American Academy of Psychiatry and the Law

47th Annual Meeting

October 27-30, 2016
Portland, Oregon

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-seventh Annual Meeting
American Academy of Psychiatry and the Law
October 27-30, 2016
Portland, Oregon

OFFICERS OF THE ACADEMY

Emily A. Keram, MD
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PAST PRESIDENTS

Graham Glancy, MB	2014-15
Robert Weinstock, MD	2013-14
Debra Pinals, MD	2012-13
Charles Scott, MD	2011-12
Peter Ash, MD	2010-11
Stephen B. Billick, MD	2009-10
Patricia R. Recupero, MD, JD	2008-09
Jeffrey S. Janofsky, MD	2007-08
Alan R. Felthous, MD	2006-07
Robert I. Simon, MD	2005-06
Robert T.M. Phillips, MD, PhD	2004-05
Robert Wettstein, MD	2003-04
Roy J. O'Shaughnessy, MD	2002-03
Larry H. Strasburger, MD	2001-02
Jefrey L. Metzner, MD	2000-01
Thomas G. Gutheil, MD	1999-00
Larry R. Faulkner, M.D	1998-99
Renée L. Binder, MD	1997-98
Ezra E. H. Griffith, MD	1996-97
Paul S. Appelbaum, MD	1995-96
Park E. Dietz, MD, PhD, MPH	1994-95
John M. Bradford, MB	1993-94
Howard V. Zonana, MD	1992-93
Kathleen M. Quinn, MD	1991-92
Richard T. Rada, MD	1990-91
Joseph D. Bloom, MD	1989-90
William H. Reid, MD, MPH	1988-89
Richard Rosner, MD	1987-88
J. Richard Ciccone, MD	1986-87
Selwyn M. Smith, MD	1985-86
Phillip J. Resnick, MD	1984-85
Loren H. Roth, MD	1983-84
Abraham L. Halpern, MD	1982-83
Stanley L. Portnow, MD	1981-82
Herbert E. Thomas, MD	1980-81
Nathan T. Sidley, MD	1979-80
Irwin N. Perr, MD	1977-79
G. Sarwer-Foner, MD	1975-77
Seymour Pollack, MD	1973-75
Robert L. Sadoff, MD	1971-73
Jonas R. Rappeport, MD	1969-71

2016 ANNUAL MEETING CHAIR

Charles Dike, 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

Jeffrey Janofsky, MD
Medical Director

Jacquelyn T. Coleman, CAE
Executive Director

CALL FOR PAPERS 2017

The 48th Annual Meeting of the
American Academy of Psychiatry and the Law will be held in
Denver, CO – October 26-29, 2017

Inquiries may be directed to Reena Kapoor, MD

The Program Chair welcomes 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, 2017

FUTURE ANNUAL MEETING DATES and LOCATIONS

49th Annual Meeting
October 25-28, 2018 – Austin, TX

50th Annual Meeting
October 24-27, 2019 – Baltimore, MD

51st Annual Meeting
October 22-25, 2020 – Chicago, IL

GENERAL INFORMATION

Table of Contents

REGISTRATION DESK
(Plaza Foyer)

Hours of Operation

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

AAPL BOOKSTORE
Plaza Foyer

NOETIC FILMS
Plaza Foyer

PRESENTATION 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

SUPPORT THE AIER!
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 contributions to forensic education and research programs.

MERCHANDISE FOR SALE

All proceeds used to fund AIER grants.

	ORIGINAL PRICE	AT MEETING PRICE
AAPL Logo Shirt	$35.00	$25.00
AAPL Logo Hat	$20.00	$10.00
AAPL Shirt and Hat Combo	$50.00	$30.00
AAPL Logo Tie	$25.00	$15.00

Available shirt sizes are: Men's M, L, XL and Women's S, M, L, XL

Merchandise purchases or additional contributions (cash, check, Visa or MasterCard) to the Institute can be made at the AAPL registration desk.

To place an order or contribute to the AIER after the meeting please contact the AAPL Executive Office at 800-331-1389.

Contributions can be also be made online at www.aapl.org.

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 Christopher Thompson, 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.

Also, please note that while discussing one's book is <u>not</u> a conflict of interest, presenters are discouraged from actively promoting it.

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:

Ali, A.; Ali, F.; Allen, T.; Anfang, S.; Annas, G.D.; Antoniak, S.; Antonius, D.; Aoun, E.; Appel, J.; Appelbaum, P.; Armstrong, C.; Ash, P.; Bachmann, L.; Balsamo, D.; Baranoski, M.; Baron, D.; Barton, D.J.; Bazzi, L.; Benedek, D.; Billick, S.; Binder, R.; Bloom, H.; Blum, B.; Bobadila, L.; Boehnlein, J.; Booth, B.; Britton, J.; Brown, J.; Bruner-Dehnert, A.; Buchanan, J.; Bucina, C.; Busch, K.; Byrd, T.; Calhoun, D.; Candilis, P.; Canning, R.; Cartun, S.; Castillo, J.; Cerny, C.; Chakravarty, M.; Champion, M.; Chan, E; Chan, G; Charder, N.; Charoensook, J.; Chastang, S.; Cheng, J.; Chern-Shnaidman, V.; Chien, J.; Choi, O.; Christopher, K.; Christopher, S.; Ciccone, J.R.; Clarke, S.; Coffman, K.; Coggins, E.; Cohen, M.; Colley, J.; Collins, T.; Coonan, L.; Costanza, W.; Cotoman, D.; Cotterell, M.; Croarkin, P.; Daou, M.; Darby, W.; Datta, V.; Davies, M.; Dekmar, L.; DeLuca, M.; Demarco, E.; Desagani, K.; DeTrana, C.; DiCiro, M.; Drizin, S.; Dvoskin, J.; Dwyer, R.G.; Dyer, C.; Ebrahim, Z.; Edgar, O.; Egan, G.; Ellis, L.; Evans, S.; Farrell, H.; Faulkner, L.; Fedoroff, J.P.; Felthous, A.; Ferguson, E.; Fetterolf, F.; Fischer, C.; Fisher, K.; Foellmi, M.; Foerschner, A.; Fozdar, M.; Frances, A.; Frank, J.; Fresenius, A.; Frierson, R.; Frischer, K.; Gaby, L.; Gambow, G.; Gangahar, D.; Genova, N.; Georgakas, J.; Gerritsen, L.; Gervais, R.; Glancy, G.; Glezer, A.; Gold, L.; Gonzalez, L.; Gordon, J.; Gottfried, E.; Graham, D.; Graham, N.; Granacher, R.; Green, V.; Gregoire, C.; Griffith, E.; Griffith, J.; Grover, M.; Gulrajani, C.; Gutheil, T.; Guyton, M.; Hager, T.; Hall, R.; Hand, S.; Hart, K.; Hatters Friedman, S.; Hoge, K.; Holmberg, T.; Holoyda, B.; Holzer, J.; Howie, A.; Huang, Y.; Jain, A.; Jal, E.; Janofsky, J.; Jensen, S.; Jindal, A.; Johnson, D.; Jones, T.; Jones, J.; Jones-Jacques, M.; Joseph, A.; Judd, S.; Kapoor, R.; Kenedi, C.; Kenner, W.; Keram, E.; Kerner, J.; Khin Khin, E.; Kirwin, P.; Klein, C.; Knoll, J.; Kolla, N.; Korenis, P.; Kornbluh, R.; Krause, M.; Krueger, R.; Kuntz, L.; Kushner, D.; Lam, D.; Lamoureux, I.; Lang, M.; Leidenfrost, C.; Leonard, C.; Levin, A.; Levitt, G.; Lewis, A.; Lewis, E.T.; Lluberes, N.; Lopez, C.; Ly, T.; Lyons, C.; Mammen, O.; Marasa, L.; Marshall, P.; Martin, P.; Martinez, R.; Martinez, S.; Martone, C.; Maskel, L.; Matlasz, T.; Matto, M.; McArthur, S.; McClung, M.; McCoy, B.; McCoy, K.; McCully, J.; McDermott, B.; McKay, K.; McKee, S.; McNiel, D.; Metzner, J.; Meyer, J.; Michaelsen, K.; Miller, D.; Miller, K.; Minhas, H.; Mobbs, K.; Montross, C.; Morgan, P.; Morse, S.; Mossman, D.; Mroczkowski, M.; Mufti, M.; Murakami-Brundage, J.; Murphy, L.; Nadaban, G.; Nanton, A.; Naqvi, H.; Neumann, C.; Newman, A.; Newman, W.; Nissan, D.; Norko, M.; O'Leary, P.; Orman, R.; Parker, G.; Patel, R.; Penn, J.; Peterson, S.; Piel, J.; Pinals, D.; Prabhu, M.; Pratt, J.; Preziosi, S.; Puckett, K.; Puthumana, K.; Ramachandran, G.; Ramshaw, L.; Rao, S.; Rasmussen, K.; Ravven, S.; Read, S.; Recupero, P.; Regehr, C.; Reid, W.; Reiss, P.; Remmert, B.; Resnick, P.; Rioja, V.; Ritchie, E.; Rivera, W.; Roberts, V.; Rodgers, C.; Roof, J.; Rosenbaum, K.; Rosenfeld, B.; Rosin, R.; Rosmarin, D.; Rotter, M.; Rummans, T.; Ryan, E.; Sageman, M.; Salas, A.; Saleh, F.; Saphier, D.; Scalco, M.; Schak, K.; Schouten, R.; Schutt, P.; Secarea, C.; Sethi, S.; Shah, N.; Shak, N.; Shankar, C.; Shen, F.; Shepherd, C.; Shivale, S.; Shraberg, D.; Shugarman, R.; Sidhu, N.; Smith, K.; Soliman, S.; Sonnier, L.; Sorrentino, R.; Spanggaard, M.; Sparr, L.; Sperry, L.; Stankowski, J.; Stark, A.; Steele, I.; Stolar, A.; Strockbine, B.; Subedi, B.; Swartz, M.; Tamburello, A.; Tan, D.; Tatugade, A.; Thom, R.; Thompson, C.; Thrower, N.; Torres, F.; Trestman, R.; Turkel, S.; Van Amsterdam, J.; Vanderpool, D.; Velasquez, S.; Wagoner, R.; Walker, K.; Walkup, J.; Wall, B.; Wasser, T.; Waugh, S.; Way, B.; Weinstock, R.; Weisman, R.; Weiss, K.; Weller, J.; Westbrook, S.; Westmoreland, P.; Westphal, A.; Wollert, R.; Wygant, D.; Yarnell, S.; Yeaw, J.; Zito, A.; 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, S.; Ash, P.; Billick, S.; Dike, C.; Fedoroff J.P.; Frierson, R.; Gold, L.; Greiner, C.; Holoyda, B.; Holzer, J.; Johnson, N.; Kaempf, A.; Kapoor, R.; Keram, E.; Knoll J.; Krueger, R.; Lee, L.; Leong, G.; Lewis, C.; Lewis R.; Ostermeyer, B.; Newman, A.; Newman, W.; Noffsinger, S.; Parker, G.; Pinals, D.; Preven, D.; Price, M.; Rai, S.; Reichlin, S.; Resnick, P.; Rosmarin, D.; Ryan, E.; Schiffman, E.; Scott, C.; Silberberg, J.; Sokolov, G.; Srinivasaraghavan, J.; Stolar, A.; Thompson, C.; Wagoner, R.; Weinstock, R.; 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.

Gary Chaimowitz, MBChB: Received speaker honoraria and research grant from Janssen Pharmaceuticals and speaker honoraria from Sunvion Pharmaceuticals, Inc.

Niel Kaye, MD: Received speaker honoraria from Janssen Pharmaceuticals, Inc.

SPECIAL EVENTS

THURSDAY, OCTOBER 27

Past Presidents' Breakfast	7:00 a.m. – 8:00 a.m.	Director's Suite, 3rd Floor
Opening Ceremony - President's Address (open to all attendees)	8:00 a.m. – 10:00 a.m.	Ballroom I, Ballroom Level
Association of Directors of Forensic Psychiatry Fellowships Reception (for fellowship program faculty, fellows, and potential applicants)	6:00 p.m. – 7:00 p.m.	Ballroom II Ballroom Level
Women of AAPL Reception	9:00 p.m. – 10:00 p.m.	Broadway IV, Plaza Level
Presidential Symposium	7:00 p.m. – 9:00 p.m.	Ballroom I Ballroom Level

FRIDAY, OCTOBER 28

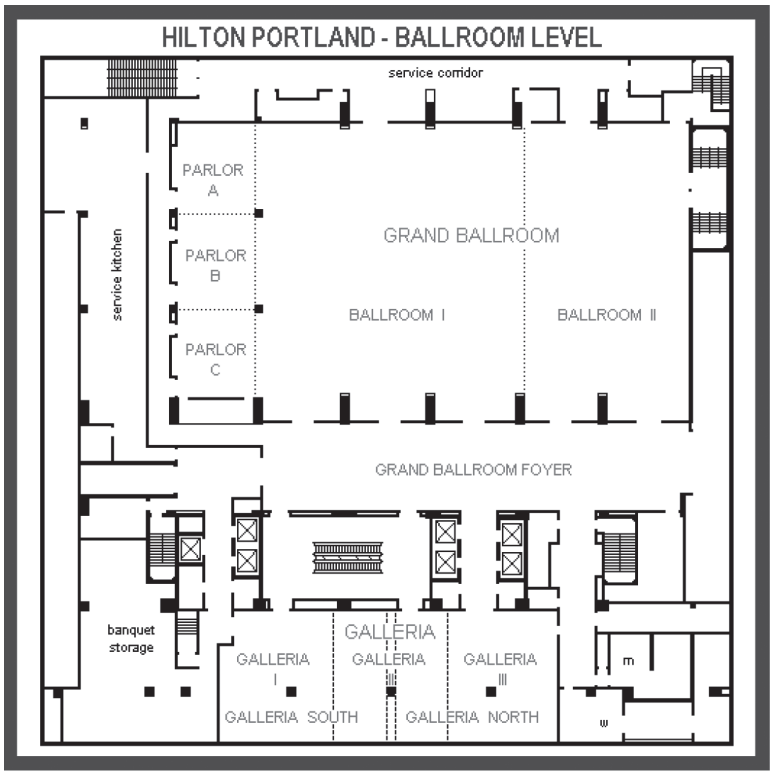
Rappeport Fellows Breakfast (Rappeport Fellows and Committee)	7:00 a.m. – 8:00 a.m.	Director's Suite, 3rd Floor
Reception (for all meeting attendees)	6:00 p.m. – 7:30 p.m.	Ballroom II Ballroom Level

SATURDAY, OCTOBER 29

Early Career Development and Fellows Breakfast (for those in the first seven years after training and current fellows)	7:00 a.m. – 8:00 a.m.	Ballroom III-IV, Ballroom Level
AAPL Business Meeting (members only)	8:00 a.m. – 9:30 a.m.	Ballroom I Ballroom Level
Mid-West AAPL Chapter Meeting (Chapter Meetings by request only, please contact AAPL Staff)	6:00 p.m. – 7:00 p.m.	Broadway IV, Plaza Level

COFFEE BREAKS WILL BE HELD IN THE PLAZA FOYER

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


HILTON PORTLAND - BALLROOM LEVEL
service corridor
PARLOR A
PARLOR B
PARLOR C
GRAND BALLROOM
BALLROOM I
BALLROOM II
service kitchen
GRAND BALLROOM FOYER
banquet storage
GALLERIA
GALLERIA I
GALLERIA II
GALLERIA III
GALLERIA SOUTH
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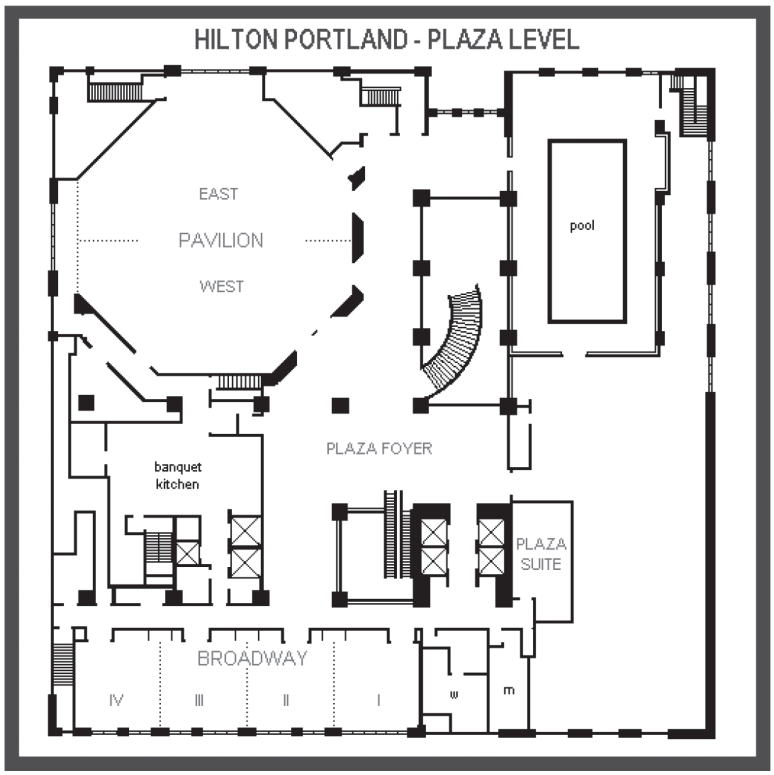
HILTON PORTLAND - PLAZA LEVEL
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banquet kitchen
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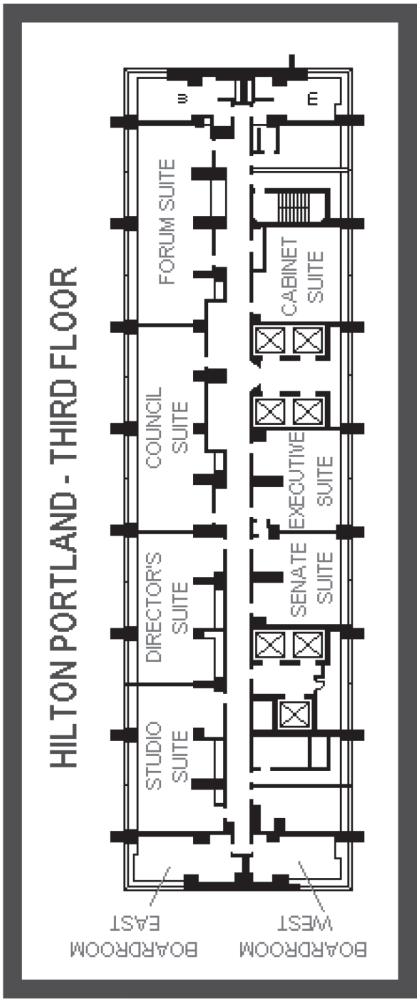
HILTON PORTLAND - THIRD FLOOR
FORUM SUITE
CABINET SUITE
COUNCIL SUITE
EXECUTIVE SUITE
DIRECTOR'S SUITE
SENATE SUITE
STUDIO SUITE
BOARDROOM EAST
BOARDROOM WEST

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-seventh Annual Meeting

OPENING CEREMONY

Thursday, October 27, 2016
8:00 a.m. - 10:00 a.m.

WELCOME, INTRODUCTIONS — Emily Keram, MD, *President*

PRESENTATION OF RAPPEPORT FELLOWS — Susan Hatters Friedman, MD; Britta Ostermeyer, MD, *Co-Chairs, Rappeport Fellowship Committee*

Lara Cox, MD, MS
New York University

William Connor Darby, MD
UCLA Semel Institute for Neuroscience

Christopher Fischer, MD
University of Southern California

Ariana Nesbit, MD
Harvard Medical School

Jason Quinn, MD
University of Toronto

Rocksheng Zhong, MD
University of Pennsylvania

AWARD PRESENTATIONS

Golden Apple Award
John Bradford, MB

Seymour Pollack Award
Richard Frierson, MD

Red Apple Awards
Charles Dike, MD
Marilyn Price, MD

Amicus Awards
Kristin Loney
Marie Westlake

Award for Outstanding Teaching in a Forensic Fellowship Program
Ryan Shugarman, MD

Young Investigator Award
Seth Judd, DO

Andrew Kaufman, MD
Chair, Research Committee

2015 Poster Awards
David Bobb, Jr., MD
Samuel House, MD

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

OVERVIEW OF THE PROGRAM — Charles Dike, MD, *Chair, Program Committee*

INTRODUCTION OF THE PRESIDENT — Sally Johnson, MD

PRESIDENT'S ADDRESS — Emily Keram, MD

ADJOURNMENT — Charles Dike, MD, *Chair, Program Committee*

AWARD RECIPIENTS

RED AAPL OUTSTANDING SERVICE AWARDS

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

CHARLES DIKE, MD

Charles Dike, MD has contributed greatly to AAPL over the years. He was a member of the Education Committee from 2002-2006. He chaired the Ethics Committee from 2007 to ¬2013. He has served the Journal of the American Academy of Psychiatry and the Law (JAAPL) in several roles. Dr. Dike has been a peer reviewer for the journal since 2003. He was the Assistant to the Editor from 2005-2008. Last year he was appointed to the Editorial Board. Dr. Dike served as the Newsletter Editor from 2008-2016, and oversaw a steady transition toward a more academically oriented, evidenced based approach to selected articles. At the same time, he initiated and expanded important sections of the Newsletter, such as Faces of AAPL and Ask an Expert that have been particularly relevant to younger members seeking mentorship and practical advice from the organization. He became chair of the Forensic Services Committee during 2015. Dr. Dike was AAPL's Allied Organization Representative to the APA's Ethics Committee from 2008-2009. He is the Program Chair for the 2016 annual AAPL meeting. AAPL has been the beneficiary of Dr. Dike's academic work as well. He has presented at 12 annual meetings and has published articles in both JAAPL and in the newsletter. Dr. Dike completed medical school in Nigeria, specialist training in psychiatry in England and in the USA and a Masters of Public Health at the University of Illinois. He completed his forensic fellowship training at Yale, and is now Associate Program Director of the Law and Psychiatry Fellowship Program. He is also Medical Director, Office of the Commissioner, Connecticut Department of Mental Health and Addiction Services. Dr. Dike has brought to AAPL an international perspective on ethics and correctional psychiatry that has meaningfully broadened the experience and knowledge base of AAPL members.

MARILYN PRICE, MD

Marilyn Price, MD became the founding member of the Gender Issues Committee during 1999, which was her first year of AAPL membership. The following year she became the founding chair of the Law Enforcement Liaison Committee and served as chair of the committee until 2005. Dr. Price began serving on the Education Committee in 2005 and served as chair from 2005 through 2011. During that time she was responsible for the successful reaccreditation of AAPL as a provider of continuing medical education for our profession. Dr. Price was involved in several extensive accreditation efforts over many years on this committee. She continues to serve as a member of the education committee presently and is actively involved in working with the Self-Assessment Task Force. She has also served as Chair of the Program Committee in 2009. Dr. Price has served as an Associate Editor for the Journal of the American Academy of Psychiatry and the Law from 2006 through 2012. She also contributed to the development of the practice guidelines within AAPL. She contributed to the disability guidelines by providing information regarding the fitness of duty of police officers and physicians, areas of her particular expertise. She also contributed to the forensic assessment guidelines. She served as an active and contributing member of the Guttmacher Award Committee from 2006 through 2008 and served as chair from 2008 through 2012. The Guttmacher award is jointly administered by both The American Academy of Psychiatry and the Law and the American Psychiatric Association. AAPL has recognized Dr. Price's many contributions by electing her to office as Councilor, Treasurer and Vice President. Not a year has gone by since Dr. Price joined AAPL that she has not contributed in multiple ways to the advancement of our organization. She clearly merits the Red Apple Award.

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.

JOHN BRADFORD, MBCHB

John Bradford, MBChB has contributed significantly to forensic psychiatry in North America and internationally. He has also been President of the American Academy of Psychiatry and the Law and has served on numerous AAPL committees. Dr. Bradford founded the Canadian Academy of Psychiatry and the Law. In addition to having received awards that are too numerous to mention, Dr. Bradford has also received recognition from the Canadian Psychiatric Association for his contribution to the National Strategy in Postgraduate Education working group. Due to his extensive curriculum vitae, only a sampling of Dr. Bradford's wide range of contributions to the field of forensic psychiatry will be summarized. He was an Advisor to the Sexual Disorders Workgroup for DSM IV (1991-1994) as well as being an International Advisor to the APA Task Force on DSM-IV. Dr. Bradford was a consultant to the working group of the Canadian Conference of Catholic Bishops to propose guidelines for priests who were involved in sexual abuse (1991-1992). He was a member of the Ontario Ministry of Health's forensic operations committee for mental health programs and services. He was the chair of the Ontario forensic directors group for 12 years beginning in 2000. He has been actively involved with the World Federation of Societies of

Biological Psychiatry in developing guidelines for the biological treatment of paraphilias. Due to limitation of space, a summary of Dr. Bradford's extensive participation in research grants and his voluminous publications will not be provided other than to indicate that a major focus has been on diagnosis and treatment of sexual deviation as well as other aspects of forensic psychiatry.

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.

RYAN SHUGARMAN, MD

Ryan Shugarman, MD is the 2016 awardee of the best junior faculty teacher (<10 years) in a forensic fellowship program. After completing a forensic psychiatry fellowship program at the University of Pittsburgh Medical Center in 2009, he relocated to the Washington, D.C. area to work at Saint Elizabeth's Hospital, where he has been teaching actively and holds a formal faculty appointment in the hospital's forensic psychiatry fellowship.

Excerpts from his nomination letter included the following:

> "As a new program, we have been eager to identify strong teachers and have truly been fortunate to have Ryan supervise and lead a number of our seminars. He has applied his training at Western Psych and his own writing and experience to topics ranging from Workers' Comp to the use of structured instruments in assessing competence to stand trial. Moreover, because he has developed expertise in assessing pilots' fitness-for-duty, he is a unique resource for our fellows during their elective time."

> "Ryan's capacity to provide historical context and structure to his presentations and supervision is a particular strength. Positive feedback from attendees in fellowship seminars comes from the entire range of fellows and forensic psychology residents, medical students and externs. They underscore his clarity and detail along with his enthusiasm and energy. "He is an exceptional educator," writes one fellow; "It is evident that he has passion for his work." Ryan's use of case reports and examples are "extremely helpful, and trace the logic and thought process behind each forensic evaluation," writes a forensic psychology resident."

Dr. Shugarman's approach is rich, varied, and creative, combining slides, video, and written materials to match student learning styles and strengths. His engagement with trainees is appreciated by faculty and students alike, and highlights his commitment to education.

SEYMOUR POLLACK AWARD

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

RICHARD FRIERSON, MD

Richard Frierson, MD completed his fellowship in forensic psychiatry at the William S. Hall Psychiatric Institute during 1993. He was named the program director for the forensic psychiatry fellowship at the University of South Carolina during 2007, where he is currently Professor of Psychiatry and Vice Chair for Education. Dr. Frierson has devoted his career to education in forensic psychiatry for almost 20 years, which has been recognized with many teaching awards. He has embraced additional duties as the Vice Chairman for Education within the Department of Neuropsychiatry and Behavioral Sciences. He is responsible for all medical student education, residency training programs, and fellowship training programs. Dr. Frierson has become a leader in his field. He has over 40 publications in national peer-reviewed journals and book chapters on various topics in general and forensic psychiatry. Dr. Frierson has been invited by various medical schools, national psychiatry organizations, and prominent legal organizations to give presentations on these topics. Dr. Frierson also served eight years on the ABPN Examination Committee in the Subspecialty of Forensic Psychiatry and an additional eight years on the Examination Committee for Recertification in Psychiatry. He assisted the Accreditation Council on Graduate Medical Education (ACGME) in the development of milestones in forensic psychiatry. Dr. Frierson is currently President of the Association of Directors of Forensic Psychiatry Fellowships (ADFPF). He is also a Co-Chair of the AAPL Education Committee where he has worked tirelessly to improve the educational mission of AAPL and he is a former recipient of the Red AAPL award for service to AAPL.

AMICUS AWARDS

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

KRISTIN LONEY

Before joining AAPL in 2007, Kristin Loney rose quickly through the ranks of Kaman Music Corporation, maker of musical instruments, and especially known for their guitars. As Artist Relations Administrator, she got to travel around the United States, supplying Ovation, Takamine and Hamer guitars to musical artist of all genres. While organizing and handling artists, Kristin learned a lot of the skills that she has been able to apply in her relations with AAPL members. Unfortunately, the AAPL "green room" doesn't contain all the amenities she experienced in her earlier career. Kristin joined AAPL at a crucial time in our history, in that as AAPL and our activities grew, she was able to develop time-saving and efficient processes to enable us to economically, but efficiently serve our growing diverse membership. We are sorry to note however, that Kristin will be leaving us soon to become a fulltime mother to a baby girl, whose name she has not divulged. We think AAPL has prepared her well for the complexities of raising a family.

MARIE WESTLAKE

Marie Westlake joined AAPL eighteen years ago after a career at the Connecticut Children's Medical Center. She worked there as Manager of the Department of Psychiatry and then as Graduate and Postgraduate Medical Education Coordinator in the Department of Pediatrics. She has been involved with AAPL's CME efforts since she began. She coordinates all the recordkeeping and reporting for meetings, courses, and Maintenance of Certification, such as the Self-assessment exam. She also manages financial operations and the website. In 2000, Marie was named Associate Executive Director of AAPL. From the start Marie distinguished herself as the one to learn each new software program and teach it to others. The past several years have seen many revolutions in software and hardware and integrating new processes into AAPL's operations has become her task. Outside of work, Marie's passion is equine rescue. She has volunteered as barn manager, board member, and senior volunteer, training other volunteers. Her own rescue horse is "Sassy Una," affectionately known as Annie.

DISTINGUISHED LECTURERS

Thursday, October 27

ZAK EBRAHIM

The Terrorist's Son: My Path to Peace

Zak Ebrahim was only seven years old when, on November 5, 1990, his father, El-Sayyid Nosair, shot and killed the leader of the Jewish Defense League. While in prison, Nosair helped plan the bombing of the World Trade Center in 1993. In one of his infamous video messages, Osama bin Laden urged the world to "Remember El-Sayyid Nosair." For Ebrahim, a childhood amid terrorism was all he knew. After his father's incarceration, his family moved more than twenty times, haunted by and persecuted for the crimes of his father. Though his radicalized father and uncles modeled fanatical beliefs, the hateful ideas never resonated with the shy, awkward boy. The older he grew, the more fully Ebrahim grasped the horrific depths of his father's acts. The more he understood, the more he resolved to dedicate his life to promoting peace. In his book, The Terrorist's Son: A Story of Choice, Ebrahim traces his remarkable journey to escape his father's terrible legacy. Crisscrossing the eastern United States, from Pittsburgh to Memphis, from a mosque in Jersey City to the Busch Gardens theme park in Tampa, The Terrorist's Son is the story of a boy inculcated in dogma and hate—a boy presumed to follow in his father's footsteps—and the man who chose a different path.

Friday, October 28

EMMANUEL JAL

Story of a Warchild

Emmanuel Jal was born into the life of a child soldier on an unknown date in the early 1980s in the war-torn region of Southern Sudan. Through unbelievable struggles, Emmanuel managed to survive and go on to emerge as a recording artist, achieving worldwide acclaim for his unique style of hip hop with its message of peace and reconciliation born out of his personal experiences. Despite his accomplishments in music and film, one of Emmanuel's biggest passions is Gua Africa, the charity he has founded to work with individuals, families and communities to help them overcome the effects of war and poverty. Besides building schools, the charity provides scholarships for Sudanese war survivors in refugee camps and sponsors education for children in the most deprived slum areas in Nairobi. Gua Africa is now fundraising to complete phase 2 of Emma Academy, the education center in Leer named after the British aid worker, Emma McCune, who rescued Emmanuel from a life as a child soldier. In 2010, Jal released "We Want Peace," as part of the wider campaign of the same name calling for peace, protection and justice for all in Sudan. In 2012 he organized and hosted the first of its kind Peace Dinner and Concert in Juba, South Sudan.

Saturday, October 29

ATTORNEY CHRISTY LOPEZ

Transforming the Police: The Department of Justice Civil Rights Division and Police Accountability

Christy E. Lopez is a Deputy Chief in the Civil Rights Division of the U.S. Department of Justice. Ms. Lopez heads the Special Litigation Section's police practice group, which has primary responsibility for conducting "pattern-or-practice" investigations of law enforcement agencies. Ms. Lopez led the team that investigated the Ferguson Police Department and is the primary drafter of the Ferguson Report. She is currently leading the team investigating the Chicago Police Department. She also led the investigations of the New Orleans Police Department, the Los Angeles Sheriff's Department, the Newark (New Jersey) Police Department, and the Missoula, Montana investigation, which was the Division's first investigation focusing on the collective law enforcement response to allegations of sexual assault. Ms. Lopez was also the Deputy Chief overseeing the Division's recent successful litigation against the towns of Colorado City (Arizona) and Hildale (Utah), in which a jury found that the towns' law enforcement agency enforced the edicts of the a religious sect rather than the rule of law. Ms. Lopez helped formulate and draft the DOJ statement of interest in the Floyd litigation challenging the New York Police Department's stop-and-frisk practices. Christy received her B.A. from the University of California, Riverside, and her J.D. from Yale Law School. She clerked for Alaska Supreme Court Justice Robert L. Eastaugh from 1994 to 1995.

THURSDAY, OCTOBER 27, 2016

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

T1 ***Social Media and Patient Self-Disclosure: A Teaching Moment***
Jennifer Piel, MD, JD, Seattle, WA

T2 ***Amygdala Morphology in Antisocial Personality Disorder***
Nathan Kolla, MD, PhD, Toronto, ON, Canada
Raihaan Patel, BSc, (I) Montreal, PQ, Canada
Mallar Chakravarty, PhD, (I) Montreal, PQ, Canada
Jeffrey Meyer, MD, PhD, (I) Toronto, ON, Canada

T3 ***Karsjens vs. Minnesota Department of Human Services***
Matthew Kruse, MD, Minneapolis, MN
Chinmoy Gulrajani, MBBS, Minneapolis, MN

T4 ***Trauma Among Individuals Charged with a Sexual Offense***
Emily Gottfried, PhD, (I) Charleston, SC
E. Thomas Lewis, III, MD, Charleston, SC
Sheresa Christopher, PhD, (I) Charleston, SC
Keilan Christopher, (I) Albany, NY
R. Gregg Dwyer, MD, EdD, Charleston, SC

T5 ***PTSD/TBI and Capacity in Sensitive Occupations***
Jacob Holzer, MD, Belmont, MA
Joanna Georgakas, (I) Belmont, MA
Juliana Van Amsterdam, (I) Montreal, QC, Canada
Nina Shak, (I) Middlebury, VT

T6 ***Characteristics in Individuals who Pose Security Risks***
Jacob Holzer, MD, Belmont, MA
WIlliam Costanza, DLS, (I) Arlington, VA

T7 ***Facial Affect Perception and the Incompetent Defendant***
Ashlee Zito, PhD, (I) Atlanta, GA
Stephanie Chastang, (I) Atlanta, GA
Ginny Chan, (I) Atlanta, GA
Amy Gambow, PhD, (I) Atlanta, GA
Brittany Remmert, PsyD, (I) Atlanta, GA
Katharine Miller, MA, (I) Atlanta, GA
Glenn Egan, PhD, (I) Atlanta, GA
Victoria Roberts, MEd, (I) Atlanta, GA
Peter Ash, MD, Atlanta, GA

T8 ***Challenges: Trauma-Informed Care and Competency Restoration***
Joy Stankowski, MD, Cleveland, OH

T9 ***Malingering: A Result of Trauma or Civil Litigation?***
Lauren Marasa, MD, Lexington, KY
David Shraberg, MD, Lexington, KY
Timothy Allen, MD, Lexington, KY

T10 ***New Gun Control Measures Pertaining to the Mentally Ill***
Eindra Khin Khin, MD, Washington, DC
Tyler Byrd, MD, (I) Oneonta, AL

T11 ***A Model for Teaching Forensic Asylum Evaluations***
Eindra Khin Khin, MD, Washington, BC
Carol Ann Dyer, MD, (I) Washington, DC
Julia Frank, MD, (I) Washington, DC
Lynne Gaby, MD, (I) Washington, DC
James Griffith, MD, (I) Washington, DC
Anjali Jindal, MD, (I) Annandale, VA

T12 ***Animal Cruelty to Violent Crimes: Biopsychosocial Approach***
Gowri Ramachandran, MD, Washington, DC
Eindra Khin Khin, MD, Washington, DC

T13 ***Humanitarian Asylum and the Role for Forensic Psychiatrists***
Drew Calhoun, MD, Pittsburgh, PA
Nubia Lluberes, MD, Pittsburgh, PA
Sheila Velez Martinez, JD, (I) Pittsburgh, PA
Abhishek Jain, MD, Pittsburgh, PA

T14 ***The Brain of a Sociopath: What We Know Now***
Ian Steele, MD, (I) Boston, MA
Fabian Saleh, MD, Boston, MA

T15 ***Between an Ethical Rock and an Institutional Hard Place***
Margarita Abi Zeid Daou, MD, (I) Nashville, TN
William Kenner, MD, (I) Nashville, TN

T16 ***Oregon State Hospital Forensic Evaluations: 2006-2015***
Joseph Chien, DO, Marylhurst, OR
Mandy Davies, PsyD, (I) Marylhurst , OR
Emily Demarco, MD, (I) Marylhurst, OR
Karl Mobbs, MD, Wilsonville, OR

T17 ***Je Ne Regrette Rien: The Use of Remorse in Psychiatry and Law***
Jorge Castillo, MD, Syracuse, NY
James Knoll IV, MD, Syracuse, NY
Bruce Way, PhD, (I) Syracuse, NY

T18 ***Epidemiology Among Forensic Psychiatric Examinees in Central Taiwan***
Yu-Fei Huang, MD, (I) Taiwan

T19 ***Psychological Autopsies of Mass-Shooters' Online Lives***
Chelsea Bucina, BSc, (I) Portland, OR
Karlee McCoy, BA, (I) Hillsboro, OR
Leonardo Bobadilla, PhD, (I) Hillsboro, OR

T20 ***Closing the Revolving Door: Denial of Commitment Petitions***
Navneet Sidhu, MD, Washington, DC
Philip Candilis, MD, Washington, DC

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

T21 ***Trauma and Transformation: The History and Future of Child Soldiers***
Emily Keram, MD, Santa Rosa, CA

COFFEE BREAK **10:00 AM – 10:15 AM**

PANEL 10:15 AM - 12:00 PM **BALLROOM I**

T22 ***Balancing Conflicting Duties in Forensic Ethics Dilemmas***
Robert Weinstock, MD, Los Angeles, CA
William Darby, MD, Santa Monica, CA
Ezra Griffith, MD, New Haven, CT
Michael Norko, MD, New Haven, CT

PANEL 10:15 AM - 12:00 PM **PAVILION EAST**

T23 ***Do All Roads Lead to Rome? Empathy in Autism and Psychopathy***
Child and Adolescent Psychiatry Committee
Camilla Lyons, MD, MPH, Bedford, NY
Alexander Westphal, MD, New Haven, CT
Eileen Ryan, DO, Staunton, VA
Laurie Sperry, PhD, (I) New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT

WORKSHOP — 10:15 AM - 12:00 PM — **PAVILION WEST**

T24 ***Suicide Terrorism – The Psychology and Gender Differences***
Suicidology and Gender Issues Committees

Anna Glezer, MD, San Francisco, CA
Joseph Penn, MD, Conroe, TX
Hassan Naqvi, MD, Atlanta, GA

PANEL — 10:15 AM - 12:00 PM — **GALLERIA**

T25 ***Internet Crimes Against Children: A Forensic Analysis***
Sexual Offenders and Liaison with Forensic Sciences Committees

Karen B. Rosenbaum, MD, New York, NY
R. Gregg Dwyer, MD, EdD, Charleston, SC
D.J. Barton, MS, (I) Columbia, SC
J. Paul Fedoroff, MD, Ottawa, ON, Canada

WORKSHOP — 10:15 AM - 12:00 PM — **BROADWAY I-III**

T26 ***Miss Mary: A Journey of Trauma and Transformation***

Sherif Soliman, MD, Hinckley, OH
Cathleen Cerny, MD, Seven Hills, OH
Cheyenne Shepherd, (I) Kokomo, IN

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

T27 ***The Terrorist's Son: My Path to Peace***

Zak Ebrahim, (I) New York, NY

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

T28 ***Putting the "Super" in Supervision***
Early Career Psychiatry Committee

Andrew Nanton, MD, Tualatin, OR
Susan Hatters Friedman, MD, Cleveland Heights, OH
Phillip Resnick, MD, Cleveland, OH
Thomas Gutheil, MD, Brookline, MA

COURSE (TICKET REQUIRED) — 2:15 PM - 6:15 PM — **PAVILION EAST**

T29 ***Forensic Evaluations in the Elderly***
Geriatric Psychiatry and the Law Committee

Sherif Soliman, MD, Hinckley, OH
Stephen Read, MD, San Pedro, CA
Philip Marshall, MS, (I) Bristol, RI

WORKSHOP — 2:15 PM - 4:00 PM — **PAVILION WEST**

T30 ***Hospital Security Officer Weapon Use: Is it Ever Appropriate?***

Jeffrey Janofsky, MD, Timonium, MD
Michael Champion, MD, Honolulu, HI
Ken Hoge, MD, New York, NY
Debra Pinals, MD, Ann Arbor, MI

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

T31 ***In The Name of God: Evaluating Perilous Belief***

Brian Holoyda, MD, MPH, Sacramento, CA
James Knoll IV, MD, Syracuse, NY
William Newman, MD, Saint Louis, MO
Jason Roof, MD, Sacramento, CA

PANEL — 2:15 PM - 4:00 PM — **BROADWAY I-III**

T32 ***Forensic Aspects of Subcortical Dementias: A Primer***
Forensic Neuropsychiatry Committee

Manish Fozdar, MD, Wake Forest, NC
Timothy Allen, MD, Lexington, KY
Robert Granacher, MD, MBA, Lexington, KY
Jacob Holzer, MD, Belmont, MA

COFFEE BREAK **4:00 PM – 4:15 PM**

PANEL 4:15 PM - 6:15 PM **BALLROOM I**

T33 APA Council on Psychiatry and Law: An Update

Ken Hoge, MD, New York, NY
Marvin Swartz, MD, Durham, NC
Debra Pinals, MD, Ann Arbor, MI
Stuart Anfang, MD, Longmeadow, MA

PANEL 4:15 PM - 6:15 PM **PAVILION WEST**

T34 Lessons From Psychiatrists Who Were Stalked

George David Annas, MD, MPH, Syracuse, NY
Kevin Smith, MD, Saugerties, NY
James Knoll IV, MD, Syracuse, NY
William Newman, MD, Saint Louis, MO
Sandra Antoniak, MD, Kingston, NY

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

T35 Development-Trauma Nexus: Psychiatric and Behavioral Effects

Lucas Bachmann, MD, New Haven, CT
Hassan Minhas, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Josephine Buchanan, BA, (I) New Haven, CT

SCIENTIFIC PAPER SESSION/RESEARCH-IN-PROGRESS #1 4:15 PM - 6:15 PM **BROADWAY I-III**

T36 Sex Offenders in the Digital Age

Eric Chan, MD, San Francisco, CA
Dale McNiel, PhD, ABPP, (I) San Francisco, CA
Renee Binder, MD, San Francisco, CA

T37 Court-Ordered Evaluations from a Mental Health Court

Seth Judd, DO, Indianapolis, IN
George Parker, MD, Indianapolis, IN

T38 The Greats: Expertise in Forensic Psychiatry

Graham Glancy, MB, Toronto, ON, Canada
Daniel Miller, MPH, (I) Toronto, ON, Canada

T39 Training Residents in the Digital Age: A Survey

Natasha Thrower, MD, Boston, MA
Fabian Saleh, MD, Boston, MA

PRESIDENTIAL SYMPOSIUM 7:00 PM - 9:00 PM **BALLROOM I**

T40 Police Response to Persons with Mental Illness

Emily Keram, MD, Santa Rosa, CA
Chief Louis Dekmar, (I) LaGrange, GA
Debra Pinals, MD, Ann Arbor, MI
Commander Sara Westbrook, (I) Portland, OR

Your opinion on today's sessions is very important!
While it's fresh in your mind, PLEASE complete the evaluation form for today's program so we can continue to offer CME in the future.

T1 SOCIAL MEDIA AND PATIENT SELF DISCLOSURE: A TEACHING MOMENT

Jennifer Piel, MD, JD, Seattle, WA

EDUCATIONAL OBJECTIVE

Social media presents both opportunities and potential pitfalls for our patients. This poster reviews results of a pilot study of mental health clinicians' knowledge of social media, inquiry into their patients' online behaviors, and efforts to educate their patients about their use of social media.

SUMMARY

Patients are increasingly coming into contact with social media tools. Some social media venues offer easily-accessible information that can support or educate patients with mental health conditions. Others offer platforms for patients to discuss their symptoms or concerns. Little is known about the discussions mental health clinicians are having with their patients about their use of social media in disclosing personal information about their mental health. For this poster, the author surveyed a group of mental health clinicians about their familiarity with social media resources, whether they ask patients about their social media presence, and whether they discuss with their patients the utility and risks associated with posting personal information to social media sites. Few clinicians in this study ask their patients about posting mental health information on social media platforms. Clinicians are most likely to discuss the pros and potential pitfalls with a patient when prompted by a specific patient concern about their recent public disclosures. Survey respondents reported high variability in their comfort level in discussing the relative benefits and risks in using these platforms. The author provides a series of suggested screening questions for clinicians to focus the discussion of patients' online presence.

REFERENCES

Housen M, Borycki E, Kushniruk A: Empowering patients through social media: the benefits and challenges. Health Inform J 20(1):50-55, 2014

JM Faman, LS Sulmasy, BK Worster, et al: Online medical professionalism: patient and public relationships: policy statement from the American College of Physicians and the Federation of State Medical Boards. Ann Intern Med 158(8): 620-627, 2013

QUESTIONS AND ANSWERS

1. In this survey of mental health clinicians, the majority of respondents stated that they inquired about a patient's online presence at what regularity?

a. Never
b. Rarely
c. Sometimes
d. Frequently

ANSWER: b

2. Which of the following is a potential risk to patients who disclose personal mental health information over social media?

a. Obtain information about their illness.
b. Exchange information between like-minded individuals.
c. Unintended privacy and security concerns.
d. Destigmatize illness.

ANSWER: c

T2 AMYGDALA MORPHOLOGY IN ANTISOCIAL PERSONALITY DISORDER

Nathan Kolla, MD, PhD, Toronto, ON, Canada
Raihaan Patel, BSc, (I) Montreal, PQ, Canada
Mallar Chakravarty, PhD, (I) Montreal, PQ, Canada
Jeffrey Meyer, MD, PhD, (I) Toronto, ON, Canada

EDUCATIONAL OBJECTIVE

To learn about genetic influences regulating brain structures that are implicated in the pathogenesis of aggression.

SUMMARY

Antisocial personality disorder (ASPD) is linked to violent offending. Morphological abnormalities of the amygdala, a key emotion processing region, are seen in individuals with ASPD and low monoamine oxidase A (MAO-A) is also present. It is currently unknown whether amygdala morphology in ASPD relates to specific MAO-A genetic polymorphisms. We studied 18 males with ASPD and 20 healthy male controls. Genomic DNA was extracted from peripheral leukocytes with MAO-A genetic polymorphisms determined using standard PCR procedures. Each subject

underwent a T1-weighted MRI anatomical brain scan. Results revealed a group × genotype interaction for the left amygdala (t=4.14, p=0.0002, FDR 5%, df=32), such that ASPD subjects with MAOA-L had decreased surface area on the anterolateral aspect of the left amygdala and increased surface area on the posteromedial aspect of the left amygdala (t=2.89, p=0.0069, FDR 10%). No group differences were observed among carriers of the high MAO-A (MAOA-H) allele. This is the first study to describe genotype-related morphological differences of the amygdala in a clinical population marked by high aggression and violence. Deficits in emotional regulation that contribute to the violence of ASPD may relate to morphological abnormalities of emotion processing regions under genetic control.

REFERENCES

Boccardi M, Frisoni GB, Hare RD, et al: Cortex and amygdala morphology in psychopathy. Psych Res 193(2):85-92, 2011
Kolla NJ, Matthews B, Wilson AA, et al: Lower monoamine oxidase-a total distribution volume in impulsive and violent male offenders with antisocial personality disorder and high psychopathic traits: an [(11)C] harmine positron emission tomography study. Neuropsychopharmacology 40(11):2596-2603, 2015

QUESTIONS AND ANSWERS

1. Which of the following combinations in males has been shown in meta-analysis to increase risk of violence?
a. Low MAO-A allele and no history of childhood abuse.
b. Low MAO-A allele and history of childhood abuse.
c. High MAO-A allele and no history of childhood abuse.
d. High MAO-A allele and history of childhood abuse.
ANSWER: b

2. Which of the following is a physiological function of MAO-A?
a. Dopamine metabolism
b. Increase cellular oxidative stress level
c. Facilitating the induction of apoptotic pathways
d. All of the above
ANSWER: d

T3 KARSJENS VS. MINNESOTA DEPARTMENT OF HUMAN SERVICES

Matthew Krause, MD, Minneapolis, MN
Chinmoy Gulrajani, MBBS, Minneapolis, MN

EDUCATIONAL OBJECTIVE

The poster will allow readers to describe difficulties in the Minnesota Sex Offender Program, discuss why the Minnesota Sex Offender Program was deemed unconstitutional in Karsjens vs. Minnesota Department of Human Services and review basic standards for sex offender civil commitment as outlined in Kansas vs. Hendricks.

SUMMARY

In Kansas vs. Hendricks, the U.S. Supreme Court found involuntary confinement of sex offenders for the purpose of treatment was constitutional, establishing a "wide latitude" for states to develop their own sex offender treatment programs. The current Minnesota Sex Offender Program (MSOP) was established in 1994. Since then, the program's committed population at its two secure facilities has grown substantially as have the program's problems. There are no less restrictive settings available to those committed. Since its inception, only four individuals have been provisionally discharged. The rate of commitment for sex offenders (highest per capita in the country) has left the treatment arm of the program understaffed and inadequate. Meanwhile, justification for ongoing commitment is tied to treatment progress instead of assessment of risk and there is no provision for assessment of risk at timely intervals. These issues led to a class action lawsuit (Karsjens v. Minnesota Department of Human Services) in which the MSOP in its present state was found to be unconstitutional by federal district court in 2015. In this poster, we provide a summary of this class action lawsuit and describe its impact on sex offender management in the state of Minnesota.

REFERENCES

Kansas v. Hendricks, 521 U.S. 346 (1997)
Civil Case No. 11-3659 – Karsjens et al vs. Minnesota Department of Human Services et al. Available at https://www.gpo.gov/fdsys/pkg/USCOURTS-mnd-0_11-cv-03659/content-detail.html. Accessed February 23, 2016

QUESTIONS AND ANSWERS

1. When is indefinite civil commitment of sex offenders constitutional?
a. Indefinite civil commitment is never constitutional.
b. When the risk of commitment is shown to deter others from committing sexual violence.
c. When the purpose of commitment is treatment and not punishment.
d. When criteria for ongoing commitment are proven beyond a reasonable doubt.
ANSWER: c

2. As of 2011, which of the following states has the highest rate of sexual offender commitment per capita?
a. Texas
b. New York
c. Minnesota
d. Wisconsin
ANSWER: c

T4 TRAUMA AMONG INDIVIDUALS CHARGED WITH A SEXUAL OFFENSE

Emily Gottfried, PhD, (I) Charleston, SC
E. Thomas Lewis, III, MD, Charleston, SC
Sheresa Christopher, PhD, (I) Charleston, SC
Keilan Christopher, (I) Albany, NY
R. Gregg Dwyer, MD, EdD, Charleston, SC

EDUCATIONAL OBJECTIVE

The educational objective for this project is to further research and professional service by examining the prevalence of trauma within a sample of individuals undergoing comprehensive evaluations of sexual behavior. Additionally, the relationship between trauma and the evaluator's opinion regarding dangerousness will be examined.

SUMMARY

Previous research demonstrates that men charged with a sexual offense have a high prevalence of abuse e.g., 1, 2, 3. Compared to the general population, men charged with a sexual offense are nearly twice as likely to have experienced physical abuse and three times as likely to have experienced sexual abuse during childhood. Additionally, there have been shown to be differences in abuse history between men who offend against children and those who offend against adults. The current research in progress presentation examines the prevalence of various types of trauma within a sample of individuals referred for a comprehensive sexual behavior evaluation at a large southeastern medical university. This presentation examines trauma reported during clinical interviews and elevations on a subscale of traumatic stress on a widely-used multi-scale assessment measure of personality and psychopathology. Differences in trauma histories between individuals accused of sexual offending solely against children are compared to those who are accused of offending solely against adults and those accused of offending against both children and adults. Finally, we will examine if trauma histories have a relationship with the evaluator's opinion of dangerousness and, when applicable, if the defendant meets the statutory definition of being a sexually violent predator (SVP).

REFERENCES

Levenson J, Willis G, Prescott D: Adverse childhood experiences in the lives of male sex offenders: Implications for trauma-informed care. Sexual Abuse A Journal of Research and Treatment 28(4): 1-20, 2014
Maniglio R: The role of childhood trauma, psychological problems, and coping in the development of deviant sexual fantasies in sexual offenders. Clinical Psychology Review 31(5): 748-756, 2011

QUESTIONS AND ANSWERS

1. What is the relationship between trauma and sexual offending?
ANSWER: Previous studies have suggested that individuals charged or convicted with a sexual offense have higher rates of trauma in their histories than individuals in the general population.

2. What is the relationship between trauma and the evaluator 's opinion regarding dangerousness?
ANSWER: This question has yet to be fully explored in the literature to date and this presentation aims to examine this question. The research is currently in progress.

T5 PTSD/TBI AND CAPACITY IN SENSITIVE OCCUPATIONS

Jacob Holzer, MD, Belmont, MA
Joanna Georgakas, (I) Belmont, VA
Juliana Van Amsterdam, (I) Montreal, QC, Canada
Nina Shak, (I) Middlebury, VT

EDUCATIONAL OBJECTIVE
To teach the audience about the impact of combat-related PTSD and TBI on capacity/ability to work in sensitive occupational roles such as law enforcement, security, or intelligence.

SUMMARY
Despite the growing base of knowledge in combat-related PTSD and TBI, there is very limited information on the impact of these conditions on applicants for positions in sensitive occupations such as law enforcement, security or intelligence, a particularly important topic in veterans seeking civilian positions. A growing literature on trauma re-exposure describes neurobiological changes with impact on cognition, emotions and behavior, yet a majority of combat veterans indicate they would be perceived as weak if they sought treatment. Curiously, research shows many hiring agencies did not have specific policies regarding PTSD and viewed treatment for alleviating PTSD as desirable. This poster reviews the literature and variables related to combat PTSD/TBI applicants to sensitive job positions in law enforcement, security, and intelligence.

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Hoge CW, Castro CA, Messer SC, et al: Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. NEJM 351(1):13-22, 2004

QUESTIONS AND ANSWERS
1. Related to the Ballenger-Browning study of law enforcement hiring in PTSD applicants which of the following statements is false?
a. A diagnosis of PTSD was a common reason for rejection from employment.
b. Most agencies studied did not have protocols for evaluating PTSD.
c. Alleviation of PTSD symptoms was valued in applicants.
d. If an applicant was not experiencing debilitating PTSD, they tended to be considered equally with non-PTSD candidates.
ANSWER: a

2. Which statement is accurate?
a. Deployment stressors and exposure to combat result in risks of mental health problems, including post-traumatic stress disorder (PTSD), major depression, and substance abuse.
b. Research shows that those meeting screening criteria for major depression, PTSD, or alcohol misuse were significantly higher among soldiers after deployment than before deployment, particularly with regard to PTSD.
c. Concern about stigma is a significant factor in examining barriers to treatment.
d. All of the above are accurate.
ANSWER: d

T6 CHARACTERISTICS IN INDIVIDUALS WHO POSE SECURITY RISKS

Jacob Holzer, MD, Belmont, MA
William Costanza, DLS, (I) Arlington, VA

EDUCATIONAL OBJECTIVE
To teach the audience about patterns, traits, and characteristics of people who carry a security clearance and pose a national security risk, based on a review of history of high profile cases.

SUMMARY
U.S. history is replete with examples of individuals who have, for varied reasons, breached national security and committed treason. Reasons for security breaches include greed (Robert Hanssen), acting on behalf of another country (Aldrich Ames and Jonathan Pollard), or altruism (Edward Snowden). These, and other motives, may overlap. Despite the varied causes, a review of the literature points to some common trends and factors in individuals who pose a national security risk, including being high achieving and having past contradictory and conflictual views and behaviors. This poster will review the variables, patterns and distinctions in high profile national security violation cases, and develop theories about future security risk assessment.

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Greenwald G, MacAskill E, Poitras L: Edward Snowden: The Whistleblower Behind The NSA Surveillance Revelations, London, UK: The Guardian, 2013
Pincus W: CIA: Ames Betrayed 55 Operations; Inspector General's Draft Report Blames Supervisors for Failure to Plug Leak, Washington DC: Washington Post, 1994

QUESTIONS AND ANSWERS
1. Which of the following statements are incorrect?
a. Treason and espionage are interchangeable.
b. Insurrection can be considered a sub-type of treason committed internally.
c. Edward Snowden has won several awards and recognitions since his global surveillance disclosures.
d. Robert Hanssen's early history included growing up in an abusive environment and making multiple career changes.
ANSWER: a

2. Which of the following statements are correct?
a. Warning signs for treason and heightened national security risk are not the same as for those committing mass violence in public/government settings.
b. Several high profile cases involved individuals who lost their security clearance, including a former Director of National Intelligence, having nothing to do with treason.
c. Individuals who possess a security clearance and may pose a national security risk do not neatly fit into one clinical profile or picture.
d. All of the above are correct.
ANSWER: d

T7 FACIAL AFFECT PERCEPTION AND THE INCOMPETENT DEFENDANT

Ashlee Zito, PhD, (I) Atlanta, GA
Stephanie Chastang, (I) Atlanta, GA
Ginny Chan, (I) Atlanta, GA
Amy Gambow, PhD, (I) Atlanta, GA
Brittany Remmert, PsyD, (I) Atlanta, GA
Katharine Miller, MA, (I) Atlanta, GA
Glenn Egan, PhD, (I) Atlanta, GA
Victoria Roberts, Med, (I) Atlanta, GA
Peter Ash, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE
The audience will identify the three most common emotions misperceived in others by incompetent defendants, list three ways social perception impacts competency to stand trial and identify differences and deficits in affect recognition abilities between violent and non-violent offenders.

SUMMARY
Not surprisingly, defendants found incompetent to stand trial exhibit deficits in cognitive and social functioning. Social cognition includes cognitive processes related to general intelligence and processing of social cues, including facial affect. Accurately perceiving facial affect in others enhances communication, social relatedness, and understanding of appropriate boundaries. Defendants found incompetent to stand trial typically have a major mental illness, including complex trauma, which complicates their abilities to accurately recognize facial affect. In particular, those with a formal thought disorder and history of significant trauma are more likely to recognize anger in others and misperceive benign cues that may lead to aggressive behaviors. Incompetent defendants may have trouble understanding what others are trying to communicate and instead may perceive others as threatening. Understanding how facial affect recognition is related to offending behaviors (violent versus non-violent) in incompetent defendants has implications for assessing and restoring defendants, and predicting future risk and violent recidivism. Improving affect perception may lead to a transformation in social functioning. Data will be analyzed to determine how the facial affect recognition of incompetent defendants relates to their charges and general intelligence as well as to the types of emotion portrayed.

REFERENCES
Harvey PD, Penn D: Social cognition: The key factor predicting social outcome in people with Schizophrenia? Psychiatry (Edgmont) 7(2):41-44, 2010
Wechsler D: Advanced Clinical Solutions for WAIS-IV and WMS-IV. Pearson Assessment, 2009

QUESTIONS AND ANSWERS

1. Defendants found incompetent to stand trial show which emotion?
a. fear
b. anger
c. neutral
d. surprise
ANSWER: b

2. A lesion in which area of the brain is least likely to result in a facial affect recognition deficit?
a. right posterior hemisphere
b. right anterior hemisphere
c. left hemisphere
d. frontal ventral area
ANSWER: c

T8 CHALLENGES: TRAUMA-INFORMED CARE AND COMPETENCY RESTORATION

Joy Stankowski, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

To understand and discuss ways of overcoming common challenges of providing trauma-informed care in a forensic restoration to competency setting.

SUMMARY

Hospital forensic mental health services must balance the sometimes competing goals of providing patient-centered care while fulfilling criminal court objectives. Trauma-informed care (TIC), whose guiding principles include safety, trust, collaboration, and empowerment, is increasingly recognized as an important component of recovery. Fostering such an environment on a forensic restoration to competency unit, however, can be challenging for both patients and staff. Patients that are court-ordered from jail under suspect of criminal activity, and can have characteristics such as personality disorders, substance abuse, and violent histories, which negatively affects staff perception of safety. In addition, patients are hospitalized and often treated involuntarily, with limits on confidentiality that are a barrier to trust, collaboration, and empowerment. Achieving an environment friendly to patient recovery without sacrificing staff perception of safety is difficult. Two case studies will be presented to illustrate common challenges in balancing recovery and safety, as well as suggested approaches. The first case study identifies difficulties staff must overcome in providing trauma-informed care to a patient with a serious criminal history. The second case study highlights the challenge of helping a patient feel empowered and trusting in light of a court-ordered competency report.

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Livingston J, Nijdam-Jones A, Brink J: A tale of two cultures: examining patient-centered care in a forensic mental health hospital. J Forens Psychiatry Psychol 23(3): 345-360, 2012
Muskett C: Trauma-informed care in inpatient mental health settings: a review of the literature. International Journal of Mental Health Nursing, 23, 51-59, 2014

QUESTIONS AND ANSWERS

1. What are two goals of trauma-informed care?
a. safety and trust
b. collaboration and empowerment
c. suicide and homicide risk assessment
d. all of the above
e. a and b
ANSWER: e

2. What is a challenge of providing trauma-informed care to forensic patients?
a. court ordered treatment
b. court reports
c. staff concern for safety
d. patient concern for confidentiality
e. all of the above
ANSWER: e

T9 **MALINGERING: A RESULT OF TRAUMA OR CIVIL LITIGATION?**

Lauren Marasa, MD, Lexington, KY
David Shraberg, MD, Lexington, KY
Timothy Allen, MD, Lexington, KY

EDUCATIONAL OBJECTIVE

To question how the forensic evaluation and civil litigation process will affect a plaintiff's long term mental status. This poster aims to increase awareness on the possibility of malingering being a learned behavior as a result of a civil lawsuit.

SUMMARY

This presentation follows a plaintiff over a twenty-three year span who was originally awarded a 4.5 million dollar verdict in a lawsuit against American Honda Motor Company. While riding a Honda motorbike at nine years old, the plaintiff sustained a traumatic brain injury. His mother filed suit against Honda in 1993 and the boy then underwent extensive forensic psychological evaluation by our presenter to determine deficits sustained from the injury. At that time there were worrisome signs of evolving character pathology which were excused due to alleged brain damage. Now, thirty-four years old, the plaintiff has essentially overcome his physical deficits. However, he has been arrested multiple times for theft by deception where he feigns a speech impediment and exaggerates his impairment to panhandle for money and lure disabled women into sex. He has been evaluated in the hospital by our second presenter where neuropsychological testing has supported a diagnosis of malingering and antisocial personality disorder. One may conclude it was not the trauma that caused his character pathology but the ensuing five year lawsuit by overemphasizing his disability and reinforcing learned maladaptive behaviors. This case highlights the need for further longitudinal studies to evaluate long-term outcomes following civil litigation.

REFERENCES

Lynch WJ: Determination of effort level, exaggeration, and malingering in neurocognitive assessment. J Head Trauma Rehabil 19(3):277-83, 2004
Mittenberg W, Patton C, Canyock EM, et al: Base rates of malingering and symptom exaggeration. J Clin Exp Neuropsychol 24(8):1094-1102, 2002

QUESTIONS AND ANSWERS

1. Which of the following statements are true?
a. A person with a traumatic brain injury may present with partial malingering.
b. Malingering can be learned through the litigation process.
c. A person with a traumatic brain injury can be held competent in a criminal trial.
d. A traumatic brain injury and a personality disorder are not mutually exclusive.
e. All of the above.
ANSWER: e

2. Malingering has been reported in approximately what percentage of personal injury lawsuits?
a. 9%
b. 19%
c. 29%
d. 39%
e. 49%
ANSWER: c

T10 **NEW GUN CONTROL MEASURES PERTAINING TO THE MENTALLY ILL**

Eindra Khin Khin, MD, Washington, DC
Tyler Byrd, MD, (I) Oneonta, AL

EDUCATIONAL OBJECTIVE

To stay up to date with the shifting legal and legislative landscapes pertaining the rights of the mentally ill so that we as mental health professionals can help safeguard their interests. To critically examine the new Executive Actions specifically concerning the gun control measures and the mentally ill.

SUMMARY

In an effort to address the rising tragic losses secondary to gun violence in the United States, the President set forth new executive actions in January 2016. This initiative included many commendable and pragmatic measures, including recognition of the need to improve the mental health care of Americans. This sentiment is reflected in a proposal for a $500 million investment to increase access to mental health services to order to protect the health of children and communities, prevent suicide, and promote mental health as a top priority. While this is welcome news for the mental health professionals, there are other particular facets that require a more critical examination.

A prime example is the call to use information from the Social Security Administration about beneficiaries with mental health issues in the National Instant Criminal Background Check System. The mentally ill are already a vulnerable and stigmatized group. Therefore, it is imperative for us to ensure that we do not further victimize them with our well-intentioned but potentially misguided efforts.

REFERENCES

Swanson JW, McGinty EE, Fazel S, et al: Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. Annals of Epidemiology 25(5):366-76, 2015
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. While 46% of Americans believe mental illness to be the greatest risk factor for mass shootings, it appears that limiting mental illness as a risk factor would reduce violence toward others by what percent?

a. less than 4%
b. 20%
c. 35%
d. 50%
e. more than 70%
ANSWER: a

2. What federal institution mandated by the Brady Handgun Violence Prevention Act of 1993, was created by the Congress to prevent guns from being sold to prohibited individuals?

a. Federal Bureau of Investigation (FBI)
b. National Instant Criminal Background Check System (NICS)
c. Centers for Disease Control and Prevention (CDC)
d. Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF)
e. National Integrated Ballistics Information Network (NIBIN)
ANSWER: b

T11 A MODEL FOR TEACHING FORNSIC ASYLUM EVALUATIONS

Eindra Khin Khin, MD, Washington, DC
Carol Ann Dyer, MD, (I) Washington, DC
Julia Frank, MD, (I) Washington, DC
Lynne Gaby, MD, (I) Washington, DC
James Griffith, MD, (I) Washington, DC
Anjali Jindal, MD, (I) Annandale, VA

EDUCATIONAL OBJECTIVE

To illustrate a teaching module in which psychiatric trainees get an early exposure to forensic processes in asylum mental health evaluations. To describe a model of medical and law school collaboration that is easily applicable to forensic psychiatry fellowships.

SUMMARY

Human rights advocacy is an integral element of the clinical practice of psychiatry in the George Washington University Department of Psychiatry and Behavioral Sciences and the psychiatric education of residents and medical students. Through our Human Rights Clinic, we provide psychiatric services for refugees, asylum seekers, and immigrants from all over the world. In this clinic, we have separate arms for treatment and evaluation to avoid conflict of interest due to double agency. In the evaluation arm, we conduct pro bono mental health evaluations for the asylum process, in close collaboration with Physicians for Human Rights as well as with George Washington University Law School and Georgetown University Law Center. In addition to the service aspect of this venture, it is also a fertile ground for educational exercises. Here, under the tutelage of experienced supervisors, the trainees are given an opportunity to learn first-hand about forensic processes, including doing a thorough document review, conducting a mental health evaluation, writing a report, communicating with the legal team, giving a deposition, and testifying in court. This hands-on training experience is complemented by a seminar in forensic psychiatry for PGY-II residents.

REFERENCES

Prabhu M, Baranoski M: Forensic mental health professionals in the immigration process. Psychiatric Clinics of North America 35(4):929-46, 2012
2. Meffert SM, Musalo K, McNiel DE, et al: The role of mental health professionals in political asylum processing. J Am Acad Psych Law 38(4):479-89, 2010

QUESTIONS AND ANSWERS

1. What is a crucial clinical element most commonly encountered in the evaluation of asylum seekers?
a. depression
b. anxiety
c. insomnia
d. trauma
e. substance use
ANSWER: d

2. How asylum applicants define and respond to trauma is mostly influenced by:
a. Whether or not they have a support system in the relocated country.
b. Whether or not they speak the host language.
c. Cultural factors.
d. Substance use.
e. Preexisting mental illness.
ANSWER: c

T12 ANIMAL CRUELTY TO VIOLENT CRIMES: BIOPSYCHOSOCIAL APPROACH

Gowri Ramachandran, MD, Washington, DC
Eindra Khin Khin, MD, Washington, DC

EDUCATIONAL OBJECTIVE

To understand the theoretical underpinning of the linkage between animal cruelty and interpersonal violence. To explore the biopsychosocial factors that are involved in these two phenomena and to compare and contrast them. To identify the critical factors that can allow for early intervention in the vulnerable population.

SUMMARY

Despite a well-accepted linkage between acts of animal cruelty and involvement in interpersonal violence, there is a dearth of data when it comes to the comprehensive biopsychosocial understanding of this linkage. Since violent trends often begin during childhood, in-depth appreciation of the biopsychosical factors involved in this process can enable us to better identify the children that might be more susceptible to adopting such criminal tendencies, allowing for early intervention so as to direct these children away from future lives of crime. With this goal in mind, we explore various theoretical frameworks, ranging from the Theory of Social Learning to Frustration Theory and Graduation Theory, in order to better understand this phenomenon. We then examine variables implicated in the behaviors of animal cruelty and how those may compare or contrast with the variables at play in individuals who engage in interpersonal violence. Some of the investigated factors include family structure, psychiatric history, education, income, age, and race.

REFERENCES

Hensley C, Tallichet SE: The effect of inmates' self-reported childhood and adolescent animal cruelty: Motivations on the number of convictions for adult violent interpersonal crimes. Int J Offender Ther Comp Criminol 52(2):175-184, 2008
Hensley C, Tallichet SE, Dutkiewicz EL: Recurrent childhood animal cruelty: is there a relationship to adult recurrent interpersonal violence? Criminal Justice Review 34: 248-257, 2009

QUESTIONS AND ANSWERS

1. Which of the following was included in J.M. MacDonald's childhood trial that could be predictive of future aggression?
a. Propensity for bed wetting after the age of 5.
b. Cruelty toward animals.
c. Obsession with fire.
d. All of the above.
e. None of the above.
ANSWER: d

2. The biopsychosocial attributes that have been found to be consistently associated with animal cruelty and with interpersonal violence are all of the following except:
a. domestic violence
b. caucasian race
c. prior mental illness
d. substance use
e. lower education
ANSWER: b

T13 **HUMANITARIAN ASYLUM AND THE FOLE OF FORENSIC PSYCHIATRISTS**

Drew Calhoun, MD, Pittsburgh, PA
Nubia Lluberes, MD, Pittsburgh, PA
Shelia Velez Martinez, JD, (I) Pittsburgh, PA
Abhishek Jain, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE

This poster will review the asylum process with emphasis on humanitarian asylum cases, unique exceptions to the usual criterion of a "well-founded fear of persecution." Viewers will understand what distinguishes humanitarian asylum cases from the majority of asylum applications and the specific implications this has for the forensic psychiatrist.

SUMMARY

Currently, over 200,000 immigration cases in the United States await resolution with an average wait time for cases to be heard in the immigration courts of over 400 days. Of the 80,000 asylum decisions made annually, the rate of success varies widely based on seemingly arbitrary factors such as the region of the immigration office, the judge, and the applicant's ethnicity. Mental health experts well versed in immigration and asylum law as well as refugee trauma can make valuable contributions to these cases. In this poster, we will review the general process of asylum cases and the forensic psychiatrist's role. We will then focus on the two types of humanitarian asylum, which allow asylum to be granted without the standard "well founded fear of persecution" criterion. The first is asylum based on "compelling reasons" for an applicant to be unwilling or unable to return to the country of origin based on the severity of past persecution. The second is granted when the applicant establishes a "reasonable possibility" of suffering "other serious harm" upon removal to the country of origin. Specific examples will be used to illustrate these unique asylum cases and the implications this has for the forensic psychiatrist.

REFERENCES

Meffert SM, Musalo K, McNiel DE, et al: The role of mental health professionals in political asylum processing. J Am Acad Psychiatry Law 38:479 - 89, 2010
De Jesus-Rentas G, Boehnlein J, Sparr L: Central American victims of gang violence as asylum seekers: the role of the forensic expert. J Am Acad Psychiatry Law 38:490 - 8, 2010

QUESTIONS AND ANSWERS

1. What distinguishes humanitarian asylum cases from typical asylum cases?
a. The asylum applicant is deemed able to return to a different part of their country of origin.
b. Humanitarian asylum applicants typically do not need representation by immigration attorneys.
c. A well-founded fear of future persecution of the same type is not necessary.
d. There does not need to be any past persecution.
ANSWER: c

2. Which of the following cases may qualify for humanitarian asylum, but likely only based on the "other serious harm" code?
a. A homosexual male is tortured and beaten badly because of his sexual preference in his home country by a radical group of people still at large in his country and largely uncontrolled by his country's government.
b. A man from a severely impoverished country who barely escaped with his life from multiple attempts to murder him by a notorious gang that dominated the country's capital. The gang was limited to the country's capital and has been effectively disbanded by his home country's government and does not appear to be continued threat, however the man remains unwilling to return to the country due to the severe economic strife his country faces, the lack of any remaining family/friends, and the spread of Ebola that is rampant throughout his country of origin.
c. A woman from a minority ethnic group in her country of origin that was witness to the genocide of multiple family members and friends and the victim of significant torture and rape herself by members of the ethnic majority group. The genocide has stopped and most of the perpetrators of these crimes have been prosecuted and imprisoned, but the woman remains unwilling to go back to her home country because of significant psychological sequelae of her severe past persecution.
d. A man that left his country due to the shame and constant ridicule including violence that was brought on his family because of their political opinion, the minority in the small, rural town where he resided most of his life. The man's political opinions and party are actually the majority and accepted in the country's capital, a booming metropolis located on the other side of the country from the city where he was raised and formerly persecuted.
ANSWER: b

T14 THE BRAIN OF A SOCIOPATH: WHAT WE KNOW NOW

Ian Steele, MD, (I) Boston, MA
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
To provide a comprehensive overview of current anatomical brain abnormalities in individuals who have antisocial personality disorder, how these brain abnormalities relate to symptoms of antisocial personality disorder, and how they may relate to treatment options.

SUMMARY
What makes a sociopath? Antisocial Personality Disorder (ASPD) has been a topic of research for some time, but difficult to study. Most research has been done through the prison system as people with ASPD do not often seek treatment in the community. Early research was focused on accurate diagnostic criteria and understanding common developmental backgrounds that would create a scaffolding for developing ASPD. With the recent advances in technology, research has focused on genetics and anatomical brain differences. We know adverse upbringings (e.g., trauma, neglect) have effects on our physical brain developments. Common abnormalities exist in individuals with ASPD, specifically reduced volumes in the amygdala, orbitofrontal region, temporal region, and the thalamus. These regions have been associated with the various symptoms of ASPD (decreased fear response, inability to suppress intrusive memories, impulsivity). How does this knowledge about the brain pathology help us? It helps us understand the origins of their behavior, certainly. It could also help us use specific modalities of treatments known to help patients with deficiencies in these areas. Research in neruo-anatomical abnormalities is growing and expanding our understanding, but where does that leave us with treatment options?

REFERENCES
Hyde LW, Byrd AL, et al: Amygdala reactivity and negative emotionality: divergent correlates of antisocial personality and psychopathy traits in a community sample. J Abnorm Psychol 123(1): 214–224, 2014
Yoder KJ, Porges EC, Decety J: Amygdala subnuclei connectivity in response to violence reveals unique influences of individual differences in psychopathic traits in a nonforensic sample. Human Brain Mapping 36:1417–1428, 2015

QUESTIONS AND ANSWERS
1. Which brain abnormality is associated with cold heartedness in ASPD?
a. decreased central nucleus- dorsal anterior cingulate cortex connectivity
b. larger temporal lobe grey matter
c. increased orbitofrontal connectivity with basil ganglia
d. decreased activity in left cerebellum posterior lobe
ANSWER: a

2. A reduction in reactivity in the amygdala is linked to which behavior in ASPD?
a. impulsivity
b. decreased fear response
c. lack of remorse
d. lack of goal seeking behaviors
e. sensation seeking behaviors
ANSWER: b

T15 BETWEEN AN ETHICAL ROCK AND AN INSTITUTIONAL HARD PLACE

Margarita Abi Zeid Daou, MD, (I) Nashville, TN
William Kerner, MD, (I) Nashville, TN

EDUCATIONAL OBJECTIVE
To help physicians recognize the importance of competency assessment prior to interrogations and to provide guidelines to help them perform competency assessments in medical settings.

SUMMARY
Law enforcement officers (LEOs) often demand to interrogate patients in hospital emergency rooms, post-op, or on trauma services. Severely ill patients in pain, medicated or traumatized can still face LEO's high stakes, stressful, and intense interrogation techniques. With the law's strong presumption of competency, questions regarding competency to face interrogation and give up constitutional rights arise only retrospectively. To address the competency question prospectively, we propose that physicians have an affirmative ethical duty to evaluate their patient's competency and to protect vulnerable patients with physical and cognitive impairments to their functional capacities. Psychiatric consultants should evaluate mentally ill suspects prior to LEOs' interrogation. Medical decision making capacity assessment questions are easily tailored to the Miranda issue. Since a false confession has a morbidity similar to a medical threat to life and limb, the physician's time spent on a competency evaluation and if indicated, medical supervision of the interrogation is time well spent.

REFERENCES
Greenfield DP, Witt PH: Evaluating adult Miranda waiver competency. J Am Acad Psychiatry Law 33:471-489, 2005
Kaempf A, Pinals DA: Competence to waive Miranda rights. J Am Acad Psychiatry Law 36: 400-402, 2008

QUESTIONS AND ANSWERS
1. Which landmark case resulted in the requirement that patients should be able to "knowingly, voluntarily and intelligently" waive their Miranda rights?
a. U.S. Supreme Court case of Miranda v. Arizona (1966)
b. U.S. Supreme Court case of Miranda v. Arizona (1986)
c. U.S. Supreme Court case of Cox v. Del Papa (2008)
d. U.S. Supreme Court case of Miranda v. Arkansas (1966)
e. U.S. Supreme Court case of Clark v. Arizona (2006)
ANSWER: a

2. Which of the following is not part of the Miranda Rights Comprehension Instruments?
a. Comprehension of Miranda Rights
b. Comprehension of Miranda Rights – Recognition
c. Interrogative suggestibility scale
d. Function of rights in interrogation
e. Comprehension of Miranda - Vocabulary
ANSWER: c

T16 OREGON STATE HOSPITAL FORENSIC EVALUATIONS: 2006-2015

Joseph Chien, DO, Marylhurst, OR
Mandy Davies, PsyD, (I) Marylhurst, OR
Emily Demarco, MD, (I) Marylhurst, OR
Karl Mobbs, MD, Wilsonville, OR

EDUCATIONAL OBJECTIVE
To review key take-home points from previous CST research and analyze data from court-ordered evaluations over a 10 year-period, with the goal of identifying trends in number and types of evaluations, outcomes, and demographic characteristics of subjects.

SUMMARY
In recent years the state hospital population of incompetent to stand trial (IST) patients in Oregon has skyrocketed, leading to a bed crisis. The precise reasons behind this trend are unclear; analysis of the data available on forensic evaluations done by the state hospital's Forensic Evaluation Service (FES) might elucidate some of the factors driving this trend. For quality improvement, the following data were collected over the period of 2006 to 2015: Jurisdiction of court order, type of evaluation (initial competency, competency after restoration, criminal responsibility), gender of subject, hospital location (i.e. high vs medium security), date of admission (if applicable), type of evaluator (psychologist/psychiatrist), finding of report (competent, not competent, not restorable), date of report. Data from the past ten years demonstrates a recent dramatic increase in the numbers of forensic evaluations done by the state hospital, coinciding with an increase in patients hospitalized for competency restoration. Our analysis suggests that the increase in referrals for evaluations is occurring uniformly throughout the different jurisdictions/counties in Oregon and not due to an increase in a particular type of evaluation. There was no significant difference in outcome of reports with relation to whether they were done by a psychiatrist or psychologist.

REFERENCES
Pirelli G, Gottdiener WH, Zapf PA: A meta-analytic review of competency to stand trial research. Psychology Public Policy and Law 17(1):1-53, 2011
Chien J, Novosad D, Mobbs KE. The Oregon health and science university-Oregon state hospital collaboration: reflections on an evolving public-academic partnership. Psychiatric Services, 67(3): 262-264, 2016

QUESTIONS AND ANSWERS
1. What three trends in court-ordered forensic evaluations were identified in this analysis?
ANSWER: An almost two-fold increase in forensic evaluations, particularly over the past 6 years. This increase was not due to more orders from any particular jurisdiction in Oregon This increase was not due to more evaluation requests of a particular type.

2. What three factors relating to incompetency have been identified by previous research of adjudicative competency?
ANSWER: In a meta-analysis of CST research over the past 50 years, Pirelli et al identified the following three factors as being related to incompetence: 1) a diagnosis of psychosis, 2) unemployment, and 3) a history of previous psychiatric hospitalizations.

T17 JE NE REGRETTE RIEN: THE USE OF REMORSE IN PSYCHIATRY AND LAW

Jorge Castillo, MD, Syracuse, NY
James Knoll, IV, MD, Syracuse, NY
Bruce Way, PhD, (I) Syracuse, NY

EDUCATIONAL OBJECTIVE
The educational objective is to enhance consulting skills in capital cases.

SUMMARY
Remorse is an emotional expression of regret felt by a person after committing a shameful act. The word remorse comes from the Latin root mordere (to bite back) implying one's conscience returning to bite back. Research, including the Capital Jury Project, has shown that a defendant's failure to show remorse is a salient factor in capital sentencing. Yet there is currently no evidence that remorse can be accurately evaluated in courtrooms. Similarly, lack of remorse is a DSM-5 criterion for ASPD, yet there is no compelling research suggesting its reliable detection. Defendants with severe mental illness and those with some forms of dementia may have an impaired ability to express and/or perceive emotions. Despite recent efforts to validate clinical tools to measure empathy, remorse remains a clinically ambiguous concept. We hypothesized that defendants with severe mental illness are more likely to be perceived by juries as lacking remorse. We conducted an extensive literature review in PubMed and Lexis Nexis and the results will be presented. Forensic psychiatric testimony could play an important role in educating the court about the limitations involved in assessments of remorse, and how various psychiatric factors can affect a defendant's ability to express and perceive emotions.

REFERENCES
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Zhong R, Baranoski M, Feigenson N, et al: So you're sorry? The role of remorse in criminal law. J Am Acad Psych Law 42:39-48, 2014

QUESTIONS AND ANSWERS
1. Which of the following is a valid instrument for measuring affective and cognitive empathy among mentally disordered offenders?

a. Eysenck Personality Questionnaire (EPQ-R) Psychoticism scale
b. Minnesota Multiphasic Personality Inventory
c. Victim Empathy Response Assessment 2 (VERA-2)
d. Hare Psychopathy Checklist-Revised (PCL-R)
ANSWER: c

2. According to the results of the data from the Capital Jury Project in the state of California, what percentage of capital jurors acknowledged that the defendant's lack of remorse contributed to their vote in favor of the death penalty?

a. 10 %
b. 20%
c. 30%
d. more than 50%
ANSWER: d

T18 EPIDEMIOLOGY AMONG FORENSIC PSYCHIATRIC EXAMINEES IN CENTRAL TAIWAN

Yu-Fei Huang, MD, (I) Taiwan

EDUCATIONAL OBJECTIVE
To explore how the mentally-ill get involved with the justice system, their epidemiological characteristics and associated risk factors.

SUMMARY
The relationship between mental illnesses and the judicial system is an entangled issue. People with mental illness could be the criminals, the victims or both. In this study, we analyze cases referred by the court for forensic psychiatric evaluations from January, 2002 to March, 2014 to explore how those with mental illness get involved with the justice system and the associated trends. All adults who have undergone forensic psychiatric evaluations during study-designed period were included. Descriptive analysis was performed by SPSS version 17th. 1836 cases were included in this study. Among them, 51 persons were evaluated more than once and were account for 112 times of forensic psychiatric examination. They were divided into four groups by the cause of referral. Schizophrenia and developmental disability are two most common psychiatric diagnoses in criminal offenders and victims. It infers these two mental

conditions would cause the patients to be both offenders and victims. Though the patients frequently encounter legal issues, their characteristics and mental conditions varied with the cause of referral. The people with schizophrenia and the developmentally disabled, need special attention to protect them from being offenders or victims.

REFERENCES

Tiihonen J, Isohanni M, Räsänen P, et al: Specific major mental disorders and criminality: a 26-year prospective study of the 1966 northern Finland birth cohort. Am J Psychiatry 154:840–845, 1997
Constantine R, Andel R, Petrila J, et al: Characteristics and experiences of adults with a serious mental illness who were involved in the criminal justice system. Psychiatric Services 61:451–457, 2010

QUESTIONS AND ANSWERS

1. What are the most common psychiatric conditions in criminal offenders and victims among forensic psychiatric examinees?

a. Schizophrenia and Major Depressive disorder
b. Schizophrenia and Developmental Disability
c. Schizophrenia and Alcohol Use Disorder
d. Developmental Disability and Alcohol Use Disorder
ANSWER: b

2. What is the most common use substance at the alleged criminal event?

a. Methamphetamine
b. Alcohol
c. Hypnotics
d. Heroin
ANSWER: b

T19 PSYCHOLOGICAL AUTOPSIES OF MASS-SHOOTERS' ONLINE LIVES

Chelsea Bucina, BSc, (I) Portland, OR
Karlee McCoy, BA, (I) Hillsboro, OR
Leonardo Bobadilla, PhD, (I) Hillsboro, OR

EDUCATIONAL OBJECTIVE

To provide more information on a growing problem in the United States. With more knowledge and better information, we hope to inspire more preventive care and effective treatment as well as opening the door for further research in this area.

SUMMARY

In the years from 1982-2011 and 2011-2016, mass shootings have increased in occurrence from approximately every 200 days to every 64 days. Data suggest that shooters who commit suicide carry out the most deadly of these attacks. Past studies have found evidence for mainstream media driven contagion effects for suicide in general, and possibly for mass murder-suicide shootings, particularly after high-profile cases. However, with the widespread availability of the Internet, contagion effects may now be spreading through more detrimental online means. Many shooters establish online presence on a variety of platforms (e.g., gun forums, social media) that provide insight into their state of mind and often reflect morbid preoccupation with death, revenge, extremism, and notably, idealization of other shooters. However, to date there is a significant gap in the literature examining whether online presences of previous mass shooters (e.g., manifestos) directly influence future mass-suicide shooters. The current study aims to help fill this gap by conducting a systematic qualitative examination of mass shooters from 1982 to 2016 in order to determine whether they explicitly reference previous shooters. Our preliminary data suggest a relationship between online presence and suicide contagion across shooters notably in cases with a large number of victims.

REFERENCES

Niederkrotenthaler T, Voracek M, Herberth A, et al: Role of media reports in completed and prevented suicide: Werther v. Papageno effects. British Journal of Psychiatry 197(3), 234-243, 2010
Towers S, Gomez-Lievano A, Khan M, et al: Contagion in mass killings and school shootings. Available at http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0117259. Accessed July 2016

QUESTIONS AND ANSWERS

1. Statistics regarding mass shootings are often inaccurate. In the media, numbers can range from 73 to 355 mass shootings in the past year. How do we define a mass shooting (mass killing)?

ANSWER: Following closely with the FBI definition, a mass shooting is defined by the death of four or more victims, not including the perpetrator, with the use of a firearm.

2. How can we use information provided in this study and others to benefit our future?
a. Countering misinformation in the media.
b. Providing more effective preventive measures.
c. Noting patterns and trends that can provide better public safety.
d. Inspiring future research in this area.
e. All of the above.
ANSWER: e

T20 **CLOSING THE REVOLVING DOOR: DENIAL OF COMMITMENT PETITIONS**

Navneet Sidhu, MD, Washington, DC
Philip Candilis, MD, Washington, DC

EDUCATIONAL OBJECTIVE
To explore factors contributing to the revolving door of an urban psychiatric emergency room.

SUMMARY
The primary outcome measure for patients who return to the psychiatric emergency room is time in the community until another crisis. This depends on multiple factors like treatment non-adherence, homelessness, substance use, severity of illness, and lack of community support. In order to identify the factors that influence relapse most strongly we offer data from a comparison of voluntarily admitted patients and those whose commitment petitions were denied. We present analysis of the relationship between factors to assess whether a certain characteristic or disposition increases or decreases re-admission rates, identifying factors that predict readmission inform and improve treatment approaches in this population.

REFERENCES
Strauss G, Glenn M, El-Mallakh R, et al: Psychiatric disposition of patients brought in by crisis intervention team police officers. Community Mental Health Journal 41(2):223-228, 2005
Segal S, Akutsu P, Watson M: Factors associated with involuntary return to a psychiatric emergency service within 12 months. Psychiatric Services 49(9):1212-1217, 1998

QUESTIONS AND ANSWERS
1. What percentage of ED visits in adults ages 18-25 years are estimated to involve illicit drugs, alcohol or misuse of pharmaceuticals?
a. 10-20%
b. 30-40%
c. 50-60%
d. >80%
ANSWER: c

2. What is the primary outcome measure for remission in patients who return to the psychiatric emergency room crisis?
a. adherence to medications
b. time until another episode
c. severity of illness
d. lack of community supports
ANSWER: b

T21 **TRAUMA AND TRANSFORMATION: THE HISTORY AND FUTURE OF CHILD SOLDIERS**

Emily Keram, MD, Santa Rosa, CA

EDUCATIONAL OBJECTIVE
Participants will learn the definition and history of child soldiers, their special protections under international law, and the implications of current conflicts and technology on their future status.

SUMMARY
"My squad is my family, my gun is my provider, and protector, and my rule is to kill or be killed." –Ishmael Beah, former child soldier. "Compelled to become instruments of war, to kill and be killed, child soldiers are forced to give violent expression to the hatreds of adults." -Olara Otunnu, United Nations Special Representative for Children and Armed Conflict, 1997-2005
Children have been participants in armed conflict throughout history and across cultures. Following World War I, there has been an international effort to define and enforce legitimate protections for child soldiers. This work

continues in the present as an unsettled area of law and public policy that attempts to reconcile human rights and national security against the backdrop of evolving understanding of child and adolescent brain science and the use of technology in the recruitment and deployment of children. This presentation reviews the history of child soldiers, arguments favoring and opposing their special status, and concerns about recruitment, punishment, and rehabilitation of child soldiers in light of advances in science and technology.

REFERENCES

Betancourt TS, Borisova I, Williams TP, et al: Research review: psychosocial adjustment and mental health in former child soldiers–a systematic review of the literature and recommendations for future research. Journal of Child Psychology and Psychiatry, 54(1), 17-36, 2013

Rosen DM: Who is a child-the legal conundrum of child soldiers. Conn J Int'l L (25)81, 2009

QUESTIONS AND ANSWERS

1. International law does not prohibit the prosecution of children who commit war crimes, but article 37 of the United Nations Convention on the Rights of the Child limits the punishment that a child can receive. Which of the following sentences is allowed under this convention?

a. Life imprisonment without the possibility of parole.
b. The death penalty.
c. Diversion to rehabilitation programs.
d. Indefinite detention.
e. Solitary confinement.

ANSWER: c

2. What percentage of child soldiers is estimated to be female?

a. 5%
b. 20%
c. 40%
d. 50%
e. 70%

ANSWER: c

T22 BALANCING CONFLICTING DUTIES IN FORENSIC ETHICS DILEMMAS

Robert Weinstock, MD, Los Angeles, CA
William Darby, MD, Santa Monica, CA
Ezra Griffith, MD, New Haven, CT
Michael Norko, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

To help enable attendees to determine their most ethical action when facing forensic dilemmas. They will learn how to prioritize and balance conflicting considerations that will depend on the specific cultural and narrative context.

SUMMARY

Dr. Weinstock will summarize dialectical principlism and its value in ethics dilemmas first introduced in his 2014 AAPL Presidential address. Dr. Darby will present an illustrative hypothetical dilemma of a capital murder case involving racism and use dialectical principlism to analyze and resolve the dilemma. He will demonstrate how certain variations to the example affect and change the analysis. Dr. Griffith will provide a cultural perspective and narrative and discuss how well dialectical principlism accounts for such things. Dr. Norko will explain the ethical concept of compassion and how it is relevant to such situations. Dr. Weinstock will conclude by integrating these models to help us determine what we consider the most ethical action when we strive to go beyond the minimum of staying out of trouble. This will be followed by a panel discussion and questions from the audience.

REFERENCES

Weinstock R: Dialectical principlism: an approach to finding the most ethical action. J Am Acad Psychiatry Law 43(1):10-20, 2015

Griffith EEH: Personal narrative and an African American perspective on medical ethics. J Am Acad Psychiatry Law 33(3):371-81, 2015

QUESTIONS AND ANSWERS

1. What does dialectical principlism consider?
a. roles
b. consequentialism
c. bioethical principles
d. cultural narrative
e. all of the above
ANSWER: e

2. When does an ethical dilemma arise?
a. When forensic psychiatrists are unaware of AAPL ethics guidelines.
b. When psychiatrists are unfamiliar with the AMA Principles of Medical Ethics.
c. When psychiatrists think there is no need to go beyond violating any ethics guideline.
d. When ethics obligations conflict with each other making it difficult to satisfy both.
e. All of the above
ANSWER: d

T23 DO ALL ROADS LEAD TO ROME: EMPATHY IN AUTISM AND PSYCHOPATHY

Camilla Lyons, MD, MPH, Bedford, NY
Alexander Westphal, MD, New Haven, CT
Eileen Ryan, DO, Staunton, VA
Laurie Sperry, PhD, (I) New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE

By the end of the panel presentation, participants should be able to compare and contrast youth with autism spectrum disorder and youth psychopathic (or callous-unemotional) traits with respect to mentalizing ability, emotion recognition, executive dysfunction, empathy and antisocial or aggressive behavior.

SUMMARY

Youth with both autism spectrum disorder (ASD) and psychopathic or callous-unemotional traits display difficulties in empathic and pro-social behavior. Youth with ASD may demonstrate behavior that appears unempathic due to a deficit in identifying the mental states and emotions of others. Meanwhile, youth with callous-unemotional traits may accurately identify the mental states of others but lack concern for others' feelings. This panel will explore both the overlap and distinctions in empathy deficits among youth with ASD and psychopathic traits. Dr. Ryan will present on the topic: "Autistic Spectrum Disorders and Criminal Behavior: Myths versus Potential Associations." Dr. Westphal will discuss the role of empathy deficits, either due to ASD and psychopathy, as it pertains to youth violence risk assessments. Dr. Sperry will discuss her research in the area of violent video game consumption amongst adolescents with ASD in a juvenile justice diversion treatment program. Dr. Baranoski will be the panel's discussant.

REFERENCES

O'Nions E, Tick B, Rijsdijk F, et al: Examining the genetic and environmental associations between autistic social and communication deficits and psychopathic callous-unemotional traits. Available at http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0134331. Accessed July 2016
Rogers J, Viding E, Blair RJ, et al: Autism spectrum disorder and psychopathy: shared cognitive underpinnings or double hit? Psychol Med 36(12):1789-98, 2006

QUESTIONS AND ANSWERS

1. Which of the following statements about empathy and mentalizing ability in youth with ASD and youth with psychopathic traits is false?
a. Youth with ASD most often have a higher than average level of insight into the inner states of others
b. While most youth with ASD do not act aggressively, poor mentalizing ability and impaired impulse control may increase the risk of aggressive behavior.
c. Youth with psychopathic traits tend to fail to respond to others' emotional distress despite good insight into thoughts and feelings of others
d. Youth with psychopathic traits rely on good mentalizing ability in order to manipulate others.
ANSWER: a

2. Which of the following statements about the difficulties faced by both youth with ASD and youth with callous-unemotional or psychopathic traits is false?
a. Both social and communication impairments and callous-unemotional traits are highly heritable.
b. Both youth with ASD and youth with callous-unemotional traits may demonstrate difficulties in appropriate social behavior.
c. The underlying etiology of the impairments in social interactions in both groups is the same.
d. None of the above statements are false.
ANSWER: c

T24 SUICIDE TERRORISM – THE PSYCHOLOGY AND GENDER DIFFERENCES

Anna Glezer, MD, San Francisco, CA
Joseph Penn, MD, Conroe, TX
Hassan Naqvi, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE

Participants will learn the motivations and psychological theories behind suicide and suicide terrorism. They will also understand how gender influences suicide, followed by an exploration of how gender impacts the hypotheses on suicide terrorism.

SUMMARY

The act of suicide terrorism brings with it powerful emotion from all those affected, leading to many questions and the desire to understand more about those who engage in these acts for purposes of risk assessment. This workshop will focus first on the psychology of suicide itself, and then delve into the psychology behind those who engage in suicide terror. More recently, there have been more incidents where the perpetrator of these acts has been a woman, leading to questions such as: are women suicide bombers different than men? We know suicide rates and attempts and motivations in general differ among the genders, but can that be expanded into a discussion regarding gender differences in suicide terror? These are the questions this workshop will answer, and will engage the audience participants through case examples, media, and response questions.

REFERENCES

Bloom M: Bombshells: women and terror. Gender Issues 28:1-21, 2011
Victoroff J, Kruglanski A: Psychology of Terrorism. New York, NY: Psychology Press, 2009

QUESTIONS AND ANSWERS

1. What is not a typical terrorist characteristic?
a. A terrorist has a personal stake in an ideological issue.
b. A terrorist is usually a woman.
c. A terrorist often has low cognitive flexibility and low tolerance for ambiguity.
d. A terrorist has the ability to suppress instinctive and learned moral constrains against harming innocents.
ANSWER: b

2. What are the reasons why an organization might choose to employ female terrorists?
ANSWER: This affords the terrorist group several advantages, including surprise and the ability to go under-detected. This is true in societies where women often dress more conservatively and cannot be touched by the opposite gender, but is also true more generally as the idea of a woman committing such an act of terror evokes surprise and emotion in all societies due to the view of women as the gentle and nurturing sex.

T25 INTERNET CRIMES AGAINST CHILDREN: A FORENSIC ANALYSIS

Karen B. Rosenbaum, MD, New York, NY
R. Gregg Dwyer, MD, EdD, Charleston, SC
D.J. Barton, MS, (I) Columbia, SC
J. Paul Fedoroff, MD, Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

Attendees will better understand the various Internet crimes that can occur against children, the profiles of the offenders from a law enforcement perspective, and the psychiatric evaluation and treatment of the offenders. They will also understand the pervasive role that the Internet has played in offenses against children.

SUMMARY

The Internet has been a vehicle for child pornography and other crimes against children almost since its inception. The Internet provides anonymity, ease of access, and apparent safety. People who misuse the Internet to commit

sex crimes are not all the same. In this presentation four perspectives on assessing and dealing with the problem of Internet sex crimes will be presented. There is a continuum and different risk categorizations and diagnoses of the users. Often, however these different users are prosecuted and treated the same. Meanwhile, producers and distributers of pornography are extremely difficult to find and often go undetected. In this presentation, co-sponsored by the Sex Offender and Liaison with Forensic Sciences committees, challenges of identifying, categorizing, and treating individuals who use the Internet to prey on children will be explored by Dr. Dwyer and Dr. Rosenbaum. Dr. Fedoroff will present data from a study on Internet safety and discuss how his clinic assesses and treats Internet sex criminals in Canada. Lieutenant Barton, a profiler, will explore issues related to prosecuting these offenders. He found that many Internet predators do not fit the old typologies and he coined new ones. This presentation will elaborate on his observations.

REFERENCES

Fisher WA, Kohut T, Gioachino LA, et al: Pornography, sex crime, and paraphilia. Current Psychiatry Rep 15: 362, 2013

Seto MC, Ahmed AG: Treatment and management of child pornography. Psychiatry Clin North Am 37(2):207-14, 2014

QUESTIONS AND ANSWERS

1. Which statement regarding viewers of child pornography on the internet is most accurate?
a. All of these viewers are the same.
b. People who collect child pornography all go on to offend with a child.
c. People who are prosecuted for child pornography only do not have to register as a sex offender.
d. There is a continuum of offenders who view child pornography
ANSWER: d

2. What has the internet changed about types of pedophiles?
a. Nothing
b. All pedophiles who use the internet to meet children would have met them even without the internet.
c. Some who engage in communication with a child through instant messaging would never meet a child in real life.
d. There are no new types of pedophiles since the advent of the internet
ANSWER: c

T26 MISS MARY: A JOURNEY OF TRAUMA AND TRANSFORMATION

Sherif Soliman, MD, Hinckley, OH
Cathleen Cerny, MD, Seven Hills, OH
J. Paul Fedoroff, MD, Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

We will discuss trauma in older adults, an overlooked population. We will use a case study to illustrate the effects of severe trauma, the response of the legal system, and the psychological healing process in an elderly victim. We will utilize a publicly available video interview with the victim.

SUMMARY

In keeping with the theme of Trauma and Transformation, we will present the case of Miss Mary, a 96 year-old victim of financial abuse and later of a brutal sexual assault at the hands of her grandson. We will show portions of a publicly available video interview with Miss Mary describing the attack, her response to it, and her healing process. Miss Mary's family sided unanimously with her grandson in spite of physical evidence of the assault. A special guest presenter, Cheyenne Shepherd, the prosecutor who successfully prosecuted Ms. Mary's grandson, will join the talk via videoconference to discuss the unique aspects of prosecuting this case. Dr. Soliman will discuss this case in light of the known characteristics of victims and perpetrators of elder abuse. Dr. Cerny will discuss the range of psychological responses to sexual violence, with special focus on older adult victims. We will discuss the ethical obligations of treating doctors and expert witnesses in abuse cases. The audience will have the opportunity to participate through a writing exercise and brief mock testimony based on the case of Miss Mary.

REFERENCES

Teaster PB, Roberto KA: Sexual abuse of older adults: APS cases and outcomes. The Gerontologist 44(6):788-796, 2004

He Wouldn't Turn Me Loose: The Sexual Assault Case of 96-Year-Old Miss Mary, National Clearinghouse on Abuse in Later Life & Terra Nova Films, Inc., 2012. Available at http://www.films.com/ecTitleDetail.aspx?TitleID=25095&r. Accessed July 2016

QUESTIONS AND ANSWERS

1. What were challenges to prosecuting Miss Mary's case?
a. Delays sought by defense which could have resulted in the victim dying before the case was adjudicated.
b. Sensory deficits.
c. Victim's family not believing her.
d. Attempts to portray the victim as confused and not credible.
e. All of the above.
ANSWER: e

2. You are called to the ER at 3AM to see a 94 year-old woman with a history of Alzheimer's Disease. The ER physician wants her admitted for "delusional disorder or schizophrenia." She tells you that an intruder raped her in her home earlier that night. The ER doctor tells you that she was found wandering the streets in her nightgown. She was delirious when police brought her in but her condition improved after IV hydration. They found no sign of forced entry in her home. She is medically stable. What should she receive?
a. A genital exam and a rape kit.
b. Antipsychotic medication for delusions.
c. Insight oriented psychotherapy.
d. An acetylcholinesterase inhibitor for Alzheimer's Disease.
e. An antidepressant to cope with her anxiety.
ANSWER: a

T27 **THE TERRORIST'S SON: MY PATH TO PEACE**

Zak Ebrahim, (I) New York, NY

EDUCATIONAL OBJECTIVE

This presentation will improve attendee competence and/or performance by showing the value of breaking down the separations in society based on race, religions, gender and sexuality.

SUMMARY

Groomed for terror, Zak Ebrahim chose a different life. Touching on religious intolerance and extremism, anti-bullying, diversity, and breaking down stereotypes, Ebrahim traces his remarkable journey to escape his father's terrible legacy, coming to realize that the only way to overcome the challenges of his past would be to help others understand that hatred only produces more hate, but belief in non-violence heals. Those cycles of violence, no matter how old, do not have to continue forever. Crisscrossing the eastern United States, from Pittsburgh to Memphis, from a mosque in Jersey City to the Busch Gardens theme park in Tampa, Ebrahim's story is one of a boy inculcated in dogma and hate, a boy presumed to follow in his father's footsteps, and the man who chose a different path.

REFERENCES

Ebrahim Z: The Terrorist's Son: A Story of Choice, New York, NY: Simon & Schuster, 2014
Ebrahim, Z: Choosing the Path to Peace. Available at www.peaceissexy.net/zak-ebrahim-choosing-the-path-of-peace. Accessed August 2016

QUESTIONS AND ANSWERS

1. Which of these statements is true?
a. Zak was born in Egypt.
b. Zak was born in Pittsburgh.
c. Zak was a terrorist himself before he became a peace activist.
d. Zak's real last name was Muhammad.
e. None of the above.
ANSWER: b

2. Which of these statements is true?
a. Zak's father had links with Osama Bin Laden.
b. Zak's father is serving a life sentence plus 15 years in a U.S. prison for terrorist activities in the U.S.
c. Zak was trained in Yemen.
d. All of the above.
e. a and b
ANSWER: e

T28 PUTTING THE "SUPER" IN SUPERVISION

Andrew Nanton, MD, Tualatin, OR
Susan Hatters Friedman, MD, Cleveland Heights, OH
Phillip Resnick, MD, Cleveland, OH
Thomas Gutheil, MD, Brookline, MA

EDUCATIONAL OBJECTIVE
Participants will learn practical skills to be a better supervisor, find early career forensic psychiatrists to supervise, and supervise fellowship-trained vs non-fellowship-trained psychiatrists.

SUMMARY
The brief duration of forensic fellowship lends itself to supervision following training, though both finding and providing this supervision can be daunting. Few forensic psychiatrists have formal training in how to be a good supervisor. Participants will learn practical skills to be a better supervisor, find early career forensic psychiatrists to supervise, and supervise fellowship-trained vs non-fellowship-trained psychiatrists. Content includes topics of supervision, peer supervision, boundaries for good supervision, vicarious liability, and lessons from countries where career-long supervision is required for physician licensure.

REFERENCES
Pinals D: Forensic psychiatry fellowship training: developmental stages as an educational framework. J Am Acad Psychiatry Law 33:3:317-323, 2005
Recupero P, Rainey S: Liability and risk management in outpatient psychotherapy supervision. J Am Acad Psychiatry Law 35:2:188-195, 2007

QUESTIONS AND ANSWERS
1. What does supervising a forensic psychiatrist require?
a. Giving of oneself.
b. Being seen as a person with strengths and weaknesses.
c. Helping those you supervise set realistic expectations.
d. All of the above.
ANSWER: d

2. Why is vicarious liability for supervising early career forensic psychiatrists low?
a. They are independently licensed.
b. They may ignore your guidance, and make their own decision.
c. Respondeat superior generally does not apply.
d. All of the above.
ANSWER: d

T29 FORENSIC EVALUATIONS IN THE ELDERLY

Sherif Soliman, MD, Hinckley, OH
Stephen Read, MD, San Pedro, CA
Philip Marshall, MS, (I) Bristol, RI

EDUCATIONAL OBJECTIVE
The audience will learn about unique considerations in conducting forensic psychiatric evaluations of older adults. We will suggest approaches to common psycho-legal evaluations such as decision-making capacity, guardianship, testamentary capacity, and undue influence. We will also discuss special issues in the elderly such as elder abuse and financial exploitation.

SUMMARY
The U.S. Census Bureau estimates that the number of Americans age 65 and older is expected to more than double from 2010 to 2050, from 40.2 million to 88.5 million. This staggering growth will pose new challenges. Issues such as decision making capacity, contested guardianships, testamentary capacity, undue influence, and elder abuse will arise with increasing frequency. We will offer an approach to these evaluations. We will discuss some of the unique clinical aspects of the geriatric psychiatric evaluations. Evaluations often fail to take into account medical factors such as the presence of delirium, medication effects, and acute medical conditions. These factors take on a particular importance in older adults. We will discuss special issues such as elder abuse, financial exploitation, and undue influence. Special guest speaker, Professor Philip Marshall, will discuss his personal experience with elder financial abuse. Prof. Marshall is Brooke Astor's grandson. He successfully filed a guardianship petition after learning that his grandmother had been the victim of neglect and financial exploitation. His petition ultimately led to the criminal convictions his father, Anthony Marshall, and Atty. Francis Morrisey. He is currently devoting his time to advocating for elder justice. The audience will also work through case studies.

REFERENCES
Shulman KI, Cohen CA, Kirsh FC, et al: Assessment of testamentary capacity and vulnerability to undue influence. Am J Psychiatry 164(5):722-7, 2007
Factora R: Aging and Money: Reducing the Risk of Financial Exploitation and Protecting Financial Resources, New York, NY:Humana Press, 2014

QUESTIONS AND ANSWERS

1. You are consulted in a will contest in which a will is challenged on the basis of testamentary incapacity. The testator, now deceased, had Parkinson's Disease and was treated with carbidopa/levodopa. Shortly before his death, he amended his will to completely disinherit his son. Which of the following symptoms is most likely to impair his testamentary capacity?

a. Silent visual hallucinations of animals surrounding his bed.
b. A delusional belief that the government was spying on him.
c. A delusional belief that his son was poisoning him.
d. Forgetting to pay bills on time.
e. A delusion that the mafia wanted to kill him.

ANSWER: c

2. You are retained in a will contest in which a will is challenged on the basis of alleged undue influence. The testatrix, Mrs. Kindly, died at 95 years of age. Six years prior to her death, her attorney, Mr. Johnson, became her primary caregiver. Mr. Johnson began billing her for general services such as taking her to the grocery store and picking up her prescriptions. At age 92, Mrs. Kindly consulted a different attorney and changed her longstanding will to disinherit her two adult children and leave her entire estate to Mr. Johnson. Which of the following factors is a "red flag" for undue influence?

a. Mr. Johnson frequently suggested to Mrs. Kindly that her family was only interested in her money.
b. Mrs. Kindly could not recall the extent of her assets.
c. Mrs. Kindly could not recall the names of her relatives.
d. Mrs. Kindly did not know how her final will distributed her assets.
e. Mrs. Kindly did not know she was making a will when she changed her will.

ANSWER: a

T30 HOSPITAL SECURITY OFFICER WEAPON USE: IS IT EVER APPROPRIATE?

Jeffrey Janofsky, MD, Timonium, MD
Michael Champion, MD, Honolulu, HI
Ken Hoge, MD, New York, NY
Debra Pinals, MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE
Workshop speakers will review the literature and report their own experiences with the use of non-lethal and lethal force at their own institutions. They will engage the audience to collect audience member 's experiences with the use of non-lethal and lethal force by security officers at their institutions.

SUMMARY
On February 12, 2016, the New York Times reported on an incident where a patient with psychotic mania became verbally and physically agitated. Hospital security responded and entered the patient's room without clinical staff. They first utilized tasers and then shot the patient, causing him serious injury. In a 2010 sentinel event alert the Joint Commission noted that health care institutions are confronting increasing rates of violence. Suggested actions included requiring staff members to undergo training. The Joint Commission did not specify what that training should include, nor does the Joint Commission have a position on the use of tasers, pepper spray, or lethal force by hospital staff responding to behavioral emergencies. The AMA and APA have no current positions on this issue either. However CMS' interpretive guidelines states that, "CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention." The APA's Council on Psychiatry and Law is of drafting a possible Position Statement or Resource Document on the use of weapons in the health care setting

REFERENCES
Rosenthal E: When the Hospital Fires the Bullet. New York Times. Available at http://www.nytimes.com/2016/02/14/us/hospital-guns-mental-health.html?_r=0. Accessed February 2016
Schoenfisch A, Pompeii L: Weapons Use Among Hospital Security Personnel. International Healthcare Security and Safety Foundation. Available at http://ihssf.org/PDF/weaponsuseamonghosptialsecuritypersonnel2014.pdf. Accessed July 2016

QUESTIONS AND ANSWERS

1. According to an article by Schoenfisch and Pompeii, the observed percentage of hospitals with tasers available to be carried and used by hospital security personnel is?

ANSWER: 47%

2. According to an article by Schoenfisch and Pompeii, the observed percentage of hospitals with hand guns available to be carried and used by hospital security personnel is?

ANSWER: 52%

T31 IN THE NAME OF GOD: EVALUATING PERILOUS BELIEF

Brian Holoyda, MD, MPH, Sacramento, CA
James Knoll, IV, MD, Syracuse, NY
William Newman, MD, Saint Louis, MO
Jason Roof, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

To review the defining characteristics of cults, including charismatic leadership, recruitment techniques, and brainwashing, describe the history of cult membership and cult activity in psychiatric expert testimony and delineate diagnostic dilemmas arising from atypical cult beliefs that may appear delusional.

SUMMARY

Through history and popular media cults have developed a mysterious and concerning reputation. Events such as the Peoples Temple atrocity in Jonestown and television programs like The Following raise many questions about the effect that fringe doctrine and charismatic leadership can have on an individual's thought and behavior. How can individuals be recruited into organizations that espouse such atypical religious doctrine? How can cult leaders convince their members to engage in odd, sometimes violent behavior? From a psychiatric perspective, cults force us to examine the difference between belief and delusion and to wonder if "brainwashed" individuals operating under harsh cult leadership may be considered psychotic. This panel will review the fundamental characteristics that define cults, including charismatic leadership, recruitment, manipulation, and brainwashing. We will describe the history of cult membership and behavior in psychiatric expert testimony. We will delineate practical considerations pertaining to the forensic evaluation of cult members, including diagnostic confusion arising from cult beliefs that may appear delusional. Lastly, we will examine modern religious extremist groups such as the Islamic State and compare them to cults to highlight implications for forensic assessment, treatment, and management of potential recruits.

REFERENCES

Holoyda BJ, Newman WJ: Between belief and delusion: cult members and the insanity plea. J Am Acad Psychiatry Law 44:53-62, 2016

Galanter M: Cults and zealous self-help movements: a psychiatric perspective. Am J Psychiatry 147:543–551, 1990

QUESTIONS AND ANSWERS

1. Which of the following is true regarding the Diagnostic and Statistical Manual of Mental Disorders and cults?

a. The DSM precludes diagnosis of cult members due to the similarity of cults and religions.
b. The DSM-IV-TR diagnosis of shared psychotic disorder (or folie à deux) allowed for the diagnosis of cult members with odd beliefs not held by one of the world's major religions.
c. The DSM-5 describes cult membership in the criteria for the diagnosis of other specified dissociative disorder.
d. The cultural formulation in DSM-5 acknowledges involvement in cult activities as an important part of understanding an individual's culture.

ANSWER: c

2. Which of the following is true regarding cult members and forensic psychiatric evaluation?

a. Cult involvement prohibits an individual from pleading not guilty by reason of insanity.
b. Cult members commonly receive mitigated sentencing due to their perceived reduced capacity to make decisions.
c. In the 1980s civil suit plaintiffs seeking damages from cults that they joined frequently received the DSM-III diagnosis of Atypical Dissociative Disorder.
d. Cult members who commit crimes are typically found to be incompetent to stand trial because they are unwilling to work with their attorneys.

ANSWER: c

T32 FORENSIC ASPECTS OF SUBCORTICAL DEMENTIAS: A PRIMER

Manish Fozdar, MD, Wake Forest, NC
Timothy Allen, MD, Lexington, KY
Robert Granacher, MD, MBA, Lexington, KY
Jacob Holzer, MD, Belmont, MA

EDUCATIONAL OBJECTIVE
To become familiar with various subcortical dementias, understand the clinical differences between subcortical and c ortical dementias and learn to apply clinical knowledge of subcortical dementias to various medicolegal case scenarios.

SUMMARY
Dementias have become a hot topic for neuroscience research due to aging population and increased incidence of dementia. Last year, the Forensic Neuropsychiatry committee presented a panel discussion on frontotemporal dementia. This year we focus on subcortical dementias. Most clinicians are familiar with various cortical dementias such as dementia of Alzheimer type and frontotemporal dementia. Various subcortical dementias, for example, vascular dementia, Lewy Body dementia, Parkinson 's disease dementia, HIV dementia, and hypoxic-ischemic brain damage present unique challenges for a clinician. Clinical presentation can be quite heterogeneous depending on the areas of subcortical structures involved. Associated neurological impairments can vary. Neurocognitive impairments are different than what can be seen in cortical dementias. For example, impairments of memory, language and praxis are more prominent with cortical dementias. Whereas in subcortical dementias such as vascular dementia frontal-striatal circuitry is damaged. This leads to predominant deficits in attention, information processing and executive functions. Neuropsychiatric features often overlap with cortical dementias. Apathy and depression are more common with subcortical dementias. Hallucinations and delusions are more common with cortical dementias. We will focus on how these differences play a role in various types of forensic evaluations such as competency evaluations and disability evaluations

REFERENCES
Weiner M, Lipton A: Alzheimer Disease and Other Dementias, Arlington, VA: American Psychiatric Association Publishing, 2009
O 'Brien JT, Thomas A: Vascular dementia. Lancet 386:1698-1706, 2015

QUESTIONS AND ANSWERS
1. Which of the following are subcortical dementias?
a. Vascular Dementia
b. Parkinson's Disease
c. HIV/AIDS
d. Lewy Body Dementia
e. All of the above
ANSWER: e

2. Which of the following cognitive deficits are more common with subcortical dementias?
a. attention/concentration
b. information processing
c. executive functioning
d. none of the above
e. all of the above
ANSWER: e

T33 APA COUNCIL ON PSYCHIATRY AND LAW: AN UPDATE

Ken Hoge, MD, New York, NY
Marvin Swartz, MD, Durham, NC
Debra Pinals, MD, Ann Arbor, MI
Stuart Anfang, MD, Longmeadow, MA

EDUCATIONAL OBJECTIVE
Participants will understand the function of the APA Council on Psychiatry and the Law. Participants will be updated on current, ongoing issues including US Supreme Court decisions and emerging policy issues of importance to psychiatry.

SUMMARY
This workshop will provide an overview of the process by which the Council on Psychiatry and Law develops APA policy documents, such as Position Statements and Resource Documents. The goal of the workshop is to provide an update on recent and ongoing issues that the Council is addressing. This workshop will provide AAPL members

with an opportunity to provide feedback to the Council regarding a range of important areas. Dr. Hoge will provide an overview of the process. Dr. Swartz will discuss Wollschlaeger v. Governor of Florida, a case involving state law prohibition of physician discussion of gun ownership with their patients. Dr. Pinals will discuss emergency department boarding, the subject of a proposed APA Position Statement. Dr. Anfang will discuss ongoing work concerning physician-assisted suicide (PAS). PAS has been in place in a handful of states and California recently passed legislation allowing for its use. A number of states have faced proposed legislation on PAS. These topic areas may be changed if more important issues arise prior to the Annual Meeting.

REFERENCES

Weinberger SE, Lawrence HC, Henley DE, et al: Legislative interference with the patient–physician relationship. N Engl J Med 367:1557-1559, 2012

Bloom JD: Psychiatric boarding in Washington state and the inadequacy of mental health resources. J Am Acad Psychiatry Law 43(2):218-22, 2015

QUESTIONS AND ANSWERS

1. Which statements about the Florida 2011 Firearm Owners' Privacy Act (Act) are true?

a. It bans doctors from inquiring about a patient's gun ownership under any conditions.

b. It bans pediatricians from inquiring about gun ownership in the child's home.

c. It permits doctors to inquire about gun ownership if the patient has a history of a felony.

d. None of the above.

ANSWER: d

2. Longer waits in the emergency room for psychiatric patients have been associated with which of the following?

a. Insurance status.

b. Prior authorization practices.

c. Inadequate medication practices.

d. Complexity of clinical presentation.

e. All of the above.

ANSWER: e

T34 **LESSONS FROM PSYCHIATRISTS WHO WERE STALKED**

George David Annas, MD, MPH, Syracuse, NY
Kevin Smith, MD, Saugerties, NY
James Knoll, IV, MD, Syracuse, NY
William Newman, MD, Saint Louis, MO
Sandra Antoniak, MD, Kingston, NY

EDUCATIONAL OBJECTIVE

To discuss the current literature on prevalence of stalking and clinician victimization, understand the phenomenon via firsthand accounts of psychiatrists who were stalked and become familiar with methods of early recognition, threat minimization, support and coping.

SUMMARY

While not at the same level as celebrities or those who hold high profile public office, physicians, and in particular psychiatrists, are vulnerable to being stalked. Despite being experts in the field of mental health, psychiatrists are not immune to the substantial social and psychological strain that such an experience can cause, in addition to the financial toll that stalking typically engenders. While often the ones being consulted as experts in the phenomenon of stalking, forensic psychiatrists may find that such expertise provides little in regard to avenues of protection or relief when they are the ones being victimized. This panel will discuss the current research on mental health professionals as stalking victims. The panel will include firsthand accounts of psychiatrists who went through life-threatening and life-changing turmoil while attempting to free themselves from being stalked. Based on the research and these first person narratives, the panel will explore important lessons in early recognition, risk management and effective coping for the psychiatrist who becomes a victim of stalking.

REFERENCES

Nelsen AJ, Johnson RS, Ostermeyer B, et al: The prevalence of physicians who have been stalked: a systematic review. J Am Acad Psychiatry Law 43(2):177-82, 2015

Pathé MT, Meloy JR: Commentary: Stalking by patients--psychiatrists' tales of anger, lust and ignorance. J Am Acad Psychiatry Law 41(2):200-5, 2013

QUESTIONS AND ANSWERS

1. Being the victim of stalking can lead increase one's risk of which of the following?
a. PTSD
b. Suicidal ideation
c. Financial hardship
d. Depressive disorder
e. All of the Above
ANSWER: e

2. In a UK survey of inpatient psychiatrists by McIvor et al. in 2008, among the 198 surveyed, roughly what percentage reported that they had been stalked by a patient?
a. >20%
b. 15-19%
c. 11-14%
d. 5-9%
e. <4%
ANSWER: a

T35 DEVELOPMENT-TRAUMA NEXUS: PSYCHIATRIC AND BEHAVIORAL EFFECTS

Lucas Bachmann, MD, New Haven, CT
Hassan Minhas, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Josephine Buchanan, BA, (I) New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will be prepared to consider brain development, critical developmental periods, seminal events and protective factors in assessing the contribution of abuse and trauma on disruptive behaviors, psychiatric disorders, and violence and criminality; and formulating forensic opinions.

SUMMARY

The negative consequences of abuse and trauma on development and adult personality can contribute to personality and psychiatric disorders and criminality. Recent USSC decisions in cases Roper v. Simmons, Graham v. Florida, and Miller v. Alabama have determined that youth, either as a legal class or as a factor requiring special consideration at the time of sentencing or for post-sentencing relief, as in Montgomery vs. Louisiana. The decisions refer to scientific findings on brain development and potential for rehabilitation. They certainly may expand the role for forensic psychiatrists in pre-sentencing assessments of youth and in risk assessments of incarcerated adults who were sentenced as youths. Consideration of the impact of trauma, loss, and abuse on development stages and possible sequelae is essential in conducting these assessments. Using case vignettes, this workshop will review critical stages of psycho-social-sexual development, neurophysiological brain development, and environmental factors to identify critical periods, behavioral patterns, and protective factors relevant to the presentence and resentencing evaluations. The audience will participate in formulating a case and opining on the "Miller factors" in a resentencing evaluation.

REFERENCES

Mills CD: DSM-5 and neurodevelopmental and other disorders of childhood and adolescence. J Am Acad Psychiatry Law 42:165-172, 2014
Stein P, Kendall JC: Psychological Trauma and the Developing Brain: Neurologically Based Interventions for Troubled Children. New York, New York: Routledge, 2014

QUESTIONS AND ANSWERS

1. In Miller vs. Alabama (2012), the USSC barred which type of sentence for youths?
a. the death penalty
b. mandatory life without parole
c. commitment to a psychiatric hospital for more than half the sentence
d. registration as a sex offender
ANSWER: b

2. Based on current research, effects of trauma and abuse depend on the development stage of the child and what other factors?
a. protective factors, social supports, type and duration of trauma
b. protective factors, gender, and parental substance use
c. cognitive ability, substance use, and treatment
d. birth order, cognitive ability, and parental substance use
ANSWER: a

T36 **SEX OFFENDERS IN THE DIGITAL AGE**

Eric Chan, MD, San Francisco, CA
Dale McNiel, PhD, ABPP, (I) San Francisco, CA
Renée Binder, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE
This paper is intended to inform forensic mental health professionals who work with sex offenders about the rapidly evolving legal landscape surrounding the Internet and social networking sites.

SUMMARY
With the vast majority of youths now using the Internet and social networking sites, the public has become increasingly concerned about risks posed by online predators. In response, lawmakers have begun to pass laws that ban or limit sex offenders' use of the Internet and social networking sites. At the time of this article, twelve states and the federal government have passed legislation attempting to restrict or ban the use of social networking sites by registered sex offenders. These laws have been successfully challenged in four states. This article will discuss examples of case law that illustrate evolving trends regarding Internet and social networking site restrictions on sex offenders on supervised release, as well as those who have already completed their sentences. We will also review constitutional issues and empirical evidence concerning Internet and social networking use by sex offenders. To our knowledge, this is the first paper in the psychiatric literature that addresses the evolving legal landscape in reference to sex offenders and their use of the Internet and social networking sites. It is intended to help inform forensic mental health professionals who work with sex offenders on current issues in this rapidly evolving legal landscape.

REFERENCES
Wynton J: Myspace, yourspace, but not theirspace: the constitutionality of banning sex offenders from social networking sites. Duke Law J 60:1860-1903, 2011
Wolak J, David Finkelhor D, Mitchell K, et al: Online "predators" and their victims: myths, realities, and implications for prevention and treatment. Am Psychol 63(2):111-28, 2008

QUESTIONS AND ANSWERS
1. As of 2016, how many states have passed statutes attempting to limit social networking site use by registered sex offenders?
a. five
b. eight
c. two
d. nine
e. twelve
ANSWER: e

2. Laws banning sex offenders from use of the Internet and social networking sites have been challenged on what constitutional grounds?
a. Violation of the first amendment right to freedom of assocation and speech.
b. Violation of ex-post facto.
c. Violation of privacy rights.
d. All of the above.
e. None of the above
ANSWER: d

T37 **COURT-ORDERED EVALUATIONS FROM A MENTAL HEALTH COURT**

Seth Judd, DO, Indianapolis, IN
George Parker, MD, Indianapolis, IN

EDUCATIONAL OBJECTIVE
To provide insight about the concordance between clinical and CST opinions in a mental health court when two or more forensic evaluators are involved. Additionally, to identify common demographics and clinical features of defendants who receive a court-order for an evaluation in a mental health court.

SUMMARY
Mental health courts (MHC) have been in existence for over 20 years, but little is known about the demographics, clinical features and court outcomes of MHC defendants court-ordered to undergo evaluations of competence to stand trial (CST). This study examined the clinical features, demographics, evaluator opinions, and court outcomes of defendants who underwent CST evaluations for the Marion County, Indiana, MHC. Pairs of forensic reports were obtained for 97 of the 107 defendants who had CST evaluations, by four evaluators, between 2007 and 2011. The MHC defendants were likely to be male, black, and unemployed and to have a history of prior arrests and psychiatric treatment. Defendants found incompetent to stand trial (ICST) by the court (n=45, 46.4%) were significantly more likely than defendants found CST to have a psychotic disorder and significantly less likely to have a mood disorder, be on psychiatric medication or to cooperate with the forensic interviews. Evaluator concordance of primary diagnoses was 74.6% and of CST opinions was 74.0%. Evaluator concordance with the court CST decisions was 100% for concordant CST opinions and 88.9% for concordant ICST opinions; the court found 48.0% of defendants ICST when the evaluators' CST opinion was discordant.

REFERENCES
Stafford KP, Wygant DB: The role of competency to stand trial in mental health courts. Behavioral Sciences and the Law 23: 245–258, 2005
Gowensmith WN, Murrie DC, Boccaccini MT: Field reliability of competence to stand trial opinions: how often do evaluators agree, and what do judges decide when evaluators disagree? Law and Human Behavior 36:130-139, 2012

QUESTIONS AND ANSWERS
1. Defendants found ICST in the Marion County Mental Health court were more likely to be associated with which demographic feature?
a. Black
b. White
c. Currently taking psychiatric medication.
d. Mood disorder
ANSWER: a

2. What was the approximate concordance rate of evaluators' CST opinion?
a. 100%
b. 75%
c. 50%
d. 25%
ANSWER: b

T38 THE GREATS: EXPERTISE IN FORENSIC PSYCHIATRY

Graham Glancy, MB, Toronto, ON, Canada
Daniel Miller, MPH, (I) Toronto, ON, Canada

EDUCATIONAL OBJECTIVE
The central objectives of this presentation are to stimulate critical thought and discussion about the basic and advanced functions of forensic psychiatry and identify and explore potential contributors to the attainment and maintenance of expertise.

SUMMARY
Forensic psychiatry is a unique and fairly young sub-specialty. As such, understanding of the forensic-psychiatric role is evolving. While defining basic competencies is essential, the forensic psychiatrist's role as expert implies not merely static competence, but continuous striving towards excellence. In this study, we examine the meaning and development of excellence in forensic psychiatry by exploring the views and experiences of six expert practitioners. Six semi-structured interviews were conducted, followed by thematic content analysis of audio transcripts. Participants identified a variety of abilities and tendencies that distinguish excellent from competent practice, including: meticulous attention to detail, recognizing patterns in large amounts of information, incorporating insights from a wide range of disciplines, reasoning and argumentation, written and oral exposition, social skills, empathy, and exceptional clinical ability. In describing their development, most participants identified the benefit of working long hours and entering the field when it was young. Personal practices such as frequent consultation with colleagues, striving to learn, self-critique, extensive preparation, and selectiveness about cases, were indicated as important. Preliminary findings indicate a dynamic interplay between circumstances, practices and personal characteristics in the development of expertise, and support an adaptive model of the expert practitioner.

REFERENCES
Scardamalia M, Bereiter C: Computer support for knowledge-building communities.
Journal of the Learning Sciences 3:265-83, 1994
Ericsson KA, Krampe RT, Tesch-Römer C: The role of deliberate practice in the acquisition of expert performance.
Psychological Review 100: 363-406, 1993

QUESTIONS AND ANSWERS
1. According to Scardamalia and Bereiter, when expertise is conceived of as a process, experts are characterized not only by how well they perform, but also by:
a. How much they know and how colleagues perceive this knowledge.
b. The complexity and sophistication of the strategies they use to solve a given problem, or answer a given question.
c. The continuous reinvestment of mental resources to solve progressively more difficult problems.
d. The number and variety of processes they have access to when considering the optimal solution for a given problem.
ANSWER: c

2. In terms of how they are experienced, peak experience and deliberate practice in sport are:
a. Essentially the same, in that both always involve maximal effort, intense concentration and dynamic use of available resources.
b. Essentially opposite, in that peak experience involves the pleasurable exercise of graceful mastery, while deliberate practice is highly structured and may not be inherently pleasurable.
c. Only different in the degree of effort required.
ANSWER: b

T39 TRAINING RESIDENTS IN THE DIGITAL AGE: A SURVEY

Natasha Thrower, MD, Boston, MA
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
To summarize knowledge about the various potential consequences of problematic juvenile sexual behavior, understand limitations in formal training provided to physician trainees concerning problematic juvenile sexual behaviors and identify ways in which residents and fellows might be taught to identify, assess, and manage their patients' online problematic behaviors.

SUMMARY
Juveniles engage in a variety of normal, exploratory, and potentially problematic sexual behaviors both online and offline. Today's generation of youth has ready access to the Internet via communication devices that provide a plethora of educational and social opportunities. However, these technologies may also place children at risk of becoming "addicted" to the Internet, engaging in problematic sexual behaviors (e.g., sexting) or falling victim to cyberbullies or online sexual predators. Given the prominent role of technology in the lives of adolescents, physicians working with this population should be knowledgeable of available technologies and their potential associated clinical and legal risks.
This study aims to examine the extent of training residents and fellows receive in identifying, assessing, and managing problematic online activities in this age group.
Pending IRB approval an electronic questionnaire will be disseminated to program directors of specialties most likely to encounter this issue. Participants will include U.S. Pediatric, Child Psychiatry, and Forensic Psychiatry residency and fellowship programs.
We expect results to support our hypothesis that residents and fellows are inadequately trained to identify, assess, and manage their patients' online problematic behaviors and thus may miss opportunities to intervene on behaviors that could result in distress or outright victimization.

REFERENCES
Saleh FM, Grudzinskas A, Judge A (Eds.), Adolescent Sexual Behavior in the Digital Age: Considerations for Clinicians, Legal Professionals, and Educators. New York, NY: Oxford University Press, 2014
Moreno MA, Jelenchick L, Cox E, et al: Problematic internet use among US youth: a systematic review. Pediatrics Adolescent Medicine 165(9), pp.797-805, 2011

QUESTIONS AND ANSWERS

1. Which of the following is true about sexting?
a. Sexting represents problematic sexual behaviors only and is not a form of normal adolescent behavior.
b. Sexting minors are not subject to the harsh punishments under federal or state child pornography statutes.
c. Sexting usually associated with secure attachment.
d. Residents educated about about sexting behaviors, should speak to patients/families about potential legal, psychological, emotional and developmental consequences.
ANSWER: d

2. Which of the following are ways in which doctors can serve to prevent or address internet related issues with patient's and their families as they arise?
a. Advising parental restrictions on internet and cell phone use.
b. Encouraging open discussion between parents and children about the public and enduring nature of information sent out over the Internet.
c. Increasing their own knowledge of digital technology.
d. All of the above
ANSWER: d

T40 POLICE RESPONSE TO PERSONS WITH MENTAL ILLNESS

Emily Keram, MD, Santa Rosa, CA
Chief Louis Dekmar, (I) LaGrange, GA
Debra Pinals, MD, Ann Arbor, MI
Commander Sara Westbrook, (I), Portland, OR

EDUCATIONAL OBJECTIVE

Participants will learn about local and national programs aimed at improving police response to persons with mental illness while gaining familiarity with core police practices, including use of force decision-making.

SUMMARY

The use of force by law enforcement (LE) has come under increasing public scrutiny in the wake of recent high profile officer-involved shootings nationwide. Several of these incidents have focused attention on police contacts with mentally ill subjects. What expertise do civilians, whether critics or supporters of LE, bring to their analysis of these interactions and their outcomes? From a young age, many Americans are exposed to a myriad of books, television shows, and movies that depict police policy and procedures. This may leave them with a false sense of knowledge of police work and a lack of appreciation for its complexities. At the same time, Americans are rightfully interested in ensuring that LE adhere to policies and procedures that recognize and protect the constitutional rights of citizens. This is particularly important for vulnerable citizens, such as the mentally ill. This Presidential Symposium is an effort to improve understanding of LE policies and procedures and foster AAPL members' interest in working at the interface of LE and mental illness on a local level.

REFERENCES

Compton MT, Bakeman R, Broussard B, et al: The police-based crisis intervention team (CIT) model: II. Effects on level of force and resolution, referral, and arrest. Psychiatric Services, 2014
Coleman T, Cotton D: TEMPO: A contemporary model for police education and training about mental illness. International Journal of Law and Psychiatry 37(4), 325-333, 2014

QUESTIONS AND ANSWERS

1. According to Graham v. Connor (490 U.S. 386, 1989) which of the following does the fact finder consider when evaluating allegations of excessive use of force by law enforcement against a mentally ill subject?
a. The subject's medication compliance.
b. Deliberate indifference.
c. The Americans with Disabilities Act.
d. The perspective of a reasonable officer on the scene.
e. The subject's diagnosis.
ANSWER: d

2. CIT-trained officers are more likely than officers without CIT training to end contacts with mentally citizens with referral or transport to a treatment facility. Which factor present during an encounter was most strongly associated with this finding?
a. Gender of the subject.
b. Gender of the officer.
c. Use of physical force by law enforcement.
d. Length of officer's employment.
e. Officer carrying a Taser.
ANSWER: c

FRIDAY, OCTOBER 28, 2016

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

F1 ***Psychosis with Butane Hash Oil and a Question of Competency***
Gwen Levitt, DO, Phoenix, AZ
Jennifer Weller, PhD, (I) Mesa, AZ

F2 ***Malingering Inpatients Receiving Competency Restoration***
Sarah Duhart Clarke, BS, (I) Salem, OR
Jonathan McCully, BS, (I) Salem, OR
Jessica Murakami-Brundage, PhD, (I) Salem, OR

F3 ***Predicting Inpatient Readmissions for Competency Restoration***
Jonathan McCully, BS, (I) Salem, OR
Sarah Duhart Clarke, BS, (I) Salem, OR
Jessica Murakami-Brundage, PhD, (I) Salem , OR

F4 ***Educator Sexual Misconduct - Research, Laws, and Prevention***
Kamaloshini Puthumana, MD, Fayetteville, NY
Nicole Charder, MD, New York, NY
James Knoll IV, MD, Syracuse, NY

F5 ***Look What I did! Social Media and Self-Incrimination***
Mustafa Mufti, MD, Newark, DE
Kenneth Weiss, MD, Bala Cynwyd, PA

F6 ***Don't Gimme Shelter: Homelessness, SMI, and Competency***
Jeffrey Kerner, MD, Bronx, NY
Bridget McCoy, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY

F7 ***Traits, Biases and Quality in U.S. Intelligence Analysis***
Jacob Holzer, MD, Brookline, MA
Steve Cartun, MD, Erie, PA
Joseph Gordon, PhD, (I) Washington DC
William Costanza, DLS, (I) Arlington, VA

F8 ***Trauma Diagnosis in Incompetence to Stand Trial***
Cristina Secarea, MD, Alexandria, VA
Philip Candilis, MD, Alexandria, VA

F9 ***Second Language and Interpreter Use In Forensic Evaluations***
Wilhem Rivera, MD, Washington, DC
Philip Candilis, MD, Alexandria, VA
Carla Rodgers, MD, Wynnewood, PA

F10 ***A Continuum of Competency Restoration Services***
Aniket Tatugade, MBBS, Augusta, GA
Kelly Coffman, MD, Atlanta, GA
Joyce Brown, MA, (I) Atlanta, GA
Louisa Ellis, MSW, (I) Atlanta, GA
Victoria Roberts, MEd, (I) Atlanta, GA
Peter Ash, MD, Atlanta, GA

F11 ***Designer Drugs: Sugar, Spice, and Everything (Not So) Nice***
Casey Gregoire, DO, (I) Augusta, GA
Eindra Khin Khin, MD, Washington, DC

F12 ***A Novel Diversion Program for Mentally Ill Female Offenders***
Kelly Coffman, MD, MPH, Atlanta, GA
Swati Shivale, MD, Syracuse, NY
Victoria Roberts, MEd, (I) Atlanta, GA
Peter Ash, MD, Atlanta, GA

F13 ***Effective De-Escalation Strategies in a Forensic Hospital***

Rebecca Kornbluh, MD, Claremont, CA
David Lam, MSW, (I) Sacramento, CA
Susan Velasquez, PhD, (I) Sacramento, CA

F14 ***Nursing Documentation as a Screening Tool for Competency***

Joy Stankowski, MD, Cleveland, OH

F15 ***Assessment of the Cognitively Impaired Sex Offender***

Fabian Saleh, MD, Boston, MA
Robyn Thom, MD, (I) Boston, MA

F16 ***Interventions for Reducing Inpatient Violence***

Danielle Kushner, MD, New York, NY
Deepali Gangahar, MD, (I) New York, NY
Nikita Shah, MD, New York, NY

F17 ***The Prevalence of PTSD in a Forensic Mental Health Unit***

Bentley Strockbine, MD, Baldwinsville, NY
George David Annas, MD, MPH, Syracuse, NY
James Knoll IV, MD, Syracuse, NY
Bruce Way, PhD, (I) Syracuse, NY

F18 ***How Has the Supreme Court Transformed Juvenile Justice?***

Fahad Ali, MD, Bryn Mawr, PA
Kenneth Weiss, MD, Philadelphia, PA

F19 ***Parole Violations in Psychiatrically Hospitalized Offenders***

Bipin Subedi, MD, Brooklyn, NY
Ashley Fresenius, LMSW, (I) Brooklyn, NY

F20 ***Decoding New York State's Prescription Monitoring Program***

Lama Bazzi, MD, Stony Brook, NY
Elie Aoun, MD, Providence, RI
Nicholas Genova, MD, St. James, NY
Felix Torres, MD, Brooklyn, NY

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

F21 ***AAPL Practice Guidelines on Competence to Stand Trial Update***

Barry Wall, MD, Providence, RI
Jeffrey Janofsky, MD, Baltimore, MD
Christopher Thompson, MD, Los Angeles, CA
Debra Pinals, MD, Ann Arbor, MI

COURSE (TICKET REQUIRED) 8:00 AM - 12:00 PM **PAVILION EAST**

F22 ***Hastening the Future: Onsite Research Consultation Research Committee***

Nathan Kolla, MD, PhD, Toronto, ON, Canada
Philip Candilis, MD, Washington, DC
Douglas Mossman, MD, Cincinnati, OH
Robert Trestman, MD, PhD, Farmington, CT
Alexander Westphal, MD, PhD, New Haven, CT

WORSKHOP 8:00 AM - 10:00 AM **PAVILION WEST**

F23 ***Cultural Challenges in Immigration Competency Assessments***

Dalia Balsamo, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Reena Kapoor, MD, New Haven, CT
Howard Zonana, MD, New Haven, CT

WORKSHOP 8:00 AM - 10:00 AM **GALLERIA**

F24 ***Sex Tech Ed 101: Technology in Sexual Offender Evaluations***

Matthew Lang, DO, Pittsburgh, PA
R. Gregg Dwyer, MD, EdD, Charleston, SC
Abhishek Jain, MD, Pittsburgh, PA

RESEARCH-IN-PROGRESS #2 8:00 AM - 10:00 AM **BROADWAY I-III**

F25 ***Efficacy of Specialized Treatment for Mentally Ill in Jails***
Daniel Antonius, PhD, (I) Buffalo, NY
Corey Leidenfrost, PhD, (I) Buffalo, NY
Peter Martin, MD, MPH, Buffalo, NY
Evelyn Coggins, MD, Hamburg, NY

F26 ***Felony Veterans Court: Progress Towards Goals After 5 Years***
Andrea Stolar, MD, Houston, TX
Loretta Coonan, LCSW, (I) Houston, TX
David Graham, MD, Houston, TX
George Nadaban, MD, Humble, TX

F27 ***Sexually Violent Predator Defense Teams: Do They Matter?***
Jeremy Colley, MD, Folsom, CA
Melinda DiCiro, PhD, (I) Sacramento, CA

F28 ***Insane Sex Offenders: Clinical and Forensic Characteristics***
Brian Holoyda, MD, Sacramento, CA
Barbara McDermott, PhD, (I) Sacramento, CA
William Newman, MD, Saint Louis, MO

COFFEE BREAK **10:00 AM – 10:15 AM**

PANEL 10:15 AM - 12:00 PM **BALLROOM I**

F29 ***A Proposed Resource Document on Prescribing in Corrections***
Correctional Committee
Anthony Tamburello, MD, Glassboro, NJ
Jeffrey Metzner, MD, Denver, CO
Elizabeth Ferguson, MD, Augusta, GA
Michael Champion, MD, Honolulu, HI
Graham Glancy, MB, Toronto, ON, Canada

PANEL 10:15 AM - 12:00 PM **PAVILION WEST**

F30 ***A Tale of Two PSRBs: Thirty Years of Outcome Data Explored***
Tobias Wasser, MD, New Haven, CT
Michael Norko, MD, New Haven, CT
Juliette Britton, JD, (I) Portland, OR
Simrat Sethi, MD, Salem, OR

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

F31 ***Mass Killers: How Worried Should the Masses Be?***
Criminal Behavior Committee
Melissa Spanggaard, DO, Sioux Falls, SD
Hy Bloom, MD, FRCP(C), Toronto, ON, Canada
Marc Cohen, MD, Beverly Hills, CA
Stephen Peterson, MD, Kansas City, KS
Ryan Shugarman, MD, Alexandria, VA

SCIENTIFIC PAPER SESSION #2 10:15 AM - 12:00 PM` **BROADWAY I-III**

F32 ***Nightmares of Traumatized Central American Asylum Seekers***
James Boehnlein, MD, Portland, OR

F33 ***Feminist Ethics, Human Rights, and Maternal-Fetal Conflict***
Navneet Sidhu, MD, Washington, DC
Philip Candilis, MD, Alexandria, VA

F34 ***Chemical Dependency Commitment: Does it Work?***
Ian Lamoureux, MD, Rochester, MN
Paul Schutt, MD, (I) San Francisco, CA
Keith Rasmussen Jr., MD, Rochester, MN

LUNCH (TICKET REQUIRED) 12:00 PM – 2:00 PM **BALLROOM II**

F35 ***Story of a Warchild***

Emmanuel Jal (I), Toronto, ON, Canada

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

F36 ***Non-State Political Violence and Identity***

Emily Keram, MD, Santa Rosa, CA
Kathleen Puckett, PhD, (I) Danville, CA
Marc Sageman, MD, PhD, Rockville, MD

COURSE (TICKET REQUIRED) 2:15 PM - 6:15 PM **PAVILION EAST**

F37 ***Expert Testimony in Suicide Malpractice Litigation***

Liza Gold, MD, Arlington, VA
Donna Vanderpool, MBA, JD, (I) Arlington, VA
Jeffrey Metzner, MD, Denver, CO
Barry Wall, MD, Providence, RI

PANEL 2:15 PM - 4:00 PM **PAVILION WEST**

F38 ***A Jury of Thousands***
Child and Adolescent Psychiatry Committee

Lynn Maskel, MD, Madison, WI
Steven Drizin, JD, (I) Chicago, IL
Paul O'Leary, MD, Birmingham, AL

PANEL 2:15 PM - 4:00 PM **GALLERIA**

F39 ***Community Forensics: AAPL Outside of the Courtroom***

Merrill Rotter, MD, White Plains, NY
Reena Kapoor, MD, New Haven, CT
Debra Pinals, MD, Ann Arbor, MI
Christine Martone, MD, Pittsburgh, PA
Katherine Michaelsen, MD, Seattle, WA
Ken Hoge, MD, New York, NY

WORKSHOP 2:15 PM - 4:00 PM **BROADWAY I-III**

F40 ***Administrative Separations, Medical Boards***

Elspeth Ritchie, MD, Silver Spring, MD

COFFEE BREAK **4:00 PM – 4:15 PM**

DEBATE 4:15 PM - 6:15 PM **BALLROOM I**

F41 ***MOC: Keep, Polish or Abolish?***
Private Practice Committee

Trent Holmberg, MD, Draper, UT
Dan Cotoman, MD, Charlotte, NC
Celestine DeTrana, MD, Indianapolis, IN
Larry Faulkner, MD, Chicago, IL
Richard Frierson, MD, Columbia, SC
Nicole Graham, MD, South Windsor, CT
Richard Rosin, MB, FRCPC, (I) Vancouver, BC, Canada

PANEL 4:15 PM - 6:15 PM **PAVILION WEST**

F42 ***Violence Reduction: Promising Tools for a Problematic Task***

Merrill Rotter, MD, White Plains, NY
Debra Pinals, MD, Ann Arbor, MI
Barry Rosenfeld, PhD, (I) Bronx, NY
Ken Hoge, MD, New York, NY

PANEL — 4:15 PM - 6:15 PM — **GALLERIA**

F43 ***Managing Threats on Campus***

Cheryl Regehr, PhD, (I) Toronto, ON, Canada
Graham Glancy, MB, Toronto, ON, Canada
Joel Dvoskin, PhD, (I) Tucson, AZ
Scott Waugh, PhD, (I) Los Angeles, CA
Lisa Ramshaw, MD, Toronto, ON, Canada

SCIENTIFIC PAPER SESSION # 3 — 4:15 PM - 6:15 PM — **BROADWAY I-III**

F44 ***Geriatric Population in the Legal System: A Review***

Stephanie Yarnell, MD, PhD, New Haven, CT
Paul Kirwin, MD, West Haven, CT
Howard Zonana, MD, New Haven, CT

F45 ***Forensic Rotations for Residents: Navigating the Challenges***
Forensic Training Committee

Katherine Michaelsen, MD, Seattle, WA
Tobias Wasser, MD, New Haven, CT
Alan Lewis, MD, PhD, Hamden, CT
Peter Morgan, MD, PhD, New Haven, CT
Sherry McKee, PhD, (I) New Haven, CT

F46 ***Trial 1 versus Trial 2 of the Test of Memory Malingering***

Douglas Mossman, MD, Cincinnati, OH
Roger Gervais, PhD, (I) Edmonton, AB, Canada
Kathleen Hart, PhD, (I) Cincinnati, OH
Dustin Wygant, PhD, (I) Richmond, KY

F47 ***Gun Safety in General Psychiatry Residency Training***

Jennifer Piel, MD, JD, Seattle, WA

Your opinion on today's sessions is very important!
While it's fresh in your mind, PLEASE complete the evaluation form for today's program so we can continue to offer CME in the future.

F1 PSYCHOSIS WITH BUTANE HASH OIL AND A QUESTION OF COMPETENCY

Gwen Levitt, DO, Phoenix, AZ
Jennifer Weller, PhD, (I) Mesa, AZ

EDUCATIONAL OBJECTIVE

This poster aims to increase the knowledge base of practicing psychiatrist as well as fellows and students. Knowing about the effects of dabbing and how that may impact competency and other legal matters is important to provide thorough assessments. This case has promoted research on dabbing and effects on cognition.

SUMMARY

Butane Hash Oil contains 60-90% cannabis. The mechanism for ingestion of BHO is called "dabbing." Users report vomiting, elevated pulse and blood pressure and loss of consciousness. Psychiatric symptoms include paranoia, tactile hallucinations, and anxiety. Dabbing is a relatively new phenomenon, and little evidence-based research has been conducted to determine its prevalence or the extent of cognitive and psychiatric sequelae. A 19-year-old male with no prior psychiatric history was arrested for Aggravated Assault. His parents reported several months of bizarre behaviors. He stopped bathing, dismantled the electrical sockets, was eating flour and baking soda and drinking salt water. His parents found a "greasy, yellow substance" in his bathroom. The defendant talked about his "inventions;" machines that could turn garbage into gold, clean the world's oceans, and generate an endless energy supply. His urine drug screen was positive for cannabis. The patient admitted to using BHO for the past six months. He was determined to be incompetent to stand trial. Dabbing is likely to present with increasing in courtroom, and psychiatry settings. Attorneys should be familiar with how dabbing may influence their clients' ability to cooperate and engage in their legal defense.

REFERENCES

Day A, Metrik J, Spillane NS, et al: Working memory and impulsivity predict marijuana-related problems among frequent users. Drug Alcohol Depen 131:171-174, 2013
Hart L, Ilan B, Gevins A, et al: Neurophysiological and cognitive effects of smoked marijuana in frequent users. Pharmacol Biochem Beh 96:333-341, 2010

QUESTIONS AND ANSWERS

1. Which of the following is not a consequence of dabbing?
a. Vomiting
b. Diarrhea
c. Elevated heart rate
d. Hallucinations
e. Anxiety
ANSWER: b

2. Which of the following is a false statement?
a. BHO has a 60 to 90% concentration of cannabis.
b. Psychosis may be observed in BHO users in an emergency room.
c. Asking someone if they use marijuana does not necessarily identify dabbing.
d. Lawyers and court personnel do not need to know about dabbing.
ANSWER: d

F2 MALINGERING INPATIENTS RECEIVING COMPETENCY RESTORATION

Sarah Duhart Clarke, BS (I) Salem, OR
Jonathan McCully, BS, (I) Salem, OR
Jessica Murakami-Brundage, PhD (I) Salem, OR

EDUCATIONAL OBJECTIVE

Participants will learn specific commonalities among malingering patients with court orders for competency restoration in a forensic hospital.

SUMMARY

This research examines and analyzes over 2,000 forensic evaluation reports from 2012 through 2015; these reports consist of the evaluations of inpatients at the Oregon State Hospital court ordered for competency restoration. Analysis of this data will compare demographics, personal histories, criminal charges, length of hospital stay, diagnoses, and number of seclusions and restraints between malingering patients and non-malingering patients. The purpose of this research is to determine common characteristics, behaviors, and patterns among malingering patients, and to examine if these commonalities are unique to malingering patients. This research will further knowledge on malingering

patients, as this field of research is currently sparse, and may increase the effectiveness of identifying malingering patients hospitalized for competency restoration. Currently, the evaluation reports are still being examined, so the analysis of this data is expected to occur in spring of 2016 and be completed in summer of 2016.

REFERENCES

Gacono CB, Meloy JR, Sheppard K, et al: A clinical investigation of malingering and psychopathy in hospitalized insanity acquittees. J Am Acad Psychiatry Law 23: 387-97, 1995

Lanyon RI, Almer ER, Curran PJ: Use of biographical and case history data in the assessment of malingering during examination for disability. J Am Acad Psychiatry Law 21: 495-503, 1993

QUESTIONS AND ANSWERS

1. Based on the literature, which of the following charges is most associated with malingering?
a. Theft
b. Trespassing
c. Attempted Murder
d. Criminal Mischief
ANSWER: c

2. Based on the literature, how prevalent are malingerers in forensic populations?
a. 25%
b. 11%
c. 2%
d. 17%
ANSWER: d

F3 PREDICTING INPATIENT READMISSIONS FOR COMPETENCY RESTORATION

Jonathan McCully, BS, (I) Salem, OR
Sarah Duhart Clarke, BS (I) Salem, OR
Jessica Murakami-Brundage, PhD (I) Salem, OR

EDUCATIONAL OBJECTIVE

Participants will be able to identify the characteristics of patients who are readmitted to Oregon State Hospital (OSH) for competency restoration.

SUMMARY

Although research has been conducted on predictors of readmission to psychiatric inpatient settings, little is known about the predictors of readmission to state hospitals for competency restoration. This study examines the characteristics of incompetent to stand trial (IST) patients at OSH who have been readmitted to the hospital for competency restoration at least once since 2012. Although the majority of IST patients are not readmitted to the hospital for competency restoration, a significant percentage of patients are readmitted under the same or additional charges. The study will investigate whether or not there are differences between these two groups in terms of demographic information, counties of origin, criminal charges, diagnoses, and hospital course. Additionally, the study will discuss reasons why patients are readmitted to the hospital for competency restoration, and ways to reduce the likelihood of readmission. This study is currently in progress and is expected to be completed this summer.

REFERENCES

Zhang J, Harvey C, Andrew C: Factors associated with length of stay and the risk of readmission in an acute psychiatric inpatient facility: A retrospective study. Aust Nz J Psychiat 45:578-585, 2011

Niehaus DJ, Koen L, Galal U, et al: Crisis discharges and readmission risk in acute psychiatric male inpatients. BMC Psychiatry 8(44):1-6, 2008

QUESTIONS AND ANSWERS

1. According to evidence from previous research, what factors are good predictors of adult psychiatric readmissions?
a. Previously found to be malingering
b. Gender
c. Length of stay
d. Number of previous admissions
e. b, c, and d
ANSWER: e

2. What is the approximate percentage of IST patients who are readmitted to OSH for competency restoration?
a. 25%
b. 42%
c. 17%
d. 2%
e. 66%
ANSWER: c

F4 **EDUCATOR SEXUAL MISCONDUCT – RESEARCH, LAWS, AND PREVENTION**

Kamaloshini Puthumana, MD, Fayetteville, NY
Nicole Charder, MD, New York, NY
James Knoll, IV, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE
Educate psychiatrists on forensic psychiatric aspects of educator sexual misconduct. Educate psychiatrists on state statutes and case law addressing educator sexual misconduct.

SUMMARY
Sexual abuse of students by teachers has received increasing attention in recent years. Prior to the 1990s, there was little formal research on this subject (Knoll, 2015). A 1991 survey of high school students found that 14% reported having had sexual intercourse with a teacher (Wishnietsky, D. H. 1991). A 2014 study concluded that, on average, 15 young people were sexually victimized by educators each week in the U.S (Abbott, 2014). These findings have led to state statutes and state supreme court rulings on educator sexual misconduct. Educators are in a position of power and authority, and some teachers use this position to select, groom and seduce students into sexual relationships. Forensic psychiatrists may be retained in cases of educator sexual misconduct for a variety reasons. This poster will review the extant research on educator sexual misconduct, give a breakdown of criminal laws by state, describe the varied definitions of sexual educator misconduct, and suggest basic prevention strategies.

REFERENCES
Educator's Guide to Controlling Sexual Harassment. Available at https://www.ncherm.org/documents/ControllingSexualHarassmentApril2011.pdf. Accessed August 2016
Moulden HM, Firestone P, Kingston DA, et al: A description of sexual offending committed by Canadian teachers. J Child Sex Abus 19(4):403-18, 2010

QUESTIONS AND ANSWERS
1. In cases of educator sexual misconduct, school districts may be held liable under which law?
a. Title IX of the Education Amendments of 1972
b. Title 42 USC §1983
c. Title VII of the Civil Rights Act of 1964
d. a and b
ANSWER: d

2. All of the following are potential warning signs of educator sexual misconduct except?
a. Excessive time spent with student outside of class.
b. Repeated time spent in private spaces with a student.
c. Being a teacher's pet.
d. After hours or excessive phone calls to a student.
e. Other students suspect, make jokes or references
ANSWER: c

T5 **LOOK WHAT I DID! SOCIAL MEDIA AND SELF-INCRIMINATION**

Mustafa Mufti, MD, Newark, DE
Kenneth Weiss, MD, Bala Cynwyd, PA

EDUCATIONAL OBJECTIVE
In this discussion we will examine how self-incrimination on social media may raise the question of mental state and possibly assist the trier of fact in determining criminal responsibility. Additionally, we will propose a typology of self-incriminating posts that may aid the forensic psychiatric evaluator in a case formulation.

SUMMARY
Information such as photographs, status updates, and communications on social media have been used as evidence in legal proceedings. In Trenda v. State, information obtained from a MySpace account was admitted as evidence in

a murder trial. In another case, a man later referred to as the "Facebook Killer" posted pictures of his wife's bloody corpse shortly after killing her. Review of an individual's digital footprint may provide evidence about character, cognitive abilities, impulse control and problems with thought content and process. Additionally, an evaluator may look into the dynamics of the posting or confession. This could be analogous to Francis Wharton's suggested classification of confessions. Was the posting a result of a personality disorder, overwhelming guilt, disinhibition from drugs or alcohol, or was there a thought disorder which compelled him to do so? Scarcity of collateral information coupled with an uncooperative evaluee can often result in a challenging forensic psychiatric evaluation. In such cases a typology self-incriminating postings may aid the evaluator by providing a roadmap to questions of mental state. Furthermore, it may assist the legal system in weighing of mitigating and/or aggravating factors of criminal responsibility.

REFERENCES

Recupero PR: The mental status examination in the age of the internet. J Am Acad Psychiatry Law 38:15-26, 2010
Weiss KJ: Classics in psychiatry and the law: Francis Wharton on involuntary confessions. J Am Acad Psychiatry Law 40(1):67-80, 2012

QUESTIONS AND ANSWERS

1. Which one of the following situations would result in the inadmissibility of an online posting or confession?
a. As a way to gain fame.
b. Deliberately due to excessive shame and guilt.
c. The defendant was actively psychotic at the time of the said posting.
d. The defendant was under the influence of alcohol or another substance.
e. None of the above.
ANSWER: e

2. How may a careful evaluation of a defendant's social media account and self-incriminating posting help a forensic evaluator?
a. It may help create a more comprehensive clinical picture of the defendant.
b. It may tell you about the defendant's mental state at the time of alleged offense.
c. Information obtained may assist in learning more about the defendant's cognitive abilities, social interests, and possible emotional state.
d. All of the above.
ANSWER: d

FRIDAY

F6 DON'T GIMME SHELTER: HOMELESSNESS, SMI, AND COMPETENCY

Jeffrey Kerner, MD, Bronx, NY
Bridget McCoy, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE

The objective is to explore and discuss the complex and dynamic relationship between homelessness, mental illness, and competency. We aim to educate colleagues about how government agencies have responded to the street homeless population when behavior disrupts social order but is not necessarily acutely dangerous.

SUMMARY

In advance of a winter cold front, Governor Andrew Cuomo instructed state and municipal agents to remove homeless individuals from the street "who are unwilling or unable to find necessary shelter" when temperatures dip below 32 degrees F. Citing New York State Mental Hygiene law, the directive established a connection between an individual's failure to find appropriate accommodations and the mental illness and dangerousness that are required by statute for police to take action. The executive order underscores the delicate and interconnected relationship between behavioral manifestations of mental illness and the disruption of social order. There may be explanations for avoiding public shelter that would not be common, but do not directly imply serious mental illness or a lack of decisional capacity. In this poster we will review the literature regarding the mental illness burden on the street homeless population. Further, we will review how local governments have interpreted mental hygiene law to address disorderly behaviors and unsafe lifestyle practices with particular attention to the relationship between homelessness, mental illness and assessment of decisional capacity.

REFERENCES

McQuistion H, Sowers W, Ranz J, et al: Handbook of Community Psychiatry. Homelessness and Behavioral Health in the New Century, New York, NY: Springer, 2012
Hudson CG: Socioeconomic status and mental illness: tests of the social causation and selection hypotheses. Am J Orthopsychiatry 75(1):3-18, 2005

QUESTIONS AND ANSWERS

1. Which effect is more profound?

a. The stresses of poverty, including chronic unemployment and poor housing, lead to serious mental illness.

b. Serious mental illness leads to poverty.

ANSWER: a

2. What percent of adults with Medicaid coverage suffer from serious mental illness?

ANSWER: The percent of adults, 26-49, with serious mental illness, covered by Medicaid is 20.7%, compared to 8.1% of adults with private health insurance.

F7 TRAITS, BIASES AND QUALITY IN U.S. INTELLIGENCE ANALYSIS

Jacob Holzer, MD, Brookline, MA
Steve Cartun, MD, Erie, PA
Joseph Gordon, PhD, (I) Washington, DC
William Costanza, DLS, (I) Arlington, VA

EDUCATIONAL OBJECTIVE

Teach the audience about how psychological traits and bias influence intelligence analysis and provide an update on measures for quality improvement.

SUMMARY

Analyzing raw intelligence data in an effort to provide meaningful national security information has been increasingly critical in light of a growing terrorism threat, yet by definition is subjective and sensitive to a variety of human fallibilities, including personality traits, rigidity in thinking, and misperceptions. Several types of cognitive biases have been described in the intelligence literature. This poster reviews the literature on cognitive biases, and presents an updated review of strategies drawn from the medical literature, in an effort to provide approaches to reduce biases and improve intelligence analysis.

REFERENCES

Heuer RJ: Psychology of Intelligence Analysis, Reston, VA: Pherson Associates, LLC, 2007
Groopman J: How Doctors Think, Boston, MA: Houghton Mifflin Co., 2007

QUESTIONS AND ANSWERS

1. What strategy may improve the quality of intelligence analysis?

a. Data immersion, the more the better.

b. Simultaneous evaluation of multiple, competing hypotheses.

c. Improving memory strategies to apply techniques and hypotheses to new situations.

d. Use of a team effort to develop a working hypothesis and reject any contrarian views.

ANSWER: b

2. Which statement is least true?

a. There are numerous biases and "traps" in analysis, such as misperception, mirror-imaging, inappropriate analogies, and the creation of mental shortcuts.

b. Stereotyping others in the analysis process can be highly problematic.

c. Reducing misperceptions and biases, and improving the quality of intelligence analysis, is an individual, rather than cultural or organizational, responsibility.

d. Inter-agency communication is an important aspect of quality improvement.

ANSWER: c

F8 TRAUMA DIAGNOSIS IN INCOMPETENCE TO STAND TRIAL

Cristina Secarea, MD, Alexandria, VA
Philip Candilis, MD, Alexandria, VA

EDUCATIONAL OBJECTIVE

To analyze factors influencing restorability and length of time to restoration in a group of IST patients diagnosed with PTSD.

SUMMARY

Given the lack of data on PTSD and its effect on competence restoration, we isolated a group of IST patients diagnosed with PTSD from a large sample of inpatient restoration subjects. In analyzing factors influencing restorability and length of time to restoration, we compared the PTSD group to those without PTSD. Of 312 incompetent patients, 5% (n=16) were diagnosed with PTSD. The majority, 69% were females between the age of 18 and 40. Substance use was the most common disorder associated with a diagnosis of PTSD (69%). 75% were charged with a misdemeanor, 25% with a felony. 50% of both groups were adherent to medication treatment by local definitions.

Only 37.5% of patients with PTSD had one or more emergency episodes that required involuntary medications, less than the comparison group. Overall, the average length of time to restorability among IST patients with PTSD was 5 days less (51 days) compared to those without PTSD (57 days). Although the sample is small, it matches PTSD prevalence and demographics in the general population. We offer a number of reasons for expanding this research and theorize on potential positive effects on competence restoration duration and costs.

REFERENCES

Donley S, Habib L, Jovanovic T, et al: Civilian PTSD symptoms and risk for involvement in the Criminal Justice System. J Am Acad Psychiatry Law 40:522-9, 2012
Kristiansson M, Sumelius K, Sondergaard H: Post-traumatic Stress Disorder in the Forensic Psychiatric Setting. J Am Acad Psychiatry Law 32:399-407, 2004

QUESTIONS AND ANSWERS

1. In the general population, which is the most common diagnosis associated with PTSD?
a. Personality disorder
b. Psychotic disorder
c. Substance use disorder
d. Mood disorder
ANSWER: c

2. In what age group is PTSD most prevalent?
a. 18 to 40 years
b. 40 to 50 years
c. 50 to 60 years
d. 60 and above
ANSWER: a

F9 SECOND LANGUAGE AND INTERPRETER USE IN FORENSIC EVALUATIONS

Wilhem Rivera, MD, Washington, DC
Philip Candilis, MD, Alexandria, VA
Carla Rodgers, MD, Wynnewood, PA

EDUCATIONAL OBJECTIVE

To describe the experience of AAPL members in using interpreters or a language other than English in forensic evaluations.

SUMMARY

Forensic psychiatrists are called upon to evaluate individuals from multiple linguistic backgrounds. Among these evaluees, many of them from non-dominant groups who are over-represented in the criminal justice system, English speaking ability varies greatly. Interpreters themselves can vary widely depending on their training and experience. For example, interpreters may minimize symptoms, editorialize, and role exchange, all of which interfere with forensic assessment. We present first-of-its kind data on the experience of AAPL members with evaluations either using interpreters or conducted in a language other than English. Surveys assessed the frequency of use of a language other than English, the extent of interpreter use, the type of forensic evaluations performed in a language other than English, strengths and weaknesses of forensic interpreter services, and feedback received from third parties. These data will inform linguistic and cultural practice by offering areas for potential improvement in the evaluation of non-English speaking examinees, and improve sensitivity to the language difficulties of evaluees and evaluators.

REFERENCES

Vasquez C, Javier RA: The problem with interpreters: communicating with Spanish-speaking patients. Hospital and Community Psychiatry 42, 163-5, 1991
Ryan C: Language Use in the United States. 2011 American Community Service Reports.
Available at http://www.census.gov/prod/2013pubs/acs-22.pdf. Accessed August 2016

QUESTIONS AND ANSWERS

1. What is the most common error committed by interpreters?
a. Lying
b. Editorializing
c. Using the wrong dialect
d. Using word-for-word substitution for the meaning of a statement
ANSWER: b

2. Which group has the lowest English speaking proficiency?
a. Greek
b. Russian
c. Hispanic
d. Chinese
ANSWER: d

F10 A CONTINUUM OF COMPETENCY RESTORATION SERVICES

Aniket Tatugade, MBBS, Augusta, GA
Kelly Coffman, MD, Atlanta, GA
Joyce Brown, MA, (I) Atlanta, GA
Louisa Ellis, MSW, (I) Atlanta, GA
Victoria Roberts, Med, (I) Atlanta, GA
Peter Ash, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE
To promote understanding of the advantages of utilizing a contiunum of competency restoration services.

SUMMARY
In many jurisdictions, a finding of incompetency to stand trial results in the defendant's hospitalization for restoration, a one-size-fits-all approach. This study examines outcomes for defendants admitted to a program which provides a continuum of restoration services, ranging in intensity across out-patient, jail general population, a specialized jail restoration unit, and a forensic hospital inpatient unit. Over a 4-year period, defendants were assigned to a modality of restoration services based on an individualized assessment of the level of intensity deemed necessary for remedying their deficits. Results support the hypothesis that many defendants can be either restored or diverted out of the criminal justice system without utilizing intensive and expensive forensic hospital services.

REFERENCES
Rice K, Jennings JL: The ROC program: accelerated restoration of competency in a jail setting. Journal of Correctional Health Care 20(1):59-69, 2014
Kapoor R: Commentary: jail-based competency restoration. J Am Acad Psych Law 39(3):311-5, 2011

QUESTIONS AND ANSWERS
1. What are the advantages of a jail-based competency restoration program over sending all incompetent defendants to an inpatient forensic unit?
a. Shorter waitlists for hospitalization
b. Save money
c. More rapid institution of restoration services
d. More defendants may be diverted from the correctional to mental health system
e. All of the above
ANSWER: e

2. In the study being presented, approximately what percentage of incompetent defendants were diverted from the correctional system prior to being admitted to a forensic inpatient unit?
a. Very few
b. A tenth
c. A third
d. Half
e. More than half
ANSWER: c

F11 DESIGNER DRUGS: SUGAR, SPICE, AND EVERYTHING (NOT SO) NICE

Casey Gregoire, DO, (I) Augusta, GA
Eindra Khin Khin, MD, Washington, DC

EDUCATIONAL OBJECTIVE
To become familiar with various classes of designer drugs and their associated clinical effects. To appreciate the challenges involved in detecting, treating, and regulating these drugs. To explore effective ways to deal with these multi-layered challenges.

SUMMARY
Synthetic cannabinoids, cathinones, hallucinogens, and opioids are considered designer drugs. Their effects often vary significantly even among the same brand name, making the clinical presentations widely unpredictable. Their popularity can be attributable to the widespread availability, the lack of practical detection assays, the lack of age restriction, the low cost, and the belief that these drugs are "legal highs" and therefore safer options than illicit drugs. The usage of synthetic cannabinoids and synthetic cathinones peaked in 2011 and decreased in the following years. However, although the use of synthetic cathinones remains low, the use of synthetic cannabinoids has begun to rise again. Despite the scheduling of a larger number of specific compounds in recent years, drug designers are continuously creating new substances and distributors are finding loopholes in legislation to avoid regulation. This study explores the clinical effects, access, detection, usage, treatment, and legislation of designer drugs. In addition, recommendations are offered to address the challenges associated with these drugs.

REFERENCES
Crews BO, Petrie MS: Recent trends in designer drug abuse. Clinical Chemistry 61(7):1000-1001, 2015
Weaver MF, Hopper JA, Gunderson EW: Designer drugs 2015: assessment and management. Addiction Sci Clinical Practice 10(8), 2015

QUESTIONS AND ANSWERS
1. According to the National Drug Threat Assessment from 2015 conducted by the Drug Enforcement Agency (DEA), what was the most commonly abused designer drug in the United States?
a. Synthetic cannabinoids
b. Synthetic cathinones
c. Synthetic hallucinogens
d. Synthetic opioids
e. None of the above
ANSWER: a

2. In 2010, the Drug Enforcement Agency (DEA) reported what percentage of specimens submitted by juvenile probation departments positive for synthetic cannabinoids?
a. 0-5%
b. 10-15%
c. 30-35%
d. 50-55%
e. 70-75%
ANSWER: c

F12 A NOVEL DIVERSION PROGRAM FOR MENTALLY ILL FEMALE OFFENDERS

Kelly Coffman, MD, MPH, Atlanta, GA
Swati Shivale, MD, Syracuse, NY
Victoria Roberts, MEd, (I) Atlanta, GA
Peter Ash, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE
This poster will educate the reader on a pilot diversion program in the State Court of Fulton County. It will review the need that was identified leading to development of the program, how the program works, and preliminary data on the first females who have moved through the program.

SUMMARY
Traditionally, female defendants in Fulton County, Georgia, with misdemeanor charges were referred for competency to stand trial evaluations. If found incompetent, their charges were often dismissed. They were typically psychotic and were released from jail in the early morning hours with no plan for medication or mental health treatment. They were at high risk for both recidivism and victimization. We designed a pilot project diversion program in which these women could be identified, referred for psychiatric evaluation, and transferred to a hospital for further psychiatric evaluation and treatment. At the hospital, treatment planning begins immediately and includes identifying community resources, such as SSI/SSDI, housing, and mental health follow up, often with referral to an ACT team. Defendants are released from the hospital into the community on conditions of bond and their case is revisited after 3-6 months, with the possibility to have their charges dismissed if they remain compliant with their discharge plan.

REFERENCES
Women in detention: A guide to gender-sensitive monitoring, 2nd edition. Available at www.penalreform.org. Accessed February 2016
No entry: A national survey of criminal justice diversion programs and initiatives. Available at www2.centerforhealthandjustice.org. Accessed February 2016

QUESTIONS AND ANSWERS
1. In a sample of female defendants with misdemeanor charges in Fulton County who were found incompetent to stand trial, how many had their charges dismissed and were not referred for competency restoration?
a. None
b. 15%
c. 25%
d. >50%
ANSWER: d

2. Why is this diversion program unique compared to other diversion programs?
a. The defendants are all women.
b. The defendants are involuntarily sent to a hospital for evaluation and treatment.
c. The defendants do not have to initially agree to enter the program.
d. All of the above.
ANSWER: d

F13 EFFECTIVE DE-ESCALATION STRATEGIES IN A FORENSIC HOSPITAL

Rebecca Kornblush, MD, Claremont, CA
David Lam, MSW, (I) Sacramento, CA
Susan Velasquez, PhD, (I) Sacramento, CA

EDUCATIONAL OBJECTIVE
To improve knowledge about how to prevent harm to staff and patients and provide guidance on how to select a program that will help improve de-escalation skills in a forensic state hospital.

SUMMARY
Patients committed to forensic psychiatric hospitals are at increased risk for committing acts of violence. This can lead to multiple adverse outcomes, including patient and staff injury, seclusion, and restraint. Research has indicated that the violence committed by this population is often in reaction to an identifiable stimulus, variously called reactive or impulsive aggression. Unfortunately, staff members hired to work with this high-risk population often lack the education and training necessary to understand and lower risk. Managing risk in impulsively violent patients requires familiarity with de-escalation techniques. However, when seeking validated strategies for enhancing staff skills in de-escalation, the evidence base is inconsistent and rigorous tests of the efficacy of these methods are rare. We will discuss several available de-escalation approaches, summarizing the common elements across various methods. We will provide recommendations for implementing these strategies that incorporate all aspects of de-escalation techniques evidencing some utility in managing aggression in an inpatient forensic psychiatric setting. Finally, we will discuss recommendations for conducting research in this area to establish the evidence-based efficacy of the described strategies.

REFERENCES
Quanbeck CD, McDermott BE, Lam J, et al: Categorization of aggressive acts committed by chronically assaultive state hospital patients. Psychiatric Services 58:521-52, 2007
Price O, Baker J: Key components of de-escalation techniques: A thematic synthesis. International Journal of Mental Health Nursing 21:310–319, 2012

QUESTIONS AND ANSWERS
1. Impulsive aggression in chronically violent state hospital patients is:
a. the least common type of aggression reported.
b. easily predicted by staff.
c. often due to staff directing patient actions.
d. less common than planned and organized aggression.
ANSWER: c

2. De-escalation strategies:
a. aim to prevent harm.
b. are well researched and validated.
c. are best used when a patient is in restraints.
d. give patients an opportunity to cause harm.
ANSWER: a

F14 NURSING DOCUMENTATION AS A SCREENING TOOL FOR COMPETENCY

Joy Stankowski, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE
To review the impact of competency-specific staff education on rates of restoration to competency and length of stay.

SUMMARY
Reducing hospital length of stay for competency restoration has value for both patients and hospitals. Shorter lengths of stay allow competent patients to more rapidly address outstanding legal issues, and allow hospitals to improve community access to limited psychiatric beds. Timely identification and evaluation of patients who are likely competent, therefore, is important. Several studies have examined the use of cognitive screening tools to help predict patient competency. Screening tools, however, often require medical staff resources, which may be limited. One alternative to a screening tool is the use of routine nursing documentation that includes competency-relevant observations. Such observations may provide an early alert of when a patient is ready for competency evaluation, ultimately reducing length of stay. Clinical staff at one state hospital was educated regarding common competency issues over the course of an academic year. Education included grand rounds, workshops, and unit-based teaching with examples of patient behaviors suggesting competency. Rates of competency restoration and lengths of stay were then compared before and after the completion of training. Although competency restoration rates did not change, restoration lengths of stay decreased. In addition, staff performing competency evaluations reported increased ease and confidence of reaching a competency opinion.

REFERENCES
Toofanian Ross P, Padula CB, Nitch SR, et al: Cognition and competency restoration: using the RBANS to predict length of stay for patients deemed incompetent to stand trial. Clinical Neuropsychologist 29(1): 150-165, 2015
Mueller C, Wylie M: Examining the effectiveness of an intervention designed for the restoration of competency to stand trial. Behavioral Sciences and the Law 25:891-900, 2007

QUESTIONS AND ANSWERS
1. How can staff education of competency issues improve restoration?
a. Targeted documentation
b. Improved communication of forensic issues
c. Increased awareness of competency-relevant behaviors
d. All of the above
ANSWER: d

2. What factors impact length of stay for restoration to competency?
a. Diagnosis
b. Hospital location
c. Alleged offense
d. All of the above
ANSWER: d

F15 ASSESSMENT OF THE COGNITIVELY IMPAIRED SEX OFFENDER

Fabian Saleh, MD, Boston, MA
Robyn Thom, MD, (I) Boston, MA

EDUCATIONAL OBJECTIVE
To provide a current review of risk assessment, and legal issues of problematic and sexual offending behaviors among individuals with dementia and intellectual disability.

SUMMARY
Although the cognitively impaired are frequently included in heterogeneous studies of problematic sexual behavior, the epidemiology, etiology, and approach to assessment and treatment of sex offending behaviors among persons with dementia and intellectual disability are distinct from those of the general population. The incidence of inappropriate sexual behavior among the intellectually disabled is reported to be 15-33%, however the nature of these behaviors tend to be more socially inappropriate than with violative intent. Limited sociosexual education likely accounts for many of these behaviors, and better addressing this area of development offers a target for prevention and treatment. A thorough clinical assessment of problematic sexual behaviors in the cognitively impaired requires understanding the patient's internal experience, which can be challenging in this population. Assessment tools validated for the general population have not been validated for this population. Very few studies have assessed treatment approaches specifically among the cognitively impaired, however research does suggest utility in habilitative, psychotherapeutic, and pharmacologic approaches which have been validated among the general population.

REFERENCES
Saleh FM, Grudzinskas A, Malin M, et al: The management of sex offenders: perspectives for psychiatry. Harv Rev Psychiatry 18(6):359-368, 2010
Guay DR: Inappropriate sexual behaviors in cognitively impaired older individuals. Am J Geriatr Pharmacother 6(5):269-88, 2008

QUESTIONS AND ANSWERS
1. What are the two major aims of the habilitative model for treating problematic sexual behavior in the cognitively impaired?

ANSWER: The aims of the habilitative model are two-fold: to develop an appropriate sociosexual environment for the cognitively impaired and to develop an individual's social skills and strengths. Both aims must be satisfied for this model to be successful. An appropriate environment is described as one where conditions are set up such that an individual can assume dignity and responsibility for their sexual behavior. Individual skill development focuses on using proactive strategies for analyzing antecedents that provoke an individual's problematic sexual behavior and replacing problematic behaviors with ones that are more socially normative.

2. What risk assessment tools exist that can be used to assess problematic sexual behavior in the cognitively impaired?

ANSWER: There are currently no risk assessment tools designed specifically or validated specifically in the cognitively impaired population. Furthermore, commonly used risk assessment tools in the general population, such as the SORAG and the Violence Risk Appraisal Guide (VRAG) may be invalid among the cognitively impaired. In a case-matched study between sex offenders with intellectual disability and sex offenders without intellectual disability, the intellectually disabled scored significantly higher both on SORAG and VRAG. This is likely because certain items on the SORAG and VRAG have different significance in the cognitively impaired population.

F16 INTERVENTIONS FOR REDUCING INPATIENT VIOLENCE

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Deepali Gangahar, MD, (I) New York, NY
Nikita Shah, MD, New York, NY

EDUCATIONAL OBJECTIVE
Participants will better understand various strategies to help decrease violence on inpatient psychiatric units.

SUMMARY
Aggression and violence in inpatient psychiatric settings is continuing to rise. Previous studies have found that increased violence causes not only psychological and physical consequences, but reduced job motivation, increased staff turnover, and increased avoidance with fewer client interactions, among others. Overall, there have been two main positions regarding dealing with patient violence. The first emphasizes containment responses, maintaining order, and setting limits, while the second emphasizes listening, understanding, and minimizing coercion. Research is also starting to conceptualize inpatient violence as not originating exclusively with the individual client, but also from staff, environmental, and situational factors. With these issues in mind, this poster discusses a pilot project that was started on Bellevue Hospital inpatient psychiatric units to help reduce violent events. Pamphlets were given and read to patients on admission by both nursing and medical staff, which identified what is violence and how the unit staff addresses violent events. The goal of the project has been to start a dialogue between patients and staff regarding affective expression, validation of frustration, and obtain solutions to decrease inpatient violence. The Bellevue project will be discussed in comparison to other interventions, but specific Bellevue violence data will not be discussed.

REFERENCES
Goetz SB, Taylor-Trujillo A: A change in culture: violence prevention in an acute behavioral health setting. J Am Psych Nurses Assoc 18(2): 96-103, 2002
Cutcliffe JR, Riahi S: Systemic perspective of violence and aggression in mental health care: towards a more comprehensive understanding and conceptualization: part 1. Int J Mental Health Nursing 22:558-567, 2013

QUESTIONS AND ANSWERS
1. What is the cause of violence on inpatient units?

a. Patients
b. Staff
c. Environment
d. All of the above

ANSWER: d

2. What is not caused by inpatient violence?

a. Increased staff turnover
b. Increased staff injury
c. Increased job motivation
d. Increased sick days
ANSWER: c

F17 **THE PREVALENCE OF PTSD IN A FORENSIC MENTAL HEALTH UNIT**

Bentley Strockbine, MD, Baldwinsville, NY
George David Annas, MD, MPH, Syracuse, NY
James Knoll, IV, MD, Syracuse, NY
Bruce Way, PhD, (I) Syracuse, NY

EDUCATIONAL OBJECTIVE
The educational objective of this presentation is to review the diagnosis of PTSD in a correctional setting and to present the results of a study evaluating PTSD and possible over reporting in a specific correctional population.

SUMMARY
Results from our previous research and the work of others suggests that lifetime rates of exposure to traumatic events reported by incarcerated mental health patients is high, but the rate of diagnosis of post-traumatic stress disorder in the same group is low. Concerns for the over reporting of symptoms and the validity of self-reporting may affect rates of PTSD diagnosing. With the aim of helping to clarify this issue, this poster presentation will describe the results of a study evaluating the prevalence of PTSD in a sample of patients at the Auburn Correctional Facility. The study was approved by the NY Office of Mental Health Central Office Institutional Review Board (IRB), the Upstate Medical University IRB, and the Office of the Director of Research of the Department of Corrections and Community Supervision of the State of New York. Participants were randomly selected by the Chief of the Mental Health Unit from inmates in the general population who attended the outpatient mental health services. The study was conducted with standardized instruments, including the Clinician Administered PTSD Scale (CAPS) and the Structured Interview of Reported Symptoms (SIRS), to add validity to the primary measurement of PTSD prevalence.

REFERENCES
Hall RC, Hall RC: Malingering of PTSD: forensic and diagnostic considerations, characteristics of malingerers and clinical presentations. General Hospital Psychiatry 28:525-35, 2006
Wolff N, Huening J, Shi B, et al: Trauma exposure and posttraumatic stress disorder among incarcerated men. Journal of Urban Health: Bulletin of the New York Academy of Medicine 91: 707-19, 2014

QUESTIONS AND ANSWERS
1. According to the DSM 5, what characteristic would make a diagnosis of PTSD unlikely?
a. Symptoms lasting more than 6 months.
b. Symptoms that include depersonalization.
c. Symptoms that started 9 months after the original stressor.
d. Symptoms due to substance use.
e. Symptoms lasting more than 6 months.
ANSWER: d

2. According to the U.S. Department of Justice, Bureau of Justice Statistics report, Correctional Populations in the United States, which included data through the year 2014, in which year was the U.S. prison population the highest?
a. 1981
b. 1990
c. 1999
d. 2009
e. 2014
ANSWER: d

F18 **HOW HAS THE SUPREME COURT TRANSFORMED JUVENILE JUSTICE?**

Fahad Ali, MD, Bryn Mawr, PA
Kenneth Weiss, MD, Philadelphia, PA

EDUCATIONAL OBJECTIVE
The participants will have a better understanding of how the Supreme Court's decisions regarding juvenile punishment has affected forensic evaluations.

SUMMARY
The U.S. Supreme Court has shaped juvenile justice through a series of opinions since 2005. The three cases, Roper v. Simmons (2005), Graham v. Florida (2010) and Miller v. Alabama (2012) dealt with capital punishment of juveniles. Roper held death penalty to be cruel and unusual punishment for offenders who committed their crimes when they were under the age of 18. Graham ruled life imprisonment without parole for non-homicidal crime to be unconstitutional while the Miller Court outlawed life imprisonment without possibility of parole for homicidal crimes by juveniles. It emphasized differences between juveniles and adults based on mental maturity and brain development. and outlined various factors that relate to juveniles' immaturity and diminished culpability. Recently, through Montgomery v. Louisiana (2016), the Court determined that Miller should be applied retroactively. We discuss how these Supreme Court cases provide a road map for the forensic psychiatrist who provides opinion about various developmental factors that may affect criminal culpability of juveniles. We also discuss the potential impact of Miller's retroactivity on hundreds of inmates. People who were sentenced to mandatory life in prison without possibility of parole for crimes as juveniles have the right to seek parole.

REFERENCES
Montgomery v. Louisiana. US Supreme Court, No 14-280
Scott E, Grisso T, Levick M, et al: The Supreme Court and the Transformation of Juvenile Sentencing. Models for Change. Available at http://modelsforchange.net/publications/778. Accessed August 2016

QUESTIONS AND ANSWERS
1. Compared to adults, adolescents are:
a. susceptible to peer influence.
b. impulsive.
c. prefer immediate rewards.
d. All of the above
ANSWER: d

2. The Graham Court concluded life without parole when imposed on juveniles violates what amendment?
a. Fourteenth
b. Eighth
c. Seventh
d. Fourth
ANSWER: b

F19 PAROLE VIOLATIONS IN PSYCHIATRICALLY HOSPITALIZED OFFENDERS

Bipin Subedi, MD, Brooklyn, NY
Ashley Fresenius, LMSW, (I) Brooklyn, NY

EDUCATIONAL OBJECTIVE
To review and explore how certain clinical and demographic factors may be associated with specific types of parole violations in offenders with a history of mental illness. This information can be used to improve legal and treatment interventions for this population.

SUMMARY
Many individuals leaving jails or prisons will reenter into the community on probation or parole. Those with mental illness are susceptible to technical violations based on factors associated with their illness. We will be presenting results from our study of the demographic, clinical, and legal factors associated with specific parole violations in subjects who have been hospitalized on the Bellevue Hospital Forensic Service. We will also discuss the role of clinical providers in parole treatment planning.

REFERENCES
Baillargeon J, Williams BA, Mellow J, et al: Parole revocation mmong prison inmates with psychiatric and substance use disorders. Psychiatr Serv 60(11) 1516-152, 2009
Louden JE, Skeem JL: Parolees with mental disorder: toward evidenced based practice, UC Irvine Center for Evidence Based Corrections Bulletin 7(1): 1-9, 2011

QUESTIONS AND ANSWERS
1. According to Louden and Skeem 's 2011 report regarding mentally ill parole violators in California, what percentage violated for not attending Parole Outpatient Clinics (POC)?
a. 2.5%
b. 7.6%
c. 21.6%
d. 17%
ANSWER: b

2. Baillargeon et al., 2009 reported that which group of individuals had the highest risk of recidivism within the first year of release on parole?
a. Parolees with a major psychotic disorder.
b. Parolees with a history of abuse.
c. Parolees with a substance use disorder.
d. Parolees with a dual diagnosis of major psychotic disorder and substance use disorder.
ANSWER: d

F20 **DECODING NEW YORK STATE'S PRESCRIPTION MONITORING PROGRAM**

Lama Bazzi, MD, Stony Brook, NY
Elie Aoun, MD, Providence, RI
Nicholas Genova, MD, St. James, NY
Felix Torres, MD, Brooklyn, NY

EDUCATIONAL OBJECTIVE
The audience will be able to improve the quality of treatment provided to patients with substance use disorders by understanding the rationale and proper application of Prescription Monitoring Systems. Improving consultations between treating physicians while ensuring compliance to federal and state prescribing mandates will help decrease prescription drug misuse.

SUMMARY
In August 2013, with the goal of limiting prescription drug misuse, New York State legislators passed the Internet System for Tracking Over-Prescribed/Prescription Drug Monitoring Program (I-STOP/PMP) Law. Many psychiatric patients in jails, prisons, and in court mandated assisted outpatient treatment programs struggle with substance use, including prescription drug abuse. Prescribers are mandated to check the PMP system before prescribing any schedule II-IV medications. Medical documentation must include PMP accession codes and note prescription discrepancies. Prescribers are mandated to consult other physicians prescribing controlled substances to their patients. Psychiatrists are rarely aware that the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) allows for such communication without the patient's explicit permission. Such consultation could save lives and prevent legal recidivism. In our analysis of I-STOP/PMP legislation, we performed a literature review, identifying articles addressing the rules and regulations governing the law's application. We use two composite and fictionalized cases to describe patients' refusal to grant their physician permission to speak to another doctor who is prescribing said patient controlled substances. Finally, we discuss the interactions between I-STOP/PMP and HIPAA regulations, illustrating resolutions to these challenging scenarios to encourage physicians to remain in compliance with federal and state mandates.

REFERENCES
Sharp MJ, Melnik TA: Poisoning deaths involving opioid analgesics - New York State, 2003-2012. Centers for Disease Control and Prevention (CDC). MMWR Morb Mortal Wkly Rep 64(14):377-80, 2015
Davis CS, Johnston JE, Pierce MW: Overdose epidemic, prescription monitoring programs, and public health: a review of state laws. Am J of Public Health 105(11):e9-e11, 2015

QUESTIONS AND ANSWERS
1. What does the privacy rule of the Health Insurance Portability and Accountability Act (HIPAA) allows covered entities to do?
a. Disclose protected health information to family members without the patient's permission.
b. Refuse to disclose protected health information to the patient themselves if they request it.
c. Rely on the patient's informal permission to disclose information about the individual's location or general condition to family members.
d. Disclose protected health information to an individual's employer as long as the employer is not a federal entity.
ANSWER: c

2. A prescriber does not have to check the New York I-STOP/PMP system if:
a. they are still in residency training and do not have their own DEA number yet.
b. they are prescribing a five-day supply of medication from a private clinic.
c. they are prescribing the medication to a patient who does not have insurance.
d. they are prescribing a five-day supply of medication from an emergency department.
ANSWER: d

F21 AAPL PRACTICE GUIDELINES ON COMPETENCE TO STAND TRIAL UPDATE

Barry Wall, MD, Providence, RI
Jeffrey Janofsky, MD, Baltimore, MD
Christopher Thompson, MD, Los Angeles, CA
Debra Pinals, MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE
Participants will review the draft update to the AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial and provide feedback to improve the document. The updated Practice Guideline will improve forensic practice by updating best practices in the forensic evaluation of competence to stand trial.

SUMMARY
AAPL's first Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial was published in 2007. Task Force Members and others have produced a draft update. The purpose of this workshop is to obtain feedback from AAPL members and to improve the draft before it is submitted to Council for approval. The latest draft of the Guideline is available to AAPL members only in the members section at www.aapl.org.

REFERENCES
Mossman D, Noffsinger SG, Ash P, et al: AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial. J Am Acad Psychiatry Law 35 (Suppl):S3–72, 2007
Pablo AC, Martinez Garcia L, Miguel Carrasco J, et al: The updating of clinical practice guidelines: insights from an international survey. Implementation Science 6:107, 2011

QUESTIONS AND ANSWERS
1. How often are Practice Guidelines recommended to be updated?
a. 1 to 2 years
b. 3 to 5 years
c. 6 to 8 years
d. 9 to 11 years
ANSWER: b

2. What is the goal of the AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial?
ANSWER: To aid the individual forensic psychiatrist in the evaluation of competence to stand trial and to provide a comprehensive approach for the subspecialty.

F22 HASTENING THE FUTURE: ONSITE RESEARCH CONSULTATION

Nathan Kolla, MD, PhD, Toronto, ON, Canada
Philip Candilis, MD, Washington, DC
Douglas Mossman, MD, Cincinnati, OH
Robert Trestman, MD, PhD, Farmington, CT
Alexander Westphal, MD, PhD, New Haven, CT

EDUCATIONAL OBJECTIVE
Following this course, participants will demonstrate an improved understanding of the process of generating a researchable idea and working with a research mentor to develop a fundable project.

SUMMARY
A major obstacle to conducting research is translating the research question into a feasible project. Clinicians can generate research questions with high clinical relevance but may lack the knowledge, experience, or mentorship to execute their ideas. This course is designed for participants who have developed ideas for a potential research project and want practical advice on how to implement their study. Participants will benefit from the interactive and individualized learning environment that this course offers. Participants wanting instruction on how to develop their research project will be expected to submit their research question to AAPL prior to the meeting. Course facilitators will then provide on-site mentorship to assist in developing the research proposal. Audience feedback and participation will be encouraged to generate topics of discussion relevant to the proposed project. As an additional incentive to participate, longitudinal mentorship will be offered to one or two participants whose project is best poised to apply for peer-reviewed funding. The aim of this mentorship would be to enhance the participant's chance of success for a grant offered by the APPL Institute for Education and Research (AIER). Course facilitators are experienced educators in research methods and grantsmanship and are actively involved in conducting research.

REFERENCES
Feldman MD, Huang L, Guglielmo BJ, et al: Training the next generation of research mentors: the University of California, San Francisco, clinical & translational science institute mentor development program. Clin Transl Sci 2(3), 216 – 221, 2009
Pololi L, Knight S: Mentoring faculty in academic medicine: A new paradigm? J Gen Intern Med, 20, 866 – 870, 2005

QUESTIONS AND ANSWERS
1. Which NIH sponsored grant is designated for early career development?
a. R series
b. K series
c. T series
d. P series
e. F series
ANSWER: b

2. Which NIH sponsored grant is designated for research projects?
a. R series
b. K series
c. T series
d. P series
e. F series
ANSWER: a

F23 **CULTURAL CHALLENGES IN IMMIGRATION COMPETENCY ASSESSMENTS**

Dalia Balsamo, MD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Reena Kapoor, MD, New Haven, CT
Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE
The participants will understand the legal foundations for competency in immigration and asylum proceedings and the consequences of the finding of incompetence and will explore strategies to address barriers of language, literacy, and cultural in forensic psychiatric assessments.

SUMMARY
Immigration proceedings are matters of civil law. Therefore, individuals facing deportation and asylum proceedings do not have a constitutional right to counsel. Until recently, immigration courts were also not required to assess competency. In 2011, the USSC in Matter of M-A-M- held that immigration judges should inquire into an individual's competency in the presence of any indicia of incompetency. Soon after, a class action lawsuit, Franco-Gonzalez v. Holder (also know as the Franco litigation) gained procedural safeguards for people who showed evidence of incompetence in immigration proceedings. These safeguards involve psychiatric evaluations to determine competence and the appointment of counsel at government expense for those found incompetent. With the legal foundation for competency, an expanded role for forensic psychiatrists in immigration has been established. Despite the clarity in the legal standard and the application of the Dusky criteria for determining competency, the challenges facing the forensic examiner are myriad, including barriers of language, culture, and education. The usual techniques for assessing mental status, intelligence, and psychiatric disorders may lack validity in indigenous populations. This workshop will review the legal underpinnings of competency, present strategies to manage cultural challenges and involve the audience in a competency assessment and mock testimony.

REFERENCES
Korngold C, Ochoa K, Inlender T, et al: Mental health and immigrant detainees in the United States: competency and self-representation. J Am Acad Psych Law 43:277-281, 2015
Mossman D, Noffsinger SG, Ash P, et al: AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial. J Am Acad Psych Law 35:S3-S72, 2007

QUESTIONS AND ANSWERS

1. All of the following have been listed in the AAPL Practice Guideline as useful tools to improve a clinician's effort to work with different cultures, except:

a. Knowledge of the patient's culture, including history, traditions, values, and family systems.
b. Awareness of how language, speech patterns, and communication styles differ among cultural communities.
c. Knowledge of culture bound syndromes and their treatment.
d. Recognition of how professional values may conflict with or accommodate the emotional and legal needs of evaluees.

ANSWER: c

2. Pursuant to Franco Gonzalez v. Holder, a federal judge ordered the US government to provide legal representation for immigrants found to be incompetent to represent themselves in the following states, except:

a. California
b. Oregon
c. Arizona
d. Washington

ANSWER: b

F24 SEX TECH ED 101: TECHNOLOGY IN SEXUAL OFFENDER EVALUATIONS

Matthew Lang, DO, Pittsburgh, PA
R. Gregg Dwyer, MD, EdD, Charleston, SC
Abhiskek Jain, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE

To describe current operating systems (Windows, Macintosh), software (p2p networks, file-sharing), and social media (Facebook, Craigslist) involved in sexual offenses, learn technological knowledge that can be useful in a forensic interview and discuss case examples that illustrate how sexual offending may involve social media, the internet, and computer-based technology.

SUMMARY

According to a recent study, an estimated 775,000 computers worldwide have been involved in sharing child pornography (Wolak 2013). The increasing prevalence of information sharing, social networks, and internet access have eased access to illegal sexual activities; notably when combined with the perception of anonymity while online. According to the National Sex Offender Public Website, 1 in 25 youths received an online sexual solicitation to make offline contact. Although the role of technology in sexual offenses is varied, it is becoming an increasingly common vehicle for perpetration. Forensic psychiatrists are often called upon to evaluate defendants and testify regarding sexual offenses. Having familiarity with technological modalities that are used in sexual offenses has become increasingly important, especially to help with diagnostic considerations, detection of malingering, and criminal responsibility. In this workshop, we will review basic terminology and current internet and computing trends; we will explore incorporating this information when reviewing records and conducting forensic psychiatry interviews. Furthermore, we will have audience participation as we discuss sample sexual offender cases that demonstrate the advantages of having basic familiarity with information technology.

REFERENCES

Truman J, Langton L, Planty M: Criminal Victimization 2012. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Available at http://www.bjs.gov/content/pub/pdf/cv12.pdf. Accessed August 2016
Wolak J, Liberatore M, Levine B: Measuring a year of child pornography trafficking by U.S. computers on a peer-to-peer network. Child Abuse and Neglect 38(2):347-356, 2014

QUESTIONS AND ANSWERS

1. Which of the following is a decentralized method of sharing files?

a. Email
b. Facebook
c. Instagram
d. Bittorrent
e. iCloud

ANSWER: d

2. In Kansas v. Crane (2002), the United States Supreme Court decided which of the following must be demonstrated when civilly committing a sexual offender following their criminal sentence?
a. Difficulty in controlling behavior.
b. Inability in controlling behavior.
c. A personality disorder.
d. A psychotic disorder.
ANSWER: a

F25 **EFFICACY OF SPECIALIZED TREATMENT FOR MENTALLY ILL IN JAILS**

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Corey Leidenfrost, PhD, (I) Buffalo, NY
Peter Martin, MD, MPH, Buffalo, NY
Evelyn Coggins, MD, Hamburg, NY

EDUCATIONAL OBJECTIVE
This presentation will focus on the psychiatric care delivery system in a jail setting. Participants will learn about the efficacy of specialized treatment for seriously mentally ill offenders and the impact on providing effective treatment or managing increasing demands for forensic evaluations.

SUMMARY
Decades of changes to inpatient and outpatient policies have led to jails and prisons becoming a primary setting for the treatment of individuals with serious mental illness. The staggering number of incarcerated individuals with mental health problems in jails only continues to increase, causing strain on a system already ill-prepared to deal with the influx of psychiatric patients. Forensic psychiatry is faced with the challenge of adapting to this situation, whether it is through providing effective treatment or managing increasing demands for forensic evaluations. At the Erie County Correctional (jail) System, we have developed a specialized treatment unit for individuals with serious mental illness. We will present data from more than 100 inmates, demonstrating significant efficacy of the treatment provided, including improvement in psychopathology ($p<0.001$), anxiety and depression ($p<0.001$), thought disturbance ($p<0.001$), psychological well-being ($p=0.08$), negativistic thinking ($p<0.001$), negative affect ($p<0.001$), and anger ($p=0.001$). We will also present ancillary data that demonstrate the Unit's impact on recidivism and outcomes of forensic evaluations (e.g. competency to stand trial). Our study highlights the importance of specialized psychiatric treatment units or teams in jail settings, which can have significant implications for the job of the forensic psychiatrist.

REFERENCES
Torrey EF, Kennard AD, Eslinger J, et al: More mentally ill persons are in jails and prisons than hospitals: A survey of the states. Available at http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf. Accessed August 2016
Lamb HR, Weinberger LE: The shift of psychiatric inpatient care from hospitals to jails and prisons. J Am Acad Psyh Law (33)529–534, 2005

QUESTIONS AND ANSWERS
1. What has become a major challenge for psychiatric care in correctional settings?
ANSWER: Jails and prisons.

2. What has become a major challenge for psychiatric care in correctional settings?
ANSWER: Adapting to the increasing numbers of inmates with psychiatric problems and creating new approaches to treatment, while also adapting these new approaches to the larger continuity-of-care-focused model.

F26 **FELONY VETERANS COURT: PROGRESS TOWARDS GOALS AFTER 5 YEARS**

Andrea Stolar, MD, Houston, TX
Loretta Coonan, LCSW, (I) Houston, TX
David Graham, MD, Houston, TX
George Nadaban, MD, Humble, TX

EDUCATIONAL OBJECTIVE
Understand the unique opportunities and challenges in creating a felony mental health court for veterans, raise awareness of the goals of jail diversion, both realized and unrealized, after five years of court experience and provide a framework for quality improvement in veteran court programs.

SUMMARY
In December 2009 the Harris County Veterans Court held its inaugural docket. Established as the first Veterans Court in Texas and built through collaboration between a forensic psychiatrist, social worker, Drug Court Program Director,

attorneys, Judges, and community supervision, it was an opportunity to create a jail diversion program for a high risk population that included integrated clinical care, judicial oversight and coordinated follow-up. Now, after more than five years' experience and over 175 participants the Court reviews its progress towards the primary goals and objectives of the program: 1) Improving access to needed mental health and addictions treatment for jailed veterans; 2) Reducing criminal recidivism through successful treatment outcomes and community reintegration; 3) Improving long-term mental health recovery and community reintegration through involvement in structured, comprehensive treatment; 4) Reducing jail time and resolving felony charges related primarily to mental health, TBI and addiction issues; and 5) Reducing costs associated with unnecessary incarceration. This session will present the results of analysis of five years of clinical and judicial outcome data for the court, recognizing that some goals, in retrospect, may not be readily measurable, implications for program development, and recommendations for quality improvement.

REFERENCES

Johnson RS, Stolar AG, McGuire JF, et al: US veterans' court programs: an inventory and analysis of national survey data. Community Ment Health J 52(2):180-6, 2016
Johnson RS, Stolar AG, Wu E, et al: An analysis of successful outcomes and associated contributing factors in veterans' court. Bull Menninger Clin 79(2):166-73, 2015

QUESTIONS AND ANSWERS

1. What is a primary goal of Veterans Courts?

ANSWER: To address mental health conditions of justice involved veterans thereby reducing criminal recidivism.

2. What is the most significant difference between services provided to Veterans Court participants as compared to those provided to civilian mental health court participants?

ANSWER: Access to comprehensive wrap-around services provided by the VA, facilitated through case management by designated veterans justice outreach coordinators.

F27 SEXUALLY VIOLENT PREDATOR DEFENSE TEAMS: DO THEY MATTER?

Jeremy Colley, MD, Folsom, CA
Melinda DiCiro, PhD, (I) Sacramento, CA

EDUCATIONAL OBJECTIVE

Participants will be able to identify how geography and availability of specially trained attorneys to detainees undergoing adjudication as Sexually Violent Predators (SVPs) affect hearing outcomes.

SUMMARY

In accordance with the California Sexually Violent Predator Law, inmates being released from prison, who have a conviction for a specific, violent sexual crime, involving at least one victim, are referred to the Department of State Hospitals (DSH) for clinical evaluations. The District Attorney can then chose to petition the court for a civil commitment trial. In a number of cases the jury determines the inmate does not meet the legal definition of a sexually violent predator. Whether jury decisions that are counter to the recommendations of the evaluators are attributable to defense characteristics is explored. Specifically, we will examine two characteristics that may to contribute to these outcomes: county of jurisdiction and the presence or absence of a Sexually Violent Predator Unit in the Public Defender's Office in the county concerned. We will first examine differences in referral rates between counties with liberal and conservative District Attorneys. We will then look for significant differences in jury commitment rates among counties and between the counties with and without Sexually Violent Predator Defense Teams. Any additional salient factors emerging from the data will also be examined. Ethical considerations and alternative hypotheses for variations among commitment and referral rates will also be examined.

REFERENCES

Sreenivasan S, Weinberger LE, Garrick T: Expert testimony in sexually violent predator commitments: conceptualizing legal standards of "mental disorder" and "likely to reoffend." J Am Acad Psych Law 31:4:471-485, 2003
Levinson J: Factors predicting selection of sexually violent predators for civil commitment. Int J Offender Ther Comp Criminol (5)6: 609-629, 2006

QUESTIONS AND ANSWERS

1. Does the political party of the district attorney in California counties affect rates of civil commitment under the state's sexually violent predator law?

ANSWER: yes

2. Does the availability of Sexually Violent Predator Defense Teams in California counties affect rates of civil commitment under the state's sexually violent predator law?

ANSWER: yes

F28 INSANE SEX OFFENDERS: CLINICAL AND FORENSIC CHARACTERISTICS

Brian Holoyda, MD, Sacramento, CA
Barbara McDermott, PhD, (I) Sacramento, CA
William Newman, MD, Saint Louis, MO

EDUCATIONAL OBJECTIVE

To summarize the literature regarding sexual offenders with severe mental illness, including those found not guilty by reason of insanity, describe the demographic, clinical, and forensic characteristics of a sample of NGRI sexual offenders and identify future research needs in a unique population of sexual offenders.

SUMMARY

Research has demonstrated the high prevalence of mental illness among those who sexually offend, but there is comparatively little known about sexual offenders with severe mental illness. Of particular concern for forensic mental health clinicians and experts conducting violence risk assessment is the population of sexual offenders whose mental illness results in forensic commitment, such as sexual offenders committed as not guilty by reason of insanity (NGRI). Prior research on NGRI sexual offenders has identified high rates of diagnoses including primary psychotic disorders, substance use disorders, and antisocial personality disorder. We studied sexual offenders committed to a state hospital in California as NGRI. Our results describe the demographic, clinical, and forensic characteristics of the largest sample of NGRI sexual offenders examined to date. We identify a unique population of sexual offenders with severe mental illness that requires further research to improve the understanding of their treatment needs, sexual violence recidivism risk, and appropriate management strategies.

REFERENCES

Novak B, McDermott BE, Scott CL, et al: Sex offenders and insanity: an examination of 42 individuals found not guilty by reason of insanity. J Am Acad Psychiatry Law 35:444-50, 2007
Dunsieth NW Jr, Nelson EB, Brusman-Lovins LA, et al: Psychiatric and legal features of 113 men convicted of sexual offenses. J Clin Psychiatry 65:293-300, 2004

QUESTIONS AND ANSWERS

1. Which of the following is not true regarding sexual offenders and mental illness?
a. Sexual offenders have a low rate of substance use disorders compared to the general population.
b. More than half of sexual offenders report being under the influence of alcohol and/or drugs at the time of the commission of their sexual offenses.
c. According to Novak et al., two-thirds of subjects found NGRI for a sexual offense have a diagnosis of schizophrenia or schizoaffective disorder.
d. A smaller number of NGRI sexual offenders have a diagnosis of a paraphilic disorder compared to general sexual offending populations.
ANSWER: a

2. Which of the following is true regarding the NGRI plea and sexual offending?
a. A history of sexual offense conviction is common among those found NGRI.
b. Erotomanic delusions are a symptom present in the histories of the majority of NGRI sexual offenders.
c. Given the high comorbidity of psychosis and paraphilic disorders, the majority of NGRI sexual offenders have a paraphilic disorder diagnosis.
d. The typically rational motive behind sexual offenses may make experts less likely to opine that an individual was insane at the time of commission of a sexual offense than other types of offenses.
ANSWER: d

F29 A PROPOSED RESOURCE DOCUMENT ON PRESCRIBING IN CORRECTIONS

Anthony Tamburello, MD, Glassboro, NJ
Jeffrey Metzner, MD, Denver, CO
Elizabeth Ferguson, MD, Augusta, GA
Michael Champion, MD, Honolulu, HI
Graham Glancy, MB, Toronto, ON, Canada

EDUCATIONAL OBJECTIVE

Participants will be able to describe a resource document and contrast it with other professional publications, like guidelines and position statements, list the similarities and differences between prescribing in the community vs. correctional settings and describe the process used to develop a resource document for prescribing in corrections.

SUMMARY

The AAPL Correctional Psychiatry Committee recommended the creation of a resource document on the prescription of psychiatric medications in correctional facilities. Practicing psychiatry in jails and prisons is substantially different than it is in the community. Some of these differences include strict formulary controls, high rates of comorbidities

such as substance use disorders and personality disorders, high rates of malingering, the abuse and diversion of prescription medications, and various operational challenges unique to these environments. The resource document is intended to be a thorough, yet concise and practical resource for correctional psychiatrists involved in clinical care for patients. While not a guideline, the resource document will review best practices based on available research and may draw on existing resources intended for community practice as applied to correctional settings. The panel will consist of members of the AAPL Task Force charged with creating this document. We will present the development process, outline, selections from the most current draft, and potential controversies. Substantial time will be reserved for interaction. Audience members are encouraged to ask questions, engage in discussion, and suggest feedback. Such input may be incorporated into the final version of the resource document if appropriate.

REFERENCES

The American Psychiatric Association Work Group to Revise the APA Guidelines on Psychiatric Services in Jails and Prisons. Psychiatric Services in Correctional Facilities, Third Edition. Arlington, VA: American Psychiatric Publishing, 2016
Berger RH, Wahl RJ, Chaplin MP: Formulary Management/ Pharmacy and Therapeutics Committees. In: Oxford Textbook of Correctional Psychiatry, First Edition; Editors: R Trestman, J Metzner, K Appelbaum New York, NY: Oxford University Press, 2015

QUESTIONS AND ANSWERS

1. Which is the goal for treatment quality articulated by the American Psychiatric Association Task Force for Psychiatric Services in Correctional Facilities?

a. To receive the same level of care available in the community.
b. To receive the same level of care that should be available in the community.
c. To receive minimally adequate care.
d. To receive deliberately indifferent care
ANSWER: b

2. An appropriate role for a correctional Pharmacy and Therapeutics Committee includes:

a. Drug court adjudication.
b. Creation of a pre-authorization process that effectively bars prescription of high-cost medications.
c. Review, approval, and monitoring of time and attendance policies for psychiatrists.
d. Determining medications that require pre-authorization because of cost or safety issues
ANSWER: d

F30 A TALE OF TWO PSRBS: THIRTY YEARS OF OUTCOME DATA EXPLORED

Tobias Wasser, MD, New Haven, CT
Michael Norko, MD, New Haven, CT
Juliette Britton, JD, (I) Portland, OR
Simrat Sethi, MD, Salem, OR

EDUCATIONAL OBJECTIVE

To describe supervision models for insanity acquittees under the Psychiatric Security Review Boards (PSRBs) in Connecticut and Oregon, compare outcome data, including recidivism, for the two PSRB systems with similar populations studied in other systems and identify ways in which recent findings may influence future research and policy.

SUMMARY

In 1978 Oregon established the country's first Psychiatric Security Review Board (PSRB). Connecticut established its PSRB in 1985. After over 30 years of implementation, there have been hundreds of acquittees who have been under PSRB supervision in each state, providing a wealth of data from which to study the effectiveness of PSRBs as a model for managing insanity acquittees in the community while preserving public safety. We will provide a brief history of the PSRB in each state and describe current models of oversight and supervision within both hospital and community settings. We will then present recent study data pertaining to several outcome metrics of interest, including length of hospitalization, rates of revocation and rehospitalization while on conditional release in the community, and criminal recidivism following discharge from the board's oversight, noting factors that are predictive of community success. These data will be compared to recidivism studies with other offender and acquittee populations. We will discuss the potential implications of these recent findings for public policy and practice, and identify relevant inquiries for future research on the management of insanity acquittees.

REFERENCES

Norko MA, Wasser TD, Magro H, et al: Assessing insanity acquittee recidivism in Connecticut. Behav Sci Law 34(2-3):423-43, 2016
Bloom JD, Buckley MC: The Oregon psychiatric security review board: 1978-2012. J Am Acad Psychiatry Law 41:560-7, 2013

QUESTIONS AND ANSWERS

1. In Connecticut, what percentage of individuals have been rearrested following discharge from the PSRB?
a. 6%
b. 16%
c. 25%
d. 50%
ANSWER: b

2. From 2011-2014, what percentage of insanity acquittees on conditional release in Oregon were convicted of a new felony or misdemeanor charge?
a. Fewer than 1%
b. 3%
c. 10%
d. 15%
ANSWER: a

F31 **MASS KILLERS: HOW WORRIED SHOULD THE MASSES BE?**

Melissa Spanggaard, DO, Sioux Falls, SD
Hy Bloom, MD, FRCP(C), Toronto, ON, Canada
Marc Cohen, MD, Beverly Hills, CA
Stephen Peterson, MD, Kansas City, KS
Ryan Shugarman, MD, Alexandria, VA

EDUCATIONAL OBJECTIVE

To increase participants' knowledge and understanding of individuals who perpetrate mass murder, with specific emphasis on the suggested typologies of perpetrators, risk factors, comparison of adults vs. adolescent perpetrators, potential means of identifying and intervening with at-risk individuals, and helpful techniques for helping survivors of these events recover.

SUMMARY

Like other low-incident-rate phenomena, mass murders are difficult, if not impossible, to predict. However, some patterns have begun to emerge. This panel will discuss known risk factors for perpetrating mass murder and review the previously proposed typologies in order to better understand the motivations of these perpetrators. Potential means of identifying at-risk individuals and intervening prior to the perpetration of these acts will be examined, and differences between adult and adolescent perpetrators will be discussed. Finally, some of the ways that clinicians can be helpful to survivors of these events will be reviewed.

REFERENCES

Knoll, J.L. (2010). The "pseudocommando" mass murderer: part I, the psychology of revenge and obliteration. J Am Acad Psychiatry Law 38:87 – 94, 2010
Knoll JL, Meloy JR: Mass murder and the violent paranoid spectrum. Psychiatric Annals 44(5): 236 – 43, 2014

QUESTIONS AND ANSWERS

1. How is mass murder defined?
a. 10 or more murders occurring over more than 1 week
b. 10 or more murders occurring in one event
c. 4 or more murders occurring over more than 1 week
d. 4 or more murders occurring in one event
ANSWER: d

2. Common factors in mass murder include all but which of the following?
a. Planning of the event.
b. Bringing multiple guns and large amounts of ammunition.
c. Expecting to escape after the event.
d. Occur in the daytime.
ANSWER: c

F32 NIGHTMARES OF TRAUMATIZED CENTRAL AMERICAN ASYLUM SEEKERS

James Boehnlein, MD, Portland, OR

EDUCATIONAL OBJECTIVE
Summarize how, for forensic consultants, the content and temporal course of nightmares can be important for understanding the psychological and emotional challenges faced by asylum seekers and, for clinicians, how they are a key indicator of the extent of treatment success.

SUMMARY
Across cultures, dreams are imbued with important meaning in the understanding and interpretation of life experiences, and this includes nightmares following trauma. In this paper, case studies of traumatized asylum seekers from El Salvador and Guatemala will be presented to contextualize cultural aspects of the nightmare experience. As a group, these cases will address certain questions concerning trauma-related nightmares: the relationship of the nightmare to the original trauma; what triggers worsening of nightmares; how nightmares change during treatment; how the discussion and treatment of nightmares can become a part of the therapeutic process; how nightmares can lead to a more comprehensive understanding of the person's experience; and how nightmares can be reduced in intensity and frequency. The form and time course of posttraumatic nightmares can follow similar patterns across cultures, but the variability in frequency and content depend on the history of the individual person. For forensic consultants, nightmares serve as a window to the psychological and emotional challenges faced by the asylum seeker, and for clinicians they are a key indicator of the extent of treatment success.

REFERENCES
De Jesus-Rentas G, Boehnlein J, Sparr L: Central American victims of gang violence as asylum seekers: the role of the forensic expert. J Am Acad Psychiatry Law 38: 490-498, 2010
Hartmann E: Nightmare after trauma as paradigm for all dreams: a new approach to the nature and functions of dreaming. Psychiatry 61:223-238, 1998

QUESTIONS AND ANSWERS
1. Trauma nightmares can:
a. literally replay the original trauma.
b. be symbolic of the original trauma.
c. be representative of a trauma anniversary.
d. be associated with separation and loss.
e. All of the above
ANSWER: e

2. Treatment of trauma nightmares can:
a. enhance overall functioning.
b. allow the survivor to more readily meet the demands of the asylum process.
c. diminish the survivor's ability to process the original trauma.
d. a and b
e. All of the above
ANSWER: d

F33 FEMINIST ETHICS, HUMAN RIGHTS, AND MATERNAL-FETAL CONFLICT

Navneet Sidhu, MD, Washington, DC
Philip Candilis, MD, Alexandria, VA

EDUCATIONAL OBJECTIVE
To offer a framework for practicing forensic psychiatry at a time of change in reproductive rights

SUMMARY
Since the 1973 Roe v. Wade decision, political and religious interests have continued to advance legislation that restricts women's reproductive rights. These include the Supreme Court's Partial-Birth Abortion ban of 2003, the prosecution of pregnant substance users in Tennessee, Alabama and South Carolina, and more recently, laws restricting access to abortion in Texas by imposing stringent credentialing standards. In 2015, an Indiana woman was convicted under the state's feticide and neglect statutes. The legal justification for these laws often arises from assigning personhood to the fetus in a way that supersedes the rights of the woman. At the same time, the Zika virus epidemic has opened an avenue for advancing reproductive rights in deeply religious Brazil. This changing landscape at a time of evolving human rights discussions at the World Health Organization, raises potential problems for forensic practitioners who perform evaluations in these jurisdictions. They are caught between legislative requirements and traditional interpretations of individual rights. We propose a new framework to address these tensions through the lens of feminist ethics and human rights – using principles of security and dignity of person, equality, and individual liberty interests.

REFERENCES
Gilligan C. In A Different Voice: Psychological Theory and Women's Development. Cambridge, MA: Harvard University Press, 1982
Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations. Geneva, Switzerland: World Health Organization 2014

QUESTIONS AND ANSWERS
1. In which state was the first woman convicted of feticide of her own pregnancy?
a. Tennessee
b. Alabama
c. Indiana
d. Mississippi
e. Texas
ANSWER: c

2. What challenges do forensic practitioners face in criminal cases brought under fetal rights laws?
a. Maintaining professional standards for conducting forensic evaluations.
b. Participating in evaluations with uncertain and evolving penalties.
c. Balancing professional and personal ethics.
d. Keeping up to date with jurisdictional requirements
e. All of the above.
ANSWER: e

F34 CHEMICAL DEPENDENCY COMMITMENT: DOES IT WORK?

Ian Lamoureux, MD, Rochester, MN
Paul Schutt, MD, (I) San Francisco, CA
Keith Rasmussen, Jr., MD, Rochester, MN

EDUCATIONAL OBJECTIVE
Identify the legal basis for civil commitment for patients with substance use disorders. Understand the competing ethical interests, and describe the tangible benefits/drawbacks of civilly committing patients with substance use disorders.

SUMMARY
Patients suffering from chemical dependency (CD) are commonly encountered on medical and surgical wards, often for illness and injuries sustained as a direct result of their substance abuse. When these patients are repeatedly admitted to medical or surgical wards in certain states which provide a legal framework to commit chemically dependent persons to a treatment facility, clinicians often wonder if they should initiate that process, and consult psychiatry. Should the consulting psychiatrist choose to initiate the commitment process, he puts into motion a resource-intensive, and time consuming process, whose outcome is uncertain, both in the courtroom and at the bedside. Outcomes of patients committed to chemical dependency treatment from medical and surgical services are poorly understood. Here, the authors examine a series of patients for whom judicial commitment in the state of Minnesota was pursued between the years of 2012 – 2013, and examine the demographics and outcomes of this cohort of patients. The authors further describe potential limitations of the commitment system, as well as potential alternatives to CD commitment that could be explored further.

REFERENCES
Christopher PP, Pinals DA, Stayton T, et al: Nature and utilization of civil commitment for substance abuse in the United States. J Am Acad Psychiatry Law 43(3):313-20, 2015
Sullivan MA, Birkmayer F, Boyarsky BK, et al: Uses of coercion in addiction treatment: clinical aspects. Am J Addict 17(1):36-47, 2008

QUESTIONS AND ANSWERS
1. What landmark case prohibited the state from imposing criminal penalties on individuals suffering from substance use disorders, but affirmed the right of the state to civilly commit these persons?
a. Rennie v. Klein, 720 F.2d 266 (1983)
b. Robinson v. California, 370 U.S. 660, 82 S.Ct. 1417 (1962)
c. Specht v. Patterson, 386 U.S. 605, 87 S.Ct. 1209 (1967)
d. Powell v. Texas, 392 U.S. 514, 88 S.Ct. 2145 (1968)
ANSWER: b

2. Which medical ethical principles should inform policy for civil commitment of those suffering from substance use disorders?
a. Justice
b. Benefice
c. Non-maleficence
d. All of the above
ANSWER: d

F35 STORY OF A WARCHILD

Emmanuel Jal, (I) Toronto, ON, Canada

EDUCATIONAL OBJECTIVE

Mr. Jal's personal experiences of being a child caught up in conflict, his recruitment as a child soldier and then his subsequent escape is hugely inspiring. He shows the resilience of the human spirit and how education and forgiveness created a pathway to peace; one that has brought him the fruits of success and the ability to help others through his charity work and businesses.

SUMMARY

Mr. Jal starts with his personal experiences: Growing up in South Sudan, the civil conflict and how his father told him to walk to Ethiopia with thousands of others in the hope of going to school. Emmanuel walked thousands of miles along with other children, some who were eaten by wild animals and many who died of starvation and thirst. Arriving in Ethiopia they were put into refugee camps and willingly recruited by the SPLA to become child soldiers under the eyes of the UN. Emmanuel fought in many battlefields and at the age of 9 or 10 escaped with some others and undertook a journey of epic proportions – walking barefoot across barren landscape for 3 months where eventually rations ran out and many were forced to eat human bodies. Arriving into safety Emmanuel emerged as only one of 15 that survived the journey from 400 people. There he met a British Aid worker called Emma McCune who smuggled him to Kenya and took him in like a son. Through her love and learning at school Emmanuel started to realize that he could forgive and use his education as a way out. Emma was sadly killed in a car crash but her friends rallied around and kept Emmanuel off the streets and in school. From there he started becoming a well-known spokesperson and accidentally he became a spoken world artist and rapper. Through many ups and downs he became a famous singer and released a book and DVD of his story. Emmanuel then talks about his recent successes as an international recording artist with 5 award nominated albums under his belt, his film appearances and his charity work with his own charity Gua Africa, his social enterprise 'The Key is E' and his business Jal Gua. Emmanuel talks of his belief that education as the key to allowing people the freedom to express themselves and equip themselves for success – the route-way to sustainable peace. He will touch on the current crises we are now all facing with conflict, forced migration and the ever going 'refugee crisis' and how important it is to invest in education and 1:1 care in order to create a peaceful planet. Emmanuel will open with his song 'We Want Peace', include his spoken word 'Forced to Sin' and finish with his song 'Dusu' with everyone up on their feet dancing and celebrating life!

REFERENCES

Jal E: Warchild, Little Brown, 2008
Jal E: Warchild: A Child Soldier's Story. New York, NY: St. Martin's Press, 2009

QUESTIONS AND ANSWERS

1. Which of the following statements is true about Emmanuel Jal?
a. His mother was killed by soldiers when he was 7 years old.
b. He fought in the Civil War for several years before he turned 11.
c. His father protected him and his siblings from the ravages of war.
d. a and b
ANSWER: d

2. Later in his life, Emmanuel Jal:
a. performed with notable musicians such as Will Smith at Nelson Mandela's 90th birthday celebration.
b. Returned to Sudan to fight in a new civil war.
c. Contested to be president of South Sudan.
d. Shunned all activities regarding war and strife.
ANSWER: a

F36 NON-STATE POLITICAL VIOLENCE AND IDENTITY

Emily Keram, MD, Santa Rosa, CA
Kathleen Puckett, PhD (I) Danville, CA
Marc Sageman, MD, PhD, Rockville, MD

EDUCATIONAL OBJECTIVE
Participants will gain familiarity with historical and current understanding of non-state political violence, the use of social science methodology in delineating subsets of terrorists, and translating social science information into operationally useful material.

SUMMARY
Social science methodology has radically improved qualitative analysis, creating a more nuanced and accurate understanding of the process of transformation from individual to terrorist. Examining aspects of identity across cases provides the basis for describing subsets of terrorists, often with surprising insights into the range of their psychological functioning and the value of violence in their intra-psychic economy. This panel provides an introduction to social science methodology. Using this methodology, we review the historiography of terrorist studies and the evolution of the understanding of terrorists over 200 years, from the French Revolution to ISIS. We also examine whether this qualitative analysis sheds light on the development of effective prevention and rehabilitation strategies. Marc Sageman, MD, PhD, served as a case officer in the CIA from 1984-1991. He has consulted with most national security agencies in the US and the West. He is the author of Understanding Terror Networks, Leaderless Jihad, and The Turn to Political Violence (2016). Kathleen Puckett, PhD, retired FBI Special Agent, was the behavioral analyst on the UNABOM case. She authored the FBI's 2001 study on Lone Wolf offenders and co-authored Hunting the American Terrorist. Emily Keram, MD has consulted in numerous Guantanamo detainee/domestic terrorism cases.

REFERENCES
George AL, Bennett A: Case Studies and Theory Development in the Social Sciences. 4th edition Cambridge, MA: MIT Press, 2005
Sageman M: The Turn To Political Violence. New York, NY: Basic Books, 2016.

QUESTIONS AND ANSWERS
1. Studies have found a causal relationship between which psychiatric diagnosis and an individual's likely participation in terrorist acts?
a. Anti-social personality disorder
b. Delusional disorder
c. Schizophrenia
d. Schizotypal personality disorder
e. There is no causal relationship between any diagnosis and terrorism
ANSWER: e

2. What are examining causal mechanisms between observed variables known as?
a. coding
b. hermeneutics
c. constant comparison
d. domain analysis
e. process tracing
ANSWER: e

F37 EXPERT TESTIMONY IN SUICIDE MALPRACTICE LITIGATION

Liza Gold, MD, Arlington, VA
Donna Vanderpool, MB, JD, (I) Arlington, VA
Jeffrey Metzner, MD, Denver, CO
Barry Wall, MD, Providence, RI

EDUCATIONAL OBJECTIVE
To familiarize attendees with providing courtroom testimony in professional negligence claims, educate attendees the role of psychiatric experts in the litigation of such claims and improve attendees' skills and performance in providing courtroom testimony in general and in professional negligence claims in particular.

SUMMARY
Forensic fellows and early career psychiatrists often have limited opportunities to view or participate in psychiatric professional negligence tort cases. This course uses a videotaped mock trial of a professional negligence claim brought against a psychiatrist after the suicide of a patient shortly after discharge from an inpatient psychiatric admission.

Faculty will review the legal elements of a psychiatric professional negligence case, the roles of plaintiff's and defense experts, and the provision of trial testimony. We will review these issues through interactive use of the video before and after elements of the court proceedings, including plaintiff's testimony, the defendant psychiatrist's testimony, and the direct and cross-examination testimony of the expert witnesses. Donna Vanderpool, MBA, JD will review the legal elements and the roles of the expert witness in a psychiatric professional negligence case. Three experienced forensic psychiatrists, Barry Wall, MD, Jeffrey Metzner, MD, and Liza Gold, MD provide the testimony, respectively, of the plaintiff's expert, defense expert, and defendant psychiatrist. Experienced litigation lawyers conduct direct and cross-examination of the witnesses. Attendees will be invited to discuss all aspects of roles and testimony, including testimony regarding standard of care and challenges in providing direct and cross-examination testimony.

REFERENCES

Meyer DJ, Simon RI, Shuman DW: Professional Liability in Psychiatric Practice and the Requisite Standard of Care. In Simon RI, Gold LH (eds): The American Psychiatric Publishing Textbook of Forensic Psychiatry, 2nd edition. Arlington, VA: American Psychiatric Publishing, Inc., 2010

Scott CL, Resnick PJ: Patient Suicide and Litigation. In The American Psychiatric Publishing Textbook of Suicide Assessment and Management, 2nd edition. Arlington, VA: American Psychiatric Publishing, Inc., 2012

QUESTIONS AND ANSWERS

1. How is the standard of care established in a professional negligence case?
a. The patient's treatment records.
b. The treating psychiatrist's fiduciary duty.
c. The treating psychiatrist's education and experience.
d. The expert witnesses' testimony
ANSWER: d

2. What may medical standard of care be defined by?
a. Legal precedent
b. Practice guidelines
c. Medical literature
d. State statute
e. All of the above
ANSWER: e

F38 A JURY OF THOUSANDS

Lynn Maskel, MD, Madison, WI
Steven Drizin, JD, (I) Chicago, IL
Paul O'Leary, MD, Birmingham, AL

EDUCATIONAL OBJECTIVE

To explore evolving genre of documentaries (potential "miscarriage of justice"/exoneration), both in terms of the specific case as well as broader effects on various elements of the legal system. To examine specific aspects of purported false confession cases, especially involving juveniles, which make up a large component of this phenomenon.

SUMMARY

In 1988, Errol Morris's independent film, The Thin Blue Line, played in just under a hundred theaters. Yet, within a year of its release, the film was instrumental in exonerating a Texas inmate who had been sentenced to death for the murder of a police officer. Documentaries, docuseries and serial podcasts not only can free the innocent, but they also introduce a new variable which may alter base-rate judgments in legal decisions (akin to the CSI effect). Today, when shows like Serial and Making a Murderer go viral, their power to rapidly shape the public perception grows exponentially. This session will examine the evolution and impact of documentary film, using multiple film clips to spark discussion. Primary focus will be on documentaries with a potential false confession component (particularly juvenile cases). Northwestern University Clinical Professor of Law Steven Drizin has had direct involvement in several of the cases and films we will highlight, including Scenes of A Crime (2011), The Central Park Five (2012), West of Memphis (2012) and Making a Murderer (2015). The session will explore, among other issues, the extent to which a film can engender a huge paradigm shift to the conventional wisdom that "the innocent don't confess."

REFERENCES

Kassin S, Drizin S, Grisso T, et al: Police-induced confessions, risk factors, and recommendations: looking ahead. Law Hum Behav 34: 49-52, 2010

Dillon MK: Making a Murderer may make better defense jurors, Jury Research | Social Media, Feb 2016

QUESTIONS AND ANSWERS

1. A third of false confessions come from youth under 18. Aspects of juveniles and the interrogation process that contribute to this high percentage, as explored in documentaries, can include:

a. Juveniles, in lengthy interrogations, are more sensitive to the ensuing stress and can come to view confessing as an “escape hatch”, believing they will be able to "just go home.”

b. Juveniles are more suggestible and often fail to have even a reasonably minimal understanding of potential short and long term consequences, a particular concern as frequently this involves a homicide case.

c. Juveniles are more susceptible to doubting their own memories as they are questioned by authority figures who may use bluffing technique, misrepresenting evidence or lying as an interrogation technique.

d. Juveniles are more impulsive or may exhibit symptoms of ADHD which can contribute to increased "acting before thinking" when responding to questions.

e. All of the above

ANSWER: e

2. Which is the single best reform available to stem the tide of false confessions in juveniles?

a. Set reasonable time limits for interrogation.

b. Do not allow minors to be questioned without a parent, guardian, or legal representative present.

c. Videotape all interrogations, from the reading of rights to the end, with the tape running continuously.

d. Make it illegal for law enforcement to lie to suspects.

ANSWER: c

F39 **COMMUNITY FORENSICS: AAPL OUTSIDE OF THE COURTROOM**

Merrill Rotter, MD, White Plains, NY
Reena Kapoor, MD, New Haven, CT
Debra Pinals, MD, Ann Arbor, MI
Christine Martone, MD, Pittsburgh, PA
Katherine Michaelsen, MD, Seattle, WA
Ken Hoge, MD, New York, NY

EDUCATIONAL OBJECTIVE

To describe and review a structured approach to understanding and planning for community-based programming for forensic patients including specific program examples, as well as implementation strategies and opportunities for forensic psychiatric leadership.

SUMMARY

Forensic psychiatrists evaluate and treat justice-involved individuals at various stages and places within the justice system -- jails, prisons, and courts -- but also in the community, where offenders are most likely to be found. The Community Forensics Committee aims to focus on both systems-level and client-level approaches to meeting the needs of offenders with mental illness outside of custodial settings. In this panel, we introduce the work of the Committee by discussing the Sequential Intercept Model (SIM), a nationally utilized mapping strategy for identifying opportunities to intervene and divert offenders with mental illness. The panel presentations will include a) an introduction to SIM and its role in policy development, b) innovative, evidenced-based diversion and re-entry programs, c) the challenges of communicating between criminal justice and mental health professionals, c) integration of SIM into statewide forensic services, and d) the rationale for forensic psychiatrists to play a leadership role in community treatment of offenders with mental illness.

REFERENCES

Munetz M, Griffin P: Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. Psychiatric Services 57: 544-549, 2006

Pinals D: Forensic services, public mental health policy, and financing: charting the course ahead. J Am Acad Psychiatry Law 42(2):7-19, 2014

QUESTIONS AND ANSWERS

1. According to federal statistics, what is the ratio between justice-involved individuals who are under community supervision and those who are incarcerate?

a. 1:4

b. 1:5

c. 2:5

d. 10:1

ANSWER: c

2. Common interventions that directly link to justice recidivism reduction goals in accordance with the Sequential Intercept Model include all but the following?
a. CIT
b. Specialty courts
c. Interpersonal psychotherapy
d. APIC reentry planning
e. Specialized probation
ANSWER: c

F40 ADMINISTRATIVE SEPARATIONS, MEDICAL BOARDS

Elspeth Ritchie, MD, Silver Springs, MD

EDUCATIONAL OBJECTIVE

To uderstand the relevant personnel and medical regulations around psychiatric conditions in service members, know what an administrative separation and medical board process, and learn how a psychiatrist can assist in making the appropriate disposition.

SUMMARY

Psychiatric conditions which impair fitness for duty may cause discharge from the military. Service members with diagnosed mild psychiatric conditions, such as mild depression or PTSD, may stay on active duty but with duty restrictions. Persistent or severe psychiatric conditions may lead to an administrative separation or to a "medical board". An administrative separation is not a medical process but psychiatrists and psychologists often provide input. An example is a "Chapter 5-13" for a personality disorder or a "Chapter 5-17" for other medical or mental conditions. A medical board is a longer process which may lead to a medical separation and/or retirement. Service members with bipolar disorder or schizophrenia should receive a medical board. Medical retirement has significantly more health and economic benefits than an administrative separation. The form of discharge also has impact on the veteran's eligibility for benefits and health care from the Veterans Administration. While active duty service members should be treated in the Military Care System, many reservists and/or veterans will be seen by civilian psychiatrists. Psychiatrists who are involved with service members or veterans should understand the relevant regulations that impact their fitness for duty.

REFERENCES

Ritchie EC: Forensic and Ethical Issues in Military Behavioral Health. Textbook of Military Medicine, Borden Pavilion. Washington, DC: Office of The Surgeon General, US Department of the Army and Borden Institute, 2014
Ritchie EC, Benedek D, Malone R, et al: Military psychiatry: an update. Psychiatric Clinics of North America (29)3:2006

QUESTIONS AND ANSWERS

1. In the military system, what does schizophrenia lead to?
a. An administrative separation
b. A medical board
c. A punitive discharge
d. a and c.
ANSWER: b

2. In the military system, what does PTSD lead to?
a. An administrative separation
b. A medical board
c. A punitive discharge
d. All of the above
ANSWER: d

F41 **MOC: KEEP, POLISH OR ABOLISH?**

Trent Holmberg, MD, Draper, UT
Dan Cotoman, MD, Charlotte, NC
Celestine DeTrana, MD, Indianapolis, IN
Larry Faulkner, MD, Chicago, IL
Richard Frierson, MD, Columbia, SC
Nicole Graham, MD, South Windsor, CT
Richard Rosin, MB, FRCPC, (I) Vancouver, BC, Canada

EDUCATIONAL OBJECTIVE

By attending this debate, the audience will better understand the current controversy regarding maintenance of certification (MOC) requirements in psychiatry. Whether the current ABPN MOC program accomplishes the goal of demonstrating lifelong learning without imposing unreasonable fees, meaningless busy work, or an onerous burden on diplomates will be warmly debated.

SUMMARY

We got it wrong and sincerely apologize. This startling admission by the American Board of Internal Medicine regarding their MOC program, has reverberated throughout the medical community and even garnered coverage in the popular press. Specialty organizations have made increasingly vocal calls for MOC reform, including the American Academy of Neurology. A physician group has even created an alternative Board offering recertification for all specialties. Despite mounting criticism, the American Board of Medical Specialties (ABMS) issued a Statement last year reaffirming its commitment to "all of the elements of MOC." The ABMS called on its 24 Member Boards (of which ABPN is one) to "listen to participants, to improve their processes and to deliver real value to physicians," while simultaneously implementing ABMS standards regarding MOC. The ABPN has responded by reducing self-assessment and performance improvement requirements, giving three years of MOC credit to diplomates who pass the forensic (or any other) subspecialty certification examination, and by reducing fees by 7% for 2016. Despite these changes, many psychiatrists are pressing for further reform. This debate will present both sides of the MOC issue. Larry R. Faulkner M.D., President and CEO of ABPN, will be present and will participate in the debate.

REFERENCES

American Board of Medical Specialties: Statement ABMS Commitment to Board Certification and Maintenance of Certification. Available at http://www.abms.org/news-events/abms-commitment-to-board-certification-and-maintenance-of-certification-moc/. Accessed August 2016
Hayes J, Jackson JL, McNutt GM, et al: Association Between Physician Time-Unlimited vs Time-Limited Internal Medicine Board Certification and Ambulatory Patient Care Quality. JAMA 312(22):2358-2363, 2014

QUESTIONS AND ANSWERS

1. Which of the following are listed standards in the Standards for the ABMS Program for Maintenance of Certification (MOC)?

a. Professionalism and Professional Standing
b. Lifelong Learning and Self-Assessment
c. Assessment of Knowledge, Judgment, and Skills
d. Improvement in Medical Practice
e. All of the above
ANSWER: e

2. Compared to internists with time-unlimited board certification, internists with time-limited board certification exhibited:

a. Better performance on quality of care measures
b. Worse performance on quality of care measures
c. The same performance on quality of care measures
ANSWER: c

F42 **VIOLENCE REDUCTION: PROMISING TOOLS FOR A PROBLEMATIC TASK**

Merrill Rotter, MD, White Plains, NY
Debra Pinals, MD, Ann Arbor, MI
Barry Rosenfeld, PhD, (I) Tucson, AZ
Scott Waugh, PhD, (I) Los Angeles, CA
Lisa Ramshaw, MD, Toronto, ON, Canada

EDUCATIONAL OBJECTIVE

To acquaint participants with promising tools in screening and assessment of violence risk, while discussing the clinical, ethical and legal challenges inherent in the creation and implementation of these tools.

SUMMARY
Despite ongoing ambiguity about the specific role of serious mental illness as a factor in societal violence, increasingly mental health systems are tasked with reducing the risk to the public posed by seemingly random acts of violence. However, who the identified population is, what is defined as violent, when to intervene and how can risk be identified reliably are all moving pieces that incorporate both social science and social policy decision-making. In this panel we present two large jurisdictions that are attempting to go to scale in bring social science and social policy to understanding the violence posed by individuals who often have both criminal justice and mental health contact. In addition to discussing these initiatives, we will present promising practices in structured violence risk screening and management, including a new tool that provides for universal screening and one that supports risk-reduction focused treatment planning. Panelists will pay particular attention to the assumptions and limitations associated with these new tools and policies, and provide the foundation for discussion of the clinical, ethical and legal challenges of our role in the violence reduction agenda.

REFERENCES
Skeem JL, Monahan J: Current directions in violence risk assessment. Current Directions in Psychological Science, 20, 38-42, 2011
Singh JP, Desmarais SL, Hurducas C, et al: International Perspectives on the Practical Application of Violence Risk Assessment: A Global Survey of 44 Countries. International J Forensic Mental Health 13(3), 2014

QUESTIONS AND ANSWERS
1. What is an acceptable community risk?
a. An ethical issue
b. A civil rights issue
c. A clinical determination
d. A legal formulation
e. All of the above
ANSWER: e

2. Risk screening differs from risk assessment in all of the following ways except:
a. determining treatment strategies
b. identifying risk factors
c. reviewing past history of violence
d. developing risk scenarios
ANSWER: c

F43 **MANAGING THREATS ON CAMPUS**

Cheryl Regehr, PhD, (I) Toronto, ON, Canada
Graham Glancy, MB, Toronto, ON, Canada
Joel Dvoskin, PhD, (I) Tucson, AZ
Scott Waugh, PhD, (I) Los Angeles, CA
Lisa Ramshaw, MD, Toronto, ON, Canada

EDUCATIONAL OBJECTIVE
To encourage the development and strengthening of partnerships between academic administrators and forensic mental health professionals in addressing threats on campus that are informed both by empirical evidence and an understanding of the university environment and culture.

SUMMARY
In recent years the public has been riveted by media images of shootings on university and college campuses and interviews of those affected. Fortunately, these horrifying high profile events remain relatively rare. However, due in part to a rapid rise in mental health issues among students and the explosion of internet communications, academic administrators are required to manage threats of violence on a regular basis. Threats of violence on campus take two primary forms, those in which the perpetrator and the intended victim(s) are clearly identified; and anonymous online threats to commit acts of larger scale violence. Complicating factors in threat assessment and management on campuses include: fear contagion; mass media and social media attention; responsibilities to all members of the university community including individuals issuing the threat and the intended victims; demands for safety and security measures that are often at odds with professional risk assessment advice; and permeable campus boundaries that cause security challenges. This panel of university provosts and forensic risk assessment experts will discuss the changing Iandscape of threat assessment and incident management on campuses. Models for partnerships between forensic mental health professionals and academic administrators will be explored.

REFERENCES
Dunkle JH, Silverstein ZB, Warner SL: Managing violent and other troubling students: The role of threat assessment teams on campus. JC & UL, 34, 585, 2007
Hollister BA, Scalora MJ: Broadening campus threat assessment beyond mass shootings. Aggression and Violent Behavior (25)43-53, 2015

QUESTIONS AND ANSWERS
1. What is the most common precursor to campus violence?
ANSWER: Approximately 1/3 of violent episodes on campus relate to intimate partner violence, refused advances motivate another 10% of cases.

2. To what degree does academic stress motivate violence on campus?
ANSWER: In approximately 10% of cases.

F44 GERIATRIC POPULATION IN THE LEGAL SYSTEM: A REVIEW

Stephanie Yarnell, MD, PhD, New Haven, CT
Paul Kirwin, MD, West Haven, CT
Howard Zonana, MD, New Haven, CT

EDUCATIONAL OBJECTIVE
This presentation seeks to review the current state of elders in the correctional system with an emphasis on the growing numbers of incarcerated elderly. Causes, issues with, and possible solutions to this situation will be reviewed. In doing so, this presentation presents rationale for increased geriatric training for forensic psychiatrists.

SUMMARY
The baby-boomers will reach advanced age by 2020. With them they bring a lifetime of experiences, cultural norms, and habits some of which place them at higher risk of contact with the legal system compared to previous older-cohorts, such that they are now the fastest growing group of prisoners. The struggling U.S. correctional system will be further challenged by the significant needs of this population. Mental health and general medical care for older adults requires expertise in geriatric medicine and/or psychiatry, as well as potential changes in infrastructure, both of which may be prohibitively expensive. To address this situation, strategic revisions of the criminal justice system are needed to alleviate prison overcrowding and consequent inadequate medical care for inmates, especially the elderly. The unique, age-related demands of this older population predicts an increased need for forensic psychiatrists with a thorough knowledge and expertise in geriatrics, as more forensic psychiatric evaluations will be needed prior to trial for both civil and criminal cases, during incarceration, and at the time of parole. This paper reviews the current state of elders in correctional institutes and advocates for increased geriatric training for forensic psychiatrists in anticipation of this growing need.

REFERENCES
Chettiar IM, Bunting W, Schotter G: At America's expense: The mass incarceration of the elderly, in Washington, DC: American Civil Liberties Union. Available at http://www.aclu.org/criminal-law-reform/americas-expense-mass-incarceration-elderly. Accessed August 2016
Pastore A, Maguire K: Sourcebook of Criminal Justice Statistics. Available at http://www.albany.edu/sourcebook/pdf/t472010.pdf. Accessed August 2016

QUESTIONS AND ANSWERS
1. At what stage of the legal system are forensic psychiatrists with geriatric training needed?
a. Pre-trial
b. During incarceration
c. At parole
d. Civil cases
e. All of the above
ANSWER: e

2. What are some of the possible solutions to the mass incarceration of the elderly?
a. A combination of release programs, specialized housing, and more stringent sentencing reform.
b. A combination of release programs, specialized housing, and sentencing reform.
c. A combination of release programs, non-selective housing, and more stringent sentencing reform.
d. A combination of release programs, non-selective housing, and sentencing reform.
ANSWER: b

F45 FORENSIC ROTATIONS FOR RESIDENTS: NAVIGATING THE CHALLENGES

Katherine Michaelsen, MD, Seattle, WA
Tobias Wasser, MD, New Haven, CT
Alan Lewis, MD, PhD, Hamden, CT
Peter Morgan, MD, PhD, New Haven, CT
Sherry McKee, PhD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE

To understand the common challenges faced when introducing forensic clinical experiences into psychiatry residencies, appreciate the creative solutions required to develop these experiences and identify opportunities to develop novel forensic experiences for residents within their own institutions.

SUMMARY

Psychiatry residents' experiences in forensic psychiatry vary greatly across the country and many psychiatry programs meet the Accreditation Council for Graduate Medical Education requirements for a forensic experience through general psychiatry rotations (e.g. on a consult-liaison service) or classroom-based activities (1, 2). We believe that early forensic experiences during psychiatry residency are important not only for generating interest in forensic psychiatry, but also for preparing future general psychiatrists. General psychiatrists are called upon to perform safety assessments and testify in court on a variety of civil issues (including disability, personal injury, and custody determinations). Thus, it is critical that we improve psychiatry resident understanding of legal questions and processes. Unfortunately, residency programs face multiple challenges to implementing forensic clinical experiences, including those created by current regulatory frameworks, the nature of forensic practice itself, and intradepartmental politics. Here we will describe these challenges and then detail our efforts to create a novel forensic clinical rotation for residents at our training institution. We will utilize our experience to highlight some of the challenges and how we navigated them. We hope that educators can use our experiences as a framework for further discussion and development of offerings at their institutions.

REFERENCES

Marrocco MK, Uecker JC, Ciccone JR: Teaching forensic psychiatry to psychiatric residents. Bull Am Acad Psychiatry Law 23(1): 83-91, 1995
Williams J, Elbogen E, Kuroski-Mazzei A: Training directors' self-assessment of forensic education within residency training. Acad Psychiatry 38(6): 668-71, 2014

QUESTIONS AND ANSWERS

1. What percentage of residencies had mandatory forensic psychiatry rotation in a survey of psychiatry residency programs?
a. 51%
b. 43%
c. 29%
d. 16%
ANSWER: c

2. Which of the following is not a challenge faced by the presenters when developing a novel forensic rotation?
a. Lack of other subspecialty buy-in.
b. Lack of resident interest.
c. Geographical and scheduling mismatch with resident rotations.
d. Lack of specific regulatory guidelines regarding forensic experiences.
ANSWER: b

F46 TRIAL 1 VERSUS TRIAL 2 OF THE TEST OF MEMORY MALINGERING

Douglas Mossman, MD, Cincinnati, OH
Roger Gervais, PhD, (I) Edmonton, AB, Canada
Kathleen Hart, PhD, (I) Richmond, KY

EDUCATIONAL OBJECTIVE

At the conclusion of this presentation, listeners will describe the strategy used in neuropsychological performance validity tests (PVTs), summarize the accuracy characteristics of the TOMM and explain, in general terms, the difficulties encountered when trying to evaluate neurocognitive PVTs.

SUMMARY
This study examines the accuracy of the Test of Memory Malingering (TOMM), a frequently administered measure for evaluating effort during neurocognitive testing. In the last few years, however, several authors have suggested that the initial recognition trial of the TOMM (TOMM1) might be a more useful index for detecting feigned impairment than Trial 2 (TOMM2), which is the source for inference recommended by the original instruction manual (Tombaugh 1996). This study used latent class modeling (LCM) implemented in a Bayesian framework to compare TOMM1 and TOMM2 data collected from 1301 subjects who had undergone real-life forensic evaluations. All subjects also were tested with at least two other performance validity tests (the Word Memory Test and the Computerized Assessment of Response Bias) and 69% also had test data available for the California Verbal Learning Test-Retention Trial. LCM showed that more than half the subjects had TOMM1 scores that would warrant saying their probability of malingering was low—a conclusion that even a perfect TOMM2 score does not justify. The TOMM1 and TOMM2 performed about equally, however, and would identify with high confidence fewer than half of the 30% of subjects who were actually malingering.

REFERENCES
Mossman D, Miller WG, Lee ER, et al: A Bayesian approach to mixed group validation of performance validity tests. Psychological Assessment (27)763–776, 2015
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. When considering potential feigning by middle-aged individuals who respond coherently to interview questions but report significant memory impairment, which statement about Trial 2 of the TOMM (TOMM2) is true, based on this presentation?
a. Scores on the TOMM2 sort evaluees into two distinct groups with low and high likelihoods of feigning.
b. Some TOMM2 scores are associated with a high sensitivity but a low specificity.
c. Some TOMM2 scores are associated with a low sensitivity but a high specificity.
d. A high TOMM2 score implies that feigning is very unlikely.
e. Most malingerers scores below chance on the TOMM.
ANSWER: b

2. Compared to the TOMM2, scores on Trial 1 of the TOMM:
a. Are far better at identifying feigned memory impairment.
b. Less often support a conclusion that an evaluee is responding genuinely.
c. More often support a conclusion that an evaluee is responding genuinely.
d. Have much lower overall accuracy as measured by the area under the ROC curve.
ANSWER: c

F47 GUN SAFETY IN GENERAL PSYCHIATRY RESIDENCY TRAINING

Jennifer Piel, MD, JD, Seattle, WA

EDUCATIONAL OBJECTIVE
Little is known about what, if anything, is currently being taught to psychiatry residents about gun safety devices, storage, and local gun safety programs. This session will review a pilot study aimed to assess current residency program training and interest in training in gun safety devices and programs.

SUMMARY
Gun violence has become a matter of public discourse. Given the increased attention to gun violence – both for suicide and violence to others – it is possible that residency programs are providing more instruction on firearm injury prevention than in the past. Little is known about what – if anything – is currently being taught to psychiatry residents with regard to gun safety devices, storage, and local gun safety programs. This scientific paper session will review the results of a pilot study aimed to assess current residency program training and interest in training in gun safety devices, storage and programs. A survey using surveymonkey.com was e-mailed to general psychiatry residency program directors. Of respondents, few programs currently have formal training on gun safety and programs. The majority expressed interest in incorporating the topic into their residents' training and in sampling a model curriculum on the topic. The author discusses avenues to partner with law enforcement or other firearm groups and next steps in providing education on this topic.

REFERENCES

Butkus R, Weissman A: Internists' attitudes toward prevention of firearm injury. Ann Int Med 160:821-827, 2014
Price JH, Thompson AJ, Khubchandani J, et al: Firearm anticipatory guidance training in psychiatric residency programs. Acad Psychiatry 34(6): 417-423, 2010

QUESTIONS AND ANSWERS

1. In Price (2010), residency program directors identified the following as a barrier to providing training on firearm injury prevention:

a. Not an appropriate topic for residency training.
b. Residents get this training through rotations on other non-psychiatric services.
c. Lack of faculty expertise about firearms.
d. Residents are not interested in this topic.

ANSWER: c

2. Of respondents in this pilot study of general psychiatry residency program directors, which percentage of programs currently have formal training on gun safety devices and programs?

a. 1%
b. 18%
c. 36%
d. 66%

ANSWER: b

SATURDAY, OCTOBER 29, 2016

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

S1 ***Adolescent Violence Risk by MacArthur Risk Factor Categories***
Megan Mroczkowski, MD, New York, NY
John Walkup, MD, New York, NY
Paul Appelbaum, MD, New York, NY

S2 ***A Review: Brain, Borderline Personality Disorder, Competence***
Frank Fetterolf, MD, Pittsburgh, PA
Abhishek Jain, MD, Pittsburgh, PA
Agnes Joseph, MD, Pittsburgh, PA
Nubia Lluberes, MD, Morgantown, WV
Oommen Mammen, MD, Pittsburgh, PA

S3 ***Capacity for Two! The Complexities of Capacity in Pregnancy***
Anna Glezer, MD, San Francisco, CA
Tara Collins, MD, MPH, San Francisco, CA

S4 ***Online Child Sexual Exploitation***
Thanh Ly, BSc, (I) Nepean, ON, Canada
Lisa Murphy, MCA, (I) Ottawa, ON, Canada
J. Paul Fedoroff, MD, Ottawa, ON, Canada

S5 ***Use of a Screening Tool in Predicting Inpatient Violence***
Amina Ali, MD, New York, NY
Katya Frischer, MD, JD, New York, NY
Ali Khadivi, PhD, (I) Bronx, NY
Merrill Rotter, MD, Bronx, NY
Barry Rosenfeld, PhD, (I) Bronx, NY
Melodie Foellmi, MA, (I) Bronx, NY

S6 ***Management of Patients Who Make Threats Against the POTUS***
Paulina Riess, MD, Bronx, NY
Luisa Gonzalez, MD, Bronx, NY
Panagiota Korenis, MD, Bronx , NY

S7 ***Cognitive Status and Profile Validity: Competency Implications***
Corey Leidenfrost, PhD, (I) Buffalo, NY
Daniel Antonius, PhD, (I) Buffalo, NY
Matthew Scalco, MA, (I) Buffalo, NY
Peter Martin, MD, MPH, Buffalo, NY
Tataiana Matlasz, BS, (I) Buffalo, NY

S8 ***Teaching the Insanity Defense to Psychiatry Residents***
Matthew Grover, MD, Durham, NC
Amina Ali, MD, Bronx, NY
Katya Frischer, MD, JD, New York, NY

S9 ***Effect of Juvenile Incarceration on Vulnerable Siblings***
Gowri Ramachandran, MD, Washington, DC
Eindra Khin Khin, MD, Washington, DC

S10 ***Correctional Adaptation: Recent Findings and Future Research***
Allison Foerschner, MA, (I) Hillsboro, OR
Leonardo Bobadilla, PhD, (I) Hillsboro, OR
Michelle Guyton, PhD, (I) Portland, OR

S11 ***Consenting to AOT: Requiring Cooperation From the Uncooperative***
Katya Frischer, MD, JD, New York
Makeda Jones-Jacques, MD, White Plains, NY
Merrill Rotter, MD, Bronx, NY
Matthew Grover, MD, Durham, NY

S12 ***Nitrous Oxide - Dental Dreams, Manic Moments***

Cecilia Leonard, MD, Fairfax, VA
Mark DeLuca, MD, Palm Beach, FL
Dan Cotoman, MD, Charlotte, NC

S13 ***Treating Inmates Involuntarily: Data Support and Policy Concern***

Leena Rajagopal, MD, Jersey City, NJ
Jeremy Colley, MD, Folsom, CA
Merrill Rotter, MD, Bronx, NY

S14 ***Restraint Usage Patterns in Forensic Psychiatric Inpatients***

Kayla Fisher, MD, JD, Patton, CA
Sean Evans, PhD, (I) Patton, CA

S15 ***Human Sex Trafficking: from Trauma to Treatment***

Natasha Thrower, MD, Boston, MA
Helen Farrell, MD, Boston, MA
Fabian Saleh, MD, Boston, MA

S16 ***Trauma and Juvenile Delinquency: An ACES – Based Review***

Douglas Saphier, MD, New York, NY
Merrill Rotter, MD, Bronx, NY
Kathleen McKay, PhD, (I) Hartsdale, NY

S17 ***Assessment of the Cognitively Impaired Sex Offender***

Robyn Thom, MD, (I) Boston, MA
Fabian Saleh, MD, Boston, MA

S18 ***Violence in the Mentally Ill: Hospitalization or Diversion?***

Janet Charoensook, MD, Arleta, CA
Kishore Desagani, MD, Irvine, CA

AAPL BUSINESS MEETING (MEMBERS ONLY) 8:00 AM – 9:30 AM **BALLROOM I**

COFFEE BREAK **9:30 AM – 10:00 AM**

PANEL 10:00 AM - 12:00 PM **BALLROOM I**

S19 ***Updating Ethics and Evidence-Based Child Custody Evaluations***

Stephen Billick, MD, New York, NY
Peter Ash, MD, Atlanta, GA
William Darby, MD, Santa Monica, CA
Suchet Rao, MD, New York, NY
Robert Weinstock, MD, Los Angeles, CA

PANEL 10:00 AM - 12:00 PM **PAVILION EAST**

S20 ***The Asylum and Community: Transforming the Continuum of Care***

J. Richard Ciccone, MD, Rochester, NY
Josh Jones, MD, Port Angeles, WA
Debra Pinals, MD, Ann Arbor, MI
Robert Weisman, DO, Rochester, NY
Philip Candilis, MD, Washington, DC

PANEL 10:00 AM - 12:00 PM **PAVILION WEST**

S21 ***Ten Years' Experience on a Corporate Threat Assessment Team***

Mark McClung, MD, Seattle, WA
Scott McArthur, CPP, (I) Redmond, WA
Orna Edgar, Esq., (I) Redmond, WA

WORKSHOP 10:00 AM - 12:00 PM **GALLERIA**

S22 ***Lovemaps: The Paraphilias in Film and Documentaries***

Ryan Wagoner, MD, Lutz, FL
Bradley Booth, MD, Ottawa, ON, Canada
Susan Hatters Friedman, MD, Cleveland Heights, OH
Renee Sorrentino, MD, Weymouth, MA

WORKSHOP 10:00 AM - 12:00 PM **BROADWAY I-III**

S23 ***Vicarious Trauma: What is the Role for Forensic Psychiatry?***
Trauma and Stress Committee

Andrew Levin, MD, Hartsdale, NY
Maya Prabhu, MD, New Haven, CT
David Nissan, MD, New York, NY
Loretta Sonnier, MD, New Orleans, LA

LUNCH (TICKET REQUIRED) 12:00 PM – 2:00 PM **BALLROOM II**

S24 ***Transforming the Police: The Department of Justice Civil Rights Division and Police Accountability***
Attorney Christy Lopez, (I) Washington, DC

AV SESSION 2:15 PM - 4:00 PM **BALLROOM I**

S25 ***Reversing the 1944 Judicial Lynching of a 14 Year-old Boy***
Peer Review Committee (AAPL Members only)

David Rosmarin, MD, Newton, MA
Ezra Griffith, MD, New Haven, CT
Amanda Salas, MD, Beaufort, SC

COURSE (TICKET REQUIRED) 2:15 PM - 6:15 PM **PAVILION EAST**

S26 ***Neurolaw 101: Intro to Neurolaw for Forensic Psychiatrists***
Neuropsychiatry Committee

Octavio Choi, MD, PhD, Portland, OR
Vivek Datta, MD, MPH, San Francisco, CA
Manish Fozdar, MD, Raleigh, NC
Stephen Morse, JD, PhD, (I) Philadelphia, PA
Francis Shen, JD, PhD, (I) Minneapolis, MN

WORKSHOP 2:15 PM - 4:00 PM **PAVILION WEST**

S27 ***Social Media in Forensic Psychiatry: Ethics and Law***
Ethics Committee

Susan Hatters Friedman, MD, Cleveland Heights, OH
Cathleen Cerny, MD, Seven Hills, OH
Jennifer Piel, MD, JD, Seattle, WA
Patricia Recupero, MD, JD, Providence, RI
Navneet Sidhu, MD, Alexandria, VA

PANEL 2:15 PM - 4:00 PM **GALLERIA**

S28 ***Youth Concussions: Psychiatric Risks, Legal Implications***
Child and Adolescent Psychiatry Committee

Christopher Fischer, MD, West Hollywood, CA
David Baron, DO, (I) Los Angeles, CA
Susan Turkel, MD, (I) Los Angeles, CA

PANEL 2:15 PM - 4:00 PM **BROADWAY I-III**

S29 ***Can the Recovery Model Be Integrated Into Leverage?***

Simha Ravven, MD, Putney, VT
Reena Kapoor, MD, New Haven, CT
Debra Pinals, MD, Ann Arbor, MI
Marvin Swartz, MD, Durham, CT
Madelon Baranoski, PhD (I), New Haven, CT

COFFEE BREAK **4:00 PM – 4:15 PM**

WORKSHOP 4:15 PM - 6:15 PM **BALLROOM I**

S30 ***Transforming Forensic Experience into Creative Writing***

Reena Kapoor, MD, New Haven, CT
Richard Martinez, MD, MH, Denver, CO
Christine Montross, MD, MFA, Barrington, RI
Jacob Appel, MD, JD, New York, NY
Ezra Griffith, MD, New Haven, CT

PANEL 4:15 PM - 6:15 PM **PAVILION WEST**

S31 ***Should Video Recording of Sanity Evaluations be Mandatory?***

Patricia Westmoreland, MD, Denver, CO
William Reid, MD, MPH, Horseshoe Bay, TX
Jeffrey Metzner, MD, Denver, CO
Steven Jensen, JD, (I) Golden, CO
Rich Orman, JD, (I) Centennial, CO

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

S32 ***Police Crisis Intervention:Creating a Multilayered Response***

Landy Sparr, MD, Beaverton, OR
Amy Bruner-Dehnert, BA, (I) Portland, OR
Liesbeth Gerritsen, PhD, (I) Portland, OR
Tashia Hager, BS, (I) Portland, OR

RESEARCH-IN-PROGRESS #3 4:15 PM - 6:15 PM **BROADWAY I-III**

S33 ***Autism and Personality: Challenges in Assessment***

Kyle Walker, MD, Boston, MA
Alexander Westphal, MD, PhD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Laurie Sperry, PhD, (I) Denver, CO

S34 ***Forcing Treatment: Does the Legal Approach Matter?***

Scott Walmer, DO, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT

S35 ***Is Trauma a Criminogenic Risk Factor: PTSD and Outcome***

Katya Frischer, MD, New York, NY
Virginia Barber Rioja, PhD, (I) New York, NY
Susanna Preziosi, PhD, (I) Bronx , NY
Merrill Rotter, MD, Bronx, NY

S36 ***Self-Harm in California Prisons: Phenomenology and Treatment***

Jeremy Colley, MD, Folsom, CA
Melinda DiCiro, PhD, (I) Sacramento, CA
Robert Canning, PhD, (I) Folsom, CA

Your opinion on today's sessions is very important!
While it's fresh in your mind, PLEASE complete the evaluation form for today's program so we can continue to offer CME in the future.

S1 ADOLESCENT VIOLENCE RISK BY MACARTHUR RISK FACTOR CATEGORIES

Megan Mroczkowski, MD, New York, NY
John Walkup, MD, New York, NY
Paul Appelbaum, MD, New York, NY

EDUCATIONAL OBJECTIVE
Violence and aggression among adolescents is a common problem and of enormous public health significance. Homicide is the second leading cause of death among those aged 15-24 and third leading cause of death among those aged 10-14. MacArthur Risk Factors can be used to assess adolescent violence risk.

SUMMARY
Violence and aggression among adolescents is a common problem and of enormous public health significance. Homicide is the second leading cause of death among those aged 15-24 and third leading cause of death among those aged 10-14. We searched PubMed and PsychInfo databases (1966-2/12/2016) for studies that reported risk factors for violence in adolescents using the MacArthur Risk Factor categories as organizing principles. Risk factors for adolescent violence can be organized by MacArthur Risk Factor categories. Personal characteristics include male sex and lower IQ. Historical characteristics include a younger age at first offense, high number of previous criminal offenses, criminal history in one parent, physical abuse, experiencing poor child-rearing, and low parental education level. Low grade point average and poor academic performance, low connectedness to school, truancy, low motivation and school failure are all risk factors. Social relations included high peer delinquency or violent peer group, along with victimization. Firearm access is a risk factor for violence in children and adolescents. Clinical characteristics include depressive mood, ADHD, antisocial traits, callous/unemotional traits, grandiosity, justification of violence, and psychopathy. Utilizing MacArthur risk factor categories can be useful in assessing violence risk in an adolescent.

REFERENCES
Tremblay RE, Nagin DS, Séguin JR, et al: Physical aggression during early childhood: trajectories and predictors. Pediatrics 114:43-50, 2004
Loeber R, Burke JD, Lahey BB, et al: Oppositional defiant and conduct disorder: a review of the past 10 years, part I. J Am Acad Child Adolesc Psychiatry 39:1468-84, 2000

QUESTIONS AND ANSWERS
1. What is one evidence-based means to assess violence risk in adults?
ANSWER: The MacArthur Violence Risk Assessment Study risk assessment.

2. Which of the following are risk factors for adolescent violence?
a. younger age at first offense
b. criminal history in parent
c. low grade point average
d. truancy
e. all of the above
ANSWER: e

SATURDAY

S2 A REVIEW: BRAIN, BORDERLINE PERSONALITY DISORDER, COMPETENCE

Frank Fetterolf, MD, Pittsburgh, PA
Abhishek Jain, MD, Pittsburgh, PA
Agnes Joseph, MD, Pittsburgh, PA
Nubia Lluberes, MD, Morgantown, WV
Oommen Mammen, MD, Pittsburgh, PA

EDUCATIONAL OBJECTIVE
This poster will highlight the challenges in assessing competency to stand trial, examine the specific impairments in cooperating with counsel; review appellate cases involving borderline personality disorder (BPD); and briefly summarize the most up-to-date clinical neuroscience of BPD.

SUMMARY
Determining competence to stand trial in defendants with borderline personality disorder (BPD), particularly with severe affective instability, impulsive aggression, and suicidal behavior, can be complex and challenging. Generally, symptoms don't render the defendant unable to "consult with his lawyer with a reasonable degree of rational understanding" or unable to have "a rational as well as factual understanding of the proceedings against

him." However, in some legal cases, BPD has been a significant consideration in determining competence to stand trial. Neuroscientific clues are emerging about how BPD symptoms impact cognitive and behavioral functioning. Neuroimaging data suggests that prefrontal brain regions that normally control expressions of aggression and emotion fail to become activated in response to emotional stress, while several areas of the limbic system are overly sensitized. Thus, this might be a potential "biological" explanation for a defendant's impaired ability to rationally consult with his or her attorney. We aim to explore the clinical neuroscience of BPD and how its pathology might impact competency to stand trial. Though definitive scientific conclusions cannot yet be made, this poster will allow forensic psychiatrists to review the relevant clinical neuroscience, as well as consider a potential neuroscientific basis for defendants' difficulties with legal competencies.

REFERENCES

Stanley B, Siever LJ: The interpersonal dimension of borderline personality disorder: toward a neuropeptide model. Am J of Psychiatry 167(1):24-39, 2010
Krause-Utz A, Winter D, Niedtfeld I, et al: The latest neuroimaging findings in borderline personality disorder. Current Psychiatry Reports 16(3):1-13, 2014

QUESTIONS AND ANSWERS

1. Which areas of the brain, thought to be affected in BPD, are responsible for controlling expressions of aggression and emotion?

a. Orbitofrontal Cortex
b. Nucleus Accumbens
c. Anterior Cingulate Cortex
d. a and b
e. a and c
f. all of the above
g. none of the above
ANSWER: e

2. According to the "Dusky Standard," patients with borderline personality disorder often demonstrate competency to stand trial due to which of the following:

a. Understanding of the trial's nature and objectives.
b. Assistance in his or her own defense.
c. Providing detailed account of the offense.
d. a and b
e. a and c
f. All of the above
g. None of the above
ANSWER: d

S3 CAPACITY FOR TWO! THE COMPLEXITIES OF CAPACITY IN PREGNANCY

Anna Glezer, MD, San Francisco, CA
Tara Collins, MD, MPH, San Francisco, CA

EDUCATIONAL OBJECTIVE

Participants will become familiar with ethical recommendations related to the management of pregnant women when capacity to make medical decisions is an issue and will review the origins of our informed consent and capacity assessment recommendations as they apply to pregnant patients.

SUMMARY

The origin of our informed consent doctrine comes from the Bill of Rights, with the right to privacy and protection from that which may threaten bodily integrity. From this upholding of self-determination, with the bioethical principle of autonomy, comes our doctrine of informed consent, which is integral to the evaluation of capacity in a patient. Capacity evaluations are based on the ability to communicate a consistent choice, to understand the relevant information and appreciate the situation and its consequences, and the ability to rationally reason about treatment options. However, this becomes much more challenging with pregnant patients because of societal desire to balance the rights of the woman with that of the fetus. This conflict can lead to contentious situations, particularly around issues of cesarean section refusal and substance use. This poster will walk the reader through the ethical and legal nuances of such situations with the use of a case example, a 32-year-old woman admitted with severe preeclampsia, with history of substance use and psychosis, who declined a medically recommended cesarean section.

REFERENCES
Appelbaum PS, Roth LH: Patients who refuse treatment in medical hospitals. JAMA 250(10):1296-301, 1983
ACOG Ethics Committee Opinion. Available at https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co297.pdf?dmc=1&ts=20160817T0029304786. Accessed August 2016

QUESTIONS AND ANSWERS
1. What is the most common reason for refusal of a treatment?
a. Psychosis/delusions
b. Problems in communication
c. Hospital fatigue syndrome
d. History of prior negative hospital experience
ANSWER: b

2. Which of the following statements does ACOG support?
a. Informed consent follows the bioethical principle of non-maleficence.
b. When a woman chooses to become pregnant, there is an enhanced duty to assure the welfare of the fetus, sufficient even to compel her to undergo caesarean surgery.
c. Court-ordered intervention against the wishes of a pregnant woman is rarely if ever acceptable.
ANSWER: c

S4 ONLINE CHILD SEXUAL EXPLOITATION

Thanh Ly, BSc, (I) Nepean, ON, Canada
Lisa Murphy, MCA, (I) Ottawa, ON, Canada
J. Paul Fedoroff, MD, Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE
To review current research on the role of the Internet on child sexual abuse and to compare characteristics of the three types of child sex offenders. Lastly, to discuss the prevention of future child sexual abuse and treatment of child sex offenders.

SUMMARY
In the past three decades, the worldwide availability of the Internet and devices able to access online materials has increased exponentially. This review investigated whether increased accessibility of Internet child pornography (CP) increases the risk of in-person child sexual exploitation. The current review found little to no evidence that availability of the Internet has increased the worldwide incidence or prevalence of in-person child sexual abuse. In fact, during the time period in which the Internet has flourished, international crime statistics have shown a steady decrease in the rates of in-person child sexual abuse. This paper reviews the impact of the Internet on child sexual abuse. It also reviews the characteristics of online CP offenders. Treatment of these offenders and prevention of such offenses is also discussed.

REFERENCES
Müller K, Curry S, Ranger R, et al: (2014). Changes in sexual arousal as measured by penile plethysmography in men with pedophilic sexual interest. J Sex Med 11(5):1221-1229, 2014
Diamond M, Jozifkova E, Weiss P: Pornography and sex crimes in the Czech Republic. Archives of Sexual Behavior 40(5):1037-1043, 2011

QUESTIONS AND ANSWERS
1. Which of the following group is more likely to be a first time offender?
a. Online offenders
b. Mixed offenders
c. In-person offenders
d. Mixed offenders and in-person offenders
ANSWER: a

2. According to a study by Steel (2015), how much did online CP searches in the United States decrease by after ads on Google and Bing cautioned that child sexual abuse material was illegal and recommended the user seek help?
a. 12%
b. 67%
c. 83%
d. 0%
ANSWER: b

S5 USE OF A SCREENING TOOL IN PREDICTING INPATIENT VIOLENCE

Amina Ali, MD, New York, NY
Katya Frischer, MD, JD, New York, NY
Ali Khadivi, PhD, (I) Bronx, NY
Merrill Rotter, MD, Bronx, NY
Barry Rosenfeld, PhD, (I) Bronx, NY
Melodie Foellmi, MA, (I) Bronx, NY

EDUCATIONAL OBJECTIVE
To assess the effectiveness of a newly developed violence screening tool Fordham Risk Screening Tool (FRST), in predicting inpatient aggression.

SUMMARY
The ability to predict violent behaviors on an inpatient psychiatric unit is of high concern to health care professionals. Studies show that during an acute hospitalization 18% of patients engage in violence towards others. To this date, there are a limited number of screening tools available to predict inpatient aggressive behavior. The FRST is a recently developed screening tool for violence to help identify patients who require an HCR-20 assessment. This study will examine the effectiveness of FRST to predict violent behavior on an inpatient psychiatric unit. A chart review will be conducted on 217 patients on 3 adult inpatient psychiatric units who have already been screened with FRST. In this study inpatient violent behavior will be defined as the number of assaults, use of seclusion and restraints, and the use of emergent intramuscular and oral medications.

REFERENCES
Newton VM, Elbogen EB, Brown CL, et al: Clinical decision-making about inpatient violence risk at admission to a public-sector acute psychiatric hospital. J Am Acad Psychiatry Law 40(2):206-14, 2012
Chu CM, Hoo E, Daffern M, et al: Assessing the risk of imminent aggression in institutionalized youth offenders using the dynamic appraisal of situational aggression. J Forens Psychiatry Psychol 23(2): 168–183, 2012

QUESTIONS AND ANSWERS
1. What percentage of patients engage in violence during acute hospitalizations?
a. 50%
b. 20%
c. 5%
d. 18%
ANSWER: d

2. Which of the following was not defined as violent behavior during this study?
a. Use of restraints
b. Use of emergent intramuscular medications
c. Use of PRN standing medications
d. Use of seclusions
ANSWER: c

S6 MANAGEMENT OF PATIENTS WHO MAKE THREATS AGAINST THE POTUS

Paulina Riess, MD, Bronx, NY
Luisa Gonzalez, MD, Bronx, NY
Panagiota Korenis, MD, Bronx, NY

EDUCATIONAL OBJECTIVE
We would like to present a case of patient with a long standing history of mental illness and treatment noncompliance who made threats against the President of the United States. We would like to discuss the management of such patients on the inpatient unit with effective results.

SUMMARY
Federal law makes it a crime to threaten the President of the United States. The Secret Service conducts thousands of violence risk assessments each year. Literature suggests that 75% of individuals who make threats have been diagnosed with a mental illness. Studies show that prominent symptoms in presidential assassins include persecutory and grandiose delusions. We present a case of a man diagnosed with schizoaffective disorder brought to CPEP by the Secret Service for repeatedly dialing 911 and making threats to the President. In the past year he had been hospitalized three times for similar behavior. Initial presentation included acute symptoms of psychosis and mania including persecutory delusions, command auditory hallucinations, grandiosity, and thought disorder. Clinicians

were faced with unique challenges and consulted the forensic service to navigate the role of the Secret Service and develop a plan to prevent future episodes. The patient was discharged with a court order for treatment, long acting medication, and an outpatient appointment. The treatment plan has been effective and the Secret Service has ceased their investigation. We aim to explore issues in patient confidentiality, duty to both report and protect. We will also provide strategies and recommendations for such patients on the inpatient unit.

REFERENCES

Meloy JR, James D, Farnham F, et al: A research review of public figure threats, approaches, attacks, and assassinations in the United States. J Forensic Sci 49(5)1-8, 2004
Anderson E, Black L, Bostick N: Preventing tragedy: balancing physicians' ethical obligations to patients and the public. Disaster Medicine and Public Health Preparedness 1(1):S38-S42, 2007

QUESTIONS AND ANSWERS

1. How many individuals who make threats against the POTUS have been diagnosed with a mental illness?
ANSWER: The Secret Service conducts thousands of violence risk assessments each year. Literature suggests that 75% of individuals who make threats have been diagnosed with a mental illness.

2. How do mentally ill patients who make threats against the POTUS present?
ANSWER: Studies show that prominent symptoms in presidential assassins include persecutory and grandiose delusions.

S7 COGNITIVE STATUS AND PROFILE VALIDITY: COMPETENCY IMPLICATIONS

Corey Leidenfrost, PhD, (I) Buffalo, NY
Daniel Antonius, PhD, (I) Buffalo, NY
Matthew Scalco, MA, (I) Buffalo, NY
Peter Martin, MD, MPH, Buffalo, NY
Tataiana Matlasz, BS, (I) Buffalo, NY

EDUCATIONAL OBJECTIVE

In this poster we will present results of research showing that profile validity of the Personality Assessment Inventory (PAI) predicts cognitive impairment, which may suggest potential issues with legal competency. Increased awareness of cognitive issues in regard to competency is important in implementing early intervention.

SUMMARY

Inmates with serious mental illness and cognitive impairment pose a particular challenge in determining competency to stand trial. Identification of cognitive issues early on in the adjudication process may influence appropriate interventions. In order to examine this issue, we analyzed the validity profiles of the Personality Assessment Inventory (PAI), the index scores on the Wechsler Adult Intelligence Scale – IV (WAIS-IV), and competency determinations for male inmates who had a serious mental illness. Analyses revealed that individuals with non-valid profiles on the PAI had lower scores across all of the WAIS-IV indexes versus those with valid profiles, showing moderate effect size (Cohen, 1988). A binary logistic regression showed that the WAIS-IV indexes predicted an inmate's PAI validity status (chi square = 10.24, p = .001), though Wald criterion showed that only the Working Memory Index (WMI) had a significant and unique contribution to the prediction (b = -0.07, p. 004). Ancillary analysis indicated that those with invalid PAI protocols completed 30 days prior were more likely found not competent to stand trial. Our results suggest that the PAI is an effective means to assist in the early identification of potential competency issues, triggering the potential need for competency restoration efforts.

REFERENCES

Sinclair SJ, Walsh-Messinger J, Siefert CJ, et al: Neuropsychological functioning and profile validity on the Personality Assessment Inventory (PAI): An investigation in multiple psychiatric settings. The Bulletin of the Menninger Clinic 79(4), 2015
Nicholson RA, Kugler KE: Competent and incompetent criminal defendants: A quantitative review of comparative research. Psychological Bulletin 109(3): 355, 1991

QUESTIONS AND ANSWERS

1. Lower scores on the Wechsler Adult Intelligence Scale (WAIS-IV) predicted what kind of validity profile for the Personality Assessment Inventory?
ANSWER: Non-valid PAI profiles.

2. What purpose would early identification of cognitive issues in the legal adjudication process serve?
ANSWER: It may trigger the need to start competency restoration efforts.

S8 TEACHING THE INSANITY DEFENSE TO PSYCHIATRY RESIDENTS

Matthew Grover, MD, Durham, NC
Amina Ali, MD, Bronx, NY
Katya Frischer, MD, JD, New York, NY

EDUCATIONAL OBJECTIVE

Participants will be able to identify three basic standards for the insanity defense that have been used in the United States in the last 100 years and apply the currently used insanity defense standards in New York and Colorado to a recent case.

SUMMARY

The insanity defense continues to be a controversial part of American jurisprudence. It is a reflection of society's understanding of culpability and its willingness to incarcerate people who, due to mental illness, do not intend or are not capable of formulating intent to kill. The federal government and every state have made a legislative decision about the insanity defense. Learning how to evaluate a psychiatric patient and apply a specific legal standard to the factual circumstances of a criminal case is a skill taught in forensic psychiatry fellowships. By creating a teaching exercise that utilizes a case in which the defendant offered an insanity defense, general psychiatry training programs can improve resident training and promote interest among trainees in forensic psychiatry. This poster will outline a model curriculum to teach trainees the insanity defense and differences in standards used throughout the country. It will describe a group exercise that walks trainees through the James Holmes case and the main arguments presented at trial that supported and rejected the insanity defense. It will compare the insanity defense statutes in Colorado and New York and how such differences could impact jury instructions and outcomes.

REFERENCES

Marrocco MK, Uecker JC, Ciccone JR: Teaching forensic psychiatry to psychiatric residents. Bull Am Acad Psychiatry Law 23:83– 91, 1995
AAPL Practice Guideline for forensic psychiatric evaluation of defendants. J Am Acad Psychiatry Law 42(4):S3-S75, 2014

QUESTIONS AND ANSWERS

1. What is the insanity defense standard in Colorado is considered to be a variant of?
a. The M'Naughten Rule
b. The Product Test or Durham Rule
c. The Irresistible Impulse Test
d. The Model Penal Code, American Law Institute Test
ANSWER: a

2. Which legal standard for burden of proof is required in Colorado to find a defendant not guilty by reason of insanity?
a. Beyond reasonable doubt.
b. Clear and convincing evidence.
c. Preponderance of the evidence.
d. Substantial evidence
ANSWER: c

S9 EFFECT OF JUVENILE INCARCERATION ON VULNERABLE SIBLINGS

Gowri Ramachandran, MD, Washington, DC
Eindra Khin Khin, MD, Washington, DC

EDUCATIONAL OBJECTIVE

To appreciate how siblings may be affected by juvenile incarceration. To investigate the mediating factors involved in the response of the siblings. To highlight the importance of these crucial factors in ensuring positive outcomes in the siblings.

SUMMARY

The effects of incarceration extend beyond the experiences of the individual being jailed; family, friends, and even the community at large are affected by imprisonment of both adults and juveniles. Much of the current literature focuses on the effects of parental imprisonment upon minor children. Yet there is little research addressing other types of interfamilial relationships that are affected by incarceration. In particular, the effects of juvenile imprisonment upon siblings are largely unknown. Here, we seek to address this dynamic and how it is affected, examining the current literature to determine what biopsychosocial factors, if any, serve as mediators in determining the

response of siblings when one of their own is jailed. The findings indicate that the imprisonment of a sibling is often seen as a source of stress for the un-incarcerated siblings, which, when coupled with inadequate support systems, can lead to the onset of self-destructive coping mechanisms such as substance use and an overall decline in their mental health. Increasing awareness of protective as well as harmful factors is essential in promoting positive outcome in this vulnerable population.

REFERENCES

Wagner DV, Borduin CM, Sawyer AM, et al: Long-term prevention of criminality in siblings of serious and violent juvenile offenders: a 25-year follow-up to a randomized clinical trial of multisystemic therapy. Journal of Consulting and Clinical Psychology 82(3):492-9, 2014

Wasserman GA, Keenan K, Tremblay RE, et al: Risk and protective factors of child delinquency (NCJ 193409). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 2003

QUESTIONS AND ANSWERS

1. Common psychiatric diagnoses observed in incarcerated juveniles include all of the following except:
a. Disruptive behavior disorders
b. Substance use disorders
c. Obsessive compulsive disorder
d. Affective disorders
e. Post-traumatic stress disorder
ANSWER: c

2. What are the factor(s) that have a significant impact on the outcome of siblings due to juvenile incarceration?
a. Birth order
b. Age spacing
c. Gender of the sibling
d. All of the above
e. None of the above
ANSWER: d

S10 CORRECTIONAL ADAPTATION: RECENT FINDINGS AND FUTURE RESEARCH

Allison Foerschner, MA, (I) Hillsboro, OR
Leonardo Bobadilia, PhD, (I) Hillsboro, OR
Michelle Guyton, PhD, (I) Portland, OR

EDUCATIONAL OBJECTIVE

The objective of this presentation is for viewers to understand the correctional adaptation construct and its corresponding assessment measure. Viewers will learn the construct's history, recent research findings, and directions for future research as well as the relevance of correctional adaptation in working with formerly incarcerated mental health clients.

SUMMARY

A substantial number of individuals receiving care in community mental health settings have historical correctional involvement, resulting in treatment engagement processes that are doubly complicated by clinical issues and effects of incarceration. Rotter and colleagues (2006, 2011) established the construct of correctional adaptation, which describes attitudes and behaviors of inmates with mental illness that are adaptive in dangerous correctional environments but are antithetical to common goals of community treatment. The researchers developed the Structured Assessment of Correctional Adaptation (SACA) to explore the construct and measure the accompanying attitudes and behaviors. The current presentation will cover the history of correctional adaptation and discuss implications of the latest research for clinician training and provision of mental health treatment as well as how the study supports the correctional adaptation construct and demonstrates utility of a brief SACA rating scale adapted from the original instrument. Planned research will investigate the relationship between correctional adaptation and traumatic incarceration experiences, working under the hypothesis that incarceration trauma underlies endorsement of correctional adaptations, evidenced by a positive correlation between total scores on the SACA and Posttraumatic Stress Disorder Checklist for DSM-5. Finally, the presentation will address recommendations for future research on the SACA and correctional adaptation construct.

REFERENCES
Carr WA, Rotter M, Steinbacher M, et al: Structured assessment of correctional adaptation (SACA): A measure of the impact of incarceration on the mentally ill in a therapeutic setting. International Journal of Offender Therapy and Comparative Criminology 50(5):570-581, 2006 Rotter M, Amory WA, Magyar M, et al: From incarceration to community care: Structured assessment of correctional adaptation. J Am Acad Psychiatry Law 39(1):72-77, 2011

QUESTIONS AND ANSWERS
1. What are correctional adaptations?
ANSWER: Correctional adaptations are behaviors and attitudes adopted by individuals during incarceration that are adaptive for survival in jail or prison but generally maladaptive after release.

2. How is correctional adaptation relevant to community mental health care?
ANSWER: Researchers have found a negative correlation between total scores on the SACA and the Working Alliance Inventory Bond Scale, suggesting that the presence of correctional adaptations inhibits therapeutic alliance.

S11 CONSENTING TO AOT: REQUIRING COOPERATION FROM THE UNCOOPERATIVE

Katya Frischer, MD, JD, New York, NY
Makeda Jones-Jacques, MD, White Plains, NY
Merrill Rotter, MD, Bronx, NY
Matthew Grover, MD, Durham, NY

EDUCATIONAL OBJECTIVE
To understand how AOT statutes may conflict with the Privacy requirement of HIPPA.

SUMMARY
The Assistant Outpatient treatment statute has been used in NYS as well as other states around the nation to mandate patients with serious and persistent mental illness into treatment. Patients targeted by this statute are unlikely to participate in treatment without a court order and are therefore in need of a court order and supervision to remain safely in the community. In 2011 the New York Court of Appeals in the "Matter of Miguel M. vs. Baron" held that the Privacy Rule adopted by the federal government pursuant to HIPAA did not allow the disclosure of mental health information by virtue of either the public health or treatment exception to the Privacy Rule. As a result of this case, patients need to give consent to allow their medical records to be shared before an AOT can be applied for in New York State. This poster will present the ethical and legal concerns arising out of the consent requirement in mandated outpatient treatment. We will present information about the intersection of AOT statues and HIPPA in other states.

REFERENCES
Swartz M, Swanson J, Steadman H, et al: New York State Assisted Outpatient Treatment Program Evaluation. Available at https://www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/. Accessed August 2016
Swartz M, Swanson JW, Hiday V: A randomised controlled trial of outpatient commitment in North Carolina Psychiatric Services 52: 325, 2001

QUESTIONS AND ANSWERS
1. Under current NYS case law how can a hospital mandate outpatient treatment when the patient refuses to consent to release of records?
a. Ask a family member to consent
b. Subpoena records
c. Consent is not required
ANSWER: b

2. What two exceptions to the privacy rule in HIPPA were cited by the respondents in the Miguel M. case?
a. Public safety
b. Treatment
c. a and b
ANSWER: c

S12 NITROUS OXIDE - DENTAL DREAMS, MANIC MOMENTS

Cecilia Leonard, MD, Fairfax, VA
Mark DeLuca, MD, Palm Beach, FL
Dan Cotoman, MD, Charlotte, NC

EDUCATIONAL OBJECTIVE
The discussion will focus on how the expert witness made the link between nitrous oxide and the onset of a manic episode in a man who had never had any mental illness.

SUMMARY
The case is presented of a man who had no mental illness and had never sought psychological counselling until he developed a manic episode at age 38, requiring psychiatric management. He had no family history of mental illness and had not been using alcohol or illegal substances. The only ostensible trigger was nitrous oxide, an anesthetic used during a visit to the dentist. The mania led to criminal behavior for which this man was found not responsible due to mental illness. Ten years went by and this patient had no need for ongoing treatment, until he had another dental procedure. Again he developed a manic episode and was found not guilty by reason of insanity (NGRI) for the resultant criminal conduct. The discussion will focus on the role of the forensic psychiatrist in 1) identifying the causal nexus between the nitrous oxide and the onset of an enduring manic episode in a person who otherwise had no mental illness, and 2) presenting the case to the court to elucidate how a transient illness by a thus far unknown precipitant could cause criminal conduct.

REFERENCES
State v. Tome, CR No. 96-1451 (1998)
Feix J, Wolber G: Intoxication and settled insanity: a finding of not guilty by reason of insanity. J Am Acad Psychiatry Law 35:172–82, 2007

QUESTIONS AND ANSWERS
1. Which of the following statements about expert witness are not true?
a. The expert may give an opinion "if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue."
b. An expert witness is qualified "by knowledge, skill, experience, training, or education."
c. The expert witness tries to help the retaining attorney win the case
d. One of the main functions of the expert witness is to educate the court on matters that are "beyond the ken" of the average layperson
ANSWER: c

2. The forensic expert must consider which of the following possibilities during an insanity defense evaluation?
a. Whether the defendant's crime was merely coincidental with his mental illness.
b. Whether the defendant knew "right from wrong" at the time of the crime.
c. Whether the defendant's mental illness was actually a result of the crime.
d. Whether the defendant is malingering insanity
e. All but b
ANSWER: b

S13 TREATING INMATES INVOLUNTARILY: DATA SUPPORT AND POLICY CONCERN

Leena Rajagopal, MD, Jersey City, NJ
Jeremy Colley, MD, Folsom, CA
Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE
To explore the need for a jail-based treatment over objection policy through studying the relationship between medication non-adherence in jail and hospital re-admission and reviewing the legal, ethical and systems considerations for and against establishing such a policy.

SUMMARY
It has been 25 years since the Supreme Court supported a more flexible standard for medicating inmates over objection in Washington v. Harper relative to the more stringent, capacity-based evidence that is usually required for treating psychiatric inpatients involuntarily. There remains variability between jurisdictions in approaches to ensuring medication continuity for offenders who choose to refuse treatment while incarcerated. This variability exemplified in New York State where an inpatient order for treatment over objection for a prisoner may continue to be enforced even after the offender is discharged from the hospital to the prison facility from which he came, however the same heretofore legally unchal-

lenged policy is not applied at Rikers Island, the New York City administered jail. In this study we report on a chart review investigation of Rikers inmates with repeat inpatient admissions to determine the relationship, if any, between their readmission and medication non-adherence when the inmate returned to Rikers following the initial hospitalization. Results might suggest that if inpatient medication orders followed the inmates back to jail, hospital recidivism may decrease. The legal, ethical and systems considerations for and against establishing such a policy will be delineated.

REFERENCES

Washington v. Harper, 494 U.S. 210 (1990)
Levine HS, Gage BC: Commentary: Involuntary antipsychotics in prison - extending Harper, contracting care? J Am Acad Psychiatry Law 43(2):165-70, 2015

QUESTIONS AND ANSWERS

1. What U.S. Supreme Court case ruled that inmates who are dangerous to themselves or others as a result of mental illness may be treated with psychoactive drugs against their will?

a. Washington v. Harper
b. Rivers v. Katz
c. Sell v. US
d. Estelle v. Gamble
ANSWER: a

2. The Harper decision has been widely interpreted to apply to which of the following population?

a. Jails
b. State prisons
c. Federal detention centers
d. Civilly committed patients
ANSWER: b

S14 RESTRAINT USAGE PATTERNS IN FORENSIC PSYCHIATRIC INPATIENTS

Kayla Fisher, MD, JD, Patton, CA
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EDUCATIONAL OBJECTIVE

To learn about the variables affecting restraint usage patterns over a specified time frame at a 1500 bed state forensic psychiatric hospital. Variables demonstrated will include day of the week the restraint was initiated, legal commitment, severity of aggression, and target of the aggression.

SUMMARY

Use of restraint has come under increasing scrutiny by the scientific community and regulatory agencies over the past decade. There is growing consensus among psychiatric inpatient facilities that the reduction of aggression and restraint must include the analysis of trends and factors associated with these two variables, as well as interventions at multiple levels with in the facility. The current study examines a one year period of inpatient aggression and 5-point restraint following the aggressive episode. The data presented describe trends observed with aggression and the use of restraint, including the victim type, average duration of restraint by day of the week the restraint was initiated, and average duration of restraint related to legal commitment. These findings highlight areas for institutional interventions, including change to administrative review policies, hospital culture, and increasing awareness of clinical alternatives to restraint use.

REFERENCES

Fisher WA: Elements of successful restraint and seclusion reduction program and their application in a large, urban, state psychiatric hospital. Journal of Psychiatric Practice 9(1):7-15, 2003
Hellerstein DJ, Staub AB, Lequesne E: Decreasing the use of restraint and seclusion among psychiatric inpatients. Journal of Psychiatric Practice 13(5):308-317, 2007

QUESTIONS AND ANSWERS

1. What factors can affect the duration of restraint in a forensic psychiatric hospital?

a. Severity of aggression
b. Victim of aggression
c. Type of legal commitment
d. Day of week restraint was initiated
e. All of the above
ANSWER: e

2. According to data collected from Patton State Hospital:
a. Restraint episodes were longer if restraint was started on Wednesday.
b. Restraint episodes were longer if staff were victim of precipitating aggression.
c. Restraint episodes were longer if aggression was severe.
d. Restraint was eliminated six months ago
ANSWER: b

S15 **HUMAN SEX TRAFFICKING: FROM TRAUMA TO TREATMENT**

Natasha Thrower, MD, Boston, MA
Helen Farrell, MD, Boston, MA
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
To summarize knowledge regarding the problem of forced sexual exploitation of women and children, describe the various mental health conditions seen in victims of human sex trafficking and identify barriers to providing mental health care for sex trafficking survivors.

SUMMARY
Curious about modern day slavery? It exists in the form of human sex trafficking, a covert yet lucrative operation. In the United States thousands of women and children are bought, sold, and forced into prostitution under coercion, or the threat of violence each year. The traumatic effects on victims' mental health are far-reaching. A number of studies have identified the serious and often complex mental health needs of victims with the majority of research focusing on significant levels of posttraumatic stress disorder (PTSD) in this population. Symptoms of PTSD often bring victims into contact with the health systems emphasizing the potential role of the psychiatrist in identifying and assisting victims of sex trafficking. However, healthcare professionals including psychiatrist have a general lack of awareness concerning this populations' mental health needs. Forensic psychiatrists are likely to encounter victims of sex trafficking through work with law enforcement and legal professionals. They may serve as a consultant or direct care provider tasked with treating the PTSD and complex metal health issues resulting from trauma. This poster highlights the lack of educational resources available for psychiatrists to understand and effectively treat individuals suffering from trauma related mental illnesses resulting from human sex trafficking victimization.

REFERENCES
Bespalova N, Morgan J, Coverdale J: A pathway to freedom: an evaluation of screening tools for the identification of trafficking victims. Academic Psychiatry 40(1):124-128, 2016
Beck ME, Lineer MM, Melzer-Lange M, et al: Medical providers' understanding of sex trafficking and their experience with at-risk patients. Pediatrics 135(4):e895-e902, 2015

QUESTIONS AND ANSWERS
1. Based on recent studies, what percentage of trafficking victims in the United States have encountered health care professionals while in captivity, but were not identified and recognized?
a. 10-25%
b. 25-50%
c. 50-60%
d. Up to 75%
ANSWER: b

2. What is the greatest barrier to identification of human sex trafficking victims reported by healthcare professionals?
a. A lack of awareness about the problem of sex trafficking.
b. Insufficient training on identifying sex trafficking victims.
c. Limited availability of screening tools.
d. No exposure to sex trafficking victims.
ANSWER: b

S16 TRAUMA AND JUVENILE DELINQUENCY: AN ACES –BASED REVIEW

Douglas Saphier, MD, New York, NY
Merrill Rotter, MD, Bronx, NY
Kathleen McKay, PhD, (I) Hartsdale, NY

EDUCATIONAL OBJECTIVE
At the end of the presentation an attendee will be able to understand how an adolescent's trauma history impacts their risk of recidivism as well as determine if any particular trauma correlates to a specific type of offense.

SUMMARY
Multiple studies have examined psychosocial variables and their contribution to juvenile delinquency. Childhood trauma is one of the more recently recognized risk factors. In 2015, Wolff et al found that higher scores on the Adverse Childhood Experiences Survey (ACES) was associated with a decreased time of recidivism. The ACES scale measures ten different types of trauma, five personal and five familial. A score of four or more has been found to be associated with increased risk of diseases such as lung diseases, heart disease, depression, and suicide. In this study, data from a sample of adolescents adjudicated as juvenile delinquents who received court-ordered psychological evaluations will be studied to determine how total ACES scores correlate with number of past offenses and offense type. It is hypothesized that higher ACES scores will be associated with greater number of past offenses as well as more serious charges. In addition, the relationship between individual ACES factors and justice outcomes will be reviewed.

REFERENCES
Wolff K, Baglivio M, Piquero A: The relationship between adverse childhood experiences and recidivism in a sample of juvenile offenders in community-based treatment. Int J Offender Ther Comp Criminol 2015
Fox BH, Perez N, Cass E, et al: Trauma changes everything:examining the relationship between adverse childhood experiences and serious, violence and chronic juvenile offenders: Child Abuse Neglect 46:163-173, 2015

QUESTIONS AND ANSWERS
1. What are the protective factors that the ACES account for?
a. Feeling that someone in their family made them feel special; and believing that their family was a source of strength, support, and protection.
b. Only feeling that someone in their family made them feel special.
c. Only believing that their family was a source of strength, support, and protection.
d. A person feeling that someone in their family made them feel special; or believing that their family was a source of strength, support, and protection.
ANSWER: a

2. In Wolff et al's article, which ethnicity failed to have a statically significant correlation between trauma and recidivism?
a. Caucasian
b. African-American
c. Hispanic
d. Asian
ANSWER: b

S17 ASSESSMENT OF THE COGNITIVELY IMPAIRED SEX OFFENDER

Robyn Thom, MD, (I) Boston, MA
Fabian Saleh, MD, Boston, MA

EDUCATIONAL OBJECTIVE
To provide a current review of risk assessment and legal issues of problematic and sexual offending behaviors among individuals with dementia and intellectual disability.

SUMMARY
Although the cognitively impaired are frequently included in heterogeneous studies of problematic sexual behavior, the epidemiology, etiology, and approach to assessment and treatment of sex offending behaviors among persons with dementia and intellectual disability are distinct from those of the general population. The incidence of inappropriate sexual behavior among the intellectually disabled is reported to be 15-33%, however the nature of these behaviors tend to be more socially inappropriate than with violative intent. Limited sociosexual education likely accounts for many of these behaviors, and better addressing this area of development offers a target for prevention and treatment. A thorough clinical assessment of problematic sexual behaviors in the cognitively impaired requires understanding the patient's internal experience, which can be challenging in this population. Assessment tools validated for the general population have not been validated for this population. Very few studies have assessed treatment approaches specifically among the cognitively impaired, however research does suggest utility in habilitative, psychotherapeutic, and pharmacologic approaches which have been validated among the general population.

REFERENCES
Saleh FM, Grundzinskas A, Malin M, et al: The management of sex offenders: perspectives for psychiatry. Harv Rev Psychiatry 18(6):359-368, 2010
Guay DR: Inappropriate sexual behaviors in cognitively impaired older individuals. Am J Geriatr Pharmacother 6(5):269-88, 2008

QUESTIONS AND ANSWERS
1. What risk assessment tools exist that can be used to assess problematic sexual behavior in the cognitively impaired?
a. SORAG
b. VRAG
c. SORAG and VRAG
d. None of the above
ANSWER: d

2. What are the major aims of the habilitative model for treating problematic sexual behavior in the cognitively impaired?
a. Developing appropriate sociosexual environments.
b. Identifying antecedents that provoke an individual's problematic behaviors.
c. Replacing problematic behaviors with ones that are socially acceptable.
d. All of the above
ANSWER: d

S18 VIOLENCE IN THE MENTALLY ILL: HOSPITALIZATION OR DIVERSION?

Janet Charoensook, MD, Arleta, CA
Kishore Desagani, MD, Irvine, CA

EDUCATIONAL OBJECTIVE
To examine the outcomes of violence as the basis of an involuntary hold and determine alternatives that will lead to the best prognosis for the patient.

SUMMARY
The Riverside County psychiatric hospital is increasingly encountering patients brought in by police on a 5150 involuntary hold for acts of violence. They have significant histories of violence in which their mental illness played a major role. Two-thirds of patients committed involuntarily for danger to others will "engage in some type of violence" within the first 72 hours after admission. The authors entertain this provocative question, should the mentally ill be criminally charged for their acts of violence, pursuing a different disposition altogether? The authors examined the hospital course, post-discharge events, and their implications of 20 patients. 2 of the cases resulted in multiple homicides within 6 months of their discharge from the hospital. Those acutely mentally ill should receive proper treatment. Yet poor treatment adherence and prior history of violence, among other factors, are difficult to treat and are associated with violence. Is the county acute psychiatric hospital equipped to ensure long-term treatment? The authors advocate for long-term psychiatric stability which may only be in the form of effective diversion programs and mental health courts that will mandate and monitor treatment adherence, especially those with a long history of violence prone to physically aggressive behaviors when decompensating.

REFERENCES
McNiel DE, Binder RL: Predictive validity of judgments of dangerousness in emergency civil commitment. Am J Psychiatry 144:197-200, 1987
Lamb HR, Weinberger LE: Meeting the needs of those persons with serious mental illness who are most likely to become criminalized. J Am Acad Psychiatry Law 39:549-554, 2011

QUESTIONS AND ANSWERS
1. What is the percentage of patients, on an involuntary hold for danger to others, who "engage in some type of violence" within the first 72 hours of admission?
a. One-third
b. One-half
c. Two-thirds
d. One-quarter
ANSWER: c

2. What is not associated with violence?
a. Good treatment adherence
b. Prior history of violence
c. Being difficult to treat
d. History of substance abuse
ANSWER: a

S19 UPDATING ETHICS AND EVIDENCE-BASED CHILD CUSTODY EVALUATIONS

Stephen Billick, MD, New York, NY
Peter Ash, MD, Atlanta, GA
William Darby, MD, Santa Monica, CA
Suchet Rao, MD, New York, NY
Robert Weinstock, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE
The audience participant will learn evidence-based outcomes and ethical issues in child custody evaluations.

SUMMARY
Dr. Billick will present a brief historical review of child custody evaluations. Dr. Ash will present on the evidence-based outcomes of child custody evaluations and recommendations. He will help the audience participants understand how to utilize this information in forming psychiatric recommendations. Dr. Darby and Dr. Weinstock will present ethical issues for the psychiatric evaluator confronted in the child custody evaluation of parents and children. They will provide guidance on how the evaluator could avoid ethical problems and conflicts. Dr. Rao and Dr. Billick will present on the emerging challenges of evaluating children of unmarried parents, given the changing demographics of parents and family structure in society. Issues of genetic sources, biology and other confounding newer situations that children increasingly find themselves in will be discussed in relationship to psychiatric recommendations for judicial decisions. The audience will be encouraged to actively participate.

REFERENCES
Billick SB, Ciric SJ: Role of the Psychiatric Evaluator in Child Custody Disputes. In Rosner R: Principles and Practice of Forensic Psychiatry, 2nd Edition, London, UK: Arnold, 2003
Soulier MF: Ethics of Child and Adolescent Forensic Psychiatry. In Benedek EP, Ash P, Scott CL: Principles and Practice of Child and Adolescent Forensic Mental Health. Washington, DC: American Psychiatric Publishing Inc., 2010

QUESTIONS AND ANSWERS
1. Which of the following is the overwhelmingly most important criterion for child custody and visitation recommendations?
a. the preschool child's expressed desire
b. the adolescent child's expressed desire
c. the mother's expressed desire
d. the father's expressed desire
e. the best interests of the child
ANSWER: e

2. Which of the following countries have decreasing rates of children living with married parents?
a. France
b. United Kingdom
c. Iceland
d. United States
e. All of the above
ANSWER: e

S20 THE ASYLUM AND COMMUNITY: TRANSFORMING THE CONTINUUM OF CARE

J. Richard Ciccone, MD, Rochester, NY
Josh Jones, MD, Port Angeles, WA
Debra Pinals, MD, Ann Arbor, MI
Robert Weisman, DO, Rochester, NY
Philip Candilis, MD, Washington, DC

EDUCATIONAL OBJECTIVE
Participants will be familiar with the birth and death of the asylum, the criminalization of persons with serious mental illness, and explore the potential transformation of available community treatment options for individuals with serious mental illness.

SUMMARY
The deinstitutionalization of the mentally ill began in the 1950s and gathered momentum in the 1960s and 1970s. By the 1980s it was clear that many patients had benefitted from discharge from the asylum while many others had not. A number of persons with serious mental illness, left without sufficient community resources especially where there were tighter restrictions on civil commitment and sanctions against criminal behavior, became homeless with "sidewalk psychosis." Others were arrested and housed in jails and prisons. This panel will explore the birth and death of the historic asylum and the problems faced by community mental health centers when treating individuals with severe mental illness. The panel will also discuss innovative programs for community management of offenders with mental illness, the recent report of the National Association of the Mental Health Program Directors on the current and future role of the state hospital, and the call for a transformation of the continuum of care to include a reformed vision of the asylum.

REFERENCES
Torrey EF: American Psychosis. New York, NY: Oxford University Press, 2013
Lamberti JS, Weisman RL: Persons with severe mental disorders in the criminal justice system: challenges and opportunities. Psychiatric Quarterly 75:151-164, 2004

QUESTIONS AND ANSWERS
1. Deinstitutionalization was energized by the following events, except:
a. Implementation of Medicaid and Medicare
b. The anti-psychiatry movement
c. The development of an effective outpatient treatment system
d. Landmark cases re: Right to Treatment and Right to Refuse Treatment
e. Implementation of SSI and SSD
ANSWER: c

2. Which of the following is true related to forensic assertive community treatment in the United States?
a. People with severe mental disorders are overrepresented in the criminal justice system.
b. Psychosis is a risk factor for criminal recidivism.
c. FACT programs have been emerging across the USA, are highly variable and lack evidence.
d. R-FACT targets risk factors that drive recidivism and utilizes behavioral health and criminal justice partnerships to promote adherence.
e. All the above.
ANSWER: e

S21 TEN YEARS' EXPERIENCE ON A CORPORATE THREAT ASSESSMENT TEAM

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Scott McArthur, CPP, (I) Redmond, WA
Orna Edgar, Esq., (I) Redmond, WA

EDUCATIONAL OBJECTIVE
To understand how to manage role and boundary issues as a member of a multidisciplinary threat assessment team. Learn the range of response options available to respond to a potentially threatening employee.

SUMMARY
The experience of a corporate threat assessment team, composed of security, legal, human resources, management and a forensic clinician, will be reviewed. Data from multiple sources (eyewitnesses, coworkers, background check, personnel file, email/phone messages, social media) is quickly compiled and discussed, to determine a general threat level and to

plan a response. The forensic clinician provides education about psychiatric decompensation, resources for detention/ treatment, threat assessment, and advice on communication strategies with the employee. The team works to preserve employee and proprietary information confidentiality. The roles and boundaries of the team members have been worked out in practice. Case examples include paranoid decompensation, domestic violence spilling into the workplace, CEO/ celebrity stalkers, verbal/written implied or direct threats. Creative response options have been used to limit the threat.

REFERENCES

Neuman JH, Baron RA: Workplace violence and workplace aggression: Evidence concerning specific forms, potential causes, and preferred targets. J Management 24:391-419, 1998
Cao Y, Yang J, Ramirez M, et al: Characteristics of a workplace threats requiring response from a university threat assessment team. J Occup Environ Med 55: 45-51, 2013

QUESTIONS AND ANSWERS

1. What types of data can be utilized by a corporate threat assessment team?
ANSWER: Criminal background check, personnel file, witness interviews, workspace or computer search, interview of the employee, phones messages, emails, performance reviews, connecting with friends or family members, social media postings.

2. What changeable (as opposed to static historical) risk factors can be relevant in the threat assessment of an employee?
ANSWER: Recent family or financial stress; threatened layoff or demotion; suspicion of substance abuse; recent relocation/immigration; evidence of emerging paranoid or manic decompensation.

S22 LOVEMAPS: THE PARAPHILIAS IN FILM AND DOCUMENTARIES

Ryan Wagoner, MD, Lutz, FL
Bradley Booth, MD, Ottawa, ON, Canada
Susan Hatters Friedman, MD, Cleveland Heights, OH
Renée Sorrentino, MD, Weymouth, MA

EDUCATIONAL OBJECTIVE

Participants will review information regarding paraphilias and how they are classified. Learners will also observe examples in popular media of paraphilias and be able to identify both the diagnosis and the legal implications that can occur.

SUMMARY

The inclusion of paraphilias in the DSM remains a controversy today, as it did in the original DSM. The DSM-5 workgroup reached a consensus that paraphilias are not automatically considered psychiatric disorders and proposed a distinction that a paraphilia that causes distress or impairment to the individual or harm to others would be classified as a disorder. The goal of this workshop is to use popular depictions in film and documentaries to illustrate both paraphilias and paraphilic-disordered behaviors. The use of cinematography to understand sexual behavior is advantageous by allowing the viewer both a visual representation of the behavior, as well as providing a reflection of societal views of such behavior. A discussion of the paraphilic behavior will include a review of the film in which the behavior is displayed, followed by a clinical review of if the behavior reaches the threshold of a "disorder." Finally, the audience will participate in evaluating films and documentaries in which the paraphilic-disordered behavior leads to legal issues and critically evaluate how a paraphilia may play a role in court. Active participation in the evaluation of the films presented will occur throughout the workshop.

REFERENCES

Wakefield JC: DSM-5 proposed diagnostic criteria for sexual paraphilias: tensions between diagnostic validity and forensic utility. Int J Law Psychiatry 34(3):195-209, 2011
Bhugra D, Popelyuk D, McMullen I: Paraphilias across cultures: contexts and controversies. J Sex Res 47(2):242-256, 2010

QUESTIONS AND ANSWERS

1. According to the DSM-5, which of the following is NOT a disorder which is commonly identified as an anomalous activity preference?
a. Pedophilic disorder
b. Voyeuristic disorder
c. Exhibitionistic disorder
d. Sexual masochism disorder
ANSWER: a

2. What is the primary difference between a paraphilia and a paraphilic disorder?
a. The type of interest present.
b. The intensity of the interest.
c. The timeframe of the interest.
d. If the interest causes distress or impairment.
ANSWER: d

S23 **VICARIOUS TRAUMA: WHAT IS THE ROLE FOR FORENSIC PSYCHIATRY?**

Andrew Levin, MD, Hartsdale, NY
Maya Prabhu, MD, New Haven, CT
David Nissan, MD, New York, NY
Loretta Sonnier, MD, New Orleans, LA

EDUCATIONAL OBJECTIVE
In this workshop participants will learn the signs and impact of vicarious trauma (VT), how VT affects legal personnel and what types of interventions can be made by forensic psychiatrists to minimize the impact of VT on legal personnel.

SUMMARY
Vicarious trauma (VT) can develop during occupational exposure to traumatic material and encompasses symptoms of posttraumatic stress disorder (PTSD) and alterations in identity and worldview. The initial work in this area focused on VT in therapists, medical professionals, and first responders. The field subsequently broadened to recognize VT in legal personnel including corrections officers, judges, and attorneys. Following an overview of the VT concept and review of the available data in the legal arena, the presentation will focus on the role of forensic psychiatry in three settings where professionals are at risk for developing VT. Each presenter will review the relevant literature and describe a specific scenario: 1)Training of corrections officers to identify and address VT; 2) Work with asylum lawyers and adjudicators for the United Nations High Commission on Refugees; 3) The impact of VT on decision-makers in the juvenile court. The audience will be asked to share their experience in each of these settings and their recommendations for interventions. Each of the presenters will then describe the interventions undertaken and the impact on the professionals in that setting.

REFERENCES
Chamberlain J, Miller MK: Evidence of secondary traumatic stress, safety concerns, and burnout among a homogeneous group of judges in a single jurisdiction. J Am Acad Psychiatry Law 37: 214–224, 2009
Levin AP, Albert L, Besser A, et al: Secondary traumatic stress in attorneys and their administrative support staff working with trauma-exposed clients. J Nerv Ment Dis 199: 946-955, 2011

QUESTIONS AND ANSWERS
1. Which of the following is not true about vicarious trauma?
a. There is an overlap with "burnout."
b. It may include changes in worldview.
c. It is not accompanied by symptoms of PTSD.
d. It may result in increased substance use
ANSWER: c

2. Which of the following groups has avoided acknowledging vicarious trauma?
a. Attorneys
b. Judges
c. Corrections officers
d. Police officers
e. All of the above
ANSWER: e

S24 TRANSFORMING THE POLICE: THE DEPARTMENT OF JUSTICE CIVIL RIGHTS DIVISION AND POLICE ACCOUNTABILITY

Attorney Christy Lopez, (I) Washington, DC

EDUCATIONAL OBJECTIVE

To increase knowledge regarding strategies for bringing about change in organizational culture to decrease police misconduct, including the potential for mental health professionals to positively influence police conduct.

SUMMARY

Eliminating systemic violations of civil rights by law enforcement officers often requires changing the culture of the entire law enforcement agency. Increasingly it is becoming clear that this requires more than enforcing the law as it currently stands, rather it may require limiting what police officers can do to more closely align to what they should do. Rethinking policing in this way requires reconsideration of many common police practices, such as the use of consent searches and pretext stops, and the standard for what force is reasonable. It also requires reconsideration of several police practices that are of particular interest to mental health professionals, including how the police interact with persons in mental health crisis; how police are trained to act when they realize another officer has or is about to use unreasonable force; how police are selected, or de-selected, before being hired; and the support law enforcement agencies give to police officers and their families to facilitate mental and physical well-being.

REFERENCES

Baltimore Police Department Findings Report. Available at https://www.justice.gov/crt/special-litigation-section-cases-and-matters0. Accessed August 2016

Justice Department Focuses on Police Treatment of Mentally Ill. Available at https://www.washingtonpost.com/politics/courts_law/justice-dept-focuses-on-police-treatment-of-mentally-ill/2016/08/29/30392e46-6e5d-11e6-993f-73c693a89820_story.html. Accessed August 2016

QUESTIONS AND ANSWERS

1. The Department of Justice Civil Rights Division has addressed police interactions with persons in mental health crisis in which these police conduct investigative reports?

a. Baltimore police department
b. New Orleans police department
c. Seattle police department
d. All of the above

ANSWER: d

2. In what way can police departments can benefit from the input of psychiatrists, psychologists, and/or other mental health professionals?

a. Selecting appropriate police recruits.
b. Training officers to interact with persons in mental health crisis lawfully and effectively.
c. Ensuring they are providing officers and their families appropriate support for mental and physical well-being.
d. All of the above.

ANSWER: d

S25 REVERSING THE 1944 JUDICIAL LYNCHING OF A 14 YEAR-OLD BOY

David Rosmarin, MD, Newton, MA
Ezra Griffith, MD, New Haven, CT
Amanda Salas, MD, Beaufort, SC

EDUCATIONAL OBJECTIVE

Peer review analysis of video psychiatric testimony (2014) retrospectively analyzing the unrecorded 1944 confessions of African-American 14-year-old George Junius Stinney, Jr. to sheriffs admitting his simultaneous murder of two young white girls. Analysis will focus on: consistency of confession with evidence, internal consistency, interrogator-suspect interactions, and Stinney's psychological vulnerabilities.

SUMMARY

There were 3,959 documented lynchings of African-Americans in the US between 1877 and 1950, of which 164 were in South Carolina. Racial terror included the courts, and by 1915 executions outpaced lynchings in former slave states. George Stinney was a small boy in South Carolina interrogated by white sheriffs. He confessed to two different versions of the killings; his jury was 12 white men deliberating only ten minutes; and his lawyer (running for public office) presented no witnesses and filed no appeal or request for stay of execution. He was executed two months later, requiring the use of a bible as a booster seat to reach the electric helmet. George Stinney was

the youngest boy executed by electrocution in the US. A ten-year-old Cherokee, James Arcene, was the youngest boy executed in the US, in 1885. Under the theory of coram nobis, derived from Common Law, Stinney's relatives applied to have his conviction vacated, which it was. The historical and legal contexts of his conviction and posthumous justice will be presented. A short movie excerpt of his electrocution will shown.

REFERENCES

Lynching in America: Confronting the Legacy of Racial Terror Equal Justice Institute. Available at http://www.eji.org/files/EJI%20Lynching%20in%20America%20SUMMARY.pdf.
Death Penalty Information Center. Available at http://www.deathpenaltyinfo.org. Accessed August 2016

QUESTIONS AND ANSWERS

1. Explain the legal concept of coram nobis:
ANSWER: It is for use after an unjust conviction when there are no other judicial remedies available, such as after the appeal deadline. It addresses wrongful convictions based on unfair or unlawful methods or when a conviction is wrongful because based on an error.

2. What are the determinative factors promulgated in Kent v US regarding juvenile waiver?
ANSWER: Seriousness and violence of the offense. Whether the offense was against person or property. Whether probable cause existed. Desirability of trying whole case in one court. Juvenile's personal circumstances. Prior criminal record. Public safety. Likelihood of rehabilitation.

S26 NEUROLAW 101: INTRO TO NEUROLAW FOR FORENSIC PSYCHIATRISTS

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Vivek Datta, MD, MPH, San Francisco, CA
Manish Fozdar, MD, Raleigh, NC
Stephen Morse, JD, PhD, Philadelphia, PA
Francis Shen, JD, PhD, (I) Minneapolis, MN

EDUCATIONAL OBJECTIVE

Educational objectives are in the areas of service (information presented will enhance consultation skills, particularly in cases that involve neuropsychiatric conditions) and research (up to date scientific data will be presented that will help guide practice of forensic psychiatry).

SUMMARY

Neurolaw is a new interdisciplinary field which examines the role of neuroscience in the law. Recent advances in neuroscience have generated an intense amount of interest in psychiatric and legal communities, due to its potential to elucidate mental states and mental capacities that are fundamental to legal decision-making. This course will present the latest research highlighting neuroscience's potential to guide determinations of criminal responsibility, legally-relevant capacities such as testamentary capacity, lie detection, pain measurement, and violence risk prediction. Discussions regarding neuroscience's potential will be balanced against current scientific, legal, and moral limitations that prevent more widespread use of neuroscience evidence in the courtroom. The ultimate aim of this course is to equip forensic psychiatrists with the skills and knowledge base to critically examine the role of neuroscience evidence in the courtroom.

REFERENCES

Morse S: Criminal law and common sense: an essay on the perils and promise of neuroscience. Marquette Law Review 99:39, 2015
Octavio C: Using fMRI for Lie Detection: Ready for Court? Chapter 6 in Psychiatric Expert Testimony: Emerging Applications, Kenneth Weiss and Clarence Watson, Eds. New York, NY: Oxford University Press, 2015

QUESTIONS AND ANSWERS

1. What does eceological validity refer to in the context of legal admissibility of expert testimony regarding scientific research?
a. The extent to which the findings of the research studies in question are able to be applied to "real-life" settings relevant to the legal proceedings.
b. The extent to which the findings of the research studies in question having been generally accepted by the relevant scientific community.
c. Whether the research studies in question have known rates of error.
d. Wwhether the research studies in question have been subject to appropriate peer review.
ANSWER: a

2. What does the group-to-individual (G2i) inference problem refer to?
a. The problem in applying research findings, which are typically based on group averages of populations of subjects, to make inferences about particular individuals.
b. The problem of examining individual research studies to make broad conclusions about a group of studies.
c. The problem of classifying individuals into discrete categories based on population-averaged data.
d. a and c
e. None of the above
ANSWER: d

S27 SOCIAL MEDIA IN FORENSIC PSYCHIATRY: ETHICS AND LAW

Susan Hatters Friedman, MD, Cleveland Heights, OH
Cathleen Cerny, MD, Seven Hills, OH
Jennifer Piel, MD, JD, Seattle, WA
Patricia Recupero, MD, JD, Providence, RI
Navneet Sidhu, MD, Alexandria, VA

EDUCATIONAL OBJECTIVE

At the end of this workshop, the attendee will be able to describe ethical and legal considerations raised by social media in psychiatry, including ethical aspects of developing websites; dealing with negative patient reviews online; and the ethical roles of forensic psychiatrists in social media-related threat assessments.

SUMMARY

Psychiatric practice has been altered in a myriad of ways by both the internet and social media. More than half of Americans use social networks, and internationally 2.5 billion people are online. Utilized correctly, social media can be a great tool for forensic psychiatrists but it is also an ethical minefield. Digital evidence may serve as collateral information, including personal websites, social networking, tweets, blogs, youtube etc. These sources may give unguarded views or may be edited versions. As well, multiple slippery slopes exist-- even with email. This workshop will discuss email with attorneys, Metadata in emailed reports, unsolicited emails and replying to them. We will explore ethical aspects of developing psychiatric websites. In addition, it will explore ethical aspects of online doctor reviews and the limitations to a physician's ability to respond to negative reviews, as well as how to manage professional reputation. Using the case of Elonis v. United States as a starting point, the ethical role of the forensic psychiatrist in using social media and other online resources to conduct a threat assessment will be discussed. The Audience Response System will be utilized regarding ethical dilemmas with the internet. Audience questions and discussion will follow the presentations.

REFERENCES

Recupero PR: Email and the psychiatrist-patient relationship. J Am Acad Psychiatry Law 33:465-475, 2005
Cerny CA, Smith D, Friedman SH: The Internet and Forensic Psychiatry. Principles & Practice of Forensic Psychiatry. Edited by Richard Rosner, MD and Charles Scott, MD, in press, 2016

QUESTIONS AND ANSWERS

1. What percentage of psychiatrists report having researched their patients online through search engines like Google?
a. 15%
b. 35%
c. 55%
d. 75%
e. 95%
ANSWER: b

2. Approximately what percentage of all registered Facebook users log in on any given day?
a. 25%
b. 30%
c. 50%
d. 95%
ANSWER: c

S28 YOUTH CONCUSSIONS: PSYCHIATRIC RISKS, LEGAL IMPLICATIONS

Christopher Fischer, MD, West Hollywood, CA
David Baron, DO, (I) Los Angeles, CA
Susan Turkel, MD, (I) Los Angeles, CA

EDUCATIONAL OBJECTIVE

To explore the neuropsychiatric risks and legal complexities related to repeated concussions in youth contact sports. This presentation should help improve competence in the forensic evaluation of cases involving repeated concussions in participants in youth contact sports.

SUMMARY

Over the past decade, significant media attention has been directed toward concussions in youth contact sports. Several lawsuits have focused on the neuropsychiatric risks of repeated concussions in this population. This is an important topic, given that millions of youth participate in contact sports annually. Although concussions occur in boys and girls of all ages and in all sports, they are most common in contact sports. A youth's brain may be more vulnerable to the consequences of concussion than an adult's brain and repeated concussions may place them at risk for neuropsychiatric sequelae, including depression, personality changes, and attentional problems. Second-impact syndrome, a condition in which a second concussion occurs before the first one has had time to heal, can even be fatal. There is growing evidence that repeated sub-concussive hits, a common occurrence in contact sports, could disrupt neuronal integrity and damage white matter tracts. Psychiatrists may be asked to play a role in the forensic evaluation of youth who have neuropsychiatric sequelae of repeated concussions. This panel will discuss the most recent research and forensic topics as they relate to concussions in youth contact sports.

REFERENCES

Keightley M, Sinopoli K, Davis K, et al: Is there evidence for neurodegenerative change following traumatic brain injury in children and youth? A scoping review. Frontiers in Human Neuroscience 8: 1-6, 2014
Overturf C, Cooper D: Changing the Culture of "Ding": Education, Legislation and Research on Concussive Brain Injury in Youth Athletics. Nature Precedings 1-2, 2011

QUESTIONS AND ANSWERS

1. Children under the age of 14 account for what percent of all organized football participants in the United States?
a. 5%
b. 10%
c. 30%
d. 70%
ANSWER: d

2. Which of the following risk factors is associated with an increased risk of persistent deficits after mTBI in pediatric populations?
a. premorbid cognitive limitations
b. family history of TBI
c. lower socioeconomic status
d. higher socioeconomic status
ANSWER: a

S29 CAN THE RECOVERY MODEL BE INTEGRATED INTO LEVERAGE?

Simha Ravven, MD, Putney, VT
Reena Kapoor, MD, New Haven, CT
Debra Pinals, MD, Ann Arbor, MI
Marvin Swartz, MD, Durham, CT
Madelon Baranoski, PhD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE

At the end of this presentation, participants will be able to describe the intersection of recovery models and leverage-based care from policy, health systems, and treatment perspectives. Participants will be able to identify treatment approaches that promote patient engagement and will be familiar with best practices in community-based forensic treatment.

SUMMARY

Legal leverage is the use of legal authority to engage individuals in mental health treatment. As the population of criminal justice-involved persons with serious mental illness has grown, so has the application of legally leverage. Mental health and drug courts, jail diversion programs, mandated outpatient treatment programs (i.e. outpatient commitment or Assisted Outpatient Treatment), and conditional release programs all utilize legal leverage. The leverage-based model of care has the potential to conflict with the individualized and patient-centered approaches utilized for persons with major mental illness outside of the criminal justice system, raising questions about the ethics and efficacy of mandated treatment. In this panel, we consider the question, "Is it possible to deliver high-quality treatment to justice-involved individuals who are mandated to mental health treatment?" We discuss the application of the recovery model to the care of justice-involved individuals with mental illness. We outline the tensions commonly found in leverage-based treatment, and we discuss the balance of patient autonomy and risk management from policy, health systems, and individualized treatment perspectives. We will discuss current research on patient outcomes in leverage-based treatment and provide case-based examples. Patient perception of coercion and factors that promote autonomy will also be examined.

REFERENCES

Swartz MS, Hoge SK, Pinals DA, et al: Resource Document on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment. Arlington, VA: American Psychiatric Association Operations Manual, 2015

Redlich AD, Steadman HJ, Robbins PC, et al: Use of the Criminal Justice System to Leverage Mental Health Treatment: Effects on Treatment Adherence and Satisfaction. J Am Acad Psychiatry Law 34:292–9, 2006

QUESTIONS AND ANSWERS

1. Defense attorneys sometimes oppose their clients' involvement in jail-diversion programs and other forms of leverage-based mental health treatment for which of the following reasons?

a. The treatment has been proven ineffective in reducing recidivism.
b. Penalties for defendants who participate in jail diversion programs but do not successfully complete them are harsher than for those who did not participate.
c. Judges are opposed to mental health treatment and look down upon attorneys who recommend such programs.
d. Jail diversion programs were developed by prosecutors.

ANSWER: b

2. Which of the following treatment contexts may utilize leverage-based treatment?

a. Mental health courts
b. Jail diversion programs
c. Mandated outpatient treatment programs
d. Conditional release programs
e. All of the above

ANSWER: e

S30 TRANSFORMING FORENSIC EXPERIENCE INTO CREATIVE WRITING

Reena Kapoor, MD, New Haven, CT
Richard Martinez, MD, MH, Denver, CO
Christine Montross, MD, MFA, Barrington, RI
Jacob Appel, MD, JD, New York, NY
Ezra Griffith, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

At the conclusion of this workshop, audience members will acquire skills to engage in writing exercises that use the power of creative storytelling to process emotion and trauma from forensic practice and consider the ethical and practical ramifications of publishing creative writing for forensic psychiatrists.

SUMMARY

Despite the surge of interest in narrative medicine over the past few decades, forensic psychiatrists have remained reticent to use creative writing as a tool for transforming clinical challenges into artistic expression. In this workshop, two renowned psychiatrist-authors, Dr. Christine Montross and Dr. Jacob Appel, will lead audience members in writing exercises that are designed to explore the inner emotional worlds of forensic psychiatrists, both in healing and evaluative roles. Drs. Montross and Appel will present a series of writing prompts, inviting participants to write their own fragments of health narratives, drawing upon some of the more evocative moments in their own clinical experiences. After the writing exercises, presenters will lead participants in a discussion of the process involved in

creating health narratives and explore the content that has emerged therein. Finally, presenters and participants will share some of the challenges of publishing creative writing while working as a forensic expert, such as facing questions about one's writing during testimony. The workshop is intended for any forensic practitioner who has considered or attempted turning experience into narrative.

REFERENCES

Montross C: Falling Into The Fire: A Psychiatrist's Encounters With the Mind in Crisis. New York, NY: Penguin, 2013
Adshead GMJ: Commentary: Stories and Histories in Forensic Psychiatry. J Am Acad Psychiatry Law 42: 437-42, 2014

QUESTIONS AND ANSWERS

1. Which of the following factors must a psychiatrist-author consider when writing creative nonfiction about clinical experiences?

a. The emotional impact on the involved patient.
b. Confidentiality and informed consent from the involved patient(s).
c. The effect of personal disclosures on the author's reputation.
d. All of the above
ANSWER: d

2. Which statement most accurately describes the role of fiction in forensic practice?

a. Fiction is the lie that tells the truth truer.
b. Stories have little to do with the medical/legal world.
c. It is dangerous to write fiction and be an expert examiner.
d. Attorneys prefer expert witnesses who write fiction.
ANSWER: a

S31 SHOULD VIDEO RECORDING OF SANITY EVALUATIONS BE MANDATORY?

Patricia Westmoreland, MD, Denver, CO
William Reid, MD, MPH, Horseshoe Bay, TX
Jeffrey Metzner, MD, Denver, CO
Steven Jensen, JD, (I) Golden, CO
Rich Orman, JD, (I) Centennial, CO

EDUCATIONAL OBJECTIVE

This panel consists of three forensic psychiatrists, and two prosecutors. Participants will learn about advantages and disadvantages of video recording sanity evaluations, the push for legislation to make video recording of sanity evaluations mandatory in Colorado, and concerns expressed by the Colorado Psychiatric Society regarding such legislation.

SUMMARY

The Fifth Amendment protects defendants against self-incrimination. However, once the insanity defense is raised, the adversarial process requires exchange of mental health information. In Colorado, court-ordered assessments are considered neutral evaluations administered through the state's court services division. Defendants may have additional evaluations by defense-contracted experts. Either side may request further court-ordered evaluations if they can demonstrate deficiencies in the court-ordered evaluation. Prosecution-contracted experts do not have direct access to the defendant. However, if an evaluation is recorded, prosecutors (and their experts) have access to the recording. In a recent high profile case, the Aurora Theater Shooting Trial, Dr. Reid will discuss the advantages of video-recording his interview with the defendant. Dr. Metzner will discuss why he conducted his examination without video recording. Mr. Orman, a prosecutor in the Aurora Theater Shooting Trial, will discuss how viewing the video recording impacted the jury in this case. Chief Deputy District Attorney Jensen will argue for legislation mandating video recording of sanity examinations. In addition to serving as moderator, Dr. Westmoreland will outline concerns raised by the Colorado Psychiatric Society Legislative Committee regarding this legislation, including why mandated recording may undermine the quality of information obtained in a sanity examination.

REFERENCES

The People v. Rich, 45Cal 3d; 755P.2d 960 (1988)
Illinois Public Act 098-1025, 2014

QUESTIONS AND ANSWERS

1. In People v. Rich, why did the Supreme Court of California uphold the trial court's decision to order the defendant to give the state videotapes prepared by the defendant's expert?

a. Videotaping was mandatory.
b. Defense counsel had previously given the tapes to the prosecutor, and the defense had admitted the tapes into evidence.
c. The use of videotapes would not make it easier for the state to prove its case.
d. b and c
e. a, b and c

ANSWER: d

2. According to Illinois Public Act 098-1025 of 2014, why must interviews conducted by state or defense-hired forensic psychiatric experts be videotaped?

a. Videotaping must occur under all circumstances.
b. Unless doing so would be impractical.
c. Experts who do not videotape may not testify.
d. Experts who do not videotape may testify, but their testimony will be weighted accordingly.
e. b and d

ANSWER: e

S32 POLICE CRISIS INTERVENTION:CREATING A MULTILAYERED RESPONSE

Landy Sparr, MD, Beaverton, OR
Amy Bruner-Dehnert, BA, (I) Portland, OR
Liesbeth Gerritsen, PhD, (I) Portland, OR
Tashia Hager, BS, (I) Portland, OR

EDUCATIONAL OBJECTIVE

Participants will be able to explain the benefit of a multi-layered police response to behavioral health crisis calls, identify the effective utilization of community partnerships, and describe the elements of a police behavioral health referral and triage data system.

SUMMARY

As persons with mental illnesses and law enforcement become increasingly entangled, collaboration between police and mental health providers has become critical to appropriately serving the needs of individuals experiencing mental health crises. The absence of collaboration has been posited as one factor in the emergence of "criminalization" of the mentally ill. Law enforcement officers have become primary responders, sometimes with disastrous consequences. Traditional police procedures and tactics have sometimes fallen short when attempting to resolve incidents involving people in crisis, who may or may not have a mental illness. As a result, police agencies across the country have implemented various strategies such as crisis intervention training for officers on a voluntary basis, mandatory crisis training for all officers, partnerships with local behavioral health entities, and co-locating a police officer with a mental health professional in the field. Members from the Portland Police Bureau's Behavioral Health Unit will discuss an innovative and multi-layered response strategy developed in Oregon to address calls involving police and people in crisis. By examining real cases and inviting audience participation, key elements of the strategy such as who and what to train, how to partner with community agencies, capturing data, and program evaluation will be addressed.

REFERENCES

Teller JLS, Munetz MR, Gil KM, et al: Crisis intervention team training for police officers responding to mental disturbance calls. Psychiatric Services 57:232-237, 2006

Watson AC, Fulambarker AJ: The crisis intervention team model of police response to mental health crisis: a primer for mental health practitioners. Best Pract Mental Health 8: 71-79, 2012

QUESTIONS AND ANSWERS

1. Which of the following is a result of the collaboration between the mental health system and police?

a. People in crisis will have a decreased need for sub-acute hospitalization.
b. People in crisis will not have to go to jail due to improved data gathering and sharing.
c. People with behavioral health needs who encounter the police will have increased ability to access mental health services.
d. People with psychiatric diagnoses and adverse encounters with police will be consistently referred to mental health court.

ANSWER: c

2. Which of the following are three elements of a police-based multi-layered response to behavioral health crises?
a. Core competency training, specialized training, co-responder model follow up.
b. Core competency training, co-responder follow up, jail sanctions.
c. Co-responder model follow up, wrap around services, specialized training.
d. Specialized training, case management, co-responder model follow up.
ANSWER: a

S33 AUTISM AND PERSONALITY: CHALLENGES IN ASSESSMENT

Kyle Walker, MD, Boston, MA
Alexander Westphal, MD, PhD, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT
Laurie Sperry, PhD, (I) Denver, CO

EDUCATIONAL OBJECTIVE

Participants will understand the challenges to validity of standardized personality measures in the assessment of persons with autism spectrum disorders, appreciate the need for tool validation, and be prepared to defend acceptance or rejection of results.

SUMMARY

Persons with Autism Spectrum Disorder in the criminal justice system frequently require forensic psychiatric assessments across the adjudication process. Diagnosis of the disorder, itself, is rarely adequate to address common forensic questions related to mental state, mitigation, and risk. Moreover, the diagnosis alone of a spectrum disorder does not preclude a range of personalities, morality, interpersonal experiences, and capacity for choice. Standard cognitive measures can provide reliable assessments of intellectual strengths and deficits; results from standardized measures of personality and violence/sexual risk, however, may lack validity for those with spectrum disorders. The questions are: (1) how to measure personality in autism, and (2) are personality characteristics relevant to forensic questions? This research compares profiles from two standard measures (MMPI-2, MCMI-III) of persons with and without spectrum disorders across both forensic and non-forensic populations. The pilot data on 12 sets of measures from forensic evaluations on persons with and without spectrum disorders showed that scores for anxiety, introversion, depression, and antisocial characteristics were higher for those with spectrum disorders; however, scores for depression and anxiety were consistent with diagnoses only in those without spectrum disorders. The results indicate the need for caution in interpreting results of persons with autism spectrum disorders.

REFERENCES

Ozonoff S, Garcia N, Clark E, et al: MMPI-2 personality profiles of high-functioning adults with autism spectrum disorders. Assessment12(1):86-95, 2005

Austin EJ: Personality correlates of the broader autism phenotype as assessed by the Autism Spectrum Quotient (AQ). Personality and Individual Differences 28:451-460, 2005

QUESTIONS AND ANSWERS

1. The validity of standard personality assessment measures in autistic spectrum disorders:
a. has not been established.
b. is similar to the validity of the measures for a non-spectrum population.
c. cannot be established because of the cognitive deficits in autism.
d. weaken their application in forensic assessments.
ANSWER: a

2. The characteristics of autistic spectrum disorders most likely to affect the validity of standard risk-of-violence measures in this population include:
a. The lack of empathy and significant antisocial traits associated with autism
b. Restricted interests and deficits in communication and social interactions
c. The propensities for confabulation and feigning
d. Deficient verbal processing and reasoning skills
ANSWER: b

S34 FORCING TREATMENT: DOES THE LEGAL APPROACH MATTER?

Scott Walmer, DO, New Haven, CT
Madelon Baranoski, PhD, (I) New Haven, CT

EDUCATIONAL OBJECTIVE
Attendees will understand the various ways in which states address treatment refusal by civilly-committed patients. Based on a direct comparison of data from Connecticut, which offers two different pathways for adjudication, attendees will appreciate what determines the approach and how the approach influences outcomes.

SUMMARY
States have developed different approaches to overturn a patient's right to refuse psychiatric treatment (specifically medication). While some States utilize a 'rights-driven model' adjudicated by a judge, others use a 'treatment-driven model' in which one or more independent non-treating psychiatrists are decision makers. Still other states use a 'commitment-related model' where civil commitment implies incompetence to make treatment decisions. The State of Connecticut offers both rights-driven and treatment-driven approaches when civilly committed patients exert their right to refuse treatment. To our knowledge, there are no published data describing the use and effects of the different approaches and factors related to them. This study retrospectively reviews records from (i) a private community psychiatric hospital, and (ii) the Connecticut District Probate Courts over a 14 year period to determine the frequency of upholdings and reversals of treatment refusals as well as the factors that influenced decision making in these cases, including patient demographics, disorder characteristics, and elements of risk. Summary data will also be presented on the statutory differences across different jurisdictions in the United States to give attendees an idea of the applicability of this study's findings to their own jurisdiction.

REFERENCES
Ciccone JR, Tokoli JF, Clements CD, et al: Right to Refuse Treatment: Impact of Rivers v. Katz. Bull Am Acad Psychiatry Law 18(2):203-215, 1990
Schwartz HI, Vingiano W, Perez CB: Autonomy and the Right to Refuse Tretament: Patients' Attitudes After Involuntary Medication. Hosp Community Psych 39(10):1049-1054, 1988

QUESTIONS AND ANSWERS
1. What was the impact of Rivers v. Katz in changing the approach to involuntarily medicating civilly committed patients from an administrative review process to a judicial "substituted judgment" standard?
a. Decreased numbers of patients refusing treatment and decreased time from medication refusal to resolution of dispute.
b. Decreased numbers of patients refusing treatment and increased time from medication refusal to resolution of dispute.
c. Increased numbers of patients refusing treatment and decreased time from medication refusal to resolution of dispute.
d. Increased numbers of patients refusing treatment and increased time from medication refusal to resolution of dispute.
ANSWER: b

2. Which of the following is not a landmark legal case dealing with patients' right to refuse treatment in the civil context?
a. Rennie v. Klein
b. Superintendent of Belchertown State School v. Saikewicz
c. Rogers v. Commissioner
d. Washington v. Harper
e. Application of President and Directors of Georgetown College, Inc.
ANSWER: d

S35 IS TRAUMA A CRIMINOGENIC RISK FACTOR: PTSD AND OUTCOME

Katya Frischer, MD, New York, NY
Virginia Barber Rioja, PhD, (I) New York, NY
Susanna Preziosi, PhD, (I) Bronx, NY
Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE
To better understand the overrepresentation of trauma histories among individuals facing criminal justice charges and the relationship of trauma to justice related outcomes, such as diversion success or failure.

SUMMARY
While high rates of trauma history are reported among both men and women in the criminal justice system, trauma and related syndromes are not identified as risk factors directly associated with re-arrest. However, research also

suggests that individuals experiencing symptoms of PTSD are likely to have greater difficulties responding to the broader risk reduction program elements and may require special attention and treatment resources to address these symptoms. In this study, we examine client-level demographic and diagnostic data at two New York City treatment court diversion programs, with particular attention to whether symptoms of PTSD, measured at intake, are related to success or failure within the program. Structured measures of trauma, substance use and mental health symptoms collected by the program will provide the dependent clinical measures. The relationship between PTSD symptoms and other variables (e.g. substance use) will also be explored to help delineate the pathway through which trauma may be associated with justice outcomes, although indirectly mediated by associated clinical risk factors.

REFERENCES

Pimlott Kubiak S, Fedock G: Reentry Planning for Offenders with Mental Disorder, 2010
PTSD, substance use, and veterans ' involvement in the legal system: Veterans treatment courts.
Borsari B, Conrad S, Mastroleo N, et al: Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders Second Edition Washington, DC: American Psychological Association, 2014

QUESTIONS AND ANSWERS

1. Which emotion has a relationship with PTSD?
a. Sadness
b. Paranoia
c. Anger
ANSWER: c

2. Which of the following does not predict arrest in veterans?
a. PTSD
b. PTSD with high anger and irritability
c. alcohol and drug misuse
d. combat exposure
ANSWER: d

S36 SELF-HARM IN CALIFORNIA PRISONS: PHENOMENOLOGY AND TREATMENT

Jeremy Colley, MD, Folsom, CA
Melinda DiCaro, PhD, (I) Sacramento, CA
Robert Canning, PhD, (I) San Francisco, CA

EDUCATIONAL OBJECTIVE

To understand what works and does not work to reduce the frequency of self-injurious behavior in prison. Given the complex system in which these inmates live and are in treatment, we will discuss administrative barriers to success and some novel approaches in the prison environment to successfully treat these individuals.

SUMMARY

It has been estimated that only about 2% of the nation's prison inmates engage in self-injurious behavior, but in some systems it is a daily occurrence that is quite costly. We will discuss some theoretical foundations for self-harm including extreme self-harm such as insertion and ingestion of foreign bodies, serial lacerations, and other life-threatening behaviors. We will discuss psychiatric formulations of these individuals' behavior that may aid in their treatment (e.g. factitious disorder, borderline personality disorder, antisocial personality disorder) and also formulations that may impede treatment (psychopathy, antisocial personality disorder). We will discuss psychosocial and pharmacological approaches to treatment of these individuals including functional analyses, behavior management plans, Dialectical Behavior Therapy, and even psychopharmacological treatments such as mood stabilizers and naltrexone. We will present treatment protocols including group therapy and Behavior Incentive Programs as ways to approach these patients. Finally, we will present a case series of individuals who we have treated (some successfully and some not) in a high security California prison including the treatment plans and other efforts to treat their disruptive behaviors.

REFERENCES

Appelbaum KL, Savageau JA, Trestman RL, et al: A national survey of self-injurious behavior in American prisons. Psychiatric Services 62(2):285-290, 2011
Schmidt III H, Ivanoff A: (2014). Behavior Management Plans. Oxford Textbook of Correctional Psychiatry. New York, NY: Oxford University Press, 2014

QUESTIONS AND ANSWERS

1. Name one medication that has demonstrated efficacy in reducing self-injury among California state prison inmates?

ANSWER: Naltrexone

2. What are two psychotherapeutic strategies that can be useful in addressing self-harm in prison populations?

ANSWER: DBT and Behavioral Management Plans

SUNDAY, OCTOBER 25, 2015

PANEL — 8:00 AM - 10:00 AM — **PAVILION WEST**

Z1 ***James Holmes and the Colorado Cinema Shooting Case***

William Reid, MD, MPH, Horseshoe Bay, TX
Jeffrey Metzner, MD, Denver, CO
Rich Orman, JD, (I) Centennial, CO
Phillip Resnick, MD, Cleveland, OH

PANEL — 8:00 AM - 10:00 AM — **PAVILION EAST**

Z2 ***Violent Extremist Organizations: Global Challenges***
International Relations Committee

Carolina Klein, MD, Alexandria, VA
Kenneth Busch, MD, Chicago, IL
Alan Felthous, MD, St. Louis, MO
Ronald Schouten, MD, Boston, MA

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

Z3 ***The Digital Workflow for Expert Witnesses***
Computer Committee

Alan Newman, MD, San Francisco, CA
Tyler Jones, MD, Salem, OR
Andrew Nanton, MD, Portland, OR

PANEL — 8:00 AM - 10:00 AM — **BROADWAY I-II**

Z4 ***When a Routine Toxicology Screen is Not Enough***

Ryan Hall, MD, Lake Mary, FL
Susan Hatters Friedman, MD, Cleveland Heights, OH
Christopher Kenedi, MD, MPH, (I) Auckland, New Zealand
Joseph Cheng, MD, PhD, Charleston, SC
Andrew Howie, MBChB, (I) Auckland, New Zealand

RESEARCH-IN-PROGRESS #4 — 8:00 AM - 10:00 AM — **BROADWAY III-IV**

Z5 ***To Arrest or Not? Characteristics of Arrested Inpatients***

Jeremy Colley, MD, New York, NY
Danielle Kushner, MD, New York, NY

Z6 ***Temporary Mental Health Holds: Who Gets Civilly Committed?***

Ian Lamoureux, MD, Rochester, MN
Teresa Rummans, MD, (I) Rochester, MN
Kathryn Schak, MD, (I) Rochester, MN

Z7 ***Why Do Mothers Abuse and Neglect their Children?***

Vivian Chern-Shnaidman, MD, Skillman, NJ

Z8 ***Barriers Faced by Not Competent/Not Restorable Inpatients***

Gwen Levitt, DO, Phoenix, AZ
Jennifer Weller, PhD, (I) Mesa, AZ
Samuel Hand, MD, Phoenix, AZ
Chandrika Shankar, MD, Mesa, AZ

COFFEE BREAK — **10:00 AM – 10:15 AM**

WORKSHOP — 10:15 AM - 12:00 PM — **PAVILION WEST**

Z9 ***Protecting Elders: Lessons from the Brooke Astor Case***
Geriatric Psychiatry and the Law Committee

Sherif Soliman, MD, Hinckley, OH
Philip Marshall, (I) Bristol, RI
Bennett Blum, MD, Tucson, AZ

PANEL 10:15 AM - 12:00 PM **PAVILION EAST**

Z10 ***The Scarlet Letter: Public Notification of Sex Offenders***
Sexual Offenders Committee

Lisa Murphy, MCA, (I) Ottawa, ON, Canada
R. Gregg Dwyer, MD, EdD, Charleston, SC
Richard Krueger, MD, New York, NY
J. Paul Fedoroff, MD, Ottawa, ON, Canada

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

Z11 ***Can You Hear Me? Deaf Clients in Forensic Settings***

Mark Cotterell, MD, Middletown, CT
Julie Pratt, LCSW, (I) Middletown, CT
Lisa Kuntz, EdD, (I) West Hartford, CT

PANEL 10:15 AM - 12:00 PM **BROADWAY I-II**

Z12 ***Sexual Assault Expert Testimony in the U.S. Military***

David Johnson, MD, Kensington, MD
David Benedek, MD, Bethesda, MD
Jennifer Yeaw, PsyD, (I) Colorado Springs, CO
Vanessa Green, DO, Bethesda, MD

RESEARCH-IN-PROGRESS #5 10:15 AM - 12:00 PM **BROADWAY III-IV**

Z13 ***Other Specified Paraphilic Disorders and SVP Evaluations***

Richard Wollert, PhD, (I) Vancouver, WA
Allen Frances, MD, Coronado, CA

Z14 ***False PTSD: A New Approach to Detection***

Mikel Matto, MD, San Francisco, CA
Renée Binder, MD, San Francisco, CA
Dale McNiel, PhD, ABPP, (I) San Francisco, CA

Z15 ***Crying Wolf: Understanding False Sexual Assault Allegations***

Ian Lamoureux, MD, Rochester, MN
Paul Croarkin, DO, MS, (I) Rochester, MN
Amy Stark, MD, (I) Rochester, MN

Z16 ***Youth Fitness Competency to Stand Trial in New Zealand (NZ)***

Davin Tan, FRANZCP, (I) Auckland, New Zealand
Caleb Armstrong, FRANZCP, (I) Auckland, New Zealand
Susan Hatters Friedman, MD, Cleveland Heights, OH
Chelsea Neumann, MD, Pawtucket, RI

Your opinion on today's sessions is very important!
While it's fresh in your mind, PLEASE complete the evaluation form for today's program so we can continue to offer CME in the future.

Z1 JAMES HOLMES AND THE COLORADO CINEMA SHOOTING CASE

William Reid, MD, MPH, Horseshoe Bay, TX
Jeffrey Metzner, MD, Denver, CO
Rich Orman, JD, (I) Centennial, CO
Phillips Resnick, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE
At the end of these presentations and the related discussion period, audience members will be better able to participate usefully and ethically as expert consultants and witnesses in criminal matters of unusual complexity, extended duration, and intense media attention.

SUMMARY
The panelists will describe their expert roles, working procedures, findings, opinions, and testimony in the recent Colorado shooting case of James Holmes, followed by considerable time for audience questions and discussion. Topics addressed will include the panelists' individual experiences and issues such as dealing with huge volumes of information, working with counsel and others, adapting to sometimes unusual judicial and case parameters (including access to the defendant and witnesses, intense media coverage, and restrictions related to the defendant's rights vis-a-vis broad public knowledge and curiosity), pros and cons of videorecording interviews, and other topics that may arise from the audience.

REFERENCES
The People of the State of Colorado vs. James Eagan Holmes,12CR1522 (2012)
Video recording of forensic psychiatric evaluations. AAPL Task Force. American Academy of Psychiatry and the Law (2013) www.AAPL.org/Publications

QUESTIONS AND ANSWERS
1. In the James Holmes criminal case, and most others, what does appointment as a judge's expert rather than one for the defense or prosecution mean?
a. Neither the defense nor the prosecution has access to that expert's opinions unless or until they are revealed in testimony.
b. That expert must rely primarily on information and evidence gathered separately from the defense counsel or prosecution.
c. That expert's findings and opinions are generally available to both sides before trial.
d. That expert's fees are usually paid by whichever side calls him or her to testify.
ANSWER: c

2. Which of the following is/are generally accepted as reason(s) to video-record forensic examinations?
a. Accurately documenting the questions, responses, and overall examination.
b. Minimizing the likelihood that the examiner will be accused of dishonesty or impropriety.
c. Assisting the examiner in writing reports and preparinmg for testimony.
d. All of the above.
ANSWER: e

Z2 VIOLENT TERRORIST ORGANIZATIONS: GLOBAL CHALLENGES

Carolina Klein, MD, Alexandria, VA
Kenneth Busch, MD, Chicago, IL
Alan Felthous, MD, St. Louis, MO
Ronald Schouten, MD, Boston, MA

EDUCATIONAL OBJECTIVE
To learn about the role of psychological factors in individual radicalization and terrorist group dynamics, learn about factors that impact on terrorist attacks such as social media, recruitment and training, and learn about tactics and strategies of terrorist groups through specific case examples.

SUMMARY
Terrorist attacks have become more brutal with the emergence of specific Islamic organizations such as ISIL. A new phase of terrorism is growing, which is extremely violent and shocking to the world such as the horrific attacks in Paris and San Bernardino. Violent terrorist organizations pose a large spectrum of highly lethal security threats on a daily basis. The study of international terrorism is no less important than the study of abnormal human behavior that is more routinely the clinical and forensic concern of behavioral scientists and mental health service providers. As individual acts of terrorism are prosecuted as criminal offenses, psychiatrists, psychologists, and other behavioral

scientists are directly involved as forensic experts. It behooves forensic psychiatrists to gain familiarity with contextual and historical, psychological and sociological, etiological and preventative aspects of the global challenges of international terrorism. This panel will focus on case studies of extremely violent terrorist organizations such as ISIL, Al Qaeda and others with regards to their operational capacities to promote extreme violence and threats they pose to the United States and western worlds.

REFERENCES

Weissman SH, Busch KG, Schouten R: The evolution of terrorism from 1914 to 2014. Behavioral Sciences Law 32:259-262, 2014

Felthous AR: Bias in behavioral study and analysis of international and domestic terrorism: an editorial introduction. Behavioral Sciences Law 32:263 -268, 2014

QUESTIONS AND ANSWERS

1. Which of the following factors does not play a role in the lethal behavior of terrorist groups?
a. Financial support
b. Ideology justifying violence
c. Organizational approach
d. Organizational capabilities
e. Social media
ANSWER: c

2. Which of the following tactics would best describe the Paris terror attacks at the Bataclan theatre in November, 2015?
a. Suicide bombings
b. Kidnapping
c. Hostage/barricade
d. Arson
e. Explosive devices
ANSWER: c

Z3 THE DIGITAL WORKFLOW FOR EXPERT WITNESSES

Alan Newman, MD, San Franciso, CA
Tyler Jones, MD, Salem, OR
Andrew Nanton, MD, Portland OR

EDUCATIONAL OBJECTIVE

Participants will develop competency in using electronic tools for every stage of an expert witness case and learn the advantages of an electronic workflow over traditional paper-based approaches.

SUMMARY

Expert witnesses typically use a mixture of analog and digital tools in the practice of reviewing forensic cases and writing expert reports. Attorneys are increasingly using cloud-based internet services to deliver records electronically, and experts are frequently confronted with a hybrid workflow of analog paper-based tools mixed with electronic communication and report writing. Recent technological advances can allow an expert to have a fully digital workflow, with all communications, record reviews, notes, report writing, and billing done electronically without the need for printing or paper invoicing. Three members of the AAPL Computer Committee will provide step-by-step workflows on how to create and organize electronic files and annotate records in a manner to allows access from any web-enabled device across multiple platforms. We will address common concerns such as encryption, accidental data loss, and accidental disclosure. Participants will learn advanced techniques in managing Portable Document Format files, including optical character recognition techniques, annotations, creating content summaries, and use of metadata. We will provide hands-on instruction in the use of traditional and non-traditional text management tools, as well as typography recommendations for electronically-read and printed reports. Finally, we will briefly discuss tools for time-tracking, invoicing, and online payments for services.

REFERENCES

Yale, BF:The Paperless Law Office: A Practical Guide to Digitally Powering Your Firm. Chicago, IL: American Bar Association, 2012

Citrome L: Creating a more productive, clutter-free, paperless office: a primer on scanning, storage and searching of PDF documents on personal computers. International Journal of Clinical Practice 62(3):363–366, 2008

QUESTIONS AND ANSWERS

1. Which of the following is not a cloud-based service?
a. Microsoft OneDrive
b. Dropbox
c. Scrivener
d. Acrobat Document Cloud
e. Google Drive
ANSWER: c

2. Which of the following is an advantage of a digital workflow compared paper-based workflows?
a. Rapid searching of text.
b. The use of metadata to manage information.
c. Ability to access on any web-enabled device.
d. Decreased need for physical storage space.
e. All of the above
ANSWER: e

Z4 WHEN A ROUTINE TOXICOLOGY SCREEN IS NOT ENOUGH

Ryan Hall, MD, Lake Mary, FL
Susan Hatters Friedman, MD, Cleveland Heights, OH
Christopher Kenedi, MD, MPH, (I) Auckland, New Zealand
Joseph Cheng, MD, PhD, Charleston, SC
Andrew Howie, MBChB, (I) Auckland, New Zealand

EDUCATIONAL OBJECTIVE

Discuss various substances which can lead to psychiatric symptoms but are not detected by routine toxicology screens and potential legal implications.

SUMMARY

As seen from the case of the "Miami zombie," designer drugs such as bath salts, which are often not detected in standard toxicology screens, can potentially lead to profound psychiatric symptoms (psychosis, mania) and legal questions (e.g. whether actions were due to voluntary intoxication or mental illness, violence risk assessment, compliance with probation). There are many substances, legal (e.g. over the counter cough medication or herbals), illegal, and in a legal gray zone (e.g. designer drugs) that individuals intentionally take to become intoxicated and also avoid detection. This panel will discuss common substances used in this manner such as Spice, K2, Robotripping(e.g. dxm) Bath Salts, Flacco, Kratom and other substances, presentations seen with these compounds, and what type of toxicology tests need to be ordered to detect them

REFERENCES

Andrabi S, Greene S, Moukkadam N, et al: New drugs of abuse and withdrawal syndromes. Emerg Med Clin North Am 33(4):779-95, 2015
Face-Eating Cannibal Attack May Be Latest in String of Bath Salts Incidents. Available at http://abcnews.go.com/Blotter/face-eating-cannibal-attack-latest-bath-salts-incident/story?id=16470389. Accessed August 2016

QUESTIONS AND ANSWERS

1. High doses of Robitussin DM (robotripping) has effects similar to what drug?
a. Heroin
b. PCP
c. Cocaine
d. Amphetamines
e. Downers
ANSWER: b

2. What is Kratom?
a. Name of a bath salt
b. Synthetic marijuana
c. Herbal tea with opiate-like properties
d. Designer anabolic steroid
e. Legal prescription drug from Peru for altitude sickness
ANSWER: c

Z5 TO ARREST OR NOT? CHARACTERISTICS OF ARRESTED INPATIENTS

Jeremy Colley, MD, New York, NY
Danielle Kushner, MD, New York, NY

EDUCATIONAL OBJECTIVE
Participants will be able to identify specific patient characteristics that are associated with inpatients arrested for staff assaults.

SUMMARY
Patient violence towards staff during inpatient psychiatric hospitalization is prevalent despite standard safety procedures. Prosecution of psychiatric inpatients for violence remains controversial. Some believe tolerance may encourage violence, some patients are capable of restraint, and arrest is a therapeutic intervention. Others are concerned that patient arrest disrupts the therapeutic alliance and causes adverse mental health outcomes. There is one prior study that examined patient characteristics correlated with arrest in a state hospital setting, but otherwise there are no known studies that examine this issue in an acute care setting. This study compares characteristics of Bellevue Hospital psychiatric inpatients who were arrested following staff assaults to those who were not arrested. Characteristics include sex, age, race, perception of underlying mental illness, and known history of violence and arrest, among others. We hope that acquiring more information on this group of defendants will help direct further clinical and legal interventions.

REFERENCES
Ho J, Ralston DC, McCullough LB, et al: When should psychiatrists seek criminal prosecution of assaultive psychiatric inpatients? Psychiatric Services 60:1113-1117, 2009
Volavka J: Characteristics of state hospital patients arrested for offenses committed during hospitalization. Psychiatric Services 46:796-8000, 1995

QUESTIONS AND ANSWERS
1. The patient with which admitting psychiatric disorder is most likely to be arrested following an assault on staff?
a. Borderline Personality Disorder
b. Major Depressive Disorder
c. Bipolar I Disorder
d. Psychosis NOS
ANSWER: a

2. Which patient characteristic is least likely to increase to influence patient arrests following assault on staff?
a. Suicide history
b. Sex
c. Personality Disorder
d. Length of stay
ANSWER: a

Z6 TEMPORARY MENTAL HEALTH HOLDS: WHO GETS CIVILLY COMMITTED?

Ian Lamoureaux, MD, Rochester, MN
Teresa Rummans, MD, (I) Rochester, MN
Kathryn Schak, MD, (I) Rochester, MN

EDUCATIONAL OBJECTIVE
Identify the legal basis for mental health holds and civil commitment, Identify key patient demographic factors correlated with civil commitment for those placed on emergency involuntary mental health holds.

SUMMARY
Following the deinstitutionalization movement of the 1960s, a significant number of individuals with serious mental illnesses are living independently in the community. Many of these persons have relapses of their illnesses, necessitating more intensive treatment. Unfortunately, due to the nature of many psychiatric illnesses, these patients will often refuse treatment or lack the capacity to consent to treatment. Recognizing this, as well as the danger that such individuals can pose to themselves and others, all states have laws permitting physicians acting in good faith to involuntarily hold patients for further evaluation in emergencies. Some of these patients will be civilly committed, whereas others will be deemed appropriate to return to community based treatment. In this study, the authors examine a cohort of patients admitted to an acute adult inpatient unit on an emergency mental health hold over a period of one year. We examine and discuss demographic data, and factors correlated with commitment versus discharge back to the community setting.

REFERENCES
Testa M, West SG: Civil Commitment in the United States. Psychiatry (Edgemont) 7(10):30-40, 2010
Sanguineti VR, Samuel SE, Schwartz SL, et al: Retrospective study of 2,200 involuntary psychiatric admissions and readmissions. Am J Psychiatry 153(3):392-6, 1996

QUESTIONS AND ANSWERS
1. What is the legal basis for an involuntary mental health hold?
a. Washington v. U.S., 129 U.S. App. D.C. 29, 390 F.2d 444 (1967)
b. Qui tam
c. Parens patriae and police power
d. Jacobson v. Massachusetts, 197 U.S. 11 (1905)
ANSWER: c

2. What landmark court case forms the basis for most, if not all, states' involuntary mental health hold laws?
a. Lessard v. Schmidt, 349 F.Supp. 1078 (1972)
b. Frendak v. U.S., 408 A.2d 364 (1979)
c. Baxstrom v. Herold, 383 U.S. 107, 86 S.Ct. 760 (1966)
d. Painter v. Bannister, 258 Iowa 1390, 140 N.W.2d 152 (1966)
ANSWER: a

Z7 WHY DO MOTHERS ABUSE AND NEGLECT THEIR CHILDREN?

Vivian Chern-Shnaidman, MD, Skillman, NJ

EDUCATIONAL OBJECTIVE
This presentation will identify the factors that cause mothers to abuse/neglect their children and help the forensic examiner conceptualize these categories and utilize them in risk assessment and treatment recommendations for the courts. The goals of service and research will be met in this presentation.

SUMMARY
Literature about child abuse was examined. While poverty, ignorance, lack of education, and immaturity are often correctly proposed as factors involved in child abuse and neglect, most studies ignore the factors in the mothers themselves. In this current study, emotional, cognitive, and behavioral factors are being investigated and categorized into diagnostic terms. A systematic way of approaching these cases will be proposed. Courts respect and rely upon expert testimony in cases of child abuse and neglect. A pilot study of 30 forensic evaluations for the family courts in New Jersey were initially examined. The four reasons for child abuse that emerged were: mental illness, cognitive impairment, substance abuse, and psychopathy. In order to evaluate and solidify the hypothesis, a further 100 cases are now being examined. Correlation coefficients between the existence of abuse and/or neglect to these four causative factors will be investigated. It is hypothesized that the more factors present in an individual mother, the more extensive the abuse/neglect. Additional statistical analysis will be utilized to estimate the significance of having one or more of the specified conditions. The results of the data collection and analysis are expected to fully support the anecdotally observed hypothesis.

REFERENCES
Child Maltreatmant. Available at http://www.who.int/topics/child_abuse/en/. Accessed August 2016
Children Exposed to Violence. Available at http://www.nij.gov/topics/crime/child-abuse/pages/welcome.aspx. Accessed August 2016

QUESTIONS AND ANSWERS
1. What are the four discrete reasons that mothers abuse their children?
ANSWER: Mental illness, cognitive/intellectual impairment, substance abuse, psychopathy.

2. What is the most common intervention for abusive/neglectful mothers in NJ?
ANSWER: Parenting Classes

Z8 BARRIERS FACED BY NOT COMPETENT/NOT RESTORABLE INPATIENTS

Gwen Levitt, DO, Phoenix, AZ
Jennifer Weller, PhD, (I) Mesa, AZ
Samuel Hand, MD, Phoenix, AZ
Chandrika Shankar, MD, Mesa, AZ

EDUCATIONAL OBJECTIVE
This project provides new data in the field of forensic psychiatry research. It will also enhance the knowledge base of practitioners about the potential outcomes related to opinions expressed in their evaluations. The study data may help to inform the delivery of services to a unique population.

SUMMARY
Defendants found Not Competent and Not Restorable (NCNR) in a criminal matter may proceed to civil commitment in a psychiatric facility. In 2006, Levitt et al. completed a study entitled, "Civil Commitment Outcomes of Incompetent Defendants." The study established that length of stay in an inpatient psychiatric facility and civil commitment outcomes were affected by virtue of the patient being found NCNR. Inpatient treatment teams often face "extra" challenges when treating an NCNR patient related to level of care assigned to the patient in the community, financial and insurance benefits, need for guardianship, risk to the community, and other barriers to discharge planning. Currently, the state of Arizona is entertaining legislative changes that would require NCNR defendants to be placed on a type of community supervision, akin to probation, despite never having been sentenced for a crime. Data from a retrospective review of medical records of NCNR defendants involuntarily admitted to a county psychiatric facility from 2013 to 2015 (approximately 350 records) will be used to delineate barriers that impact NCNR patient's return to the community after hospitalization.

REFERENCES
Levitt GA, Vora I, Tyler K, et al: Civil commitment outcomes of incompetent defendants. J Am Acad Psychiatry Law: 38:349-58, 2010
Morris GH, Meloy JR: Out of mind? out of sight: the uncivil commitment of permanently incompetent criminal defendants. U.C. Davis L Rev 27,1993

QUESTIONS AND ANSWERS
1. Which of the following does not impact discharge in a NCNR inpatient?
a. Diagnosis
b. Insurance benefits
c. Source of income
d. Guardianship matter(s)
e. All of the above
ANSWER: a

2. What arguments might be made to avoid legislation that would put an NCNR patient on supervision in the community?
a. Violation of patient's rights
b. Double jeopardy
c. Cruel and unusual punishment
d. a and b
e. All of the above
ANSWER: e

Z9 PROTECTING ELDERS: LESSONS FROM THE BROOKE ASTOR CASE

Sherif Soliman, MD, Hinckley, OH
Philip Marshall, (I) Bristol, RI
Bennett Blum, MD, Tucson, AZ

EDUCATIONAL OBJECTIVE
The audience will learn first-hand from Philip Marshall, Brooke Astor's grandson, about the Brooke Astor case. We will utilize the case to discuss the psychological mechanisms of elder financial exploitation. We will outline approaches to combatting this type of theft.

SUMMARY
Brooke Astor, the "first lady of New York," was a leading philanthropist throughout the latter half of the twentieth century. After her hundredth birthday, she became the victim of financial exploitation and neglect by her son, Anthony Marshall and Attorney Francis Morrissey. Her grandson, Philip Marshall, intervened by filing a guardian-

ship petition, which was awarded. He led the effort to expose and stop the exploitation. We will hear the fascinating story firsthand from Philip Marshall, who now devotes his time to combatting elder financial abuse. Financial abuse of the elderly has been called the "Crime of the 21st Century." A MetLife study found that elder financial abuse cost $2.9 billion in 2010, up twelve percent from 2008. The explosive population growth among the elderly, the relative concentration of wealth in this group, and their vulnerability have created a "perfect storm" for con artists, unscrupulous professionals, and relatives to exploit these vulnerable individuals. Dr. Soliman will discuss the psychological mechanisms of exploitation. Dr. Blum will discuss the interface between forensic psychiatry and law enforcement. A writing exercise based on the Brooke Astor case will challenge the audience to identify signs of exploitation and undue influence.

REFERENCES

Gordon M: Mrs. Astor Regrets: The Hidden Betrayals of a Family Beyond Reproach. New York, NY: Mariner Books, 2009
Factora R: Aging and Money: Reducing the Risk of Financial Exploitation and Protecting Financial Resources. Valley Stream, NY: Humana Press, 2014

QUESTIONS AND ANSWERS

1. Which of the following is a risk factor for elder financial abuse?
a. Isolated elder
b. Major neurocognitive disorder (dementia)
c. Physical illness
d. Alcohol use disorder
e. All of the Above
ANSWER: e

2. Which of the following is a mechanism by which undue influence is exerted?
a. Isolation
b. Fostering dependence
c. Disparaging independent thought
d. Indoctrination
e. All of the above
ANSWER: e

Z10 THE SCARLET LETTER: PUBLIC NOTIFICATION OF SEX OFFENDERS

Lisa Murphy, MCA, (I) Ottawa, ON, Canada
R. Gregg Dwyer, MD, EdD, Charleston, SC
Richard Krueger, MD, New York, NY
J. Paul Fedoroff, MD, Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE

Participants will understand the general characteristics, rationale and ethical concerns of public notification, know what the literature says about the effectiveness of this legislation and have a clear understanding of legal reporting requirements for forensic psychiatrists when a patient discloses sexual activity with a child.

SUMMARY

With President Barak Obama's recent signing of legislation referred to as "International Megan's Law", which permits identifiers to be placed on the passports of convicted sex offenders, the topic of public notification of sex offenders has become a critical sociopolitical and mental health issue. Since the 1980s legislation governing the management of sex offenders in the community has emerged worldwide, no country has had legislation as intensive as the United States. A number of ethical concerns have been identified regarding the use of this type of community based management. Academic research findings on the utility of these tools have largely been limited and inconsistent where available. Varying features of notification and sex offender registries (SORs) across state and national lines has severely limited the ability for cross-sectional comparisons and broad legislative improvements. This panel will provide an overview of the characteristics and rationale for the use of public notification. Literature on its effectiveness, ethical issues and case law will be explored. There will also be discussion on the application of this legislation to individuals who offended as youth. Lastly, legal reporting requirements throughout North America for forensic psychiatrists when a patient discloses sexual activity with a child will be examined.

REFERENCES
Organ A, Murphy L, Fedoroff JP, et al: Inside out: Are publicly accessible sex offender registries a good idea? Newsletter of American Academy of Psychiatry and the Law 39(2):14-16, 2014
Murphy L, Brodsky D, Brackel J, et al: Community Based Management of Sex Offenders: An Examination of Sex Offender Registries and Community Notification in the United States and Canada. New York, NY: Oxford University Press, 2009

QUESTIONS AND ANSWERS
1. Regarding public notification, which of these statements is true?
a. In some states sex offenders can be required to go door to door to notify neighbors about their presence within the community.
b. Information of convicted sex offenders, as detailed as their apartment number, can be accessed online by the public.
c. Many sex offenders' information remains on public websites long after their reporting requirements are completed.
d. In some jurisdictions adolescents convicted of a sex crime can have their information displayed on public websites along with adult sex offenders.
e. All of the above.
f. None of the above.
ANSWER: e

2. Other than the United States, what other country has a government run public notification website for sex offenders?
a. Canada
b. Australia
c. United Kingdom
d. South Africa
e. South Korea
f. None of the above
ANSWER: e

Z11 CAN YOU HEAR ME? DEAF CLIENTS IN FORENSIC SETTINGS

Mark Cotterell, MD, Middletown, CT
Julie Pratt, LCSW, (I) Middletown, CT
Lisa Kuntz, EdD, (I) West Hartford, CT

EDUCATIONAL OBJECTIVE
Participants will learn about the challenges faced by deaf clients in the court. These include problems related to language and culture. We will examine these challenges, and see how they affect engagement, evaluation, and intervention in this poorly served population.

SUMMARY
Deaf and hearing-impaired clients face challenges relating to language and culture. They might utilize non-standard forms of sign language, or even lack any training in sign language. They might have a different approach to describing their experiences and understanding their world. They come from backgrounds that see the deaf community as a separate society, or backgrounds that are antagonistic to their deafness. Often, they lack education, or even experience, with respect to the legal system. The deaf and hearing-impaired are often marginalized, and sometimes even targeted by others. Despite not having any identified mental illness, deaf defendants are remanded to psychiatric hospitals for legal assessment and recommendations to the court. At every stage, from the initial Miranda warnings, through meaningful participation in hearings and trials, and then making the transition from the hospital to the community, these clients need clinicians and systems that are sensitive to their situation and capable of addressing their needs.

REFERENCES
Gay Haskins B: Serving deaf adult psychiatric inpatients. Psychiatric Services 55(4):439-441, 2004
Legal Rights: The Guide for Deaf and Hard of Hearing People. Washington, DC: Gallaudet University Press, 2000

QUESTIONS AND ANSWERS

1. Which of the following are often challenges to engaging and evaluating hearing impaired clients?
a. Language barriers
b. Traumatic upbringing
c. Lack of experience by the client in dealing with courts
d. Lack of experience by the clinician in dealing with hearing impaired clients
e. All of the above.
ANSWER: e

2. Which of the following is not considered a useful intervention when engaging and evaluating hearing impaired clients?
a. Patience
b. Psychotropic medications
c. Use of culturally-sensitive interpreters
d. Liaison with the court and service providers
e. Education with respect to the experiences of deaf clients.
ANSWER: b

Z12 SEXUAL ASSAULT EXPERT TESTIMONY IN THE U.S. MILITARY

David Johnson, MD, Kensington, MD
David Benedek, MD, Bethesda, MD
Jenniger Yeaw, PsyD, (I) Colorado Springs, CO
Vanessa Green, DO, Bethesda, MD

EDUCATIONAL OBJECTIVE

This panel provides teaching on the scope of knowledge expected of expert witnesses at sexual assault trials, as well as the limits on what that testimony can state based on current scientific knowledge. Attendees will learn the essentials for working on these challenging cases.

SUMMARY

Differing interpretations of the traumatic effects of sexual assault supply much of the fuel for the heated adversarial proceedings during a sexual assault trial. Psychiatric expert witness testimony in sexual assault cases requires substantial knowledge of scientific literature and careful consideration of the boundaries of ethical testimony. Rather than focusing on criminal responsibility of the defendant, experts often provide general scientific education relevant to the victim's state of mind and, by extension, their credibility. Frequent testimonial topics include discussion of victim post-assault behavior, victim psychiatric history, and the effects of intoxication on the victim's memory, cognition, and ability to consent. For several years, the U.S. military has pushed for improved investigation and prosecution of these cases through changes in statute and a hierarchy of services designed to improve victim reporting. At this point, the appointment of expert psychiatrists or psychologists to both the prosecution and defense is standard in a military sexual assault trial, known as a court-martial. Participants will learn the basic science and permissible boundaries of expert testimony in this challenging arena.

REFERENCES

Long JG: Introducing Expert Testimony to explain Victim Behavior in Sexual and Domestic Violence Prosecutions. Alexandria, VA: National District Attorneys Association, 2007
Rose ME, Grant JE: Alcohol-Induced Blackout. J Addict Med 4:61-73, 2010

QUESTIONS AND ANSWERS

1. Which of the following pieces of data could prove that a victim experienced an alcohol-induced blackout?
a. Knowing how many drinks per hour they consumed.
b. Knowing the peak blood alcohol concentration for that evening.
c. History of blackouts during similar drinking experiences.
d. None of the above
ANSWER: d

2. In U.S. military surveys, which of the following is the most commonly reported reason for why a sexual assault victim would not report a sexual assault?
a. Did not think anything would be done about it.
b. Thought they would be labelled as a troublemaker.
c. Did not want anyone to know.
d. Fear of retaliation.
e. Heard about bad experiences of other victims who came forward
ANSWER: c

Z13 OTHER SPECIFIED PARAPHILIC DISORDERS AND SVP EVALUATIONS

Richard Wollert, PhD, (I) Vancouver, WA
Allen Frances, MD, Coronado, CA

EDUCATIONAL OBJECTIVE

To specify and analyze DSM-5 changes with significant implications for diagnosing paraphilic disorders in SVP cases, review arguments against diagnosing other specified paraphilic disorders in SVP cases and highlight the critical importance of psychiatry for effecting alignments between legal and psychiatric taxonomies that are consensually accepted and scientifically credible.

SUMMARY

Evaluators have used the taxonomy for the paraphilias and residual paraphilias from the Diagnostic and Statistical Manual of the American Psychiatric Association (APA) for 20 years to make mental abnormality determinations in sexually violent predator (SVP) cases. There are serious problems with including residual paraphilias in SVP evaluations. This presentation considers these issues from taxonometric, historical, and contemporary perspectives. It also describes details in DSM-5 that bear on SVP and sex offender evaluations. We discourage assigning residual diagnoses for various reasons. They are characterized by great reliability deficiencies that produce high levels of diagnostic uncertainty. Most damning is APA's explicit rejection of proposals to include paraphilic coercive disorder (rape), hebephilia, and hypersexuality in DSM-5. These labels were inappropriately included in SVP evaluations as residual paraphilias. Evaluators should warn the courts about the conceptual limits of using the paraphilias taxonomy to locate sex offenders on legal taxonomies.

REFERENCES

First MB, Frances A: Issues for DSM-V: unintended consequences of small changes: The case of paraphilias. American Journal of Psychiatry 165:1240-1241, 2008
Wollert R: Paraphilic Coercive Disorder does not belong in DSM-5 for statistical, historical, conceptual, and practical reasons. Archives of Sexual Behavior 40:1097-1098, 2011

QUESTIONS AND ANSWERS

1. Which DSM-5 criterion for the paraphilic disorders ws not restored "to its DSM-III-R wording" as recommended by First and Frances (2008)?
a. Criterion A
b. Criterion B
c. Criterion C
ANSWER: a

2. Which of the following statements regarding Wollert's findings on reliability coefficients for paraphilic disorders is true?
a. Coefficient for the nonspecific paraphilic disorders was greater than the coefficient for the specific paraphilic disorders.
b. Coefficient for the nonspecific paraphilic disorders was the same as the coefficient for the specific paraphilic disorders.
c. Coefficient for the nonspecific paraphilic disorders was less than the coefficient for specific paraphilic disorders.
ANSWER: c

Z14 FALSE PTSD: A NEW APPROACH TO DETECTION

Mikel Matto, MD, San Francisco, CA
Renée Binder, MD, San Francisco, CA
Dale McNiel, PhD, ABPP, (I) San Francisco, CA

EDUCATIONAL OBJECTIVE
The attendee will learn to identify evidence-based methods for distinguishing genuine PTSD from false variants of the disorder.

SUMMARY
While it is critical that genuine cases of PTSD are identified and managed appropriately, false positive diagnoses have impact on treatment planning, resource management, and research. The subjective nature of stressors, stereotypic presentation of symptoms, wealth of resources detailing how to malinger PTSD, and the high stakes for individuals involved in criminal, civil, and disability evaluations create particular challenges for forensic psychiatrists. This research presents a step-by-step approach to help forensic evaluators, clinicians, and researchers distinguish genuine PTSD from false variants of the disorder. It describes the types of False PTSD to be considered as alternate diagnoses including: Malingered PTSD (for secondary gain such as pension or legal), Factitious PTSD (for primary gain such as the sick or wounded role), Misattributed PTSD (pathology misdiagnosed as PTSD), and Elevated PTSD (unconsciously increased production of symptoms in trauma cases). The evidence behind clinical features and neuropsychological testing that can be leveraged to aid in accurate and unbiased diagnosis will be elucidated.

REFERENCES
Hall RC, Hall RC: Malingering of PTSD: forensic and diagnostic considerations, characteristics of malingerers and clinical presentations. Gen Hosp Psychiatry 28(6):525-35, 2006
Knoll J, Resnick PJ: The detection of malingered post-traumatic stress disorder. Psychiatr Clin North Am 29(3):629-47, 2006

QUESTIONS AND ANSWERS
1. What percentage of individuals with a principal diagnosis of PTSD also have another active psychiatric disorder?
a. 38%
b. 59%
c. 81%
d. 92%
ANSWER: d

2. While there is no universally accepted rate of malingered PTSD amongst combat veterans, what was the rate of findings of "extreme exaggerators" using two MMPI-2 validity indicators with stringent cut-offs in surveys completed at an outpatient PTSD clinic?
a. 2 and 7%
b. 8 and 16%
c. 14 and 22%
d. 38 and 48%
ANSWER: c

Z15 CRYING WOLF: UNDERSTANDING FALSE SEXUAL ASSAULT ALLEGATIONS

Ian Lamoureux, MD, Rochester, MN
Paul Croarkin, DO, MS, (I) Rochester, MN
Amy Stark, MD, (I) Rochester, MN

EDUCATIONAL OBJECTIVE
Familiarize the practitioner with the concept of factitious sexual assault. Compare and contrast factitious, delusional, and malingered accusations of sexual assault. Identify why differentiating between the potential etiologies of false accusations is important.

SUMMARY
The evaluation of an individual who is alleging another individual sexually assaulted them can be a nerve-wracking experience for a clinician, and is even more difficult when corroborating evidence is absent. On one hand, there is a risk of a victim seeking justice being dismissed. On the other, there is a risk of a person innocent of any wrongdoing being incarcerated for a crime that they did not commit. The FBI estimates that up to 8% of accusations of sexual assault are demonstrably false, or the accuser recants. Malingered accusations of sexual assault are fairly

well-known and understood by law enforcement as well as providers. Most psychiatrists will encounter a psychotic patient suffering from delusions of sexual assault at some point during their career. Substantially less common and poorly understood, however, are individuals factitiously alleging they were sexually assaulted. Here, we present cases of patients with malingered, delusional, and factitious sexual assault allegations to illustrate how they may present. We then compare and contrast the differences between the three potential etiologies of false accusations of sexual assault. We will illustrate the importance of differentiating among the three, as well as discuss their potential ramifications for the forensic examiner.

REFERENCES

Feldman MD, Ford CV, Stone T: Deceiving others/deceiving oneself: four cases of factitious rape. South Med J 87(7):736-8, 1994

Rennison CM: Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992–2000. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, NCJ 194530, 2002

QUESTIONS AND ANSWERS

1. What estimated percentage of sexual assaults goes unreported, according to the United States Bureau of Justice Statistics?

a. 10%
b. 33%
c. 66%
d. 74%
e. 95%

ANSWER: d

2. What is a potential primary gain for factitious accusations of sexual assault?

a. Fame
b. Nurturance
c. Financial
d. Revenge

ANSWER: b

Z16 YOUTH FITNESS COMPETENCY TO STAND TRIAL IN NEW ZEALAND (NZ)

Davin Tan, FRANZCP, (I) Auckland, New Zealand
Caleb Armstrong, FRANZCP, (I) Auckland, New Zealand
Susan Hatters Friedman, MD, Cleveland Heights, OH
Chelsea Neumann, MD, Pawtucket, RI

EDUCATIONAL OBJECTIVE

To describe the legal context and procedures for competency to stand trial in New Zealand as it relates to youth, and the characteristics of incompetent youth, inform service delivery policy and improve procedures for incompetent youth and describe dispositional options for incompetent youth in New Zealand.

SUMMARY

In New Zealand research into the area of juvenile fitness to stand trial is limited. It is not clear if the issues and concerns shared by our international counterparts regarding immaturity and sentencing have reached NZ. The study captures a cross-sectional view of how competency is addressed by report writers and Youth Courts in NZ. The evaluator-court agreement rate was 75%. Yet, only 9% of the sample were found unfit by the Youth Court compared with 29% opined unfit by evaluators. Mental retardation was associated with unfit opinions and legal findings of unfitness to stand trial ($p=0.002$ and $p=0.03$ respectively), and disposition was by way of Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Our findings showed that age and immaturity did not have a significant effect on evaluator opinions or court findings of unfitness to stand trial. This may be explained by an age skew towards older adolescents in the Youth Court with the majority of youth being diverted from the criminal system. Evaluators may have had a higher competency threshold than the Court. Overall the majority of youth were both opined fit and found fit to stand trial.

REFERENCES

Klinger S: Youth competence on trial. New Zealand Law Review 235 -270, 2007

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QUESTIONS AND ANSWERS

1. What is the legal standard for fitness to stand trial in New Zealand and how is mental impairment defined in legislation?

ANSWER: Mental impairment is not defined in legislation in New Zealand.
In order to be found unfit to stand trial the defendant must have a mental impairment usually by way of mental illness or cognitive deficiencies amounting to intellectual disability but also is not able to plead, nor understand court proceedings nor communicate with counsel in order to mount a defense.

2. On what basis are adolescents found unfit to stand trial in the New Zealand context?

ANSWER: Mental retardation is most strongly correlated with adolescents being found unfit to stand trial in the New Zealand youth court. International literature suggests that psychiatrists need to contemplate a young person's fitness because a proportion of younger adolescents will be incompetent to stand trial. In New Zealand however, immaturity was not found to be strongly related to a finding of unfitness to stand trial. The reason for this is that proportionally older adolescents rather than younger are brought before the youth court because most young people are diverted away from the criminal justice system.

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