marijuana laws in 50 states: Investigating the relationship between state legalization of medical marijuana and marijuana use, abuse and dependence. Drug Alcohol Depend 120(1-3):22-7,2012

QUESTIONS AND ANSWERS

1. Currently, how many states have legalized "medical marijuana"?

- a. 2
- b. 6
- c. 14
- d. 20
- e. 28

ANSWER: c

2. The American Society of Addiction Medicine states which of the following with regard to "medical marijuana"?

- a. Smoked cannabis should be made available by prescription for appropriate medical indications.
- b. Cannabinoids do not possess inherent therapeutic potential.
- c. Cannabis possession for any purpose should be decriminalized.
- d. Cannabis-based medications should be regulated by the Federal Food and Drug Administration (FDA).
- e. Sufficient scientific evidence exists to guide the process of medical cannabis distribution.

ANSWER: d

F37

SCHOOL MASS SHOOTINGS

Leanne Stoneking, MD, (I) Los Angeles, CA
Park Dietz, MD, PhD, Newport Beach, CA
Praveen Kambam, MD, Los Angeles, CA
Christopher Thompson, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE

This presentation will improve attendee competence in the following areas: 1) historical overview of "school mass shootings"; 2) awareness of potential mental health contributors; 3) impact of media coverage on violence and violence; and 4) discussion of prevention.

SUMMARY

School shootings have been occurring in the United States since the 1700s. However, since the 1990s, there has been substantial media attention paid to school shootings, specifically school mass shootings. Despite the increased

media coverage, there has not been a substantial increase in school mass shootings over the past few years. Since the tragic events in 1999 at Columbine High School, and most recently in 2012 at Sandy Hook Elementary, there has been discussion regarding possible mental health contributors to school mass shootings. The strong emotional response to school shootings, at least partially because of their tragic/violent nature, has created an upsurge of media coverage on this subject. There has been controversy surrounding the media and whether the increased coverage has potentiated these violent acts. Mental health professionals' roles in interfacing with the media and consulting with media have increased over the past years. The topic of prevention has also been discussed by law enforcement, the media, and mental health professionals. Society has posed the following questions: Is mental illness a contributing component? What can society do to help prevent these unfortunate events? Can these incidents even be prevented?

REFERENCES

Bryan V, Fein R, Reddy M, et al: The Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States. Washington, DC: United States Secret Service and United States Department of Education, 2002
Fast J: Ceremonial Violence: A Psychological Explanation for School Shootings. New York, NY: The Overlook Press, 2008

QUESTIONS AND ANSWERS

1. Are school mass shootings increasing in frequency?

ANSWER: School mass shootings have not increased in frequency over the past few years. However, government response and media attention on school mass shootings have increased.

2. Is mental illness the reason a school mass shooting occurs?

ANSWER: School mass shootings are perpetrated by individuals who come from differing ethnic backgrounds, socioeconomic classes, and who possess different psychological make-ups. Mental illness may be a contributing factor in some cases of mass school shootings.

F38

COMPUTERS AND TECHNOLOGY IN FORENSIC PSYCHIATRY

Mark Hauser, MD, Newton, MA
Tyler Jones, MD, Arlington, VA
Andrew Nanton, MD, Orlando, FL
Alan Newman, MD, Washington, DC
Paul O'Leary, MD, Birmingham, AL

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, software, cloud based resources and handheld devices that can enhance teaching of, training in, and practicing forensic psychiatry. Presenters will discuss and/or demonstrate a variety of such tools and resources that are increasingly available to forensic psychiatrists. The workshop content will be useful for beginners and more advanced users. The presenters will review various software and internet based tools, some that can be useful for teaching and learning forensic psychiatry, others being used for collaboration. Demonstrations will include the use of text expanders, Boolean search techniques, and the use of web-based literature research. The increasingly widespread adoption of electronic medical records poses pitfalls for practitioners and challenges for the forensic psychiatrist. Government mandates and regulations increasingly impact on the practice of medicine and the delivery of health care resulting in the need for heightened awareness of privacy, encryption and data security. The audience is encouraged to pose questions, share their relevant experience and interact with the presenters thereby enriching the workshop.

REFERENCES

PubMed Tutorial. Available at <http://www.nlm.nih.gov/bsd/disted/pubmedtutorial/>. Accessed 3/6/2013
HIPAA Security Rule: Frequently asked questions regarding encryption of personal health information. Available at <http://www.ama-assn.org/resources/doc/psa/hipaa-phi-encryption.pdf>. Accessed 3/6/2013

QUESTIONS AND ANSWERS

1. Which of the following statements is most accurate regarding the use of advanced internet search techniques?
 - a. They require too much effort to implement.
 - b. They require excessive ongoing maintenance.
 - c. The cost is prohibitive.
 - d. Boolean phrases are easy to use and enhance the usefulness of search results.

ANSWER: d

2. Because physicians are subject to the HIPAA security rule, the most significant benefit of encrypting Electronic Protected Health Information (ePHI) is
 - a. Respect for privacy and confidentiality.
 - b. Compliance with government regulations.
 - c. Not needing to notify patients if there is a security breach.

ANSWER: c

F39

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

Liza Gold, MD, Arlington VA
Marilyn Price, MD, Malden, MA
Donna Vanderpool, MBA, JD, (I) Arlington, VA

EDUCATIONAL OBJECTIVE

To provide knowledge and improve skills for performance in conducting psychiatric disability evaluations and writing disability reports. This course will review legal and administrative contexts of disability evaluations and provide a model and guidelines to assist in addressing commonly sought opinions.

SUMMARY

Faculty will review the complex relationship between psychiatric impairment and work disability in competitive employment contexts utilizing case examples and interactive discussion. We will discuss the most common diagnoses associated with disability claims in competitive employment contexts. We will review the information needed to provide opinions regarding impairments and associated dysfunction, and the correlation of impairments and dysfunction with specific job requirements and work skills. We will present a "work capacity" model that facilitates the development of case formulations. We will review the most frequently asked questions psychiatric disability examinations are asked to answer, including causation, motivation, and malingering. Faculty will review the AAPL Guideline for the Forensic Evaluation of Psychiatric Disability (2008) and discuss the format of the report, utilizing guideline format and discuss organizing information to provide a thorough report that responds to referral concerns. Finally, we will discuss and review relevant ethical and risk management issues, including those that arise when psychiatrists provide disability evaluations and documentation for their own patients, HIPAA issues, legal liability in the provision of disability evaluations, and risk management of these important practical aspects of disability evaluations.

REFERENCES

Gold LH, Shuman DW: Evaluating Mental Health Disability in the Workplace: Model, Process, and Analysis. New York, NY: Springer, 2009
Gold LH, Vanderpool DL, eds.: Clinical Guide to Mental Disability Evaluations. New York, NY: Springer, 2013

QUESTIONS AND ANSWERS

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

ANSWER: b

2. In regard to medical malpractice liability associated with performing IMEs
 - a. All medical malpractice professional liability insurance policies cover forensic services, such as IMEs.
 - b. Forensic activities, such as IMEs, are excluded from all medical malpractice professional liability insurance policies.
 - c. There is no uniformity among the courts, particularly in terms of duties owed by the IME physician to the evaluatee.
 - d. Because there is no treatment relationship established when performing an IME, state regulations (i.e., licensure requirements and disciplinary actions) are not relevant.
 - e. There is no significance of an evaluatee filing a lawsuit as an ordinary negligence action versus a medical malpractice action.

ANSWER: c

F40

ICD-11: A WORK IN PROGRESS

Richard Krueger, MD, New York, NY
 Nicolas Martinez Lopez, MD, (I) San Lorenzo
 Huipulco, Mexico

EDUCATIONAL OBJECTIVE

To educate the audience of forensic psychiatrists on the current proposals for ICD-11, and compare its structure and categories with those of DSM-5 to elucidate the degree of harmonization between these two diagnostic systems.

SUMMARY

Many psychiatrists in the United States are not familiar with the World Health Organization's International Classification of Diseases, which is now in its 10th Edition. ICD-10, in parallel with DSM-IV-TR, has been in a process of revision, with the 11th revision of the ICD scheduled for publication in 2015. The ICD-11 will be of interest to US forensic psychiatrists for several reasons. First, the ICD-11 has different priorities and different strategies with respect to the revision of diagnoses for mental disorders and paraphilias and is actively soliciting criticism and feedback. Second, the ICD is the dominant mental disorders manual in Europe and other parts of the world and thus extremely influential to forensic psychiatry throughout the world. Third, a U.S. adaptation of ICD-10 is about to be adopted as the official U.S. government system for collection and reporting of health information. Finally, the U.S. is obligated by treaty to report health statistics using the diagnostic codes from the ICD and it can be foreseen that the influence of the ICD on psychiatric diagnosis in the U.S. will increase. A panel will present the current state of revision of ICD-11 with particular attention to the paraphilias and contrast ICD-11 with DSM-5.

REFERENCES

Reed GM: Toward ICD-11: Improving the clinical utility of WHO's International Classification of Mental Disorders. *Professional Psychology: Research and Practice* 41(6): 457-464, 2010
 First, MB: Harmonization of ICD-11 and DSM-V: Opportunities and Challenges. *Br J Psychiatry*. 195(5): 382-90 2009

QUESTIONS AND ANSWERS

1. The main guiding principle for revision to the ICD-11 Mental Disorders Chapter is:
 - a. Any changes must be supported by solid scientific evidence
 - b. Any change must harmonize with DSM-5
 - c. Improvement of the health and health care access of the world's population
 - d. Demonstration of Interrater reliability and validity in field testing

ANSWER: c

2. ICD-10:
 - a. Has been in use in most of the world for the past 20 years
 - b. Is the diagnostic manual for medical disorders now in use in the United States
 - c. Is welcomed by the health care establishment in the United States
 - d. Contains item descriptions only for mental disorders and not for other medical/surgical disorders

ANSWER: a

F41

COURT-ORDERED TREATMENT OF SEVERE EATING DISORDERS

Patricia Westmoreland, MD, Denver, CO
 Craig Johnson, PhD, (I) Denver, CO
 Richard Martinez, MD, Denver, CO
 Michael Stafford, JD, (I) Denver, CO

EDUCATIONAL OBJECTIVE

Participants will gain a better understanding of the difficulties involved in treating patients with severe, life-threatening eating disorders. Landmark cases pertaining to civil commitment and forced medications will be discussed, as well as the right to refuse care and whether, in some cases, treatment may be futile.

SUMMARY

Anorexia nervosa is the psychiatric illness with the highest mortality rate. The cultural ideal of thinness, delusional beliefs regarding food and body image, coupled with impaired judgment and cognition due to starvation, often result in patients resisting efforts at treatment. Guardianship, while useful in assisting with treatment decisions for anorexic patients who are critically medically ill, is inadequate with respect to psychiatric treatment for these patients. Despite the severity and risk of the illness, there is often reluctance to civilly commit patients with anorexia nervosa. Refinement in criteria for involuntary treatment during the past few years may assist in defining a subset of anorexic patients for whom treatment may be life-saving. Landmark cases involving patients with anorexia nervosa have addressed the role of the committing court in authorizing treatment decisions, and in one case opining that a patient was best served by receiving treatment in another state. Other issues addressed by the courts include ensuring appropriate criteria are used for hospital admission, that the definition of grave disability as it pertains to anorexia does not necessitate that the patient be close to death, and that medications are often warranted in treating patients with eating disorders.

REFERENCES

In Re S.A.M., 695 N. W. 2d 506 (Iowa App. 2005)
Anderson AE: Eating Disorders and Coercion. Am J Psychiatry 164: 9-11, 2007

QUESTIONS AND ANSWERS

1. In Re S.A.M., 695 N. W. 2d 506 (Iowa App. 2005) the committal decision of the lower court was reversed because:

- The patient was not thought to be critically ill
- Evidence presented in support of committal was incorrect
- Incorrect criteria were used for hospitalization
- a, b and c
- b and c

ANSWER: e

2. Committal may prove difficult in patients with anorexia nervosa because:

- They do not always have laboratory abnormalities
- They are often intelligent and persuasive
- Their delusional thinking is confined to food and weight
- There is sometimes confusion between what is a culturally normative weight concern and an illness
- All of the above

ANSWER: e

F42**ASSISTED OUTPATIENT TREATMENT IN CALIFORNIA**

Gary Tsai, MD, (I) San Francisco, CA

EDUCATIONAL OBJECTIVE

To better understand the pros/cons, implementation, procedural process and clinical outcomes of assisted outpatient treatment, as experienced through the implementation of the first and only fully functional assisted outpatient treatment program in California.

SUMMARY

Treatment of the severely mentally ill, particularly for those who lack self-awareness and consistently decline care, poses unique challenges to the mental health community. Failure to treat this population often results in poor outcomes, such as recidivism and the revolving-door phenomenon of inpatient psychiatric care and the criminalization of the mentally ill. In California, Laura's Law was passed in 2002 and provided a legal framework for mandated outpatient commitment, also known as assisted outpatient treatment (AOT). Assisted outpatient treatment is court-ordered intensive outpatient services for seriously mentally ill individuals who have a history of dangerousness and/or repeated hospitalizations or incarcerations, in addition to a history of refusing voluntary treatment. In the first and only California county to fully implement Laura's Law, Nevada County's AOT program has resulted in improvements in clinical functioning, increased engagement with treatment providers, decreased dangerous behaviors, and significant cost-savings from decreased psychiatric hospitalizations and incarcerations. The aim of this presentation is to better understand the implementation, procedural process and clinical outcomes of AOT, and to explore the pros and cons of such a treatment approach.

REFERENCES

New York State Assisted Outpatient Treatment Program Evaluation. Available at www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation. Accessed July 24, 2013
Swartz MS, Swanson JW: Can states implement involuntary outpatient commitment within existing state budgets? Psychiatric Services 64:7-9, 2013

QUESTIONS AND ANSWERS

1. What are the general eligibility criteria for assisted outpatient treatment in California?

ANSWER: Mentally ill and > 18 y/o, have a history of poor treatment compliance leading to at least two hospitalizations or incarcerations in the last 36 months, or violent behavior at least once in the last 48 months, a clinical determination needs to indicate that they are unlikely to survive safely in the community without supervision, not being placed in AOT must likely result in the patient being harmful to self/others and/or gravely disabled, the person must likely benefit from AOT, participation in AOT needs to be the least restrictive measure necessary to ensure recovery and stability, they need to have been offered and to have declined voluntary treatment in the past, and their condition needs to be substantially deteriorating.

2. What are some of the pros and cons of assisted outpatient treatment?

ANSWER: Pros are reduced hospitalizations, incarcerations, violence/victimization; increased treatment engagement with providers and potential for cost-savings as a result of reduction in recidivism

Cons are concerns about violation of civil liberties and racial disparities and funding concerns.

F43

PAS: CONSIDERING EVIDENCE AND AN EMERGING ROLE FOR PSYCHIATRY

Abilash Gopal, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

Upon completion of this talk, participants will be able to (1) summarize the arguments for and against physician-assisted suicide, (2) review the evidence regarding its implementation in Oregon and the Netherlands and its practical implications, and (3) discuss the potential for an expanding role for psychiatry.

SUMMARY

Physician-assisted suicide (PAS) remains one of the most provocative topics facing society today. Given the great responsibility conferred to physicians by recent laws allowing PAS, a careful examination of this subject is warranted by psychiatrists and other specialists who may be consulted during a patient's request for PAS. In this article, recent evidence regarding the implementation of PAS in the United States and Netherlands is reviewed and support is found for some concerns about PAS, such as the fact that mental illness may be found at higher rates in patients requesting PAS, but not for other concerns, such as the fear that PAS will be practiced more frequently on vulnerable populations (the "slippery slope" argument). The implications of these data and common arguments for and against PAS are then discussed with an emphasis on the tension between values such as maximizing patient autonomy and adhering to professional obligations, the importance of tailoring end-of-life care to the distinct set of values and experiences that shape each patient's perspective, and the need for additional research that focuses more directly on the patient-centered perspective. The presentation concludes by discussing an expanding role for psychiatrists in evaluating patients who request PAS.

REFERENCES

Simon RI, Levenson JL, Shuman DW: On sound and unsound mind: the role of suicide in tort and insurance litigation. *J Am Psychiatry Law* 33(2):176-82, 2005

Ganzini L, Harvath TA, Jackson A, et al: Experiences of Oregon nurses and social workers with hospice patients who requested assistance with suicide. *N Engl J Med* 34(8):582-88, 2002

QUESTIONS AND ANSWERS

1. What are some of the questions that researchers have sought to examine with regard to physician-assisted suicide (PAS)?

ANSWER: Researchers have conducted studies on the prevalence of depression in persons requesting PAS; whether PAS is disproportionately enacted on vulnerable populations; the quality of dying experience of terminally ill patients who opt for PAS versus those who do not; mental health outcomes of relatives of patients who opt for PAS versus relatives of terminally ill patients who do not; and the psychological experience of terminally ill patients in terms of dignity and despair.

2. What are some of the considerations for psychiatrists who are consulted to evaluate patients who have requested PAS?

ANSWER: A psychiatrist's role as consultant include interpreting the meaning of a patient's request for PAS; evaluating the effect of psychiatric or medical disease on a patient's decision-making capacity; clarifying communications between treatment team, family, and patient to minimize the possibility of undue influence on a patient's ultimate decision; and offering relief of the patient's suffering by way of acknowledging the validity of his/her experience.

CORRECTIONAL PSYCHIATRY: EVOLVING AND RECOMMENDED STANDARDS

Kenneth Appelbaum, MD, Shrewsbury, MA
 Jeffrey Metzner, MD, Denver, CO
 Robert Trestman, MD, PhD, Farmington, CT
 Jason Ourada, MD, Worcester, MA

EDUCATIONAL OBJECTIVE

This presentation will provide participants with an understanding of the evolution of guidelines and standards in correctional psychiatry, their current limitations, and areas in need of guideline expansion or improvement. The presenters will offer recommendations that address emerging issues in the field.

SUMMARY

The practice of correctional psychiatry has evolved rapidly in recent years, but existing guidelines and standards have not kept pace with the changes. The National Commission on Correctional Health Care published its most recent revised Standards for Mental Health Services in Correctional Facilities in 2008 and the American Psychiatric Association last revised its guidelines with the publication of the second edition of its report on Psychiatric Services in Jails and Prisons during 2000. Drs. Appelbaum, Metzner, and Trestman will describe the historical factors that led to development of these documents, the strengths and weaknesses of their current iterations, and recommendations for improvement. The workshop will address emerging issues and recommendations regarding transition of pharmacology from community to corrections, levels of care for inmates with mental illness, substance abuse behind bars, suicide risk management, aggressive and self-injurious behaviors, LGBT issues, performance improvement, and assessment and management of personality disorders and attention deficit disorders. We will actively encourage audience participation and sharing of experiences and recommendations. Depending on participant interest, the presentation will include other guidelines and standards of current importance.

REFERENCES

American Psychiatric Association: Psychiatric Services in Jails and Prisons: A Task Force Report of the American Psychiatric Association, 2nd Edition. Washington, DC: American Psychiatric Association, 2000
 National Commission on Correctional Health Care: Standards for Mental Health Services in Correctional Facilities. Chicago, IL: National Commission on Correctional Health Care, 2008

QUESTIONS AND ANSWERS

1. What best explains why psychotropic medication revision following incarceration may lead to patient improvement?
 - a. Change to a restricted correctional formulary
 - b. Elimination of drug abuse and use of directly observed therapy
 - c. Change to a different psychiatrist
 - d. Supervised congregate living, regular diet and daily activity structure

ANSWER: b

2. Which issue best reflects evolving case law distinguishing treatment availability between correctional and community settings?
 - a. Antipsychotic medication selection
 - b. Metabolic syndrome management
 - c. Self-injurious behavior prevention
 - d. Gender identity services

- a. Antipsychotic medication selection
- b. Metabolic syndrome management
- c. Self-injurious behavior prevention
- d. Gender identity services

ANSWER: d

PREPAREDNESS WHEN DISASTER STRIKES A FORENSIC SYSTEM

Debra Pinals, MD, Boston, MA
 Elizabeth Ford, MD, New York, NY
 Panagiota Korenis, MD, Eastchester, NY
 Alan Newman, MD, Washington, DC

EDUCATIONAL OBJECTIVE

At the end of this presentation, participants will be able to describe basic principles of Continuity of Operations and discuss factors that can mitigate negative consequences of disasters that impact forensic systems.

SUMMARY

Disaster psychiatry is a growing area of interest, and improved preparedness and communication strategies have advanced the field. The Federal Emergency Management Agency (FEMA) has developed guidance related to Continuity of Operations (COOP) planning to ensure seamless operations in the face of a range of emergencies.

Forensic systems are not immune from managing challenging situations, ranging from high profile forensic cases to natural or other disasters that may impact system operations. For administrators or clinicians in forensic systems, preparedness is an essential skill for assisting in managing planned and sudden changes from the status quo. Even with planning, when difficult situations arise, not all contingencies can be anticipated. Additionally, legal and ethics challenges present themselves with regard to patient management, management of records and information, and staff safety. This workshop will review events related to Hurricanes Sandy and Katrina and the balance of professional and personal experiences. It will provide an overview of basic principles related to COOP planning and provide guidance for further instruction and resources. Unique aspects of forensic systems and management such as continuity of treatment balanced by public safety as well as specific and harm reduction strategies will be reviewed.

REFERENCES

McCabe OL, Marum F, Semon N, et al: Participatory public health systems research: value of community involvement in a study series in mental health emergency preparedness. *Am J Disaster Med.* 7(4):303-12, 2012
Call JA, Pfefferbaum B, Jenuwine MJ, Flynn BW: Practical legal and ethical considerations for the provision of acute disaster mental health services. *Psychiatry* 75(4):305-22, 2012

QUESTIONS AND ANSWERS

1. Based on outcomes following Hurricane Katrina, which of the following would likely be considered a violation of prisoners' 8th Amendment rights in the event of a natural disaster?
 - a. Lack of hygienic conditions
 - b. Protection against violence from other inmates
 - c. Refusing to evacuate despite known substantial risk
 - d. Lack of proper ventilation
 - e. lack of adequate mental health care

ANSWER: c

2. What are elements of a good disaster preparedness plan in a correctional facility?
 - a. Clear staff assignments and chain of command
 - b. 96 hours of food, potable water and medical supplies
 - c. Triage of medically and psychiatrically compromised inmates to the closest safe hospital
 - d. Procedures for managing the aftermath
 - e. all of the above

ANSWER: e

SATURDAY, OCTOBER 26, 2013

POSTER SESSION C

7:00 AM – 8:00 AM/
9:30 AM – 10:15 AM

**CROWN ROOM,
VICTORIAN BUILDING**

- S1** ***Eliminating Examiner Bias in Injured Worker WPI Ratings***
Solomon Perlo, MD, Los Angeles, CA
- S2** ***Pittsburgh Police Perceptions Study (Core)***
Ryan Wagoner, MD, Pittsburgh, PA
Frank Ghinassi, PhD, (I) Pittsburgh, PA
Loren Roth, MD, MPH, Pittsburgh, PA
- S3** ***Forensic Implications: Adolescent Sexting and Cyberbullying***
Panagiota Korenis, MD, Eastchester, NY
Stephen Billick, MD, New York, NY
- S4** ***Neuropsychological Impairment, Disability in Schizophrenia***
Christopher Wilk, MD, (I) Baltimore, MD
James Gold, PhD, (I) Catonsville, MD
- S5** ***National Recruitment and Retention in State Corrections***
Stephanie Lilly, MA, (I) Marcy, NY
Jonathan Kaplan, MD, Marcy, NY
Michelle Saltis, BA, (I) Marcy, NY
- S6** ***Involuntary Restraint Policies Among Pregnant Inmates***
Zoe Selhi, MD, Philadelphia, PA
Paul Noroian, MD, Worcester, MA
- S7** ***A Revised Sexual Homicide Crime Scene Rating Scale***
Wade Myers, MD, Providence, RI
Eric Beaugard, PhD, (I) Burnaby, BC, Canada
William Menard, BA, (I) Providence, RI
- S8** ***The Value of Medical Screening Tests for Predicting Competency***
Annette Reynolds, MD, Lexington, KY
Timothy Allen, MD, Lexington, KY
Matthew Neltner, MD, (I) Lexington, KY
- S9** ***Mental Health Care, Confidentiality, and Gun Ownership***
Katya Frischer, MD, JD, New York, NY
- S10** ***Revisions in Gun and Mental Health Laws in the Wake of Newtown***
Billy Beck, MD, Charleston, SC
Susan Knight, PhD, (I) Charleston, SC
Leonard Mulbry, Jr., MD, Charleston, SC
- S11** ***The Slippery Slope: Involuntary Treatment via Criminal Charge***
James Peykanu, MD, Tualatin, OR
Christopher Lockey, MD, Salem, OR
- S12** ***A Systematic Analysis of Fitness-For-Duty Evaluations***
R. Scott Johnson, MD, JD, Houston, TX
Jon Allen, PhD, (I) Houston, TX
Christopher Fowler, PhD, (I) Houston, TX
John Oldham, MD, Houston, TX
Kristi Sikes, MD, Houston, TX
- S13** ***In the Matter of Sex and Violence in Cartoons and Video Games***
Denise Kellaheer, DO, Folsom, CA
- S14** ***Guns and the Mentally Ill***
Michal Kunz, MD, New York, NY
Brian Belfi, PsyD, (I) New York, NY
Debbie Green, PhD, (I) Teaneck, NJ
Jeremy Schreiber, MA, (I) New York, NY
Gabriela Pequeno, (I) Teaneck, NJ

SATURDAY

S15	Forensic Client Information in the Age of Big Data	Amar Mehta, MD, Bronx, NY Merrill Rotter, MD, Bronx, NY
S16	Self Starvation Amongst Forensic Inpatients and Prisoners	Tarun Kumar, MD, Syracuse, NY Archana Kathpal, MD, Syracuse, NY Susan Chlebowski, MD, Syracuse, NY
S17	When Attorneys Withhold Material from Psychiatric Experts (Core)	Brian Falls, MD, Sacramento, CA Harold Bursztajn, MD, (I) Cambridge, MA Allison Falls, BS, (I) Houston, TX Robindra Paul, MD, San Diego, CA Gen Tanaka, MD, Brockton, MA
S18	Forensic Psychiatric Consulting for Crisis Negotiation	Sandra Antoniak, MD, Syracuse, NY James Knoll, IV, MD, Syracuse, NY
S19	Use of a Firearm Seizure Law: Seven Years' Experience	George Parker, MD, Indianapolis, IN
S20	Bad Press: Print Media Portrayal of Mental Illness	George David Annas, MD, MPH, Syracuse, NY
S21	Elderly Adult Capacity to Consent to Sexual Activity	Alicia Bales, MD, Marina Del Ray, CA Carla Rodgers, MD, Bala Cynwyd, PA
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	AAPL BUSINESS MEETING (MEMBERS ONLY)	8:00 AM – 9:30 AM BALLROOM, VICTORIAN BUILDING
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	COFFEE BREAK	9:30 AM – 10:00 AM CROWN ROOM, VICTORIAN BUILDING
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	PANEL	10:00 AM – 12:00 PM BALLROOM, VICTORIAN BUILDING
S22	PTSD in DSM-5: More Plaintiffs, More Defenses, More Awards? Trauma and Stress Committee	Andrew Levin, MD, Hartsdale, NY Stuart Kleinman, MD, New York, NY Marc Cohen, MD, Beverly Hills, CA John Adler, JD, (I) San Diego, CA
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	PANEL	10:00 AM – 12:00 PM PALM/SUNSET ROOM, CALIFORNIA CABANAS
S23	Involuntary Treatment of Severe Anorexia Nervosa	Patricia Westmoreland, MD, Denver, CO Craig Johnson, PhD, Denver, CO Richard Martinez, MD, Denver, CO Jane Miceli, MD, Denver, CO Michael Stafford, JD, (I) Denver, CO Ken Weiner, MD, Denver, CO
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	PANEL	10:00 AM – 12:00 PM CORONET ROOM, VICTORIAN BUILDING
S24	Adolescents Who Commit Sexual Homicides	Kulwant Riar, FRCPC, Vancouver, BC, Canada Roy O'Shaughnessy, FRCPC, Vancouver, BC, Canada James Hemphill, PhD, (I) Burnaby, BC, Canada Robert Clift, PhD, (I) Burnaby, BC, Canada

RESEARCH IN PROGRESS #2	10:00 AM – 12:00 PM	GARDEN ROOM, VICTORIAN BUILDING
S25 <i>Experiencing Seclusion: A Phenomenological Study</i>	<p>Natasha Knack, BA, (I) Ottawa, ON, Canada Dave Holmes, PhD, (I) Ottawa, ON, Canada Stuart Murray, PhD, (I) Ottawa, ON, Canada</p>	
S26 <i>Legal Responses to Zoophilia: A Rare Paraphilia</i>	<p>Brian Holoyda, MD, MPH, Sacramento, CA William Newman, MD, Sacramento, CA</p>	
S27 <i>Moving Target: Mental Health Firearm Laws Since Virginia Tech</i>	<p>Joseph Simpson, MD, PhD, Los Angeles, CA</p>	
WORKSHOP	10:00 AM – 12:00 PM	SEABREEZE ROOM, CALIFORNIA CABANAS
S28 <i>Evaluation and Treatment of Professional Sexual Misconduct</i>	<p>Funmilayo Rachal, MD, Atlanta, GA Gene Abel, MD, Atlanta, GA</p>	
LUNCH (TICKET REQUIRED)	12 NOON – 2:00 PM	CROWN ROOM, VICTORIAN BUILDING
S29 <i>Capital Defense and Forensic Psychiatry: One Capital Defender's View</i>	<p>Judy Clarke, Esq., (I) San Diego, CA</p>	
DEBATE	2:15 PM – 4:00 PM	BALLROOM, VICTORIAN BUILDING
S30 <i>Gun Control and Mental Illness – Room for Mandatory Reporting?</i>	<p>Patricia Recupero, JD, MD, Providence, RI Paul Christopher, MD, Rumford, RI Wade Myers, MD, Providence, RI Marilyn Price, MD, CM, Boston, MA</p>	
WORKSHOP	2:15 PM – 4:00 PM	SEABREEZE ROOM, CALIFORNIA CABANAS
S31 <i>Mother, Father Dearest: Forensic Formulations in Child Abuse</i>	<p>Madelon Baranoski, PhD, (I) New Haven, CT Dormarie Arroyo-Carrero, MD, (I) New Haven, CT Reena Kapoor, MD, New Haven, CT Josephine Buchanan, BA, (I) New Haven, CT</p>	
WORKSHOP	2:15 PM – 4:00 PM	GARDEN ROOM, VICTORIAN BUILDING
S32 <i>Evaluating Impaired Health Professionals (Core)</i>	<p>Stephen Noffsinger, MD, Hudson, OH George Parker, MD, Indianapolis, IN Douglas Smith, MD, Northfield, OH Joy Stankowski, MD, Strongsville, OH</p>	
WORKSHOP	2:15 PM – 4:00 PM	PALM/SUNSET ROOM, CALIFORNIA CABANAS
S33 <i>What Should Forensic Fellows Learn About Research? (Core)</i> <i>Research Committee</i>	<p>Andrew Kaufman, MD, Fayette, NY Philip Candilis, MD, Arlington, VA Ryan Hall, MD, Lake Mary, FL Nathan Kolla, MD, Toronto, ON, Canada Douglas Mossman, MD, Cincinnati, OH</p>	

SATURDAY

COURSE (TICKET REQUIRED)	2:15 PM – 6:15 PM	CORONET ROOM, VICTORIAN BUILDING
S34 <i>Psychological Testing of Claimed Amnesia: A Guide to Remember</i>	Charles Scott, MD, Sacramento, CA Barbara McDermott, PhD, (I) Sacramento, CA	
COFFEE BREAK	4:00 PM – 4:15 PM	CROWN ROOM, VICTORIAN BUILDING
RESEARCH IN PROGRESS #3	4:15 PM – 6:15 PM	GARDEN ROOM, VICTORIAN BUILDING
S35 <i>Can We Predict Psychosocial Outcomes of Pediatric Injuries?</i>	Seth Eappen, MD, Ann Arbor, MI Elissa Benedek, MD, Ann Arbor, MI	
S36 <i>Restraint Related Deaths in Children and Adolescents</i>	Peter Martin, MD, Rochester, NY J. Richard Ciccone, MD, Rochester, NY	
S37 <i>Defining Intellectual Disability: The Legacy of Atkins vs. VA</i>	Alexander Westphal, MD, New Haven, CT Madelon Baranoski, PhD, (I) New Haven, CT Mina Mukherjee, (I) New Haven, CT Jeanne Whalen, BA, (I) New Haven, CT Howard Zonana, MD, New Haven, CT	
S38 <i>Treatment Outcomes of Extra-Familial Child Molesters</i>	Rebekah Ranger, BSocS, BA, (I) Ottawa, ON, Canada Paul Fedoroff, MD, Ottawa, ON, Canada Susan Curry, BA, (I) Ottawa, ON, Canada John Bradford, MD, Brockville, ON, Canada Nada El Shayeb, BA, (I) Ottawa, ON, Canada Johnathan Gray, MD, Ottawa, ON, Canada Brad Booth, MD, Ottawa, ON, Canada	
WORKSHOP	4:15 PM – 6:15 PM	SEABREEZE ROOM, CALIFORNIA CABANAS
S39 <i>Excelling at Direct and Cross Examinations (Core)</i>	Stephen Noffsinger, MD, Hudson, OH Douglas Mossman, MD, Cincinnati, OH Sherif Soliman, MD, Beachwood, OH	
WORKSHOP	4:15 PM – 6:15 PM	BALLROOM, VICTORIAN BUILDING
S40 <i>Forensic Telepsychiatry: Are We Ready to Go Live?</i>	Camille LaCroix, MD, Boise, ID Ana Cervantes, MD, Amherst, MA Thomas Gutheil, MD, Brookline, MA Heidi Vermette, MD, Johnson City, TN	
WORKSHOP	4:15 PM – 6:15 PM	PALM/SUNSET ROOM, CALIFORNIA CABANAS
S41 <i>What and How to Teach: A Forensic Curriculum in Residency Rapporteur Fellowship and Forensic Training Committees</i>	Edward Poa, MD, Houston, TX Andrea Stolar, MD, Houston, TX R. Scott Johnson, MD, JD, Houston, TX Andrea Nelsen, MD, Houston, TX Kristi Sikes, MD, Houston, TX Britta Ostermeyer, MD, Houston, TX	

EDUCATIONAL OBJECTIVE

To introduce the use of cardiovascular reactivity measurements in disability examinations as an unrecognized objective evidence-based medicine metric that completely eliminates confounding variables of physician examiner bias and claimant illness behavior for accurately measuring whole person impairment in injured workers with somatoform chronic pain disorders and Axis I co-morbidities.

SUMMARY

In 1996 Reville and colleagues were authorized to do a "sweeping evaluation" of the permanent partial disability (PPD) rating system in California. They found clear evidence of significant physician examiner bias by both applicant and defense selected physician examiners. Since their initial 2003 report, physician examiner bias has never been scientifically addressed nor has any assessment protocol remedy (APR) been introduced that eliminates physician examiner bias in whole person impairment (WPI) ratings per the AMA Guides; especially in injured workers with chronic pain disorders. This proposal introduces an APR that is completely objective and evidence-based. This APR is currently used by psychophysiological researchers and paradoxically has been used by them for several decades. This APR completely eliminates confounding variables of physician examiner bias and injured worker "illness behavior" in WPI ratings. The APR measures cardiovascular reactivity (CVR) i.e., blood pressure and heart rate in response to low level stressors; e.g., postural change (lying down with eyes closed then standing up with eyes open) and handgrip. CVR measurements are performed at the beginning and at the end of a neuropsychiatric evaluation lasting several hours. CVR accurately predicts not just cardiac morbidity and mortality but overall health outcomes as well.

REFERENCES

Thayer JF, Åhs F, Fredrikson M, et al: A meta-analysis of heart rate variability and neuroimaging studies: Implications for heart rate variability as a marker of stress and health. *Neuroscience and Biobehavioral Reviews* 36:747-756, 2012
Thayer JF, Sternberg E: Beyond heart rate variability: vagal regulation of allostatic systems. *Ann NY Acad Sci* 1088: 361-372, 2006

QUESTIONS AND ANSWERS

1. Which choice best explains the relationship between heart rate variability (HRV) and a stress response (SR)?
 - a. There is no relationship.
 - b. There is a relationship but it escapes accurate measurement.
 - c. There is a relationship but it bypasses regional cerebral blood flow.
 - d. There is a relationship but it bypasses a default response to uncertainty.
 - e. HRV may serve as a proxy measure of brain mechanisms that control behavior.

ANSWER: e

2. What is the relationship between vagal tone and whole person impairment (WPI)?

- a. There is none.
- b. There is one and it can be measured with a functional MRI of the brain.
- c. Decreased vagal function and heart rate variability (HVR) are associated with decreased fasting glucose and hemoglobin A1c levels.
- d. Increased vagal function and heart rate variability (HRV) are associated with increased overnight urinary cortisol, and increased proinflammatory cytokines.

ANSWER: b

Ryan Wagoner, MD, Sacramento, CA
Frank Ghinassi, PhD, (I) Pittsburgh, PA
Loren Roth, MD, MPH, Pittsburgh, PA

EDUCATIONAL OBJECTIVE

This poster will present findings from the Police Perceptions Study in Pittsburgh, PA, which focused on police perceived usefulness of mental health professionals in various situations where they may interact.

SUMMARY

The purpose of this study was to assess situations where law enforcement officers may interact with mental health professionals in the course of their daily work, and how useful they perceived a mental health professional to be in

those situations. A survey of 664 officers at the Pittsburgh Police Department was conducted, with 17 situational vignettes. At the end of each vignette, officers were to rank the perceived usefulness of a mental health professional in that situation. Among the highest rated situations were individualized sessions with a mental health professional during periods of high stress and when symptoms of a mental illness began to manifest in an officer. Another set of situations rated very highly were ones in which a mental health professional offered practical assistance in the actual work of officers, specifically consultation to hostage negotiation and assistance with investigations. Situations found to be ranked lower in perceived usefulness included mental health professionals offering advice to departments in developing policy, interventions in a group setting, and preventive services. This study may allow for departments to target expanding services specifically requested by officers, which can be offered by mental health professionals.

REFERENCES

Butler WM, Leitenberg H, Fuselier GD: The use of mental health professional consultants to police hostage negotiation teams. *Behavioral Science and the Law* 11: 213–221, 1993
Kिताeff, J. (Ed): *Handbook of police psychology*. New York, NY: Routledge, 2011

QUESTIONS AND ANSWERS

1. Police officers were LEAST interested in which of the following services:
 - a. Individualized counseling after a critical incident.
 - b. Mental health professional assistance with hostage negotiation.
 - c. Annual wellness and resiliency checkups with a mental health professional.
 - d. Group counseling sessions after a critical incident.

ANSWER: d

2. Which of the following roles of a mental health professional ranked highly by officers has the LEAST evidence basis?
 - a. Consultation for hostage negotiation.
 - b. Profiling and helping with investigations.
 - c. Individual treatment for a mental illness.
 - d. Individual treatment for stress.

ANSWER: b

S3

FORENSIC IMPLICATIONS: ADOLESCENT SEXTING AND CYBERBULLYING

Panagiota Korenis, MD, Eastchester, NY
Stephen Billick, MD, New York, NY

EDUCATIONAL OBJECTIVE

To alert the forensic psychiatrist to the extensive prevalence of sexting and cyberbullying and what various roles they may play in the legal context.

SUMMARY

Adolescence is marked by establishing a sense of identity, core values, a sense of one's relationship to the outside world and heightened peer relationships. In addition, there is also risk taking, impulsivity, self exploration and dramatic increase in sexuality. The dramatic increase in the use of cellphones and the Internet has additional social implications of sexting and cyberbullying. Sexting refers to the practice of sending sexually explicit material including language or images to another person's cell phone. Cyberbullying refers to the use of this technology to socially exclude, threaten, insult or shame another person. Studies of cell phone use in the 21st century report well over 50% of adolescents use them and that text messaging is the communication mode of choice. Studies also show a significant percentage of adolescents send and receive sex messaging, both text and images. This poster will review this expanding literature. Various motivations for sexting will also be reviewed. This new technology presents many dangers for adolescents. The legal implications are extensive and psychiatrists may play an important role in evaluation of some of these adolescents in the legal context. This poster will also make suggestions on future remedies and preventative actions.

REFERENCES

Sadhu J: Sexting: the impact of a cultural phenomenon on psychiatric practice. *Academic Psychiatry*. 36:1, 76-77, 2012
Hua LL: Technology and sexual risky behavior in adolescents. *Adolescent Psychiatry*. 2(3): 221, 228, 2012

QUESTIONS AND ANSWERS

1. An adolescent who sends a nude self image to an agreeable girl/boy friend may have which of the following legal implications?

- a. None, they can send a photo of themselves if they want.
- b. A violation of most high school codes of conduct
- c. A municipal misdemeanor on the level of a parking ticket
- d. A state felony violation
- e. A federal felony violation

ANSWER: d and e

2. How prevalent is sexting by adolescents?

- a. < 5%
- b. 5-10%
- c. 10-15%
- d. 15-20%
- e. > 20%

ANSWER: e

S4

NEUROPSYCHOLOGICAL IMPAIRMENT, DISABILITY IN SCHIZOPHRENIA

Christopher Wilk, MD, (I) Baltimore, MD

James Gold, PhD, (I) Catonsville, MD

EDUCATIONAL OBJECTIVE

To 1) describe a cohort of patients with schizophrenia who have good vocational outcomes, but still have cognitive impairment if not frank disability, and 2) to describe these cases, as well as cases with poorer vocational outcomes, in the context of the Social Security Administration's Compassionate Allowances program.

SUMMARY

Schizophrenia is a leading cause of disability with only 15-30% able to attain and maintain competitive employment. The Social Security Administration (SSA) is considering the addition of schizophrenia to the "Compassionate Allowances" program, which may ease the burden faced by non-forensic clinicians who may feel inexperienced with these evaluations. We present data from a case-control study on people with schizophrenia with good vocational outcomes (GVO, n=38) and compared these cases to those with poor vocational outcomes (PVO, n=38) and healthy control participants (HC, n=43). Relative to HC participants, we found that both GVO and PVO groups shared core cognitive deficits in several cognitive domains, suggesting that not all cognitive impairment results in frank disability. GVO participants, however, demonstrated superior cognitive performance relative to PVO participants in most cognitive domains, with measures of processing speed strongly predicting vocational outcome (and therefore real world disability). Despite their good vocational outcome, GVO participants still showed neuropsychological impairment, which may be disabling in certain work settings. We discuss these results in the context of the rehabilitation and recovery literature, SSA's consideration of schizophrenia to the "Compassionate Allowances" program, and civil forensic psychiatric practice.

REFERENCES

Harvey PD, Heaton RK, Carpenter WT Jr, et al: Functional impairment in people with schizophrenia: focus on employability and eligibility for disability compensation. *Schizophr Res.* 140(1-3):1-8. doi: 10.1016/j.schres.2012.03.025, 2012

Wilk CM, Gold JM, McMahon RP, et al: No, it is not possible to be schizophrenic yet neuropsychologically normal. *Neuropsychology* 19(6):778-86, 2005

QUESTIONS AND ANSWERS

1. What is the cognitive domain that most strongly predicts vocational outcome in schizophrenia?

ANSWER: Measures of processing speed strongly predict vocational outcome (and therefore real world disability).

2. What is the purpose of the Social Security Administration's Compassionate Allowances Program?

ANSWER: Compassionate Allowances is a program that allows Social Security to target the most obviously disabled individuals for allowances based on objective medical information.

Stephanie Lilly, MA, (I) Marcy, NY
Jonathan Kaplan, MD, Marcy, NY
Michelle Saltis, BA, (I) Marcy, NY

EDUCATIONAL OBJECTIVE

The objective of this research is to determine the prevalence and factors contributing to recruitment and retention challenges in hiring mental health professionals in state correctional systems.

SUMMARY

Research has shown shortages in staffing mental health professionals in correctional institutions. For example, 92% of facilities in the Correctional Services of Canada report understaffing. Some factors linked to low retention and recruitment globally include: lack of funding, budget constraints, lack of available training, staff fatigue and staff burnout. It is hypothesized state correctional institutions will report lack of opportunities for training current and potential staff, staff burnout, and budget constraints as the main reasons for barriers to the recruitment and retention of staff. Data from a survey submitted to state mental health program directors will highlight the national prevalence and specific factors that affect mental health correctional recruitment and retention. The results from this study can be used to aid correctional facilities and institutions that employ mental health professionals to work with prison populations in their recruitment and retention of staff. It would also ensure satisfactory mental health treatment for the increasing numbers of mentally ill inmate-patients.

REFERENCES

Brooker C, Gojkovic D: The second national survey of mental health in-reach services in prisons. *J Forensic Psych Psychology* 20:11-28, 2009
Boothby JL, Clements CB: A national survey of correctional psychologists. *Crim Justice Behav* 27:716-732, 2000

QUESTIONS AND ANSWERS

1. All of the following are reasons for low retention and recruitment in the Correctional Services of Canada EXCEPT:
 - a. Low salaries
 - b. Low job satisfaction
 - c. Lack of vacation time
 - d. Lack of training time

ANSWER: c

2. Approximately what percent of mental health teams in the United Kingdom have reported at least one staffing shortage during the year 2008?
 - a. 25%
 - b. 50%
 - c. 70%
 - d. 95%

ANSWER: c

Zoe Selhi, MD, Philadelphia, PA
Paul Noroian, MD, Worcester, MA

EDUCATIONAL OBJECTIVE

- 1) Promote awareness about the medico-legal implications of using involuntary restraint measures during pregnancy, 2) describe the current restraint practices in use for pregnant inmates within the US correctional system, and 3) improve current practices for behavioral restraint methods within this special population.

SUMMARY

Behavioral emergencies are not rare events in women admitted to either psychiatric inpatient units or correctional facilities, and they can occur in the context of a pregnancy. Given the ethical, legal, and medical complexities that can arise when involuntary interventions (medication and physical restraint) are used in patients who are pregnant, we first showed that hospital-based policies for such patients are lacking. Of the 52 public psychiatric hospitals we initially surveyed, only 14% had specific guidelines on the safe restraint of pregnant women. We now seek similar information within state correctional facilities across the USA. Specifically we will investigate whether guidelines or policy exist for pregnant inmates with respect to involuntary restraints during behavioral emergencies. Our goal is to initiate a set of practice-based guidelines for the use of involuntary interventions among pregnant women, within both psychiatric facilities and correctional ones. Beyond circumventing lawsuits based on ill-informed and potentially dangerous current restraint practices, the benefits of guidelines in this population include the preservation of a safe milieu, improving awareness for maternal-fetal aspects of health, and discussing medicolegal implications of the topic.

REFERENCES

- Ladavac AS, Dubin WR, Ning A, Stuckeman PA: Emergency management of agitation in pregnancy. *Gen Hosp Psychiatry* 29(1):39-41, 2007
- Raskin VD, Dresner N, Miller LJ: Risks of restraints versus psychotropic medication for pregnant patients. (letter). *Am J of Psychiatry* 148(12): 1760-1, 1991

QUESTIONS AND ANSWERS

1. Which landmark case established involuntary treatment must be the least intrusive alternative; it must be medically appropriate for the individual's safety as well as that of others?
- Riggins v Nevada (1992)
 - Ford v Wainwright (1986)
 - Rouse v Cameron (1966)
 - Youngberg v. Romeo (1982)

ANSWER: a

2. What do current practices with respect to the emergency management of agitated pregnant patients suggest?
- Involuntary medication is the preferred restraint choice
 - Involuntary physical restraint is the preferred restraint choice
 - There are no studies that document the safety of one restraint measure over another in this population
 - a and c

ANSWER: d

S7

A REVISED SEXUAL HOMICIDE CRIME SCENE RATING SCALE

Wade Myers, MD, Providence, RI
Eric Beauregard, PhD, (I) Burnaby, BC, Canada
William Menard, BA, (I) Providence, RI

EDUCATIONAL OBJECTIVE

The attendee will: be able to recognize common signs of offender sexual sadism at sexual homicide crime scenes, and practice quantifying these signs by scoring a sample case using the SADSEX-SH-R.

SUMMARY

The SADSEX-SH is a 10-item rating scale that dimensionally measures the degree of offender sexual sadism exhibited in cases of suspected sexual homicide. Items are scored as criterion not present (0), possibly present/some evidence (1), or present (2). Scores range from 0-20. Scoring is accomplished using crime scene and other available investigative information. Preliminary norms for the SADSEX-SH indicate it correctly classified offenders with and without sexual sadism using a cut-off score of 8. This study further assesses sensitivity, specificity, and interrater reliability of the SADSEX-SH. A larger sample of male sexual homicide offenders, with (n=20) and without (n=20) sexual sadism, were compared. There were no significant demographic differences. Two items generally undetectable at crime scenes were removed from the scale, resulting in a revised 8-item version - the SADSEX-SH-R. There was a significant difference on resulting SADSEX-SH-R total scores (7.7 ± 3.5 , range=2-14, vs. 2.6 ± 2.0 range 0-7, $t=5.58$, $p<.001$). Interrater reliability was excellent (ICCs=0.6-1.0). Using a revised cutoff score of 6, sensitivity was 70.0% and specificity was 90%. This revised scale may prove useful for investigators and clinicians in identifying sexual sadism in sexual homicide offenders.

REFERENCES

- Jones S, Chan HA, Myers WC, et al: A proposed sexual homicide category: the psychopathic-sadistic offender, in *Criminal Psychology*. Edited by Helfgott JB. Westport, Connecticut: Praeger, 2012
- Chan HC, Heide KM: Sexual homicide: A synthesis of the literature. *Trauma Violence & Abuse* 10:31-54, 2009

QUESTIONS AND ANSWERS

1. The most judicious approach to the management of sexual sadists who have committed homicide is:
- Cognitive-behavioral therapy
 - Antiandrogen treatment
 - Incarceration in a correctional setting
 - Intensive residential treatment
 - SSRI medication

ANSWER: c

SATURDAY

2. Which the following diagnostic combinations pose the greatest risk to the public:
- a. Narcissistic personality disorder and cocaine dependence
 - b. Sexual sadism and psychopathic personality
 - c. Bipolar disorder and exhibitionism
 - d. Borderline intellectual functioning and paraphilia NOS
 - e. Alcohol dependence and fetishism
- ANSWER: b

S8

**THE VALUE OF MEDICAL SCREENING TESTS FOR
PREDICTING COMPETENCY**

Annette Reynolds, MD, Lexington, KY
Timothy Allen, MD, Lexington, KY
Matthew Neltner, MD, (I) Lexington, KY

EDUCATIONAL OBJECTIVE

This poster and associated research project seek to determine the relationships among traumatic brain injuries, aggression, and crime in a forensic hospital setting. It will investigate which neuropsychological and medical screening tests are most cost-effective and most predictive of competency in patients with histories of brain injury.

SUMMARY

A growing number of people with traumatic brain injuries, post-concussion syndromes, and organic brain diseases are being committed to forensic settings each year. Many studies have shown that traumatic brain injuries increase risk for aggressive and violent behavior. Prisoners suffer disproportionately from prior traumatic brain injuries. Multiple neuropsychological and medical screening tests are often employed in this population in order to assess for competency. Extensive screening often proves very costly to an already financially strained forensic system. This study seeks to determine which neuropsychological and medical screening tests are most cost-effective and most predictive of competency in this patient population

REFERENCES

Millenberg W, Canyock EM, Condit D, Patton C: Treatment of post-concussion syndrome following mild head injury. *J of clinical and experimental neuropsychology* 23(6): 829-836, 2001
Miller L: Traumatic brain injury and aggression. *J of Offender Rehabilitation* 21(3): 91-104, 2010

QUESTIONS AND ANSWERS

1. What percentage of patients who sustain head trauma characterized by a brief disturbance of consciousness and clinically unremarkable neuroradiologic findings meet International Classification of Diseases 10th edition (ICD-10) diagnostic criteria for postconcussion syndrome?
- a. 6%
 - b. 20%
 - c. 38%
 - d. 50%
- ANSWER: c

2. The three main syndromes of aggression seen following traumatic brain injury include all the following except:
- a. episodic dyscontrol
 - b. frontal lobe disinhibition
 - c. exacerbation of premorbid antisociality
 - d. passive dyscontrol
- ANSWER: d

S9

MENTAL HEALTH CARE, CONFIDENTIALITY, AND GUN OWNERSHIP
Katya Frischer, MD, JD, New York, NY

EDUCATIONAL OBJECTIVE

This poster will summarize the New York Secure Ammunition and Firearms Enforcement Act of 2013 (NY SAFE Act), its effect on the psychiatrist-patient relationship, and its conflict with HIPAA. The poster will also compare the NY SAFE Act with other state laws addressing firearm ownership among the mentally ill.

SUMMARY

On January 15, 2013, Governor Cuomo signed the New York Secure Ammunition and Firearms Enforcement Act of 2013 (NY SAFE Act), which was passed by the NYS legislature with the express purpose of tightening provisions governing gun ownership by persons with serious mental illness. The NY SAFE Act created Section 9.46 of the NYS Mental

Hygiene Law, which requires mental health professionals, in the exercise of reasonable professional judgment, to report to local mental health officials when there is reason to believe a patient is likely to engage in conduct that will cause serious harm to themselves or others. This information will be crosschecked against a gun registration database. If the patient possesses a gun, the license is suspended and firearm removed. As a result, mental health professionals are placed in the position of revealing confidential patient information to government employees without law enforcement capabilities. The poster will address the ethics concerns raised by this law in the area of patient confidentiality and compare the provisions of the NY SAFE Act with existing HIPAA standards. The NY SAFE Act will also be compared to other recent legislative attempts at addressing gun possession by mentally ill individuals.

REFERENCES

New York State S2230-2013: Enacts the NY SAFE Act of 2013. Available at <http://open.nysenate.gov/legislation/bill/S2230-2013>. Accessed July 29, 2013
Zahedi S, Burchuk R, Stone, DC, et al: Gun laws and the involuntarily committed: A California road map. *J Am Acad Psychiatry Law* 37(4): 545-8, 2009

QUESTIONS AND ANSWERS

1. The NY SAFE Act requires health care professionals to report patients “likely to engage in conduct that would result in serious harm to self or others” to which of the following people?

- a. Local Sheriff’s Office
- b. The Governor’s Office
- c. Local Director of Community Services
- d. The Commissioner of Mental Health

ANSWER: c

2. Under previously existing New York State law, a list of which category of mentally ill patients was crosschecked against a comprehensive, and regularly updated, gun registration database?

- a. Mentally ill patients admitted under Voluntary Status
- b. Mentally ill patients admitted under Emergency Status
- c. Mentally ill patients admitted under Involuntary Status
- d. Any admission to a psychiatric hospital

ANSWER: c

S10

REVISIONS IN GUN AND MENTAL HEALTH LAWS IN THE WAKE OF NEWTOWN

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

EDUCATIONAL OBJECTIVE

Information will be presented about the recent proposals to revise gun and mental health laws in both state and federal jurisdictions. The role of clinicians and probate courts in the reporting process will be examined. We will also discuss proposed procedures to regain the right to purchase a firearm.

SUMMARY

Since the tragic school shooting in Newtown, Connecticut, and other recent high profile mass killings, there have been many state and federal legislative proposals affecting gun ownership and the right to purchase a firearm by those adjudicated mentally ill. Following the Brady Act of 1993 the FBI introduced a National Instant Criminal Background Check System (NICS) to check records that may disqualify people from purchasing firearms. As the current legislation stands, reporting to the NICS is optional for states. After the events of Newtown, examination of such reporting procedures have been initiated by several states. Many states differ widely on the role that clinicians and probate courts play in providing information to firearm vendors concerning those who have been adjudicated mentally ill.

REFERENCES

Simpson J: Bad Risk? An Overview of Laws Prohibiting Possession of Firearms by Individuals With a History of Treatment for Mental Illness. *J Am Acad Psychiatry Law* 35:330-8, 2007
Melamed Y et al: Assessing the Risk of Violent Behavior Before Issuing a License to Carry a Handgun. *J Am Acad Psychiatry Law* 39:543-8, 2011

SATURDAY

QUESTIONS AND ANSWERS

1. According to the FBI, how many states participate in reporting those adjudicated mentally ill on behalf of the NICS as a point of contact and have agreed to have their own Brady NICS program?
- a. 3
 - b. 13
 - c. 23
 - d. 33
 - e. 43

ANSWER: b

2. Which state has been the first to pass legislation to limit access to firearms by the mentally ill?
- a. South Carolina
 - b. New York
 - c. Connecticut
 - d. Massachusetts
 - e. No state has yet passed legislation

ANSWER: b

S11

THE SLIPPERY SLOPE: INVOLUNTARY TREATMENT VIA CRIMINAL CHARGE

James Peykanu, MD, Tualatin, OR
Christopher Lockey, MD, Salem, OR

EDUCATIONAL OBJECTIVE

Describe and discuss the increasing role of forensic commitment as a means of involuntary treatment in Oregon, in the context of limited community mental health services and an unreasonably high bar to civil commitment. Is it because the burdens of proof required to initiate forensic commitment are lower?

SUMMARY

"It's difficult to get people with mental illness hooked up with any services outside of the criminal justice system. The process is more streamlined and the resources are all there." - Captain Sara Westbrook, Portland Police Bureau, Behavioral Health Unit. Is it easier to be Forensically than Civilly Committed in Oregon? Case law in Oregon has determined that people cannot be civilly committed for psychiatric treatment in Oregon unless they are imminently dangerous to themselves or others, or gravely disabled (about to die), despite the fact that experts are poor predictors of dangerousness. Patient liberty interests are jealously guarded and attempts to initiate involuntary commitment are vigorously resisted. Additionally, the process to commit a person contains several "hurdles" wherein various non-clinicians are able to "drop" a mental-health hold. The burden of proof required for civil commitment is "Clear and Convincing" evidence. The burdens to obtain an indictment ("Probable Cause") or find a person incompetent to stand trial ("Preponderance of Evidence") are significantly lower. The number of civil commitments has reduced over time, and forensic commitments either for trial competency restoration and successful insanity defenses have increased. Virtually all of the state hospital beds in Oregon are used by the forensic population.

REFERENCES

Lockey, C: We Need a More Reasonable Civil Commitment Law. *The Oregonian*, February 2013
Bloom J: Civil commitment is disappearing in Oregon. *J Am Acad Psychiatry Law* 34: 534-37, 2006

QUESTIONS AND ANSWERS

1. The Burden of Proof required to initiate civil commitment in Oregon is _____, while the burden of proof required to find a person incompetent to stand trial is _____.
- a. Beyond a Reasonable Doubt; Preponderance of Evidence
 - b. Clear and Convincing; Preponderance of Evidence
 - c. Preponderance of Evidence; Probable Cause
 - d. Reason to Believe; Clear and Convincing
 - e. Clear and Convincing; Clear and Convincing

ANSWER: b

2. The maximum (and typical) term of commitment for a person civilly committed in Oregon is _____ days before recommitment is required.
- a. 30 days
 - b. 60 days
 - c. 90 days
 - d. 180 days
 - e. 360 days
- ANSWER: d

S12

A SYSTEMATIC ANALYSIS OF FITNESS-FOR-DUTY EVALUATIONS

R. Scott Johnson, MD, JD, Houston, TX
Jon Allen, PhD, (I) Houston, TX
Christopher Fowler, PhD, (I) Houston, TX
John Oldham, MD, Houston, TX
Kristi Sikes, MD, Houston, TX

EDUCATIONAL OBJECTIVE

The purpose of this poster is to present data from our retrospective chart review of the approximately 600 professionals admitted to the Menninger Clinic, with regard to whether patients progress more rapidly in treatment when they enter on their own initiative or when mandated to do so.

SUMMARY

At present, a considerable number of professionals are routinely referred to the Menninger Clinic's Professional in Crisis Unit for evaluation and treatment at the behest of the individual's professional regulating agency, such as the Texas Bar Association, Texas Medical Board or the Airline Pilots Association, to name but a few. Still other professionals enter treatment of their own volition. Menninger's research department has collected considerable data on its PIC patients going back to 2008 when the Beck Depression Inventory ("BDI") began being routinely collected on each patient. Existing in electronic format, this BDI data, generally gathered at multiple points throughout a patient's course of treatment, allows our research team to plot the rate of improvement for patients both voluntary and mandated. It is believed that a comparison of this data between these two groups may yield a statistically significant difference in BDI score reduction rate. Furthermore, the BDI scoring involves categorization into severe, moderate and mild strata. Making use of a patient's progression from one such category to the next may allow for our research to provide greater clinical relevance to the practitioner.

REFERENCES

Anfang S, Wall BW: Psychiatric fitness for duty evaluations. *Psychiat Clin N Am* 29(3) 675-693, 2006
Blink RC, Schreibstein J: Fitness-for-duty evaluation: walking the medical-legal tightrope. *J Chem Health Saf* 14(2) 9-13, 2007

QUESTIONS AND ANSWERS

1. Customarily, informed consent for a fitness-for-duty evaluation would include all of the following except:
- a. A description of the nature and scope of the evaluation
 - b. The limits of confidentiality, including any information that may be disclosed to the employer without the examinee's authorization
 - c. The provision of the examiner's CV and references
 - d. The potential outcomes and probable uses of the evaluation
- ANSWER: c
2. Methods and data sources for a typical fitness-for-duty evaluation would include all except:
- a. A review of relevant collateral information
 - b. Psychological assessment using assessment instruments appropriate to the referral
 - c. A comprehensive, face-to-face clinical interview
 - d. Referral to a specialist when deemed necessary by the evaluatee
- ANSWER: d

SATURDAY

EDUCATIONAL OBJECTIVE

This presentation will improve knowledge of laws and legal challenges involving regulation of sexual or violent content contained in illustrated art and animated media. Relevant research will be summarized to update attendee knowledge in this area.

SUMMARY

In the last couple decades, digital art media in the form of cartoons, animated movies, and video games have become a thriving force in the marketplace and in our culture. The digital arts have achieved near virtual reality with its 3D, enhanced photographic-like qualities, character development, and storylines. In recent years, federal and state governments have focused on regulating the digital media by its specific content. The PROTECT Act of 2003, a set of federal laws governing child pornography, featured prominently in the conviction of Christopher Handley for possession of Japanese cartoons featuring unlawful sexual depictions. In *Brown v. Entertainment Merchants Association*, the Supreme Court primarily invoked first amendment protections when it struck down a California state law regulating the sale of mature rated video games to individuals under the age of 17. Multiple defendants have implicated compulsive video gaming as the inspiration for their criminal conduct, but courts have generally dismissed the gaming defense. Additionally, current research thus far has arrived at discrepant opinions on the correlations between video gaming and antisocial conduct. A summary of pertinent laws, case law, highly publicized cases, and up-to-date research is presented as a primer for the forensic mental health professional.

REFERENCES

Prosecutorial Remedies and Other Tools to end the Exploitation of Children Today (PROTECT), Public Law 108-21, 117 Stat. 650, S. 151 (2003)
Brown v. Entertainment Merchants Association and Entertainment Software Association, 564 U.S. 08-1448 (2011)

QUESTIONS AND ANSWERS

1. A cartoon depicting underage females involved in sexual activity is currently illegal in the U.S. when
 - a. it shows graphic sexual behavior
 - b. it is obscene per local standards
 - c. it lacks serious scientific or artistic merit per the current U.S. law
 - d. all of the above

ANSWER: d

2. The PROTECT Act of 2003
 - a. mandates lifelong monitoring of convicted offenders
 - b. has led to increased censorship of Hollywood movies depicting minors involved in sex
 - c. allows for an affirmative defense for possession under specified conditions
 - d. has not been a topic of debate among free speech supporters

ANSWER: c

Michal Kunz, MD, New York, NY
Brian Belfi, PsyD, (I) New York, NY
Debbie Green, PhD, (I) Teaneck, NJ
Jeremy Schreiber, MA, (I) New York, NY
Gabriela Pequeno, (I) Teaneck, NJ

EDUCATIONAL OBJECTIVE

To provide information on the prevalence of firearm and other weapon use in the sample of unfit to stand trial felony offenders in NYC and to compare this prevalence to national data.

SUMMARY

Recent mass shootings by individuals with apparent mental illness are reviving the discussion of access to guns by individuals with mental illness. Although mental illness is often raised in relation to high profile crimes, little is known about the actual prevalence of gun use in criminal offenses perpetrated by mentally ill offenders. We will present data on the use of weapons, including guns, in a sample of incompetent to stand trial criminal offenders charged with serious violent felony offenses and admitted to a New York City forensic psychiatric facility between July 2008 and February 2013. We will also provide data on demographics, mental health history and the diagnostic profile of these offenders. The extent of psychopathology and intelligence of the sample will be compared to a similar group of

defendants accused of non-violent crimes. Our data suggest that guns are rarely used in violent offenses perpetrated by mentally ill offenders, particularly when compared to the use of guns as reported by nationwide crime statistics.

REFERENCES

Wintemute G: Tragedy's legacy. *N Engl J Med* 368(5):397-9, 2013

Sterzer J: The good, the bad and the ugly. *Journal of Legal Medicine* 33:1, 171-199, 2012

QUESTIONS AND ANSWERS

1. What proportion of crimes in America is perpetrated by individuals with mental illness?

ANSWER: 3-5%

2. What factors determine the nature of state regulations concerning the possession of firearms by the mentally ill?

ANSWER: The breadth or specificity in the language describing mental conditions for which gun ownership is prohibited; whether the state regulates the purchase of firearms and ammunition based upon mental health status; whether the state prohibits mentally unfit persons from owning a firearm outright or only prohibits such individuals from obtaining a concealed weapon permit; whether the state allows for those determined to be mentally unfit to have gun ownership rights restored at a later date; and the length of time a person must wait after being declared mentally sound before gun rights are restored.

S15

FORENSIC CLIENT INFORMATION IN THE AGE OF BIG DATA

Amar Mehta, MD, Bronx, NY

Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE

1. To examine current forensic information-gathering practices regarding social media and other publicly available data.
2. To discuss the implications of public access, with special consideration of privacy, confidentiality, and reliability.
3. To suggest possible future courses for both policy and practice.

SUMMARY

Facebook, Google, and Twitter have significantly increased the number and variety of available collateral sources in the digital age. It has already become standard practice among many human resources departments and admissions committees to use publicly-available internet data to research prospective employees, applicants, and students. To what extent has forensic psychiatry kept up with this new source of information? In this study, we seek to determine the current state of practice among forensic evaluators. An anonymous web-based survey has been created for online distribution to forensic evaluators. Data will be collected to compare practices between evaluators of different ages and levels of experience, as well as how publicly available information is discussed with the evaluatee, used, and cited in a report. Questions will also include information-gathering practices and whether the nature of the case has an impact on sources used. In addition to summarizing data regarding current trends, we will discuss questions of reliability that arise when using public information as a primary source. The interplay of privacy and confidentiality is considered with reference to ethics and patient rights. Finally, future possibilities are examined, including whether the use of these sources will soon become standard practice.

REFERENCES

Metzner JL, Ash P: Commentary: the mental status examination in the age of the internet - challenges and opportunities. *J Am Acad Psychiatry Law* 38(1):27-31, 2010

Neimark G, Hurford M, DiGiacomo J: The internet as collateral informant. *Am J Psychiatry* 163:10, 2006

QUESTIONS AND ANSWERS

1. What online information can be used as evidence in a criminal prosecution?

ANSWER: All properly collected sources of information are allowed and most have been used, including personal Facebook posts, non-professional blogs, and posts on message boards.

2. What are the current guidelines regarding the search for and use of publicly accessible online information regarding evaluatees?

ANSWER: While there are no formal specific guidelines in place, some practitioners have called for the incorporation of internet information into the mental status exam. Searching for and using online information has grown more and more common, with a strong majority of respondents claiming to have found relevant, usable data. Issues surrounding privacy have not yet been discussed on a wide scale.

Tarun Kumar, MD, Syracuse NY
 Archana Kathpal, MD, Syracuse, NY
 Susan Chlebowski, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

Self starvation can communicate interpersonal distress, a desire for change, a way of communication or manipulation, suicidal intent, or the presence of a primary/secondary mental disorder. Patient management incorporates legal, ethical and administrative policies. Force feeding and constitutional rights will be discussed.

SUMMARY

Self starvation can result from a primary psychiatric illness, medical illness, interpersonal distress, manipulation, political or religious protest, or suicidal intent. Management incorporates legal, ethical medical and administrative policies. A 33-year-old female prisoner with auditory hallucinations and delusions developed food refusal. Hospitalization and placement of a nasogastric tube was indicated. Prisoners consider force feeding a violation of their rights (1st and 14th amendments) including the right to privacy, self determination and body integrity. The Saikowicz court discussed four state interests which weighed against the individual's right to privacy. These include preservation of life, prevention of suicide, maintenance of medical ethics and protection of third parties. In *Procurier v Martinez*, the USSC identified the state interest in prisons including rehabilitation and maintenance of internal order.

REFERENCES

Brockman B: Food refusal in prisoners: A communication or a method of self-killing? The role of the psychiatrist and resulting ethical challenges. *J Med Ethics*. 25(6):451-456, 1999
 Greenberg J: Hunger striking prisoners: the constitutionality of force-feeding. *Fordham Law Review* 51(4) 747-770, 1983

QUESTIONS AND ANSWERS

1. The Saikowicz court discussed which of the following?

- a. Competency to stand trial
- b. Coverage under title VII of the ADA act
- c. Preservation of life and prevention of suicide
- d. Civil commitment
- e. Execution of juveniles

ANSWER: c

2. Force feeding of prisoners violates which of their constitutional rights?

- a. 1st
- b. 6th
- c. 14th
- d. 8th
- e. 5th

ANSWER: a and c

WHEN ATTORNEYS WITHHOLD MATERIAL FROM PSYCHIATRIC EXPERTS

Brian Falls, MD, Sacramento, CA
 Allison Falls, BS, (I) Houston, TX
 Gen Tanaka, MD, Brockton, MA
 Robindra Paul, MD, San Diego, CA
 Harold Bursztajn, MD, (I) Cambridge, MA

EDUCATIONAL OBJECTIVE

Conference attendees will analyze ethical and epistemological issues raised when attorneys withhold information from psychiatric experts. More importantly, attendees will be able to apply their knowledge of these issues in determining how to proceed when attorneys withhold legal case material from them.

SUMMARY

Psychiatric expert witnesses rely on retaining attorneys to provide case material relevant to particular medicolegal issues. Such material may or may not benefit attorneys' clients. A survey of psychiatric experts at an AAPL conference found that nearly half had experienced attorneys withholding case material from them. There are a number of reasons attorneys might do this, including saving money by using less of the experts' time; inadvertently omitting information; or at worst, attempting to unduly influence experts to formulate opinions favorable to their clients. In this poster, we address how experts can identify when attorneys are withholding information and how

experts should proceed when their scope is limited by such incomplete material. We explore the epistemological heuristics that are implicit in forensic methodology and potential pitfalls intrinsic to these heuristics. To illustrate these principles concretely, we present some composite case examples. We next address the ethical question of whether experts should continue to knowingly work on cases in which attorneys withhold information. Finally, we return to an epistemological consideration of how this specific dilemma illuminates the more general problem of experts formulating opinions under dynamic conditions of probability and uncertainty.

REFERENCES

1. Gutheil TG, Commons M, Miller PM: Withholding, seducing, and threatening: a pilot study of further attorney pressures on expert witnesses. *J Am Acad Psychiatry Law* 29(3):336-9, 2001
2. Bursztajn HJ, Feinbloom RI, Hamm RM, et al: *Medical Choices, Medical Chances: How Patients, Families, and Physicians Can Cope With Uncertainty*. Lincoln, Nebraska: iUniverse, 2001

QUESTIONS AND ANSWERS

1. What are the current requirements for attorneys regarding full disclosure of case material to expert witnesses (choose all that apply)?
 - a. Statutory law mandates that lawyers fully reveal case material to experts.
 - b. Case law requires attorneys to completely disclose case material to experts.
 - c. No law mandates full disclosure of case material to experts.
 - d. ABA ethics rules state that a lawyer should not withhold "a material fact" from "third parties" when doing so might aid a client in a criminal act.

ANSWER: c and d

2. A psychiatric expert decides whether case material provided by an attorney is complete based upon:
 - a. Empirical research on what determines completeness of information.
 - b. Information available during the discovery process.
 - c. Information customarily analyzed when opining on the particular psychiatric question.
 - d. Information routinely analyzed when forming an opinion that satisfies the psychiatric question's necessary degree of medical certainty.
 - e. The attorney's assurance that all information has been provided.

ANSWER: d

S18

FORENSIC PSYCHIATRIC CONSULTING FOR CRISIS NEGOTIATION

Sandra Antoniak, MD, Syracuse, NY
James Knoll IV, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

To explore how forensic psychiatry may be of assistance to local law enforcement in crisis and hostage negotiations.

SUMMARY

For law enforcement personnel, crisis negotiation requires additional training to effectively interpret emotionally volatile situations and implement tactics to safely resolve them. Forensic psychiatrists can assist law enforcement by serving as consultants for crisis negotiation teams. Fellows at SUNY Upstate Medical University participated in a week-long Crisis Negotiation Training School hosted by the Syracuse Police Department. The school consisted of didactics and practical classroom exercises culminating with mock crisis negotiation scenarios in which each fellow was assigned to assist a crisis negotiation team as an in situ consultant. Didactic sessions were taught by present and former FBI agents and experienced Syracuse City Police Crisis Negotiators. The consultant was utilized to increase the team's understanding of the emotional dynamics at play during the scenarios by providing perspective on psychiatric issues which may be impacting the subject. Fellows gained an appreciation of the team aspect of crisis negotiation, crisis dynamics (e.g. tactical goals versus negotiator goals), technology, and negotiation techniques utilized by law enforcement.

REFERENCES

- Charles L: Disarming people with words: strategies of interactional communication that crisis (hostage) negotiators share with systemic clinicians. *J of Marital and Family Therapy* 33(1),51-68., 2007
- Butler W: The use of mental health professional consultants to police hostage negotiation teams. *Behavioral Sciences and the Law* 11(2), 213-221, 1993

QUESTIONS AND ANSWERS

1. Which of the following is not a tenet of crisis negotiation?
 - a. Allowing the subject to ventilate
 - b. Building rapport through empathetic responses
 - c. Pressuring the subject to limit the amount of time spent in negotiations
 - d. Slowing down the incident to allow for the return of rational thought
 - e. Manipulating the situation through communication

ANSWER: c

2. Which of the following is the landmark case for crisis negotiations?

- a. Payne v. Tennessee
- b. Downs v. United States
- c. Ring v. Arizona
- d. Fare v. Michael
- e. Friendak v. United States

ANSWER: b

S19

USE OF A FIREARM SEIZURE LAW: SEVEN YEARS' EXPERIENCE

George Parker, MD, Indianapolis, IN

EDUCATIONAL OBJECTIVE

1. Understand the rationale for introducing a firearm seizure law.
2. Learn how the use of the law by police and the court changed over time.

SUMMARY

In response to two tragic police shootings in 2004, Indiana passed a law in 2005 allowing police to seize, and courts to retain, firearms from people deemed to both have a mental illness and be a danger to self or others. All firearm seizure cases in Marion County (Indianapolis) were heard in one court. Court files for all cases heard from 2006 through 2012 were reviewed. Data was collected on demographics, circumstances of the firearm seizure and court outcomes. Aggregate data was used to track the use of the law over time. The number of cases heard decreased over time, particularly after the first two years. The most common circumstance for firearm seizure was suicide, particularly after the first year. The most common police action in all years was immediate detention. The court typically retained the seized firearms in the first two years, by court order in 2006 and for failure to appear in 2007, but generally returned the weapons thereafter. The circumstances of the use of the firearm seizure law by police differed from the intent of the legislature. The use of the law declined significantly after two years and court outcomes changed significantly.

REFERENCES

Parker GF: Application of a firearm seizure law aimed at 'dangerous' people: outcomes from the first two years.

Psychiatric Services, 61: 478-482, 2010

Simpson JR: Bad risk? An overview of laws prohibiting possession of firearms by individuals with a history of mental illness. J Am Acad Psychiatry Law 35:330-338, 2007

QUESTIONS AND ANSWERS

1. The most common circumstance for firearm seizure by Indianapolis police was:

- a. Intoxication
- b. Domestic violence
- c. Psychosis
- d. Threat of violence
- e. Threat of suicide

ANSWER: e

2. The common police action at the time of firearm seizure was:

- a. Arrest
- b. Voluntary transport to the hospital
- c. Immediate detention
- d. No action

ANSWER: c

EDUCATIONAL OBJECTIVE

Quantify the major print media's portrayal of mental illness.

SUMMARY

Are those with mental illness more prone to violence than the general population? A great deal of literature suggests that those with mental illness contribute only a small fraction of violent acts, yet it seems quite common to see stories about a supposedly mentally ill person committing an act of violence. I examined the representation of mental illness in the print media of the top 4 major newspapers, in the year 2011, by examining search terms and calculating the proportion of stories that focused on violence or had the major theme involving a connection with violence. When the search term "Schizophrenia OR Schizophrenic" was used, 45% of the stories focused on violence; when the search criteria of "Mentally Ill OR Mental Illness" was used, 36% of the stories focused on violence. Control groups had a substantially lower proportion of stories focusing on violence: "Alcoholic" (5%), "Drug Addict" (16%), "Homeless Man" (5%) and "Postal Worker" (4%). For this presentation I will repeat the search, using print media from the first 6 months of 2012.

REFERENCES

Elbogen EB, Johnson SC: The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Arch Gen Psychiatry* 66(2):152-61, 2009
Annas GD: Poster NR5-61 "Violence, Mental Illness, and the Media: Just How Bad is it?" Presented at the American Psychiatric Association Annual Meeting, Philadelphia, PA, Monday May 7, 2012

QUESTIONS AND ANSWERS

1. A significant amount of controversy exists over the potential causal link between mental illness and a propensity to commit violent acts. Despite this, the validity of which following statement is generally not in dispute:
 - a. Gun violence is more common among those with schizophrenia compared to the general public.
 - b. A person with mental illness is significantly more likely to be the victim of a violent act, than a perpetrator.
 - c. Homicide of a stranger is more common with perpetrators who have chronic psychotic illness.
 - d. A person with a serious mental illness is more likely to commit an act of violence towards another person, compared to harming his/herself.

ANSWER: b

2. Using data from a meta analysis by Nielssen et al, from 2009, regarding the rate of stranger homicide among those with a psychotic disorder, and generalizing their numbers to the population of the United States, a person in the United States is most likely to be the victim of which of the following over the course of a year:
 - a. Dying or being injured in a terrorist attack.
 - b. Being killed by someone you don't know who has a psychotic disorder
 - c. Dying or being injured by a lightning strike.
 - d. Dying in a plane crash

ANSWER: c

EDUCATIONAL OBJECTIVE

This poster will explore the policies that long term care facilities have developed in regard to sexual contact between residents. The poster will help the reader understand and contrast various methods that facilities use to determine whether a resident has the capacity to consent to sexual activity.

SUMMARY

In the United States, the number of elderly individuals with cognitive problems living in nursing homes is rapidly increasing. These individuals will be the people who came of age during the changing sexual milieu of the 1960s. Administrators face a problematic situation. On one hand, nursing home residents are guaranteed a degree of privacy as well as a right of "psychosocial well-being," which can be taken to include the right to freedom of sexual expression. However, many administrators are reluctant to allow sexual behavior if a resident displays cognitive problems because the resident may not have capacity to give consent to sexual activity. One proposed method used to address this issue includes a limited capacity model, in which consent is presumed between residents who have consented for years with the same partner, before diminished cognition. The resident could thereby be deemed to

have capacity to consent to certain sexual behaviors/partners, but not to others. Another model is that competency to consent should consist of an assessment of the individual's awareness of the relationship, ability to avoid exploitation, and awareness of potential risks.

REFERENCES

White MC: The eternal flame: capacity to consent to sexual behavior among nursing home residents with dementia. *The Elder Law Journal* 18:133-158, 2010
Lichtenberg PA, Strzepek DM: Assessments of institutionalized dementia patients' competencies to participate in intimate relationships. *Gerontologist* 30:117e20, 1990

QUESTIONS AND ANSWERS

1. According to the assessment guidelines used by Lichtenberg and Strzepek, all of the following have been used to assess competence to consent to sexual activity, except:
a. Ability for the patient to recognize the identity of the potential sexual partner
b. Ability to avoid exploitation
c. Awareness of potential risks, including the fact that the relationship may be time limited
d. MMSE > 21
ANSWER: d

2. All of the following models, measures, or tests have been used in the evaluation of capacity to consent to sexual activity except:
a. Limited Capacity Model
b. Guardianship Model
c. IQ
ANSWER: c

S22

PTSD IN DSM-5: MORE PLAINTIFFS, MORE DEFENSES, MORE AWARDS?

Andrew Levin, MD, Hartsdale, NY
Stuart Kleinman, MD, New York, NY
Marc Cohen, MD, Beverly Hills, CA
John Adler, JD, (I) San Diego, CA

EDUCATIONAL OBJECTIVE

The purpose of this panel is to familiarize the participants with the DSM-5 criteria for PTSD, outline the projected impact on forensic evaluation and opinions in civil and criminal matters, and provide insight into new legal strategies necessitated by these changes.

SUMMARY

The proposed DSM-5 criteria set for Posttraumatic Stress Disorder (PTSD) broadens the definition of a qualifying trauma and expands and reorganizes the list of accompanying symptoms. These changes are certain to affect civil litigation and criminal defense in a wide range of cases that involve trauma. Dr. Levin will begin the presentation with a review of the data utilized by the DSM-5 work group in revising the DSM-IV criteria. Dr. Kleinman will then explore the anticipated impact of the new criteria in employment and injury matters and the challenges in measurement of the disorder. Dr. Cohen will discuss potential impact on criminal matters. Finally, Mr. Adler, an attorney specializing in the defense of employment matters, will opine on changes in legal strategies in civil litigation necessitated by the revised criteria.

REFERENCES

Friedman MJ, Resick PA, Bryant RA, et al: Considering PTSD for DSM-5. *Depression and Anxiety*, 28: 750-769, 2011
Rohan v. Networks Presentations LLC, 375 F. 3d 266

QUESTIONS AND ANSWERS

1. What percentage of people fulfilling the A1 PTSD criteria in DSM-IV do not develop the "fear, helplessness, or horror" required to fulfill the A2 criteria?
a. 5 %
b. 10%
c. 25%
d. 60%
e. 85%
ANSWER: c

2. Which PTSD symptom in the proposed DSM-5 criteria would be likely advanced in a mens rea defense?
- a. Irritability
 - b. Recklessness
 - c. Involuntary distressing memories
 - d. Increased startle response
 - e. Dissociative reaction
- ANSWER: e

S23

INVOLUNTARY TREATMENT OF SEVERE ANOREXIA NERVOSA

Patricia Westmoreland, MD, Denver, CO
Craig Johnson, PhD, Denver, CO
Richard Martinez, MD, Denver, CO
Jane Miceli, MD, Denver, CO
Michael Stafford, JD, (I) Denver, CO
Ken Weiner, MD, Denver, CO

EDUCATIONAL OBJECTIVE

Participants will gain a better understanding of the options for treating patients with severe, life-threatening anorexia nervosa. Guidelines for guardianship, civil commitment and forced tube feeding will be discussed, as well as ethics considerations and legal ramifications of these options.

SUMMARY

Anorexia nervosa is the psychiatric illness with the highest mortality. Guardianship, while a useful mechanism for medical care decisions, may not be adequate to ensure treatment for patients with anorexia nervosa. In many states, a guardian may not initiate the commitment of a ward to a mental health institution except in accordance with that state's procedure for involuntary commitment. Psychiatric patients whose lives are in danger as a result of their psychiatric condition (such as those with anorexia nervosa) may be adjudicated to receive involuntary psychiatric treatment. Refinement in criteria for involuntary treatment may assist in defining the subset of anorexic patients who require such treatment. Landmark cases involving patients with anorexia nervosa have addressed the role of the committing court in involving itself in treatment decisions, and whether it is in the court's purview to decide that a patient is best served by receiving treatment in another state. Other issues include ensuring accurate criteria are used when presenting an argument for committal in a patient with anorexia, that the definition of grave disability does not necessitate that the patient be close to death, and that medications are warranted in treating patients with eating disorders.

REFERENCES

Eating Disorders: A Guide to Medical Care and Complications. Edited by Mehler P, Andersen A. Baltimore, Maryland: John Hopkins University Press, 2010
Holm JS, Brixen K, Andries A, et al: Reflections on involuntary treatment in the prevention of fatal anorexia nervosa: a review of five cases. *Int J Eat Disord* 45: 93-100, 2012

QUESTIONS AND ANSWERS

1. Which of the following does not confer increased risk for mortality in patients with anorexia nervosa?
- a. Diagnosis of anorexia nervosa, restricting subtype
 - b. Comorbid depression
 - c. Low body mass index
 - d. Increased number of prior treatments
 - e. Change from restricting type to binge-purge anorexia
- ANSWER: a
2. Suggested guidelines for involuntary treatment of patients with anorexia nervosa include:
- a. A body mass index (BMI) of less than 13
 - b. Cardiac arrhythmias
 - c. Suicidal ideation
 - d. Severe electrolyte abnormalities
 - e. All of the above
- ANSWER: e

SATURDAY

Kulwant Riar, FRCPC, Vancouver, BC, Canada
 Roy O'Shaughnessy, FRCPC, Vancouver, BC, Canada
 James Hemphill, PhD, (I) Burnaby, BC, Canada
 Robert Clift, PhD, (I) Burnaby, BC, Canada

EDUCATIONAL OBJECTIVE

After attending our presentation, attendees should be able to (1) identify empirical factors that are associated with youth who commit sexual homicides, (2) identify factors to consider when conducting comprehensive clinical assessments with similar groups, and (3) identify clinical targets in order to reduce risk for future violence.

SUMMARY

Sexual homicides committed by youth attract considerable public attention. Even though this type of offense is very rare, a sizable percentage of these youth go on to commit additional homicides. Despite its importance, little information is available regarding this topic. This panel discussion has two parts. In the first part, panel participants will discuss results from empirical research conducted by our group. Clinical files were obtained for all youth who committed sexual homicides during the past two decades and were assessed at Youth Forensic Psychiatric Services. Background information, history of antisocial and criminal behaviors, psychological and psychiatric adjustment, and scores on standard assessment instruments were coded from files. We will present similarities and differences between youth who committed sexual homicides and a comparison group. In the second part, panel participants will discuss their clinical experiences working with these youth. We will discuss ethics issues, and implications of our findings for clinical practice. The goals of this panel are to get a clear picture of youth who commit sexual homicides, identify factors that should be considered when conducting comprehensive clinical assessments, and identify factors to target clinically in order to reduce risk for future violence.

REFERENCES

Chan HC, Heide KM: Sexual homicide: a synthesis of the literature. *Trauma Violence Abuse* 10:31-54, 2009
 Myers WC, Chan HC, Vo EJ, et al: Sexual sadism, psychopathy, and recidivism in juvenile sexual murderers. *J Invest Psychol Off Prof* 7:49-58, 2010

QUESTIONS AND ANSWERS

1. Sexual homicide by youth is clearly associated with all of the following except :

- a. Conduct disorder
- b. Sadistic fantasy
- c. Prior arrests for sexual offenses
- d. Substance abuse
- e. Personality disorders

ANSWER: c

2. Which of the following statements is least true concerning adolescents who commit sexual homicides?

- a. Sexual homicides among adolescents are rare and difficult to predict
- b. Methodological problems of existing studies limit conclusions that can be made
- c. Characteristics of these offenders overlap substantially with those of other serious offenders
- d. Social problems are common among adolescents who commit sexual homicide
- e. Biological correlates (e.g., hormonal levels) of sexual homicide have been firmly established

ANSWER: e

Natasha Knack, BA, (I) Ottawa, ON, Canada
 Dave Holmes, PhD, (I) Ottawa, ON, Canada
 Stuart Murray, PhD, (I) Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

To increase knowledge regarding the use of seclusion rooms when caring for forensic in-patients, from the perspectives of in-patient nurses and forensic patients who themselves have been secluded. To add a forensic approach to the existing scientific literature on the use of seclusion rooms in mental health treatment.

SUMMARY

The humanitarian, ethical, and legal issues associated with seclusion rooms make them one of the most controversial management strategies available. Despite this, the use of seclusion continues to be widespread in psychiatric settings, with up to 20% of patients being secluded during their stay in North American psychiatric hospitals. This study was designed to shift the ethics discourse in a manner that is more compatible with the lived experiences of psychiatric patients and the nurses who care for them. Therefore, semi-structured interviews were conducted with

forensic inpatients and nursing staff in order to provide a phenomenological exploration of the subjective experiences of forensic psychiatric patients placed in seclusion, as well as the experiences of the nurses who must seclude them. Phenomenology also facilitates an understanding of the importance of the place of the lived body, a concept that is largely ignored in mainstream bioethics. The results of this research have the potential to help nursing staff consider the emotional impacts of seclusion on patients, and encourage them not only to better understand the experience of patients but also to prompt a reconsideration of subjectivity and ethical practice in mental health care.

REFERENCES

Holmes D, Kennedy SL, Perron A: Mentally ill and social exclusion: A critical examination of the use of seclusion from the patient's perspective. *Issues in Mental Health Nursing* 25: 559-578, 2004
Lendemeijer B, Shortridge-Baggett L: The use of seclusion in psychiatry: A literature review. *Scholarly Inquiry for Nursing Practice* 11: 299-320, 1997

QUESTIONS AND ANSWERS

1. How did the majority of the nurses interviewed feel about the use of seclusion rooms?
 - a. They are not necessary and should be gotten rid of.
 - b. They are more harmful to patients than using a restraint bed.
 - c. They are not a first resort, but are a necessary tool in some situations.
 - d. They are an effective method of punishment.

ANSWER: c

2. What was the most common reason given by nurses to explain why they secluded a patient?
 - a. In order to medicate the patient
 - b. For the safety of the patients and the staff
 - c. As a form of punishment or control
 - d. Because the patient asked to be secluded

ANSWER: b

S26

LEGAL RESPONSES TO ZOOPHILIA: A RARE PARAPHILIA

Brian Holyda, MD, MPH, Sacramento CA

William Newman, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

To summarize recent research findings on individuals who engage in human-animal sexual behaviors. To review the legal status of human-animal sexual contact in the United States. To provide a comprehensive summary and evaluation of statutory and case law pertaining to bestiality.

SUMMARY

Sexual contact between humans and animals has been documented since the earliest recorded human history. Though societies' responses to such behavior have varied internationally, the response in the United States has typically involved condemnation and prosecution. Currently, there are thirty-one states with statutes prohibiting human-animal sexual contact. These statutes vary widely in defining which acts constitute bestiality and applicable punishments. Despite the prevalence of anti-bestiality legislation, there is limited case law in the United States. Most commonly bestiality arises in legal cases involving sexually violent predator (SVP) civil commitments. Identifying offenders who commit acts of bestiality is important since these individuals are at an increased risk of committing a variety of other sexual and nonsexual violent acts against humans. Therefore, it is important for states to modernize their bestiality statutes to accord with current terminology and objectives for such laws.

REFERENCES

Aggrawal A: A new classification of zoophilia. *J of Forensic and Legal Medicine* 18: 73-78, 2011
Otto SK: State animal protection laws – the next generation. *Animal Law* 11:131-166, 2005

QUESTIONS AND ANSWERS

1. Which of the following is not true regarding United States statutory law regulating human-animal sexual contact?
 - a. Thirty-one states currently have statutory laws that punish human-animal sexual contact.
 - b. A conviction for bestiality in a state with statutory law results in a misdemeanor charge.
 - c. In some states it is still punished under "crime against nature" statutes.
 - d. Some states prescribe additional punishments like counseling, psychological assessment, and reimbursement of animal shelters for those convicted of human-animal sexual contact.

ANSWER: b

2. Which of the following findings regarding those who engage in sexual contact with animals is not true?
- Individuals who engage in bestiality have the highest rate of crossover with other paraphilias than any other paraphilic diagnosis.
 - Bestiality has been found to be a significant risk factor and predictor for committing child sexual abuse.
 - Individuals who engage in bestiality are more likely to have been convicted of a personal crime such as rape, sexual assault, robbery, or assault.
 - Bestiality is a strong predictor of future psychiatric diagnoses like major depressive disorder and panic disorder.
- ANSWER: d

S27

MOVING TARGET: MENTAL HEALTH FIREARM LAWS SINCE VIRGINIA TECH

Joseph Simpson, MD, PhD, Los Angeles, CA

EDUCATIONAL OBJECTIVE

To provide forensic practitioners with an understanding of federal and state firearm laws relating to mental illness and the changes and proposed changes in these laws since the 2007 Virginia Tech mass shooting and subsequent tragedies in Tucson, Arizona; Aurora, Colorado and Newtown, Connecticut.

SUMMARY

Federal laws prohibiting possession of firearms by certain individuals with a history of psychiatric treatment have existed for 45 years. Many states also have their own laws addressing this issue. In the wake of several high-profile mass shootings over the past six years, a number of changes to federal law have been enacted, with more being debated by the Executive and Legislative branches. Some states have also proposed or passed new laws with the goal of making it more difficult for individuals who are receiving mental health treatment and who are perceived to be dangerous to legally possess firearms. With the increasing media and political focus on firearm violence, especially since Newtown in December 2012, mental health professionals and especially forensic psychiatrists can expect to be asked for their opinions about access to firearms for individuals receiving psychiatric treatment. The presentation will review the pre-2007 federal laws and their implementation and enforcement, and discuss changes and proposed changes to federal and state laws and procedures since the recent tragedies.

REFERENCES

- Norris DM, Price M, Gutheil TG, et al: Firearm laws, patients, and the roles of psychiatrists. *Am J Psychiatry* 163:1392-1396, 2006
- Simpson JR: Bad risk? An overview of laws prohibiting possession of firearms by individuals with a history of treatment for mental illness. *J Am Acad Psychiatry Law* 35:330-8, 2007

QUESTIONS AND ANSWERS

1. Which of the following results in a lifetime federal prohibition on possession of firearms?
- A diagnosis of schizophrenia
 - Voluntary psychiatric hospitalization
 - Involuntary commitment
 - Filling a prescription for antipsychotic or mood-stabilizing medication
- ANSWER: c

2. Approximately how many names are in the federal NICS database?
- 750,000
 - 25 million
 - 1.5 million
 - 7.3 million
- ANSWER: d

S28

EVALUATION AND TREATMENT OF PROFESSIONAL SEXUAL MISCONDUCT

Funmilayo Rachal, MD, Atlanta, GA
Gene Abel, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE

This presentation will increase the clinician's awareness of the unique aspects of the independent medical evaluation and treatment of physicians referred by licensing boards for professional sexual misconduct.

SUMMARY

The evaluation of physicians accused of professional sexual misconduct (PSM) involves evaluating the individual's fitness for duty, need for treatment, and the amenability to treatment, rehabilitation, and follow-up. Our experience suggests unique methods to get a more valid history from the professional, the value of the measurement of sexual interest and response to polygraph questions, monitoring of personality characteristics, and a selection of components of cognitive behavioral treatment. The maintenance treatment is equally as important including the continued follow-up feedback from the professional's staff, patients, and ongoing polygraph measurement.

REFERENCES

Brooks E, Gendel MH, Early SR, et al: Physician boundary violations in a physician's health program: 19-year review. *J Am Acad Psychiatry Law* 40(1): 59-66, 2012
Roback HB, Strassberg D, Iannelli RJ, et al: Problematic physicians: A comparison of personality profiles by offence type. *The Canadian Journal of Psychiatry* 52(5): 315-322, 2007

QUESTIONS AND ANSWERS

1. What did the speakers report were the advantages of using polygraphs in professional sexual misconduct assessments?
 - a. To determine guilt or innocence
 - b. To catch them in a lie
 - c. Motivate doctor to disclose all actions
 - d. Reassure the licensing board that there are no other victims
 - e. c and d

ANSWER: e

2. What did the speakers indicate are the advantages of the direct measurement of sexual interest?
 - a. In allegations of sexual involvement with those underage
 - b. In allegations of sexual involvement with patients and staff
 - c. In allegations of sexual involvement with patients only
 - d. None of the above

ANSWER: a

S29

CAPITAL DEFENSE AND FORENSIC PSYCHIATRY: ONE CAPITAL DEFENDER'S VIEW

Judy Clarke, Esq., (I) San Diego, CA

EDUCATIONAL OBJECTIVE

To raise awareness of the potential for misuse of the forensic psychiatrist in capital prosecutions.

SUMMARY

Capital defense counsel seek to conduct and document a multi-generational life history, to give context to and an understanding of the offender's life and influences on it, and in doing so, to provide reasons that he or she should not be sentenced to death. Mental health experts can offer important evidence: an identification of symptoms, onset, and an understanding of the impact of mental illness and the resulting limitations on the individual in navigating the world. However, the common practice of labeling the offender, using a clinical interview to rummage through the mind, and repeat the statements of someone severely damaged by life's course, is a misuse of the expertise of a mental health professional, and can often result in the fact finder not hearing important evidence. The Academy should address these concerns, as well as examiner bias and financial interests in capital cases.

REFERENCES

American Psychiatric Association Position Statement on Capital Punishment: Adoption of AMA Statements on Capital Punishment (AMA Policy E-2.06). Available at http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2008_CapitalPunishment.pdf. Accessed August 6, 2013
American Academy of Psychiatry and Law Position Statement on the Death Penalty. Available at <http://www.aapl.org/oldsite/positions.htm>. Accessed August 6, 2013.

QUESTIONS AND ANSWERS

1. According to the US Supreme Court, which of the following capital executions are permissible?
 - a. A defendant with mental retardation
 - b. A defendant who committed a murder at age 16
 - c. A defendant who believes he will survive the execution
 - d. A defendant with paranoid schizophrenia

Answer: d

2. After Texas, which state has completed the most executions since 1976?

- a. California
- b. Florida
- c. Virginia
- d. Louisiana

Answer: c

S30

**GUN CONTROL AND MENTAL ILLNESS -
ROOM FOR MANDATORY REPORTING?**

Patricia Recupero, MD, JD, Providence, RI
Paul Christopher, MD, Rumford, RI
Wade Myers, MD, Providence, RI
Marilyn Price, MD, CM, Boston, MA

EDUCATIONAL OBJECTIVE

At the conclusion of this program, participants will be able to describe the legal and ethical issues related to the provision in New York State's "SAFE" act that requires mental health professionals to report potentially dangerous patients to public officials for potential loss of licensure and possession of firearms.

SUMMARY

Resolved: Psychiatrists should report patients presenting a danger to themselves or others to the authorities, as mandated by NY state law. After the school shooting in Newtown, CT and other events of mass violence, legislators have begun to consider gun control measures to reduce the likelihood of future tragedies. Some of the proposed measures specifically target gun ownership among patients with mental illness. New York's Secure Ammunition and Firearms Security (SAFE) Act of 2013 requires "mental health professionals to report ... to the director of community services" whenever the clinician "determines...that [a patient under their care] is likely to engage in conduct that would result in serious harm to self or others." Reported patients who are registered gun owners will have their gun license suspended and firearm(s) removed by law enforcement personnel. This debate will address the question of whether psychiatrists should report potentially dangerous patients for investigation of gun possession. Advocating for the pro-reporting position, Drs. Price and Myers will address supporting legal and ethical issues, respectively. Representing the "con" side, Drs. Recupero and Christopher will advocate against such reporting mandates. The participants will discuss issues such as HIPAA compliance, malpractice implications, violence prevention, and patient confidentiality.

REFERENCES

Frattaroli S, Webster DW, Wintemute GJ: Implementing a public health approach to gun violence prevention: the importance of physician engagement. *Ann Intern Med* ePub ahead of print, Feb. 12, 2013
Barry CL, et al: After Newtown — public opinion on gun policy and mental illness. *New England Journal of Medicine*. Epub ahead of print January 28, 2013

QUESTIONS AND ANSWERS

1. Approximately what percentage of Americans (from a recent national survey) agreed with the statement that health care providers should be required to report people who threaten to harm themselves or others to a background check system to prevent them from having a gun for 6 months?

- a. 25%
- b. 50%
- c. 75%
- d. 95%

ANSWER: c

2. Approximately what percentage of Americans (from a recent national survey) agreed with the statement that people with serious mental illness are, by far, more dangerous than the general population?

- a. 15%
- b. 25%
- c. 35%
- d. 45%

ANSWER: d

Madelon Baranoski, PhD, (I) New Haven, CT
 Dormarie Arroyo-Carrero, MD, (I) New Haven, CT
 Reena Kapoor, MD, New Haven, CT
 Josephine Buchanan, BA, (I) New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will review case law and forensic formulations in child abuse cases; explore the use of case examples and empirically established case profiles as teaching aides to promote effective integration of psychiatric, developmental, cultural, social, risk, and legal factors to examine abusive behavior; conduct risk assessments, and make treatment recommendations.

SUMMARY

Infanticide related to post-partum depression and psychosis is an established and researched area in forensic psychiatry. However, the role of the forensic psychiatrist in the more common abuse cases where there is no parental Axis I disorder has been less explored. Nevertheless, psychiatric opinions are sought by both sides in criminal cases of abuse, especially abuse of infants and young children, to address culpability, mitigation, risk, and treatment issues. Abusive behaviors have myriad causes within complicated contexts; therefore, psychiatric formulations require flexibility in appreciating the relative contribution of the various factors across cases. In addition, the expert faces public outrage, strong assumptions that explanations condone behavior, and limited treatment and placement options. In forensic psychiatry fellowship programs, these cases present opportunities for teaching assessments and formulations from an integrated approach that examines behavior from multiple perspectives, including psychiatric diagnosis; personality, social and cultural influences; developmental stages and theory; family dynamics; and risk assessment. We will present literature and research on a 20-subject cohort of child-abuse case defendants to examine multifactor modeling as an approach for teaching forensic formulation. The audience will participate in case review, mock testimony and cross examination in a demonstration of teaching methodology.

REFERENCES

Friedman SH, Resnick PJ: Child murder by mothers: patterns and prevention. *World Psychiatry* 6(3): 137-141, 2007
 Barnum R: A suggested framework for forensic consultation in cases of child abuse and neglect. *J Am Acad Psychiatry Law* 25: 4 581-93, 1997

QUESTIONS AND ANSWERS

1. All of the following have been associated with a higher prevalence of maternal filicide EXCEPT:

- a. High socioeconomic status
- b. Maternal age <30 years
- c. Social isolation
- d. Previous abuse of victim

ANSWER: a

2. Expert forensic psychiatric formulations in criminal child abuse cases require

- a. Examination of family systems and cultural factors affecting parental roles and child-rearing practices
- b. Exploration of trauma and parental abuse history
- c. Child medical and developmental history
- d. All of the above

ANSWER: d

Stephen Noffsinger, MD, Hudson, OH
 George Parker, MD, Indianapolis, IN
 Douglas Smith, MD, Northfield, OH
 Joy Stankowski, MD, Strongsville, OH

EDUCATIONAL OBJECTIVE

This workshop will hone and enhance the skills of the forensic psychiatrist in evaluating mentally ill healthcare professionals for their ability to competently and safely practice medicine.

SUMMARY

The public commonly perceives healthcare providers as stable, well-composed and competent. Yet healthcare professionals, especially physicians, have an increased prevalence of depressive disorders, substance misuse, problematic personality traits and occupational stress that may impact their ability to competently practice medicine. Allegedly impaired healthcare professionals may be referred by state medical boards, hospital executive committees or disability

insurers to the forensic clinician for a fitness-to-practice evaluation. Forensic clinicians must be able to conduct an accurate and reliable fitness-to-practice evaluation. Unfit practitioners may negligently or recklessly harm patients, incur civil liability, and damage their professional standing. In contrast, mistakenly concluding that a healthcare professional is unfit may result in stigma, reputation damage and economic loss, and deprive the community of a competent practitioner. This presentation will discuss methods to evaluate potentially disabling psychological and behavioral symptoms; statutory regulation of the unfit healthcare professional; and the potential legal liabilities facing the forensic evaluator. Vignettes will illustrate the dilemmas the forensic evaluator may encounter.

REFERENCES

Gold LH, Anfang SA, Drukteinis AM, et al: AAPL Practice Guideline for the Forensic Evaluation of Psychiatric Disability. *J Am Acad Psychiatry Law* 36 (Suppl 4):S3-S50, 2008
Anfang SA, Faulkner, LR, Fromson JA, et al: The American Psychiatric Association's Resource Document on Guidelines for Psychiatric Fitness-for-Duty Evaluations of Physicians. *J Am Acad Psychiatry Law* 33:1:85-88, 2005

QUESTIONS AND ANSWERS

1. Which of the following may cause a state medical board to refer a physician for a fitness-to-practice evaluation?
 - a. Past history of depression
 - b. Repeated interpersonal conflict with colleagues
 - c. Alcohol Dependence
 - d. All of the above

ANSWER: d

2. Which of the following are risk factors that increase a physician's risk for mood and anxiety disorders?
 - a. Institutional barriers to getting help
 - b. Working long hours
 - c. Dealing with disease/death/unhappiness
 - d. All of the above

ANSWER: d

S33

WHAT SHOULD FORENSIC FELLOWS LEARN ABOUT RESEARCH?

Andrew Kaufman, MD, Fayette, NY
Philip Candilis, MD, Arlington, VA
Ryan Hall, MD, Lake Mary, FL
Nathan Kolla, MD, Toronto, ON, Canada
Douglas Mossman, MD, Cincinnati, OH

EDUCATIONAL OBJECTIVE

To familiarize forensic psychiatrists with important aspects of scientific research pertinent to their practice. To encourage forensic psychiatrists to incorporate scientific evidence into their forensic evaluations and opinions whenever possible. To present a broad framework for the development of a research curriculum for fellowship programs.

SUMMARY

Dr. Kolla will provide a framework to guide critical appraisal of forensic psychiatry scientific literature. He will focus on study design and identification of potential sources of study bias. Dr. Mossman will discuss key elements and examples from the Cincinnati forensic fellowship's year-long program in probability and statistics, which introduces fellows to basic concepts of statistical inference (e.g., what a "p-value" says), sampling and sample size, models and their meaning, and commonly used statistical techniques such as regression. Dr. Hall will discuss the use and applicability of psychometric instruments most widely used in forensic psychiatry. He will highlight concepts such as validity, reliability, test integrity, and updating. Dr. Candilis will address the ethics issues that arise in conducting forensic research, from concerns of coercion and consent in prisons or state hospitals to the values inherent in selecting thresholds and cut-offs for data analysis. He will provide an update on the quickly evolving status of correctional research. Dr. Kaufman will introduce a novel turnkey model for multi-site direct research experience for fellows currently under development by the Research Committee.

REFERENCES

Mohr P, Höschl C, Volavka J: Teaching critical appraisal of articles on psychopharmacology. *Academic Psychiatry* 36:114-117, 2012
Meyer G, Finn S, Eyde L, et al: Psychological testing and psychological assessment: A review of evidence and issues. *American Psychologist* 56(2): 128-165, 2001

QUESTIONS AND ANSWERS

1. All of the following are examples of actuarial risk assessments EXCEPT:

- a. Psychopathy Checklist – Revised (PCL-R)
- b. Historical, Clinical, Risk-20 (HCR-20)
- c. Violent Risk Appraisal Guide (VRAG)
- d. STATIC-99
- e. Rapid Risk Assessment for Sex Offence Recidivism (RRASOR)

ANSWER: b

2. Which of the following regarding sample size is true?

- a. A large sample size is always better.
- b. Sample size is determined by how many subjects can be recruited.
- c. A larger sample can detect smaller differences between groups.
- d. The probability of an anomalous positive finding varies inversely with sample size.

ANSWER: c

S34

PSYCHOLOGICAL TESTING OF CLAIMED AMNESIA: A GUIDE TO REMEMBER

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

EDUCATIONAL OBJECTIVE

This course will provide hands-on training on the use of two structured assessments to assess malingered amnesia: the TOMM and the WMT. The participant will learn how to administer and score each instrument, how to summarize findings and how to testify on their use.

SUMMARY

Malingered amnesia is one of the most common claims in both civil and criminal forensic evaluations. For example, of defendants who have committed a violent offense, 20% to 30% claim amnesia for their crime. Despite the high frequency of malingering, structured, evidence-based assessment of evaluatee's amnesia claims is shockingly absent in most civil and criminal forensic evaluations. This course will provide direct training for the participant on structured assessments useful in the detection of feigned memory and/or cognitive deficits. Several screening instruments useful in the detection of feigned memory or cognitive deficits will be presented, to include the Structured Inventory of Malingered Symptomatology (SIMS). Two instruments that use symptom validity testing will be reviewed: the Test of Memory Malingering (TOMM) and the Green Word Memory Test (WMT). Relevant scale development information will be presented for each assessment, including validity, reliability and details of the normative samples. The administration of each instrument will be demonstrated with opportunities for attendees to receive supervised administration experience. Mock courtroom testimony will be conducted with audience participants with potential pitfalls highlighted when these instruments are used in forensic evaluations.

REFERENCES

Scott CL: Evaluating amnesia for criminal behavior: a guide to remember. *Psychiatric Clinics of North America* 35: 797-819, 2012

Tombaugh TN: Test of memory malingering (TOMM). New York: Multi-Health Systems, 1996

QUESTIONS AND ANSWERS

1. What is the cut-off score indicating suspected malingered amnesia on the TOMM on Trial 2?

- a. 45 out of 50
- b. 35 out of 50
- c. 25 out of 50
- d. 15 out of 50

ANSWER: a

2. All of the following are symptom validity tests except?

- a. TOMM
- b. Crovitz test
- c. Coin in the hand test
- d. WMT

ANSWER: b

Seth Eappen, MD, Ann Arbor, MI
Elissa Benedek, MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE

To determine whether forensic psychiatrists can predict psychosocial outcome of pediatric iatrogenic injuries.

SUMMARY

Medical malpractice lawsuits are an increasingly common issue. The ninth and eighth most common malpractice claims are emotional distress and iatrogenic injury, respectively. Forensic psychiatrists may be increasingly called upon to comment on psychosocial effects of iatrogenic injuries to children. It is a fair question to ask whether forensic psychiatrists can predict future psychosocial outcome in such cases. This paper is based on a case study in which an infant had a portion of his genitals accidentally amputated during a routine circumcision. The portion was successfully reattached, but a lawsuit was filed, and a forensic child psychiatrist was consulted on whether any psychosocial effects could result from this incident as the child matured. Based on this case-study, we state that it is possible to predict psychosocial effects of pediatric iatrogenic injuries, by both referencing what we already know about human development, and exploring the literature on the psychosocial effects of comparable injuries to children.

REFERENCES

Mureau M, Slijper F, Nijman R, et al: Psychosexual adjustment of children and adolescents after different types of hypospadias surgery: a norm-related study. *J Urol* 154(5):1902-7, 1995
Niederland WG: Narcissistic ego impairment in patients with early physical malformations. *Psychoanal Study Child* 20:518-34, 1965

QUESTIONS AND ANSWERS

1. In one study, 80% of hypospadias patients were self conscious about and approximately 25% were dissatisfied with their penile appearances after surgery. What was/were the most reported motive(s) for dissatisfaction?
 - a. Abnormal urinary stream
 - b. Penile Size
 - c. Scars
 - d. b and c
 - e. a and b

ANSWER: d

2. A key finding in early hypospadias surgery is the positive correlation between satisfaction with body appearance and having no memory of surgery. Boys have no memory of surgery if treatment is completed before what age?
 - a. 6 months
 - b. 1 year
 - c. 2 years
 - d. 4 years
 - e. 5 years

ANSWER: e

Peter Martin, MD, Rochester, NY
J. Richard Ciccone, MD, Rochester, NY

EDUCATIONAL OBJECTIVE

1. Identify risk factors that lead to restraint deaths in a child and adolescent population.
2. Develop lessons that can be applied for improving restraint outcomes in youth.

SUMMARY

There has been little research to date that has focused on deaths as a result of restraints in the child and adolescent population. Equip for Equality and the National Disabilities Rights Network, supported by multiple grants, studied deaths that resulted from restraints in various treatment settings for all age ranges. State patient advocacy organizations provided information about these deaths, including all available records. A Data Collection Form was created to guide data review and provide consistent, quantifiable results. Fifteen states provided a total of 61 records that met criteria for inclusion in the original study. This follow-up study focuses on the nine cases of restraint related death that involved individuals younger than 18. Descriptive vignettes will be presented and the quantifiable data analyzed to assess risk factors that contributed to these deaths. Comparisons will be made to determine what, if any, differences exist in outcomes between youth and adult populations. We hope to identify lessons that can be applied to both psychiatric and nonpsychiatric child and adolescent populations and future directions for research.

REFERENCES

Equip for Equality. National review of restraint related deaths of children and adults with disabilities: The lethal consequences of restraint. Available at <http://www.equipforequality.org/publications/national-death-study.pdf>. Accessed on February 20, 2013

Nunno MA, Holden MJ, Tollar A: Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child Abuse & Neglect* 30: 1333-1342, 2011

QUESTIONS AND ANSWERS

1. What are the risk factors that lead to restraint-related deaths in the child and adolescent population?
 - a. Preexisting medical conditions, such as obesity, current cardiac compromise, and current respiratory compromise
 - b. The use of improper restraint techniques, especially the use of the prone position
 - c. Lack of proper monitoring while restrained
 - d. All of the above

ANSWER: d

2. What can be modified to decrease the risk of future restraint-related deaths in the child and adolescent population?
 - a. Implementing a mandated national reporting infrastructure to improve safety monitoring
 - b. Identify signs of distress during the restraint that must be immediately addressed
 - c. Provide additional training for proper restraint techniques
 - d. Improve staff-to-patient ratios
 - e. All of the above

ANSWER: e

S37

DEFINING INTELLECTUAL DISABILITY: THE LEGACY OF ATKINS VS. VA

Alexander Westphal, MD, New Haven, CT

Madelon Baranoski, PhD, (I) New Haven, CT

Mina Mukherjee, (I) New Haven, CT

Jeanne Whalen, BA, (I) New Haven, CT

Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

This presentation will improve attendee competence and/or performance in the following way(s): By discussing the landmark case *Atkins v. Virginia* with particular emphasis on the implications of the absence of guidelines on the standards by which intellectual disability is measured.

SUMMARY

The Supreme Court of the United States established the unconstitutionality of executing offenders with intellectual disabilities (ID) in *Atkins v. Virginia*. They based this opinion on a national consensus that individuals with “disabilities in areas of reasoning, judgment, and control of their impulses...do not act with the level of moral culpability that characterizes the most serious adult criminal conduct,” thus executing them would violate the spirit of the Eighth Amendment ban on cruel and unusual punishment. They gave a general definition of ID, leaving the task of establishing the standards of evidence to which a claim of ID would be held to the individual states. Given that ID is defined by more than one variable, the absence of a uniform standard creates a number of moving parts. In this research, we review the definitions and standards used by the states and discuss several cases that exemplify the implications of varying standards.

REFERENCES

Atkins v. Virginia, 536 U.S. 304 (2002)

Hill v. Schofield, 608 F. 3D 1272 (11th Cir. 2010)

QUESTIONS AND ANSWERS

1. What are the three criteria by which Intellectual Disability is defined in the majority of states that have the death penalty?

ANSWER: IQ less than 70; Significant impairments in adaptive function; age of onset less than 18 years.

2. Which state has the most rigorous standard for an *Atkins* claim of intellectual disability and what is the standard?

ANSWER: Georgia, Clear and Convincing Evidence

Rebekah Ranger, BSocS, BA, (I) Ottawa, ON, Canada
 Paul Fedoroff, MD, Ottawa, ON, Canada
 Susan Curry, BA, (I) Ottawa, ON, Canada
 Nada El Shayeb, BA, (I) Ottawa, ON, Canada
 Johnathan Gray, MD, Ottawa, ON, Canada
 Brad Booth, MD, Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

To understand how treatment of extra-familial child molesters affects their outcome.

SUMMARY

This retrospective study was undertaken to understand the relationship between pharmacotherapy and behavioral therapy on recidivism of extra-familial child molesters. Sexual Behaviors Clinic data was collected on 165 extra-familial child molesters, including their assessment, treatment, evaluated risk of recidivism, criminal and psychiatric history and sexual preferences. Canadian Police Information Centre data (CPIC) results were available for each subject ranging from 7 to 19 years after their first assessment at the Sexual Behaviours Clinic. CPIC data was coded as "sexual," "violent/sexual" and "any recidivism." Groups were divided into treatment "types" and compared on the Static 99. Groups were then compared on compliance measures during assessment and treatment to detect any differences. A survival analysis was done in order to examine the differences in length of time to recidivism for the different groups of treatment. Survival curves were plotted on % succeeded (y axis) and time in days (x axis) to reoffense. Time to re-offense was calculated based on the stop date of treatment. This study highlights the role of treatment in all forms of recidivism for extra-familial child molesters. Using this methodology, further investigation into treatment and recidivism of other types of sex offenders is needed.

REFERENCES

Hanson RK, Bussiere MT: Predicting relapse: a meta-analysis of sexual offender recidivism studies. *J Consulting and Clinical Psychology* 66(2):348-362, 1998
 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. *The World Journal of Biological Psychiatry* 11:604-655, 2010

QUESTIONS AND ANSWERS

1. Which treatment type in extra-familial child molesters indicates higher risk assessments scores?
ANSWER: Pharmacotherapy.
2. Which type of therapy is the most associated with recidivism in this population?
ANSWER: Behavioral.

Stephen Noffsinger, MD, Hudson OH
 Douglas Mossman, MD, Cincinnati, OH
 Sherif Soliman, MD, Beachwood, OH

EDUCATIONAL OBJECTIVE

Participants will learn three techniques for delivering effective direct courtroom testimony; (2) three techniques for avoiding cross-examination pitfalls; (3) the main elements contributing to the success of a collaborative mock trial experience between two forensic psychiatry fellowship programs.

SUMMARY

Forensic psychiatrists routinely express their opinions in written reports. But contested criminal matters or high-dollar civil disputes often require forensic clinicians to testify at deposition and/or trial as well. Live testimony poses both opportunities and risks for experts. Direct testimony lets an expert provide the finder-of-fact with crucial information, and when an expert's report is not admitted into evidence or is not read by the finder-of-fact, live testimony is the only vehicle for conveying the experts' opinion. But live testimony also creates the risk of having the expert's opinion distorted or discredited by rigorous cross-examination. This presentation will explain how psychiatrists can: (1) write reports that serve as templates for future testimony; (2) undertake pre-trial planning with retaining attorneys to script effective direct testimony; (3) provide direct testimony that teaches the finder-of-fact about the pertinent issues; (4) deal with overtly or subtly hostile cross examination, including challenges to professional credentials, overcoming adverse spin and distortion of one's expert opinion, portrayal of the expert as biased, and manage stress. This workshop will also describe the Mock Trial Collaboration between forensic psychiatry fellowships at Case Western Reserve University and the University of Cincinnati, which trains fellows to deliver effective testimony.

REFERENCES

Brodsky SL, Heller P: Addressing the perfect phantom on the witness stand. *J Am Acad Psychiatry Law* 36:54-3, 2008
Cramer RJ, Brodsky SL, et al: Expert witness confidence and juror personality: their impact on credibility and persuasion in the courtroom. *J Am Acad Psychiatry Law* 37:63-74, 2009

QUESTIONS AND ANSWERS

1. Factors that increase jurors' confidence in an expert's testimony include:

- a. Moderated, stable tone of voice.
- b. Willingness to acknowledge a degree of uncertainty.
- c. Consistent eye contact.
- d. Indication of credentials and knowledge.
- e. All of the above

ANSWER: e

2. Factors that correlate with increased juror confidence include:

- a. A highly extroverted expert witness.
- b. A moderately extroverted expert witness
- c. A moderately confident expert witness
- d. a and c
- e. b and c

ANSWER: d

S40

FORENSIC TELEPSYCHIATRY: ARE WE READY TO GO LIVE?

Camille LaCroix, MD, Boise, ID

Ana Cervantes, MD, Amherst, MA

Thomas Guthel, MD, Brookline, MA

Heidi Vermette, MD, Johnson City, TN

EDUCATIONAL OBJECTIVE

The purpose of this workshop is to discuss and generate ideas on the future guidelines for forensic use of telepsychiatry.

SUMMARY

Given the advantages of the technology to reach underserved populations, the use of telepsychiatry in forensic evaluations and court applications makes good sense. However, it is not routinely used in our field, perhaps in part due to a lack of practice guidelines. The limitations and pitfalls of this technology in clinical applications are magnified when applied to forensic use, thus making forensic telepsychiatry guidelines more pertinent. AAPL does not currently have guidelines on the forensic use of telepsychiatry, and there are relatively few scholarly articles to date in this area. In fact, there have only been three telepsychiatry presentations at the AAPL annual meeting in the past decade. This workshop will focus on the implications of using telepsychiatry for forensic evaluations without the help of guidelines. Presenters will discuss their use of this modality in both clinical and limited forensic applications, along with the pitfalls and issues that need to be overcome in order to begin use routinely in forensic practice. Ideally, participants with interest in this area will attend in order to generate discussion and ideas regarding guidelines for the use of this modality in our field.

REFERENCES

Practice Guidelines for Videoconferencing-Based Telemental Health. American Telemedicine Association, 2009
Miller TW, Burton DC, Hill K, et al: Telepsychiatry: critical dimensions for forensic services. *J Am Acad Psychiatry Law* 33(4):539-46, 2005

QUESTIONS AND ANSWERS

1. What organization has published guidelines for the use of telepsychiatry in forensic evaluations?

- a. APA
- b. AAPL
- c. ATA
- d. All of the above
- e. None of the above

ANSWER: e

2. What are some potential problems with using telepsychiatry for forensic evaluations:

- a. Privacy
- b. Safety
- c. Missing nonverbal cues
- d. Scrutiny in court
- e. All of the above

ANSWER: e

S41

WHAT AND HOW TO TEACH: A FORENSIC CURRICULUM IN RESIDENCY

Edward Poa, MD, Houston, TX
Andrea Stolar, MD, Houston, TX
R. Scott Johnson, MD, JD, Houston, TX
Andrea Nelsen, MD, Houston, TX
Kristi Sikes, MD, Houston, TX
Britta Ostermeyer, MD, Houston, TX

EDUCATIONAL OBJECTIVE

This workshop will propose a model forensic psychiatry curriculum within an adult residency. The workshop will stimulate discussion about the core forensic competencies in psychiatric residency education, the methods for imparting them, and thoughts from faculty and residents on how to identify and foster interest in the forensic subspecialty.

SUMMARY

Compared to other psychiatric subspecialties, there are fewer occasions in an adult training program to expose residents to forensic psychiatry. This leads to a knowledge deficit in forensic principles, misinformation about the practice of forensics, and a lost opportunity to recruit future forensic psychiatrists. This workshop will propose a model forensics curriculum within an adult psychiatry residency program without the benefit of a forensic center or fellowship. A faculty member and a resident will propose the essential core forensic principles for residency, based on PRITE questions, board examination outlines, and the available literature. Next, another faculty member will spotlight the clinical and didactic avenues available for covering these areas. A representative resident will discuss a perspective on desired experiences and exposure to forensics in residency. Finally, faculty will comment on strategies for nurturing future forensic psychiatrists such as identifying resident interest, creating mentorship pairs, and supporting participation in AAPL and national scholarship programs. The presenters will solicit active audience participation in the form of commentary, suggestions, and experiences from their own programs. Time permitting, the workshop will conclude with a case example of how a clinical experience could be used to highlight forensic principles.

REFERENCES

Lewis, CF: Teaching forensic psychiatry to general psychiatry residents. *Academic Psychiatry*, 28(1), 40-46, 2004
Marrocco MK, Uecker JC, Ciccone JR: Teaching forensic psychiatry to psychiatric residents. *Bulletin of the American Academy of Psychiatry and the Law* 23(1), 83-91, 1995

QUESTIONS AND ANSWERS

1. Residents often struggle with recognizing situations involving dual agency because they may not have been taught about the dilemmas associated with mixing what two roles?

ANSWER: Treating psychiatrist vs. expert witness

2. What are some reasons why a discussion of malpractice and its components can be a useful teaching point on most rotations with almost any combination of residents and medical students?

ANSWER: Malpractice tends to be a topic of universal concern among physicians in any field, and its principles can be generalized regardless of what specialty the trainees enter. Additionally, it is a topic that generates a high level of interest and anxiety among the audience.

SUNDAY, OCTOBER 27, 2013

PANEL	8:00 AM – 10:00 AM	PALM/SUNSET ROOM, CALIFORNIA CABANAS
Z1	<i>Impaired Medical Decision-Making in Older Patients Geriatric Psychiatry and the Law Committee</i>	Stephen Read, MD, San Pedro, CA Debra Pinals, MD, Boston, MA Phillip Resnick, MD, Cleveland, OH Sherif Soliman, MD, Beachwood, OH Robert Weinstock, MD, Los Angeles, CA
PANEL	8:00 AM – 10:00 AM	CORONET ROOM, VICTORIAN BUILDING
Z2	<i>Crazy Like a "Crazy" Fox: The Case of Brian David Mitchell</i>	Cynthia Vitko, MD, JD, Park City, UT Paul Whitehead, MD, Salt Lake City, UT Heidi Anne Buchi, JD, (I) Salt Lake City, UT Peter Ash, MD, Atlanta, GA
PANEL	8:00 AM – 10:00 AM	SEABREEZE ROOM, CALIFORNIA CABANAS
Z3	<i>Special Topics in Stalking (Core) Gender Issues Committee</i>	Sara West, MD, Cleveland, OH Susan Hatters Friedman, MD, Cleveland Heights, OH Renée Sorrentino, MD, Quincy, MA
RESEARCH IN PROGRESS #4	8:00 AM – 10:00 AM	HANOVER ROOM, VICTORIAN BUILDING
Z4	<i>Suicide Risk Assessment: Influences on Professional Judgment</i>	Cheryl Regehr, PhD, (I) Toronto, ON, Canada Marion Bogo, MSW, (I) Toronto, ON, Canada Vicki LeBlanc, PhD, (I) Toronto, ON, Canada Jane Paterson, MSW, (I) Toronto, ON, Canada
Z5	<i>Pharmacotherapy of Impulsive Aggression: An Algorithm</i>	Alan Felthous, MD, St. Louis, MO
Z6	<i>Screening for Violence Risk: Piloting a Triage Tool</i>	Merrill Rotter, MD, White Plains, NY Melodie Foellmi, MA, (I) Bronx, NY Michael Greenspan, MD, Larchmont, NY Ali Khadivi, PhD, Bronx, NY Barry Rosenfeld, PhD, (I) Bronx, NY
Z7	<i>The Tattoo Paradigm in the Perpetuation of Prison Structure</i>	Jonathan Barker, MD, Cambridge, MA
WORKSHOP	8:00 AM – 10:00 AM	GARDEN ROOM, VICTORIAN BUILDING
Z8	<i>Departures and Variances from Federal Sentencing Guidelines</i>	Annie Steinberg, MD, Narberth, PA Gillian Blair, PhD, (I) Narberth, PA Benjamin Davis, JD, (I) San Diego, CA Tess Lopez, BS, (I) Novato, CA
COFFEE BREAK	10:00 AM – 10:15 AM	VICTORIAN BUILDING

PANEL	10:15 AM – 12:15 PM	PALM/SUNSET ROOM, CALIFORNIA CABANAS
Z9	<i>Chronic Traumatic Encephalopathy and Suicide Forensic Neuropsychiatry and Suicidology Committee</i>	Hal Wortzel, MD, Aurora, CO Lisa Brenner, PhD, (I) Denver, CO Robert Granacher, MD, Lexington, KY Morton Silverman, MD, (I) Chicago, IL
PANEL	10:15 AM – 12:15 PM	SEABREEZE ROOM, CALIFORNIA CABANAS
Z10	<i>Successful Offender Treatment – The Perils of New Paradigms</i>	Merrill Rotter, MD, White Plains, NY Marybeth Anderson, JD, (I) New York, NY Jennifer Eno Loudon, PhD, (I) El Paso, TX Debra Pinals, MD, Boston, MA
WORKSHOP	10:15 AM – 12:15 PM	GARDEN ROOM, VICTORIAN BUILDING
Z11	<i>ADHD in Correctional Settings: To Treat or Not to Treat? Child and Adolescent Committee</i>	Gregory Sokolov, MD, Davis, CA Christopher Thompson, MD, Los Angeles, CA
WORKSHOP	10:15 AM – 12:15 PM	CORONET ROOM, VICTORIAN BUILDING
Z12	<i>Not Guilty by Reason of Medication: Your Drugs Made Me Do It Criminal Behavior Committee</i>	Susan Hatters Friedman, MD, Cleveland Heights, OH Ryan Hall, MD, Lake Mary, FL Christopher Kenedi, MD, (I) Auckland, New Zealand James Knoll, IV, MD, Syracuse, NY

Stephen Read, MD, San Pedro, CA
 Debra Pinals, MD, Boston, MA
 Phillip Resnick, MD, Cleveland, OH
 Sherif Soliman, MD, Beachwood, OH
 Robert Weinstock, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE

Medical decision-making is important for the older patient since the failure to recognize impairment can compromise not only health, but also success in treating psychiatric conditions. Panelists will review these issues, bases for current judgments of incapacity, assessment matters, and considerations for future policy approaches to improve consultants' skills.

SUMMARY

Medical care complexity in the aging population increasingly leads to disputes requiring expert assessment of medical decision-making capacity. Dr. Read will review the spectrum of personal, family, and institutional issues and the implications for individuals and society. Dr. Soliman will describe the assessment process in the context of differing legal standards, the clinical implications of public policy decisions regarding involuntary treatment processes, and the clinical consequences of failing to provide medical care refused by patients under involuntary psychiatric treatment. Dr. Pinals will discuss policy development and systems management of treatment refusals at the crossroads of medical and psychiatric illness, and the limitations of civil commitment laws in capacity assessments regarding treatment decisions, the use of restraints, and staffing. Dr. Weinstock will review the difference between capacity- and danger-based models for the determination of incapacity. While capacity-based models are more appropriate for impaired medical decision-making in hospitalized elderly persons, it is a challenge to craft procedural safeguards necessary for protecting patient autonomy so as not intrude on medical care processes. Dr. Resnick's perspectives on the evolution of involuntary treatment decisions will inform the efforts necessary for developing procedures for providing alternate decision-making for medical care in our aging society.

REFERENCES

Byatt N, Pinals D, Arikian R: Involuntary hospitalization of medical patients who lack decisional capacity: An unresolved issue. *Psychosomatics* 47:443-448, 2006
 Weiss BD, Berman EA, Howe CL, et al. Medical decision-making for older adults without family. *JAGS* 60:2144-2150, 2012

QUESTIONS AND ANSWERS

1. Which of the following principles inform current models for determinations of decision-making incapacity?

- a. Best interests of the patient
- b. Dangerousness
- c. Substituted judgment
- d. Impaired capacity

ANSWER: b and d

2. Compromised medical decision-making is a significant concern in consultation on an older psychiatric patient because:

- a. Pre-existing cognitive loss can be exacerbated by neglected medical conditions.
- b. Untreated medical conditions can compromise psychiatric treatments.
- c. Delirium can result from neglect of treatment.
- d. Unattended medical conditions can cause excess morbidity and/or death.
- e. All of the above.

ANSWER: e

Cynthia Vitko, MD, JD, Park City, UT
 Paul Whitehead, MD, Salt Lake City, UT
 Heidi Anne Buchi, JD, (I) Salt Lake City, UT
 Peter Ash, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE

To enhance audience knowledge about a high profile case in the United States that involved complicated legal proceedings and significant variance in opinions and methods of assessment at the interface of psychosis and religious extremism.

SUMMARY

Defendant in the Elizabeth Smart kidnapping was found incompetent in state court based on impairments from a psychotic disorder, ineligible for involuntary medications under Sell procedure, eventually transferred to federal court and found competent with a diagnosis of personality disorder, and then convicted after highly adversarial insanity proceedings. The case highlighted various controversies, including difficulties with Sell criteria as applied to delusional disorder patients, the nebulous boundary between idiosyncratic religious extremism and psychosis, variance in diagnoses among the nine professionals involved, and methods of competency assessment contrasted against the framework of AAPL guidelines. Salient issues and experiences will be discussed regarding the assessment, treatment, and legal defense of Brian David Mitchell.

REFERENCES

- Oltman T, Maher B: Delusional Beliefs. New York: John Wiley, 1988
Mossman D, Noffsinger S, Ash P, et al: Practice Guideline: Evaluation of Competence to Stand Trial. J Am Acad Psychiatry Law 35: 4, 2007

QUESTIONS AND ANSWERS

1. Descriptive characteristics of delusions include:
a. A belief that lacks subcultural sharedness
b. Balance of evidence for/against belief is such that other people consider it completely incredible
c. A belief that results in significant preoccupation
d. A belief that involves personal reference rather than unconventional religious, scientific, or political conviction
e. All of the above

ANSWER: e

2. Estimates suggest the percent of defendants referred for competence evaluations that attempt to feign mental problems that would impair competence is:

- a. At least 10%
b. 20-30%
c. Less than 5%
d. 1%
e. No data to support an estimate

ANSWER: a

Z3

SPECIAL TOPICS IN STALKING

Sara West, MD, Cleveland, OH
Susan Hatters Friedman, MD, Cleveland Heights, OH
Renée Sorrentino, MD, Quincy, MA

EDUCATIONAL OBJECTIVE

To gain a better understanding of both the stalker and the victim through learning more about distinct populations associated with stalking: female stalkers, juvenile stalkers and victims, and the stalking of mental health professionals.

SUMMARY

Stalking is a common topic in forensic psychiatry and certainly warrants further investigation. Forensic practitioners and clinicians may be called upon to evaluate both the stalker or the victim. This talk will offer a different perspective on a few unique populations that may be involved in stalking. When one thinks of a stalker, the image of a man in a trenchcoat wearing dark glasses and lurking in shadows is often what one conjures up. However, research shows female stalkers are responsible for a solid minority of stalking events. We will discuss characteristics common to those women who stalk. The trials and tribulations of youth may both be added to by and drive stalking behavior. We will next discuss the juvenile as both the offender and the victim as well as the long term consequences of such. Finally, a topic that is vital to all practitioners, we will discuss the mental health professional as a victim of stalking behavior. This will include warning signs of and potential solutions to stalking behavior manifested by patients.

REFERENCES

1. West SG, Friedman SH: These boots are made for stalking: characteristics of female stalkers. Psychiatry 5(8):37-42, 2008
2. Mullen PE, Pathe M, Purcell R, et al: Study of stalkers. Am J Psychiatry 156:1244-1249, 1999

QUESTIONS AND ANSWERS

1. What are some common characteristics of female stalkers?

ANSWER: Caucasian, heterosexual, single, age in the mid-30s, without children, educated, employed, lack of substance abuse

2. What are some common characteristics of stalkers who target mental health professionals?

ANSWER: Male, prior history of stalking, often under the clinician's direct care, motivated by a desire for greater intimacy

Z4

SUICIDE RISK ASSESSMENT: INFLUENCES ON PROFESSIONAL JUDGMENT

Cheryl Regehr, PhD, (I) Toronto, ON, Canada

Marion Bogo, MSW, (I) Toronto, ON, Canada

Vicki LeBlanc, PhD, (I) Toronto, ON, Canada

Jane Paterson, MSW, (I) Toronto, ON, Canada

EDUCATIONAL OBJECTIVE

To present the factors that influence clinical assessment of suicide risk.

SUMMARY

In 2008, Accreditation Canada introduced a new standard that requires mental health facilities to assess each client for risk of suicide and address immediate safety needs where risk is present. However, research has demonstrated inconsistencies in clinical judgments regarding suicide risk and has raised questions about the ability of standardized measures to reliably predict risk in any given clinical situation. This project investigates the degree to which specific clinician factors (training, clinical experience, pre-existing emotional and physiological state, and stress responses) interact with the contextual factors (client characteristics and threat) in a high stress situation and in turn will influence professional judgment regarding suicide risk. An experimental design is utilized in which 50 psychiatric social workers conduct assessments of two standardized patients performing in risk scenarios, an adolescent in crisis and a depressed middle aged woman with substance abuse issues. The influences of training, experience, psychological and physiological arousal, client variables and threat variables on professional judgment are modeled. As forensic psychiatrists are responsible for the safety of patients in forensic mental health facilities and are frequently engaged in cases addressing professional negligence, this research has direct implications for forensic practice.

REFERENCES

Cochrane-Brink K, Lofchy J, Sakinofsky I: Clinical Rating Scales in Suicide Risk Assessment. *General Hospital Psychiatry* 22: 445–51, 2000

American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors. Available at http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx. Accessed July 30, 2013

QUESTIONS AND ANSWERS

1. Which commonly used standardized measures of suicide risk demonstrate highest rates of predictive validity?

ANSWER: The Columbia Suicide Rating Scale, the Beck Scale for Suicide Ideation, the Beck Depression Inventory.

2. How consistent are clinical evaluations of suicide risk?

ANSWER: Research has demonstrated considerable variability between clinicians assessing the same patient and between assessments of an individual clinician rating the same patient scenario at two different time periods.

Z5

PHARMACOTHERAPY OF IMPULSIVE AGGRESSION: AN ALGORITHM

Alan Felthous, MD, St. Louis, MO

EDUCATIONAL OBJECTIVE

1) Attendees will be able to diagnose impulsive aggression for which an anti-impulsive aggressive agent may be efficacious. 2) Attendees will be better prepared to take into account the critical factors in selecting the most promising agent for a given patient with impulsive aggression.

SUMMARY

A rational algorithm for effective pharmacotherapy of impulsive aggression takes into account ten factors: 1) Sufficiently diagnosed impulsive aggression, 2) Agents studied by trials of sufficient quality, 3) Particularly because efficacious anti-impulsive aggression agents (AIAAs) have not been approved by the FDA for treatment of impulsive aggression, it is important to consider co-occurring conditions for which the drug is indicated, 4) Percentage of subjects whose impulsive aggression improves with the drug, 5) Pharmacotherapeutic history of the patient, 6) Risks of side effects, 7) Affordability and accessibility of the drug, 8) pregnancy, 9) severity of outbursts, and 10) urgency. Clinicians in forensic and correctional treatment centers, indeed in any treatment setting, should be able to optimize their effectiveness in treating impulsive aggression by methodologically considering these ten factors.

REFERENCES

Jones RM, Arlidge J, Gilham S, et al: Efficacy of mood stabilizers in the treatment of impulsive or repetitive aggression: systematic review and meta-analysis. *Brit J Psychiatry* 198:93-8, 2011
Felthous AR, Stanford MS, Lake SL, Rundle BK: Pharmacotherapy of impulsive aggression: a quality comparison of controlled studies. *Internat J Law Psychiatry* in press 2013

QUESTIONS AND ANSWERS

1. Which SSRI has the best research evidence to support its efficacy in treating impulsive aggression?

- a. Citalopram
- b. Sertraline
- c. Escitalopram
- d. Fluoxetine

ANSWER: d

2. Which anticonvulsant does not have evidence of anti-impulsive aggression efficacy?

- a. Divalproex
- b. Valproate
- c. Levetiracetam
- d. Phenytoin

ANSWER: c

Z6

SCREENING FOR VIOLENCE RISK: PILOTING A TRIAGE TOOL

Merrill Rotter, MD, White Plains, NY

Melodie Foellmi, MA, (I) Bronx, NY

Michael Greenspan, MD, Larchmont, NY

Ali Khadivi, PhD, Bronx, NY

Barry Rosenfeld, PhD, (I) Bronx, NY

EDUCATIONAL OBJECTIVE

To improve the understanding of assessing for violence risk generally and increase participants' knowledge of the possibilities for state of the art violence risk screening.

SUMMARY

The psychiatric and forensic literature has consistently supported the use of formal risk approaches to the assessment of violence risk in psychiatric patients. The need for such assessments is clear, given the relatively high base rate of community violence in previously hospitalized psychiatric patients (25.2% in a one year follow-up period, according to the MacArthur Study of Mental Disorder and Violence). Despite this, currently available tools (including, but not limited to, actuarial and other structured clinical aides) are seen as too resource and labor intensive to be adopted by the psychiatric treatment community at large. This project aims to develop a brief and easily administered screening tool, which would assist clinicians in identifying a high risk population, for whom more intensive risk assessment and management would be warranted. In this study we present the results of our work piloting a structured screening tool (the Bronx Risk Assessment Tool) in the triage unit of a state psychiatric facility. Outcome measures include interrater reliability, validity (as measured by correlation with full risk assessment using the HCR-20) and ease of utilization.

REFERENCES

Monahan J, Steadman HJ, Silver E, et al: *Rethinking Risk Assessment*. New York: Oxford University Press, 2001
Buchanan A: Risk of Violence by Psychiatric Patients: Beyond the "Actuarial Versus Clinical" Debate. *Psychiatric Services* 59 (2), 184-190, 2008

QUESTIONS AND ANSWERS

1. The difficulties of implementing structured risk assessments in community settings include:

- a. Time consuming
- b. Requires specialized training
- c. Not considered state of the art
- d. Not relevant for most patients
- e. a, b and d

ANSWER: e

2. Screening for violence risk should include:
- History of violence
 - History of threats
 - History of involuntary hospitalization
 - a and b only
 - a, b and c
- ANSWER: e

Z7

THE TATTOO PARADIGM IN THE PERPETUATION OF PRISON STRUCTURE

Jonathan Barker, MD, Cambridge, MA

EDUCATIONAL OBJECTIVE

To learn how to categorize the ways in which tattoos serve to facilitate a structure in the prison system, and in so doing affect the survival of the prisoner on an individual and group basis. To learn about the culture of prison tattooing.

SUMMARY

Tattoos serve to encase the familiar and alienate the unfamiliar. This study investigated the protective and survival functions of tattoos in prison populations. The tattoo functions to sustain the boundaries of the individual and the group. It provides a hierarchical order and system of groups that operate in the prison. An extensive review of the literature was performed. Existing internet documents were reviewed, and documentaries and YouTube videos were watched in order to survey the meaning of tattoos in prison and nonprison populations. A preliminary categorization of types and uses of tattoos in perpetuating group formation and individual survival in prisons was derived from these searches. Tattoos are used in the following categories: to preserve group unity and identity, as a representation of ownership and rank, as a symbol of intimidation, to express internal conflict, to maintain the prisoners' humanity, and as a reaction to the vulnerability. The tattoo is used as a protective layer, injected into the skin, separating the individual from the outside world. The gang tattoo symbolizes the protective armor of the gang. It envelops the self and serves as a representation of race, an ancestral line, and fighting for the group's existence in a harsh, predatory environment.

REFERENCES

Palermo G: Tattooing and tattooed criminals. *J Forensic Psychology Practice* 4:1, 1-25, 2004
 Shoham E: Signs of honor among Russian inmates in Israel's prisons. *Int J Offender Ther Comp Criminol*, 54(6): 984-1003, 2010

QUESTIONS AND ANSWERS

- How can tattoo ink be made while in prison?
 - By grinding the soles of shoes into a powder and mixing it with urine
 - By burning toilet paper
 - By collecting soot from the cell
 - By melting red checker pieces
 - All of the above

ANSWER: e
- A prisoner with the numbers "276" tattooed on his body is most likely a member of which of the following prison gangs?
 - The Aryan Brotherhood
 - The Texas Syndicate
 - The Mexican Mafia
 - The Black Guerilla Family

ANSWER: d

Z8

DEPARTURES AND VARIANCES FROM FEDERAL SENTENCING GUIDELINES

Annie Steinberg, MD, Narberth, PA
 Gillian Blair, PhD, (I) Narberth, PA
 Benjamin Davis, JD, (I) San Diego, CA
 Tess Lopez, BS, (I) Novato, CA

EDUCATIONAL OBJECTIVE

This workshop will provide an overview of sentencing guidelines, the nature of departures and variance from the guidelines, and case examples that emphasize the defendant's role as a parent and in the family as the primary area in which a departure from the guidelines was sought.

SUNDAY

SUMMARY

Federal sentencing guidelines, once mandatory but advisory since *U.S. v. Booker* (2005), are based primarily on the offense level and the defendant's criminal history. In sentencing, district courts are required to consider and rule on motions for departures and variances from the guidelines. Departures are determined by guidelines and can involve reductions or enhancements in the sentence, but are non-binding, whereas a variance can be requested when specific elements of guidelines are not met. Controversies about federal guidelines abound, including heavier penalties for child pornography viewing than rape, increased sentencing disparities along socioeconomic lines, their use for prosecutorial threats, etc. This workshop will inform participants about the structure of sentencing guidelines and how forensic evaluations can be critical to the attorney's presentation in seeking a departure or variance. Case examples of defendants who have pleaded to a variety of criminal charges will be offered, emphasizing the impact of incarceration on the defendant's family and children. A Federal Defender will discuss the pragmatics of departures from the guidelines, and other factors in federal defense as it pertains to sentencing. A mitigation specialist will review the utility of a pre-sentencing forensic evaluation. The intricacies of federal sentencing guidelines demand close interdisciplinary collaboration.

REFERENCES

Morson D, Clay Kelly D: Federal Sentencing Guidelines. *J Am Acad Psychiatry Law* 36:587-589, 2008
United States v. Booker, 543 U.S. 220 (2005)

QUESTIONS AND ANSWERS

1. Specific situations in which a pre-sentencing forensic evaluation could benefit a motion for a departure or variance from Federal Sentencing Guidelines include:

- a. Extraordinary hardship on the family
- b. Special needs of a child or spouse
- c. Circumstances within a family, such as defendant is sole parent
- d. All of the above

ANSWER: d

2. Which of the following are true?

- a. A departure or variance from Federal sentencing guidelines are both advisory and non-binding
- b. Factors that determine whether the degree to which departure guidelines are met include specifically authorized elements
- c. Factors that fall short of the guidelines may justify a variance as they do not demand that specific criteria are met
- d. All of the above

ANSWER: d

Z9

CHRONIC TRAUMATIC ENCEPHALOPATHY AND SUICIDE

Hal Wortzel, MD, Aurora, CO
Lisa Brenner, PhD, (I) Denver, CO
Robert Granacher, MD, Lexington, KY
Morton Silverman, MD, (I) Chicago, IL

EDUCATIONAL OBJECTIVE

This presentation is designed to educate forensic psychiatrists about CTE, and the true state of the science surrounding CTE and its neuropsychiatric manifestations. There will be particular emphasis on the relationship between CTE and suicide, and proper methods for case-by-case analysis regarding causation in cases involving death by suicide.

SUMMARY

Annually millions worldwide sustain traumatic brain injuries (TBI), and recent literature has reported that even a single mild TBI can lead to chronic traumatic encephalopathy (CTE). It has been suggested that CTE may lead to neurodegenerative illness featuring cognitive, emotional, behavioral, and physical impairment. Death by suicide, specifically in athlete and military/veteran populations, has also been suggested to be a potential outcome of CTE. In light of the clinical and medicolegal implications of such assertions, and the predominant neuropsychiatric symptoms associated with CTE, a forensic neuropsychiatric perspective on this issue is long overdue. This panel will introduce the topic of CTE and the surrounding controversies. At present, the CTE literature features divergent opinions regarding the neuropathological elements of CTE across studies/authors, as well as heterogeneity in reported clinical manifestations. The results from a systematic review of the literature describing the relationship between CTE and suicide will be presented. That review indicates an overall quality of the evidence appropriately rated as very low, revealing that evidence for a relationship between CTE and suicide is presently lacking. Finally, the essential role for forensic psychiatry in analyzing suicide deaths on a case-by-case basis when making determinations of causation will be explored.

REFERENCES

Omalu BI, Bailes J, Hammers JL, et al: Chronic traumatic encephalopathy, suicides and parasuicides in professional American athletes: the role of the forensic pathologist. *Am J Forensic Med Pathol* 31:130-2, 2010
Simpson G, Tate R: Suicidality in people surviving a traumatic brain injury: prevalence, risk factors and implications for clinical management. *Brain Inj* 21:1335-51, 2007

QUESTIONS AND ANSWERS

1. Chronic Traumatic Encephalopathy is:

- a. A well defined clinical and pathological diagnosis
- b. A leading cause of suicide
- c. A sensitive and specific indication of prior TBI exposure
- d. None of the above

ANSWER: d

2. The relationship between CTE and suicide:

- a. Is well established and understood
- b. Is more robust than that already identified for TBI and suicide
- c. Remains poorly characterized and mandates more research
- d. Is established by the histopathological evidence
- e. None of the above

ANSWER: c

Z10

SUCCESSFUL OFFENDER TREATMENT - THE PERILS OF NEW PARADIGMS

Merrill Rotter, MD, White Plains NY
Marybeth Anderson, JD, (I) New York, NY
Jennifer Eno Loudon, PhD, (I) El Paso , TX
Debra Pinals, MD, Boston, MA

EDUCATIONAL OBJECTIVE

To acquaint participants with the Risk/Needs/Responsivity paradigm for decreasing recidivism and providing comprehensive treatment of mentally ill offenders; and debate the legal and ethical issues associated with its increasingly widespread implementation.

SUMMARY

The Risk/Needs/Responsivity (RNR) approach to addressing the needs of the mentally ill offender is both increasingly evidenced-based and increasingly implemented in service delivery models and programs whose goals are improved treatment and decreased criminal recidivism. Despite the benefits of the RNR approach for assessment and treatment planning, and despite its popularity with administrators and funding agencies, some aspects of RNR may present problems for offenders, particularly those who may be eligible for programmatic alternatives to incarceration. Dr. Eno Loudon will present the RNR paradigm and the research basis for it, followed by Dr. Pinals who will discuss the utility and popularity of the approach, based on her implementation experience in Massachusetts and a review of national trends. Ms. Anderson, a defense attorney and advocate, will review the legal perspective and implications for defendants. Finally, Dr. Rotter will discuss the ethical challenges of RNR implementation, where clinical, fiscal and legal priorities do not necessarily match.

REFERENCES

Rotter M, Carr W: Targeting criminal recidivism in mentally ill offenders: Structured clinical approaches. *Community Mental Health Journal* 47: 723-726, 2011
Skeem J, Manchak S, Peterson J: Correctional policy for offenders with mental disorder: Creating a new paradigm for recidivism reduction. *Law and Human Behavior* 35: 110-126, 2011

QUESTIONS AND ANSWERS

1. RNR stands for:

- a. Risk Needs Responsivity
- b. Rest N ' Relaxation
- c. Relatively Not Responsible
- d. Relapse N ' Recidivism

ANSWER: a

2. Elements of RNR that may pose challenges for offenders include:
 - a. Exclusion from program eligibility
 - b. Criminal justice expectations of treatment, not available in community
 - c. Application of group classifications to individual determination
 - d. All of the above

ANSWER: d

Z11

ADHD IN CORRECTIONAL SETTINGS: TO TREAT OR NOT TO TREAT?

Gregory Sokolov, MD, Davis, CA
 Christopher Thompson, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE

(1) Know the rates of ADHD and domains of impairment in afflicted individuals in juvenile justice and adult correctional settings; (2) learn techniques and sources of information to corroborate a self-report of ADHD symptoms; (3) learn techniques to minimize abuse or diversion of ADHD medications in correctional settings.

SUMMARY

ADHD has been reported to be overrepresented in individuals in correctional settings and cause significant morbidity in impacted individuals. Frequently, these individuals have difficulty following instructions, adhering to the jail/prison/juvenile detention facility routine, and their education (particularly for juveniles) is adversely impacted. ADHD increases the risk for antisocial behavior, both in juveniles and adults. However, treating ADHD in a correctional population presents special challenges for clinicians, as diversion and abuse of medications (e.g., stimulants, bupropion) can be problematic in both juveniles and adults; and illicit substance use may be ongoing, even in detention/correctional settings. Organizational treatment philosophies for ADHD often vary from detention/correctional setting to the community, giving rise to problems with consistency and continuity of care. This workshop presentation will focus on prevalence of the juvenile justice and adult correctional populations, ways to minimize diversion and abuse of psychotropic medications designed to treat ADHD, different treatment interventions' efficacy in treating ADHD, and the importance of consistency of treatment philosophy as individuals transition from detention/correctional facilities back to community care. Clinical case examples will be presented, and audience members will be asked to present their own challenging clinical cases for discussion and review.

REFERENCES

Mannuzza S, Klein RG, Moulton JL III: Lifetime criminality among boys with attention deficit hyperactivity disorder: a prospective follow-up study into adulthood using official arrest records. *Psychiatry Res* 160(3):237-46, 2008
 Appelbaum KL: Attention deficit hyperactivity disorder in prison: a treatment protocol. *J Am Acad Psychiatry Law* 37(1):45-9, 2009

QUESTIONS AND ANSWERS

1. Studies have shown that childhood ADHD increases the risk of all of the following EXCEPT?
 - a. Antisocial behaviors in adolescence
 - b. Substance use disorders in adolescence
 - c. Schizophrenia risk in adolescence
 - d. Criminal behavior in adulthood

ANSWER: c

2. Rates of ADHD in adult correctional populations have been reported as:
 - a. >1%
 - b. 5%
 - c. 75%
 - d. Between 9-45%

ANSWER: d

Z12

**NOT GUILTY BY REASON OF MEDICATION:
 YOUR DRUGS MADE ME DO IT**

Susan Hatters Friedman, MD, Cleveland Heights, OH
 Ryan Hall, MD, Lake Mary, FL
 Christopher Kenedi, MD, (I) Auckland, New Zealand
 James Knoll IV, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

At the end of this workshop, the attendee will be able to: discuss the findings from the literature about the use of psychotropic medications and violent/criminal behavior, and utilize this knowledge to discuss complex criminal sample cases.

SUMMARY

There is a lack of convincing scientific evidence that confirms a relationship between psychotropic agents and violent behavior. Research considering links between serotonin, SSRIs and aggression will be reviewed. Results of a literature review reveal that a small proportion of patients treated with SSRIs may show increases in anxiety in the initial phase of treatment, but no increased susceptibility to aggression or suicidality can be reliably connected with fluoxetine or any other SSRI. In fact, SSRI treatment may reduce aggression. There is an absence of convincing evidence to link SSRIs causally to violence and suicide, and the recent lay media reports are potentially dangerous, unnecessarily increasing the concerns of patients who are prescribed antidepressants. Further, there have been legal cases in which psychotropic medications have been linked to violent behaviors by experts. Multiple cases from the authors' experience in which medications were allegedly causally implicated will be presented. Recommendations for evaluation of these implications will be discussed.

REFERENCES

Daley C, McNeil DE, Binder RL: "I did what?" Zolpidem and the courts. *J Am Acad Psychiatry Law* 39: 535-542, 2011
Butler T, Schofield PW, Greenberg D, et al: Reducing impulsivity in repeat violent offenders: an open label trial of a selective serotonin reuptake inhibitor. *Aust NZ J Psychiatry* 44: 1137-1143, 2010

QUESTIONS AND ANSWERS

1. Which of the following is true:

- a. SSRIs have been conclusively linked to increase in violence
- b. Antipsychotic agents have been conclusively linked to increase in violence
- c. Antiepileptic agents have been conclusively linked to increase in violence
- d. None of the above

ANSWER: d

2. Which of the following agents have not been implicated in leading to criminal behavior in NGRI or diminished capacity cases?

- a. Zolpidem
- b. SSRIs
- c. Chloroform
- d. All of the above have been implicated

ANSWER: d

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