

AMERICAN ACADEMY
OF
PSYCHIATRY AND THE LAW

54TH ANNUAL MEETING

October 19-22, 2023
Chicago, Illinois



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.

**Fifty-Fourth Annual Meeting
American Academy of Psychiatry and the Law
October 19-22, 2023
Chicago, Illinois**

OFFICERS OF THE ACADEMY

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PAST PRESIDENTS

Susan Hatters-Friedman, MD	2021-22	Robert T.M. Phillips, MD, PhD	2004-05	William H. Reid, MD, MPH	1988-89
Lisa Gold, MD	2020-21	Robert Wettstein, MD	2003-04	Richard Rosner, MD	1987-88
William Newman, MD	2019-20	Roy J. O'Shaughnessy, MD	2002-03	J. Richard Ciccone, MD	1986-87
Richard Frierson, MD	2018-19	Larry H. Strasburger, MD	2001-02	Selwyn M. Smith, MD	1985-86
Christopher R. Thompson, MD	2017-18	Jefrey L. Metzner, MD	2000-01	Phillip J. Resnick, MD	1984-85
Emily A. Keram, MD	2015-16	Thomas G. Gutheil, MD	1999-00	Loren H. Roth, MD	1983-84
Graham Glancy, MB	2014-15	Larry R. Faulkner, M.D	1998-99	Abraham L. Halpern, MD	1982-83
Robert Weinstock, MD	2013-14	Renée L. Binder, MD	1997-98	Stanley L. Portnow, MD	1981-82
Debra Pinals, MD	2012-13	Ezra E. H. Griffith, MD	1996-97	Herbert E. Thomas, MD	1980-81
Charles Scott, MD	2011-12	Paul S. Appelbaum, MD	1995-96	Nathan T. Sidley, MD	1979-80
Peter Ash, MD	2010-11	Park E. Dietz, MD, PhD, MPH	1994-95	Irwin N. Perr, MD	1977-79
Stephen B. Billick, MD	2009-10	John M. Bradford, MB	1993-94	G. Sarwer-Foner, MD	1975-77
Patricia R. Recupero, MD, JD	2008-09	Howard V. Zonana, MD	1992-93	Seymour Pollack, MD	1973-75
Jeffrey S. Janofsky, MD	2007-08	Kathleen M. Quinn, MD	1991-92	Robert L. Sadoff, MD	1971-73
Alan R. Felthous, MD	2006-07	Richard T. Rada, MD	1990-91	Jonas R. Rappeport, MD	1969-71
Robert I. Simon, MD	2005-06	Joseph D. Bloom, MD	1989-90		

2023 ANNUAL MEETING CO-CHAIRS

Melissa Spanggaard, DO and Jungjin Kim, 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
Executive Director

CALL FOR PAPERS 2024

The 55th Annual Meeting of the
American Academy of Psychiatry and the Law will be held at the
Sheraton Vancouver Wall Centre, Vancouver, British Columbia, Canada
October 24–27, 2024

Theme of the meeting is
FORENSIC TREATMENT, ETHICS,
AND ADMINISTRATION

Inquiries may be directed to the Annual Meeting Program Chair: Cheryl D. Wills, 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, 2024



FUTURE ANNUAL MEETING DATES and LOCATIONS

56th Annual Meeting

October 30 – November 2, 2025 – Boston, Massachusetts

57th Annual Meeting

October 26 – November 1, 2026 – Tampa, Florida

GENERAL INFORMATION

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REGISTRATION DESK

Registration (5th Floor)

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.

ALL STAR MEDIA

Registration (5th Floor)

PRESENTATION CODES

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



Please note: to use the reserved lactation room, obtain key from staff at the registration desk.



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.

PRICE

AAPL Logo Hat	\$30.00
AAPL Logo Tie	\$45.00
AAPL Logo Scarf	\$45.00
AAPL Logo Dog Bandana	\$15.00

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.

Annette L. Hanson, MD and Kaustubh G. Joshi, 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



AAPL CODE OF CONDUCT AT EVENTS

AAPL has a goal to provide a welcoming environment for all participants at its activities. Participants are expected and required to engage in appropriate conduct and maintain a professional demeanor at all times. Any participants who failed to meet these expectations may be removed from any AAPL event or activities and other appropriate disciplinary measures may be taken.



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, as stated in the ACCME Standards for Integrity and Independence in Accredited Continuing Education. Refusal to disclose a conflict or the inability to resolve an identified conflict precludes participation in the CME activity.

The ACCME definition of an ineligible company is "... companies that are ineligible to be accredited in the ACCME System (ineligible companies) are those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients."

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 not a conflict of interest, presenters are discouraged from actively promoting it.

FINANCIAL DISCLOSURES

All Program and Education Committee Members, in control of content for the 54th Annual Meeting, returned signed statements indicating that they have no financial relationship(s) with ineligible companies.

Program and Education Committee Members

Anacker, L.; Annas, G.; Aoun, E.; Ash, P.; Belcher, L.; Chaimowitz, G.; Champion, M.; Darani, S.; Darby, W.; Dike, C.; Ellis, R.; Falls, B.; Ferguson, E.; Fisher, K.; Freitas, C. Frierson, R.; Ghossoub, E.; Guina, J.; Gulrajani, C.; Hall, R.; Hanson, A.; Hatters Friedman, S.; Henry, S.; Holmberg, T.; Holzer, J.; Johnson, N.; Joshi, K.; Kaempf, A.; C. Kapoor, R.; Kaye, N.; Kim, J.; Klein, C.; Lewis, C.; Marks, J.; Michaelsen, K.; Naqvi, H.; Nesbit, A.; Newman, W.; Ostermeyer, B.; Parker, G.; Penn, J.; Prabhu, M.; Price, M.; Resnick, P.; Rosenbaum, K.; Rosmarin, D.; Salem, A.; Schiffman, E.; Scott, C.; Shima, C.; Silberberg, J.; Sorrentino, R.; Spanggaard, M.; Srinivasaraghavan, J.; Stolar, A.; Subedi, B.; Tamburello, A.; Thompson, C.; Toborowsky, R. Wagoner, R.; Weinstock, R.

SPEAKERS/PRESENTERS

All 54th Annual Meeting speakers/presenters returned signed statements indicating that they have no financial relationship(s) with ineligible companies:

Adham, Z.; Adhia, S.; Agarwal, C.; Aggarwal, R.; Ahmed, W.; Ajibade, P.; Allen, T.; Almaskari, B.; Aloysius, R Amador, X; Angelotta, C. ; Annas, G.; Aparicio, J. Appel, J.; Arabski, J.; Ash, P.; Attilus, J.; Baez, A.; Baker, S.; Baranoski, M.; Barcak, D.; Barrett, J.; Baselice, K.; Belcher, L.; Berger, S.; Binder, R.; Booth, B.; Bowen, L.; Bowling, D.; Brown, B.; Buie, S.; Buongiorno, L.; Buwa, O.; Candilis, P.; Capannolo, L.; Carabellese, F.; Caruso, K.; Castle, C.; Catanesi, R.; Cerny-Suelzer, C.; Cervantes, A.; Chaimowitz, G.; Champion, M.; Chen, C.; Chen, K.; Cherro, M.; Chien, J.l Cho, G.; Choi, O.; Chowhan, S.; Clawson, K.; Clayton, B.; Coffman, L.; Condiote, A.; Considine, C.; Cripps, S.; Csjerer, K.; Czerniski, B.; Dailey, A.; Dandan, N.; Daou, M.; Darani, S.; Darby, R.; Darby, W.; Darnell, J.; Datta, V.; Davis, M.; DeTrana, C.; DeVinney, A.; Dhaliwal, A.; DiCiro, M.; Dietz, P.; Dike, C.; D'Imperio, A.; Dinwiddie, S.; Dragich, S.; Dupre, J.; Edwards, M.; Elliott, R.; Engelson, B.; Eunsol, P.; Feize, S.; Felthous, A.; Finkel, S.; Ford, E.; Fozdar, M.; Frank, B.; Frierson, R.; Gabriele, M.; Garcia-Rider, E.; Garvey, K.; Gerpe, M.; Gershan, S.; Ghossoub, E.; Gill, G.; Gilmer, B.; Glancy, G.; Glomski, A.; Godshall-Bennett, L.; Graham, G.; Grover, M.; Gulrajani, C.; Gunturu, S.; Gupta, D.; Hackman, D.; Hawco, C.; Hayre, A.; Henning, J.; Herger, M.; Heyman-Kantor, R.; Hiller, C.; Hinds, E.; Hiromoto, L.; Hmada, S.; Hobart, K.; Hogue, K.; Holmberg, T.; Holt, G.; Holzer, J.; Hughes, B.; Husain, M.; Im, D.; Jackson, D.; Jain, A.; Jain, A.; Janofosky, J.; Jas, A.; Johnson, A.; Johnson, B.; Joshi, A.; Kassir, G.; Katsev, A.; Katzman, M.; Keisari, E.; Kelly, M.; Kennedy, V.; Khan, J.; Kim, J.; Kim, L.; Klein, C.; Kletza, N.; Knoll, J.; Kochhar, H.; Kolla, N.; Kung, C.; Kushner, D.; La Tegola, D.; LaCroix, C.; Lacy, B.; Lahaie, M.; Lambert, G.; Lamoureux, I.; Landess, J.; Lapchenko, M.; Lee, E.; Lee, L.; Lehman, C.; Lentini, N.; Levin, A.; Li, L.; Lorberg, G.; Lundy, N.; MacIntyre, M.; Maddox, M.; Maestas, A.; Mandarelli, G.; Margari, A.; Martinez, R.; Masumova, F.; Maxwell, C.; McCrary, G.; McDermott, B.; McLaughlin, K.; McNiel, D.; Mele, F.; Michaelsen, K.; Miller, M.; Mohammad, I.; Moore, K.; Morris, D.; Morris, N.; Motros, M.; Mroue, R.; Mulkerin, C.; Musselman, M.; Myers, C.; Nadaban, G.; Nagle-Young, S.; Nair, M.; Nandakumar, S.; Nash, E.; Nayyar, P.; Nesbit, A.; Nestadt, P.; Newman, A.; Nguyen, V.; Noffsinger, S.; Norko, M.; Noroian, P.; Nouri, P.; Nutting, S.; Olagunju, A.; Olivero, A.; Osuruaka, G.; Packham, J.; Panzer, D.; Parente, L.; Parikh, T.; Park, K.; Park, M.; Patel, K.; Payne, A.; Penn, J.; Penney, S.; Phelan, E.; Piasecki, M.; Piel, J.; Pinals, D.; Piotrowski, H.; Poa, E.; Pope, L.; Prabhu, M.; Rachal, J.; Rahman, T.; Ramshaw, L.; Ratcliff, V.; Recupero, P.; Reid, W.; Reinstatler, K.; Resnick, P.; Ricciardi, M.; Riedford, D.; Riess, P.; Robinson, L.; Rodgers, C.; Rose, G.; Rosenbaum, K.; Rosenblatt, S.; Rosenkrantz, B.; Rotter, M.; Rowland, M.; Rozel, J.; Sagot, A.; Samenow, C.; Sanchez, A.; Sandman, D.; Satodiya, R.; Schaefer, A.; Schouten, R.; Schwenke, T.; Scott, C.; Scott, M.; Segal, Y.; Shah, A.; Sheahan, K.; Sheehy, J.; Simpson, S.; Sloan, L.; Socha, P.; Soder, S.; Soliman, S.; Spice, J.; Spring, S.; Sreenivasan, S.; Stahl, R.; Stankowski, J.; Sternat, T.; Stevens, K.; Stillman, I.; Suardi, N.; Subedi, B.; Takher, A.; Tegola, D.; Thomas, K.; Thompson, C.; Thompson, K.; Tran, A.; Ugorji, U.; VanDercar, A.; Varadarajulu, R.; Vaughan, B.; Virani, S.; Wagoner, R.; Walker, E.; Wasser, T.; Weinstock, R.; Weiss, K.; Wentz, I.; West, S.; Westphal, A.; Wheeler, R.; Wilbanks, L.; Wilkie, T.; Williams, J.; Witherell, J.; Wolfe, N.; Wolff, E.; Wood, S.; Woodward, S.; Woolfson, B.; Yadav, G.; Zinko, J.; Zon, K.; Zuchowski, S.

Disclosures mitigated by attestation that any clinical recommendations are evidence-based and free of commercial bias:

Saturday, October 21, 2022
A Forensic Psychiatrist's Journey
Park Dietz, MD

Dr. Dietz states that the following health care-related companies have been clients of Threat Assessment Group, Inc., during the past two years, and Dr. Dietz is the founder, president, and owner of Threat Assessment Group. All consulting has been on the topics of threats, violence, and misconduct; none of the consulting has had anything to do with the clients' products. Dr. Dietz will make no mention of these companies or their products in his AAPL presentation: 3M, Abbott Laboratories, AbbVie Pharmaceuticals, Allergan, American Association of Critical-Care Nurses, Amgen, Aventis Pharmaceuticals, Bayer, Health Partners, Hikma Pharmaceuticals, Moderna, Novartis, Palisade Bio, Quest Diagnostics, Sanofi Pharmaceuticals, Surescripts, Takeda Pharmaceutical Company, Teva Pharmaceuticals, TrueCare, and Walgreens

The following health care-related companies have been clients of Park Dietz & Associates, Inc., during the past two years, and Dr. Dietz is the founder, president, and owner of Park Dietz & Associates. All consulting has been for purposes of litigation of a particular case. Dr. Dietz will make no mention of these companies or their products or services in his AAPL presentation: Adeona Healthcare, Advanced Pain Medical Group, Adventist Health, Adventist Health System, Atrium Health, Express Scripts, Frederick Coville, MD, Charlotte-Mecklenburg Hospital Authority, Covenant Health, Creative Ways Therapy, CVS Health Corporation, Excel Supported Living, Duke LifePoint, Gaertner Psychiatric, Huron Regional Medical Center, Laurel Pediatrics, Memorial Health Systems, Mentor Network, Mosaic (<https://www.mosaicinfo.org/>), National Mentor Health, Psychological Assessment & Intervention Services, St. Mary's Health System, St. Mary's Regional Medical Center, Transcend Living, and Winter Park Memorial Hospital

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.

Anacker, L.; Aoun, E.; Ash, P.; Billick, S.; Chaimowitz, G.; Champion, M.; Coleman, J.; Dike, C.; Ellis, R.; Falls, B.; Fedoroff, J.; Ferguson, E.; Ferranti, J.; Frierson, R.; Gold, L.; Guina, J.; Gulrajani, C.; Hanson, A.; Hatters Friedman, S.; Henry, S.; Holzer, J.; Johnson, N.; Kaempf, A.; Kapoor, R.; Kaye, N.; Klein, C.; Michaelsen, K.; Newman, W.; Noffsinger, S.; Ostermeyer, B.; Parker, G.; Prabhu, M.; Preven, D.; Price, M.; Reichlin, S.; Rosmarin, D.; Schiffman, E.; Scott, C.; Silberberg, J.; Stolar, A.; Subedi, B.; Tamburello, A.; Thompson, C.; Wills, C.



SPECIAL EVENTS

Tuesday, October 17, 2023

Self-Assessment Exam Committee	9:00 am – 3:00 pm	Miami/Scottsdale (5th Floor)
Self-Assessment Exam Committee Dinner	6:00 pm – 8:00 pm	Location to be Determined

Wednesday, October 18, 2023

AIER Board of Directors Meeting	7:00 am – 8:30 am	Avenue Ballroom (4th Floor)
AAPL Council Meeting	8:45 am – 1:00 pm	Avenue Ballroom (4th Floor)
Council with Committee Chairs	6:00 pm – 7:00 pm	Los Angeles (5th Floor)
Committee Reception and Dinner <i>(Ticket required)</i>	7:00 pm – 10:00 pm	Chicago Ballroom E (5th Floor)

Thursday, October 19, 2023

Past Presidents' Breakfast	7:00 am – 8:00 am	Sheffield (4th Floor)
ADPPF Reception <i>(For fellowship program faculty, fellows and potential applicants)</i>	6:00 pm – 7:00 pm	Chicago Ballroom A-B-C (5th Floor)
Thursday Evening Presentation	7:00 pm – 9:00 pm	Chicago Ballroom E (5th Floor)
Women of AAPL Reception	9:00 pm – 10:00 pm	Chicago Ballroom A-B-C (5th Floor)

Friday, October 20, 2023

Research Breakfast	7:00 am – 8:00 am	Los Angeles (5th Floor)
Rappeport Fellows Breakfast	7:00 am – 8:00 am	Miami/Scottsdale (5th Floor)
AAPL Business Meeting <i>(AAPL members only)</i>	8:00 am – 9:30 am	Chicago Ballroom D (5th Floor)
Reception for Meeting Attendees	6:00 pm – 7:30 pm	Chicago Ballroom E (5th Floor)

Saturday, October 21, 2023

ECP and Fellows Breakfast <i>(For those in the first seven years after training and current fellows - Ticket required)</i>	7:00 am – 8:00 am	Denver/Houston/Kansas City (5th Floor)
Midwest AAPL Chapter Meeting	6:00 pm – 7:00 pm	Los Angeles/Miami (5th Floor)

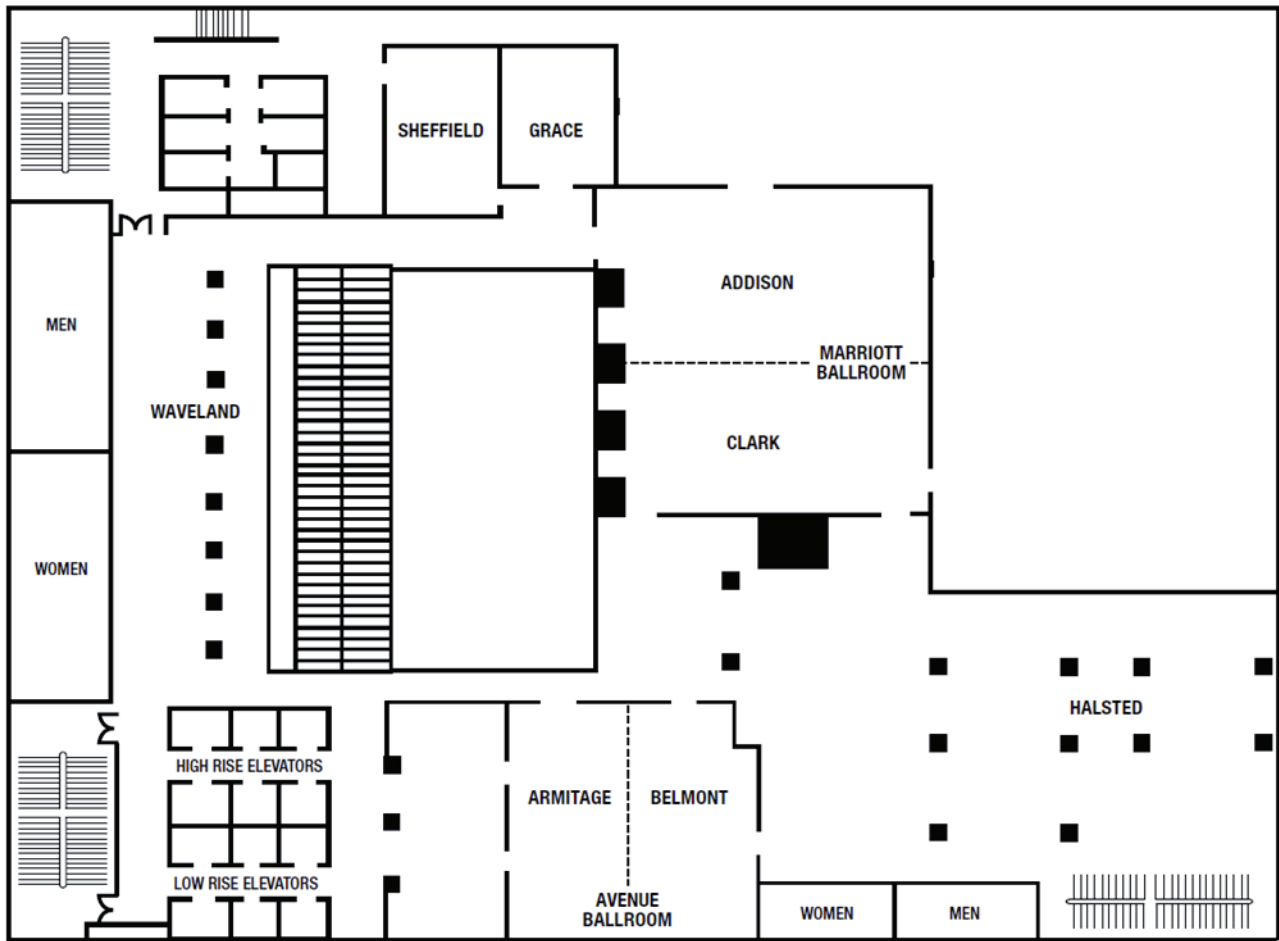
COFFEE BREAKS ARE IN CHICAGO FOYER (5TH FLOOR)

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



MARRIOTT
CHICAGO DOWNTOWN
MAGNIFICENT MILE

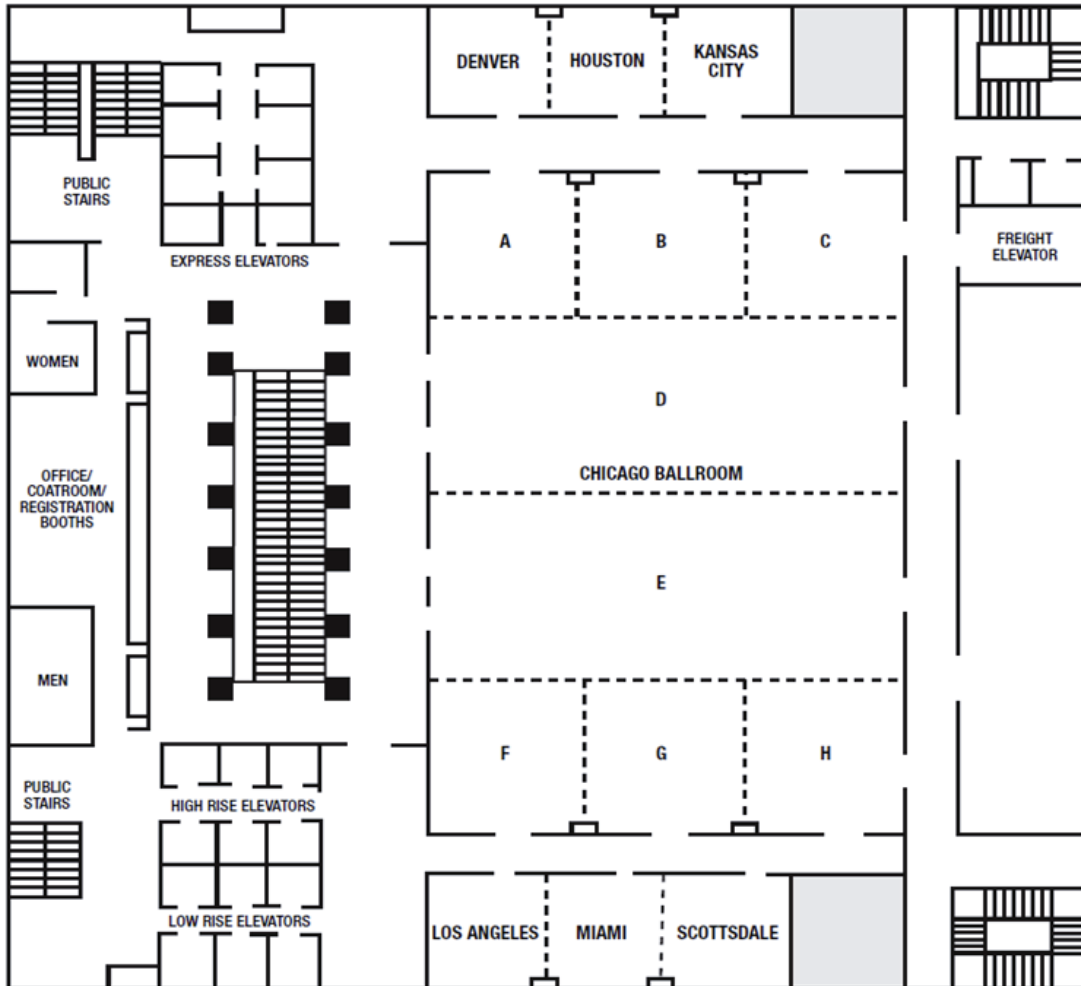
4th Floor Diagram





MARRIOTT
CHICAGO DOWNTOWN
MAGNIFICENT MILE

5th Floor Diagram



PLEASE

**BE COURTEOUS TO
YOUR FELLOW ATTENDEES.**

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

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

(SESSION MODERATORS HAVE BEEN ASKED TO ENFORCE THESE POLICIES)

**American Academy of Psychiatry and the Law
Fifty-Third Annual Meeting**

OPENING CEREMONY

Thursday, October 19, 2023

8:00 am – 10:00 am

WELCOME AND INTRODUCTIONS

James L. Knoll IV, MD
President

PRESENTATION OF RAPPEPORT FELLOWS

Britta Ostermeyer, MD and Renée M. Sorrentino, MD
Co-Chairs, Rappeport Fellowship Committee

Kimberlyn Maravet Baig-Ward, MD, PhD
*University of Texas Southwestern
Dallas, Texas*

Lee Hiromoto, MD
*Oregon Health & Science University
Portland, Oregon*

Brianna Engelson, MD
*University of Minnesota
Minneapolis, Minnesota*

Richard Seeber, MD
*Massachusetts General Hospital and
McLean Hospital, Harvard Medical School
Boston, Massachusetts*

Gurtej Singh Gill, MD
*BronxCare Health System, an affiliate of
Icahn School of Medicine
Bronx, New York*

Kyle Webster, DO, PhD
*Indiana University
Indianapolis, Indiana*

Chandler Hicks, MD
*University Hospitals/Case Western Reserve University
Cleveland, Ohio*

AWARD PRESENTATIONS

Charles Scott, MD
Chair, Awards Committee

Red Apple Award
Britta Ostermeyer, MD, MBA

Golden Apple Award
Gary A. Chaimowitz, MB, ChB

**Howard V. Zonana, MD
Best Teacher in a Fellowship Program**
Kimberly S. Resnick, MD

Seymour Pollack Award
Susan J. Hatters-Friedman, MD

Young Investigator Award
Raina Aggarwal, MD

2022 Poster Award
William Tindell, MD

Nathan Kolla, MD
Chair, Research Committee

Nathan Kolla, MD
Chair, Research Committee

**2023 CHARLES C. DIKE DIVERSITY
SCHOLARSHIP AWARDEES**

Sanya Virani, MD, MPH and Myrline Rose Belzince, MD

Charles C. Dike, MD
Chair, Diversity Committee

**AAPL INSTITUTE FOR EDUCATION AND RESEARCH
OVERVIEW OF THE PROGRAM**

Renée L. Binder, MD
Jungjin Kim, MD and Melissa Spanggaard, DO
Co-Chairs, Program Committee

INTRODUCTION OF THE PRESIDENT

Dileep Borra, MD, Vanesa Disla de Jesus, MD,
and Annette Liem, MD

PRESIDENT'S ADDRESS

James L. Knoll IV, MD

ADJOURNMENT

Jungjin Kim, MD and Melissa Spanggaard, DO
Co-Chairs, Program Committee

AWARD RECIPIENTS



RED APPLE OUTSTANDING SERVICE AWARD

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

BRITTA K. OSTERMEYER, MD, MBA, DFAPA

Dr. Ostermeyer is the Paul and Ruth Jonas Chair in Mental Health and Professor (tenured) and Chairman of the Department of Psychiatry and Behavioral Sciences, College of Medicine, at the University of Oklahoma in Oklahoma City. She is also the Chief of Psychiatry for OU Health, which is the university's clinical enterprise.

She graduated from Hanover Medical School, in Hanover, Germany and completed her last two years of medical school at Baylor College of Medicine in Houston, Texas. Dr. Ostermeyer trained in neurology at Baylor College of Medicine followed by a residency in psychiatry at The New York State Psychiatric Institute and Columbia University College of Physicians & Surgeons in New York City. She completed a fellowship in forensic psychiatry at Case Western Reserve University in Cleveland, Ohio and received her MBA degree from the University of Tennessee in Knoxville.

Dr. Ostermeyer has a long-standing interest in administrative and forensic psychiatry and has published approximately 240 scholarly papers and other writings and garnered a total of 30 million dollars in research and service grant funding, including two RO1 grants. She has presented her clinical scholarly work and research as well as forensic scholarly work at many local, regional, national, and international medical meetings and formal congresses. For the past 30 years, she has also served frequently as an expert interviewer to the media, previously in neurology and then in psychiatry, educating the public on neurological and psychiatric diseases.

She is a board-certified psychiatrist and maintains an outpatient clinical practice, focused on treating professionals and athletes. She serves as the NBA's official team psychiatrist for the Oklahoma City Thunder. As a board-certified forensic psychiatrist, she maintains an active and full forensic practice as well, steadily receiving referrals more so pertaining to administrative and civil proceedings.

Dr. Ostermeyer also received a number of teaching and service awards, including the 2001 Rappeport Fellowship Award by the American Academy of Psychiatry and the Law; the 2001 Fitzhugh Mullan Distinguished Resident Leadership Award by the United States Public Health Service and the National Consortium of Residents; the 2007 Gold Award for Service Achievement and the 2019 George Tarjan Award from the American Psychiatric Association; a 2008 and a 2011 Fulbright & Jaworski Faculty Excellence Award at Baylor College of Medicine; the 2009 Excellence in Community Service Award from the Texas Hospital Association for integrated mental health services; the 2019 Gordon Deckert Award for Sustained Excellence in Teaching in the Department of Psychiatry and Behavioral Sciences at OU, the 2021 Charles L. Scott Forensic Lecture Award by the Department of Psychiatry at Saint Louis University School of Medicine, as well as teaching awards by OU residents and the OU College of Medicine. In 2023, she was selected to the Gold Humanism Honor Society (GHHS), being recognized for exemplary demonstration of respect for human beings through the practice and teaching of medicine, and was selected by her local Oklahoman peers as Top Doctor in 405 Magazine.

As a firm believer in organized medicine, Dr. Ostermeyer is a Distinguished Fellow of the American Psychiatric Association (APA) and the incoming Treasurer of American Academy of Psychiatry and the Law (AAPL). She is also the Immediate Past President of the Oklahoma Psychiatric Physicians Association (OPPA); a Past-President of both the American Association of Chairs of Departments of Psychiatry (AACDP) and the Central Oklahoma Psychiatric Association (COPS); and Member at Large of the Forensic Section of the World Psychiatric Association (WPA). Presently, she co-chairs the Rappeport Committee and the Membership Committee within the American Academy of Psychiatry and the Law (AAPL) and chairs the Committee on Administration and Leadership within the Group for Advancement in Psychiatry (GAP).

Dr. Ostermeyer enjoys running, watching movies, eating good food, and spending time with her husband and family and is also an avid club member of FC Bayern Munch, a world-renowned soccer and basketball club.

GOLDEN APPLE 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.

GARY A. CHAIMOWITZ, MB, CHB

Professor of Psychiatry and Forensic Psychiatry Academic Division Lead, McMaster University, Canada and Head of Service of Forensic Psychiatry, St. Joseph's Healthcare, Hamilton, Canada. Dr. Chaimowitz has Royal College of Physicians and Surgeons of Canada Forensic Psychiatry Founder status, an MBA from the University of Toronto and is a Certified Physician Executive. He is a Distinguished Fellow of both the Canadian and American Psychiatric Associations.

He is President of the Canadian Psychiatric Association. He is the Canadian zone representative to the World Psychiatric Association. He is Editor-in-Chief of the International Journal of Risk and Recovery. Dr. Chaimowitz has been awarded the Ontario Medical Association Life Membership Award (2022), International Association of Forensic Mental Health Services Rüdiger Müller-Isberner Award (2021), Canadian Psychiatric Association C. A. Roberts Award for Clinical Leadership (2016), Association of General Hospital Psychiatric Services Jane Chamberlain Award (2016), Ontario Medical Association Section Service Award (2016), Canadian Academy of Psychiatry and the Law Bruno Cormier Award (2015), and St. Joseph's Healthcare, Hamilton Mission Legacy Award (2015).

He is a member of the Ontario and Nunavut Review Boards, and the Forensic Psychiatry Specialty Examination Committee (Royal College of Physician and Surgeons, Canada). He is co-chair of the Lancet Psychiatry Commission on Mental Health (Advocacy and Legal) working group. He has published over 90 articles and book chapters.

He has been actively involved with American Academy of Psychiatry and the Law, having written three editorials for the Journal, been on Council and is an active member of several committees including Rapoport Fellowship, Program, Recovery amongst others.

He was Chair of the Royal College of Physicians and Surgeons Committee that launched Forensic Psychiatry as a subspecialty status in Canada. Other past positions include President of St. Joseph's Healthcare Medical Staff Association, Chair Ontario Medical Association Psychiatry Section, President Ontario Psychiatric Association, Chair Canadian Psychiatric Association Professional Standards and Practice Committee, Vice-Chair Consent and Capacity Board, Chair Royal College of Physicians and Surgeons Forensic Psychiatry Specialty Committee, Council of the American Academy of Psychiatry and the Law, Co-Chair Forensic Directors Group of Ontario, and Board of the International Association of Forensic Mental Health.

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.

KIMBERLY S. RESNICK, MD

Dr. Resnick attended Yale University, where she graduated magna cum laude with distinction in psychology. She received her M.D. degree at the University of Pennsylvania Perelman School of Medicine where she was elected to the Alpha Omega Alpha medical honor society. She completed her residency in Adult Psychiatry at the University of Pennsylvania Health System, while simultaneously pursuing a fellowship in psychoanalytic training at the Psychoanalytic Center of Philadelphia.

Dr. Resnick completed her fellowship in Forensic Psychiatry at the Columbia University College of Physicians/Weill Cornell School of Medicine joint training director. She now serves as the Associate Director for the Cornell/Columbia Fellowship. In this role, she has worked with the Program Director to continuously revise the curriculum in response to feedback of both past and present fellows. For example, after learning about the strengths and weaknesses of one particular rotation, she help to develop a supplemental module of skill-based learning to enhance the rotation's educational value.

Dr. Resnick also serves as Site-Director for the forensic psychiatry fellowship rotation at Mid-Hudson Forensic Psychiatric Center (MHFPC), the largest forensic hospital in New York State. , In this role, she developed a risk-assessment curriculum for the fellows that involved a syllabus of selected articles, Structured Professional Judgment tools, and relevant caselaw. She instituted a framework of meeting with fellows weekly to review readings, supervise evaluations, teach report-writing and provide feedback in all aspects of forensic evaluation.

Dr. Resnick's teaching philosophy focuses on promoting critical thinking, curiosity and confidence while providing supportive, evidence-based instruction and career mentorship. She believes in creating an environment that values asking questions, emphasizes that learning how to engage in discussion is as important as knowing "the answer," and teaches trainees to embrace the discomfort when no satisfying answer exists.

Dr. Resnick has been previously recognized for her teaching and received the Voluntary Faculty Teaching Award (2021). She was inducted into the Clinical Scholars Institute at NYP Weill Cornell (2019), served as Associate Clerkship Director for psychiatry at Cornell, and was named Associate Program Director of the Forensic Psychiatry fellowship at Columbia/Cornell approximately three years after completing the program.

SEYMOUR POLLACK AWARD

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

SUSAN J. HATTERS-FRIEDMAN, MD

Susan Hatters-Friedman, MD is both a forensic psychiatrist and a reproductive psychiatrist. Dr. Friedman currently serves as the inaugural Phillip J. Resnick Professor of Forensic Psychiatry at Case Western Reserve University, where she also has appointments in the departments of Pediatrics, and Reproductive Biology (Obstetrics/ Gynecology), and at the School of Law. She serves as the Deputy Editor for the Journal of the American Academy of Psychiatry and the Law. Her academic work tends to focus the intersection of forensic psychiatry and reproductive psychiatry. Susan is the immediate past president of the American Academy of Psychiatry and the Law, and has served as Chair of the Law and Psychiatry committee at the Group for Advancement of Psychiatry (GAP). She has received the AAPL award for the Best Teacher in a Forensic Psychiatry Fellowship, the Red AAPL award for outstanding service to organized forensic psychiatry, the Manfred Guttmacher Award for editing the book Family Murder: Pathologies of Love and Hate with GAP, and the Association of Women Psychiatrists' Marian Butterfield early career psychiatrist award for her contributions to women's mental health. Dr. Friedman previously worked as for seven years in New Zealand, where she also continues to serve as honorary faculty at the University of Auckland.

DISTINGUISHED LECTURERS



Thursday, October 19, 2023

RAYMOND PATTERSON, MD

Forensic Practice Before and After the Trial

Dr. Raymond Patterson is a celebrated forensic psychiatrist with some 40 years of experience in the field. He has been able to achieve an impressive balance between consultative forensic expert work and being a leader in forensic and correctional healthcare. He has served in many leadership positions in large correctional and forensic hospital systems, including the Angola State Penitentiary in Louisiana, and the Patuxent Institution in Maryland. One of his enduring career mission has been to advocate for equitable access to medical and psychiatric treatment for inmates. He campaigned tirelessly to improve the quality and delivery of healthcare in the correctional setting. He also sought to combat the negative effect prolonged incarceration has on individuals. In addition to his leadership roles, he has served as a consultant to the U. S. Secret Service, the U. S. Marshal Service, the District of Columbia Police, Baltimore City Police, and the US Capitol Police. His accomplishments earned him the 2019 AAPL Seymour Pollack Award, and the 2021 Yochelson Visiting Professorship of Psychiatry and the Law at the Yale School of Medicine. With his warm demeanor and deep commitment to humanity, Dr. Raymond F. Patterson has inspired countless individuals within and outside of the forensic psychiatric community.

Friday, October 20, 2023

STEVEN R. CONLON

How We Arrived Here: Cases that Influenced How We Respond to Violent Crime

Steven Conlon is a seasoned veteran of criminal behavior analysis. He has devoted over 45 years to law enforcement and is currently an Instructor at the FBI Behavior Analysis Unit at Quantico, Virginia. This is an elite group within the FBI that studies and consults with other agencies on violent, sometimes perplexing and disturbing crimes. Mr. Conlon has devoted his career to understanding the motive, pattern, and meaning behind offender behaviors with the goal of mitigating and preventing future crimes.

Saturday, October 21, 2023

PARK DIETZ, MD

A Forensic Psychiatrist's Journey

Dr. Park Dietz is one of the nation's most prominent and influential forensic psychiatrists. Over his distinguished career, he has consulted and testified in some of the highest profile US criminal cases. He dedicated his career to understanding and analyzing the complex relationship between mental health and criminal behavior. He is a Past President of the American Academy of Psychiatry and the Law, a Distinguished Life Fellow of the American Psychiatric Association, and a Fellow of the American Academy of Forensic Sciences. He has served as a consultant to both the FBI's Behavioral Analysis Unit and the New York State Police Forensic Sciences Unit. Dr. Dietz has authored hundreds of articles on topics relevant to forensic psychiatry. He is the founder of the Threat Assessment Group, Inc. (TAG), which specializes in analyzing and managing threatening behavior and communications. He is widely credited for pioneering the role of forensic psychiatrist as a "forensic scientist," a non-partisan truth-seeker.

THURSDAY, OCTOBER 19, 2023

POSTER SESSION A

7:00 AM – 8:00 AM / 9:30 AM – 10:15 AM

CHICAGO BALLROOM F-G-H (5TH FLOOR)

THURSDAY

- T1 Cultural Bias in Sexual Assault: A Potential Item for Assessing Risk?**
Ambra D'Imperio, MD, Geneva, Switzerland (I)
Neva Eloisa Suardi, MD, Chene-Bourg, Switzerland (I)
- T2 Correctional Telepsychiatry Exposure for 3rd Year Medical Students**
Ibrahim Y. Z. Mohammad, MD, Toronto, Ontario, Canada (I)
Stephen F. Wood, MD, Ottawa, Ontario, Canada
- T3 Smits v. Park Nicollet and the Current Duty to Warn Landscape**
Katie K. McLaughlin, JD, MS, Hibbing, MN (I)
Chinmoy Gulrajani, MD, Minneapolis, MN
- T4 Using Litigation to Solve the Emergency Department Boarding Crisis**
Katie K. McLaughlin, JD, MS, Hibbing, MN (I)
Chinmoy Gulrajani, MD, Minneapolis, MN
- T5 Mandated Reportees – Which Perpetrators Must be Reported?**
Samuel A. Rosenblatt, MD, Philadelphia, PA
- T6 Does Testimony via Video Violate Defendants' Right to Confrontation?**
Chinmoy Gulrajani, MD, Minneapolis, MN
Brianna Engelson, MD, St. Paul, MN
- T7 Creating a MOUD Program in the NC Prison System Based Upon AAPL Guidance**
Joseph B. Williams, MD, Raleigh, NC
- T8 The Insanity Defense at the International Criminal Court**
Zachariah O. Adham, MD, Portland, OR
Lee Hiromoto, MD, Portland, OR
Jennifer L. Darnell, MD, Portland, OR
Allegra Condiote, MD, Portland, OR (I)
Katie Chen, MD, Portland, OR (I)
Joseph Chien, MD, Portland, OR
- T9 Trends in Law Enforcement Fitness for Duty Evaluations**
Alyssa N. Tran, DO, Aurora, CO
David Riedford, MD, Aurora, CO (I)
Andrea Johnson, MD, Aurora, CO (I)
Richard P. Martinez, MD, Aurora, CO
- T10 Attorneys' Obligations to Clients with Suicidal Thoughts**
Jennifer Piel, MD, JD, Seattle, WA
- T11 Primary Psychosis vs. Persistent Meth-Induced Psychosis**
Vincent R. Kennedy, DO, Harrisburg, PA
Sean S. Nutting, MD, Harrisburg, PA (I)
- T12 Forensic Outpatient Restoration Program in Arkansas: Report of Data**
Ann-Marie F. Hayre, MD, Little Rock, AR
Lindsey A. Wilbanks, MD, North Little Rock, AR
- T13 A State, Community, and Jail Partnership for Competence Restoration**
Douglas R. Morris, MD, Logansport, IN
- T14 Criminal Defense Attorneys and Suicide Prevention**
Joellyn Sheehy, MD, Seattle, WA
Jennifer Piel, MD, Seattle, WA

- T15 Does the First Amendment Protect Threats of Violence without Intent?**
Jonas Attilus, MD, MPH, Minneapolis, MN (I)
Laura Sloan, MD, Minneapolis, MN
Chinmoy Gulrajani, MD, Minneapolis, MN
- T16 The Dobbs Decision and its Impact on Justice-Involved Populations**
Seher Z. Chowhan, MD, Saline, MI
W. Grover, MD, Saline, MI
Debra A. Pinals, MD, Ann Arbor, MI
- T17 The Clinician Stalker: Medical, Behavioral and Legal Tactics**
Scott A. Gershan, MD, Chicago, IL
Justin Spring, MD, Chicago, IL
- T18 Shifting Landscapes: Climate Change and the Forensic Psychiatrist**
Scott A. Gershan, MD, Chicago, IL
Justin Spring, MD, Chicago, IL
- T19 Survey of the Use of Violence Risk Assessment Across State Hospitals**
Meghan D. Rowland, PsyD, Ypsilanti, MI (I)
Nicole T. Kletzka, PhD, Detroit, MI (I)
Debra A. Pinals, MD, Ann Arbor, MI
Matthew Davis, MA, Detroit, MI (I)
- T20 Mental Health Diversion Outcomes: An Updated Literature Review**
Omotola K. Ajibade, MD, Brick, NJ
Adam J. Sagot, DO, Brick, NJ
Peter Ash, MD, Atlanta, GA
- T21 Poster Withdrawn**
- T22 New York State Prisoner Psychological Autopsies: Beyond Suicide Notes**
Stephanie Lilly, MD, Marcy, NY (I)
Jonathan S. Kaplan, MD, Poughkeepsie, NY
Meaghan Bernstein, MA, Marcy, NY (I)
Bethanie Sherwood, MSW, Marcy, NY (I)
- T23 Human Trafficking and the Courts: Identifying and Intervening**
Rachel N. Varadarajulu, MD, New York, NY
Merrill Rotter, MD, White Plains, NY
- T24 Psychodivergence: A Neurodevelopmental Model for Psychopathy**
Loxley Godshall-Bennett, MD, Washington, DC
Cecily Lehman, DO, Rockville MD
- T25 Serial Sexual Murder by Juveniles and the Role of Sexual Sadism**
Wade C. Myers, MD, Providence, RI

OPENING SESSION AND PRESIDENTIAL ADDRESS 8:00 AM – 10:00 AM
CHICAGO BALLROOM A-B-C-D (5TH FLOOR)

T26 Seeking Balance in Forensic Psychiatry
James L. Knoll IV, MD, Syracuse, NY

COFFEE BREAK 10:00 AM – 10:15 AM
CHICAGO FOYER (5TH FLOOR)

PANEL DISCUSSION 10:15 AM – 12:00 PM
CHICAGO BALLROOM E (5TH FLOOR)

T27 How “Extreme Overvalued Belief” Discerns Thought, Action, and Blame

Tahir Rahman, MD, St. Louis, MO
 Jeffrey S. Janofsky, MD, Baltimore, MD
 Phillip J. Resnick, MD, Cleveland, OH
 Philip J. Candilis, MD, Washington, DC
 Ronald Schouten, JD, MD, Washington, DC

PANEL DISCUSSION

10:15 AM – 12:00 PM
AVENUE BALLROOM (4TH FLOOR)

T28 Battery to Nuclear Power: Balancing Approaches to Hospital Violence

(Sponsored by the Forensic Hospital Services Committee)

Cara A. Klein, MD, Bay Area, CA
 KyleeAnn Stevens, MD, Shakopee, MN
 Joy Stankowski, MD, Strongsville, OH
 Charles C. Dike, MD, New Haven, CT

PANEL DISCUSSION

10:15 AM – 12:00 PM
MARRIOTT BALLROOM CLARK (4TH FLOOR)

T29 Collateral Damage of Taking a Life

(Sponsored by the Trauma and Stress Committee)

Keith A. Caruso, MD, Brentwood, TN
 Kevin D. Moore, MD, Stafford, VA
 Jeffrey Guina, MD, Dearborn, MI
 William D. Kenner, MD, Nashville, TN (I)

WORKSHOP

10:15 AM – 12:00 PM
MARRIOTT BALLROOM ADDISON (4TH FLOOR)

T30 Balancing Life, Trauma, and Bias to Do Our Best Work

(Sponsored by the Women’s Committee)

Sarah E. Baker, MD, Dallas, TX
 Jacqueline Landess, MD, JD, Mount Horeb, WI
 Ashley H. VanDercar, MD, JD, Northfield, OH
 Matthew Edwards, MD, Dallas, TX
 Cathleen A. Cerny-Suelzer, MD, Seven Hills, OH

PANEL DISCUSSION

10:15 AM – 12:00 PM
LOS ANGELES/MIAMI/SCOTTSDALE (5TH FLOOR)

T31 The Lucid Interval in Testamentary Capacity – Not Such a Clear Concept

Michael R. MacIntyre, MD, Santa Monica, CA
 Mohan Naier, MD, Seal Beach, CA
 Kimberly Clawson, MD, Los Angeles, CA
 Piyush P. Nayyar, MD, Los Angeles, CA (I)

LUNCH (TICKET REQUIRED)

12:00 PM – 2:00 PM
CHICAGO BALLROOM A-B-C-D (5TH FLOOR)

T32 Forensic Practice Before and After the Trial

Raymond Patterson, MD, Washington, DC

PANEL DISCUSSION

2:15 PM – 4:00 PM
CHICAGO BALLROOM E (5TH FLOOR)

T33 The Silent Expert

Michael A. Norko, MD, MAR, Durham, CT
Peter Ash, MD, Atlanta, GA
Richard Martinez, MD, MH, Aurora, CO
Alexander Westphal, MD, PhD, New Haven, CT
Michael K. Champion, MD, Honolulu, HI

PANEL DISCUSSION

2:15 PM – 4:00 PM
AVENUE BALLROOM (4TH FLOOR)

T34 The Other Dr. Gilmer: Restoring Balance through Humanity

Sherif Soliman, MD, Charlotte, NC
Banjamin Gilmer, MD, Asheville, NC (I)
Steve Buie, MD, Asheville, NC (I)

WORKSHOP

2:15 PM – 4:00 PM
MARRIOTT BALLROOM CLARK (4TH FLOOR)

T35 Forensic Psychiatry Implications of Mild Neurocognitive Impairment

(Sponsored by the Forensic Neuropsychiatry Committee)

Dale E. Panzer, MD, Gladwyne, PA
Jacob Holzer, MD, Belmont, MA
Manish Fozdar, MD, Raleigh, NC
Vivek Datta, MD, MPH, San Francisco, CA
Timothy S. Allen, MD, Lexington, KY

PANEL DISCUSSION

2:15 PM – 4:00 PM
MARRIOTT BALLROOM ADDISON (4TH FLOOR)

T36 The Bad Seed: Criminal Responsibility and Competency in Children – (Core)

Savannah L. Woodward, MD, Portsmouth, VA
Graham Lambert, MD, Portsmouth, VA
Michael Ricciardi, MD, Portsmouth, VA

PANEL DISCUSSION

2:15 PM – 4:00 PM
LOS ANGELES/MIAMI/SCOTTSDALE (5TH FLOOR)

T37 Considerations for ECT in Involuntary Forensic Populations

Matthew P. Lahaie, MD, JD, Bridgewater, MA
Christopher L. Myers, MD, Bridgewater, MA
Stephen H. Dinwiddie, MD, Chicago, IL

PANEL DISCUSSION

4:15 PM – 6:15 PM
CHICAGO BALLROOM E (5TH FLOOR)

COFFEE BREAK

4:00 PM – 4:15 PM

T38 Telling the Whole Truth: Neurological Evidence in the Courtroom

(Sponsored by the Judicial Action Committee)

William Connor Darby, MD, Los Angeles, CA
Octavio Choi, MD, PhD, Stanford, CA
Robert Weinstock, MD, Los Angeles, CA
R. Ryan Darby, MD, Nashville, TN (I)
Ciaran Considine, PhD, Nashville, TN (I)

PANEL DISCUSSION

4:15 PM – 6:15 PM
AVENUE BALLROOM (4TH FLOOR)

T39 Psychiatrists Working with PNPs – More or Less Liability than We Think?

Ana Natasha Cervantes, MD, Amherst, NY
 Camille LaCroix, MD, Boise, ID
 Trent Holmberg, MD, Draper, UT

PANEL DISCUSSION

4:15 PM – 6:15 PM

MARRIOTT BALLROOM CLARK (4TH FLOOR)

T40 Does Forensic Knowledge Require a New Way of Thinking

Susan Hatters-Friedman, MD, Cleveland, OH
 Kiri Prentice, MB ChB, Auckland, New Zealand
 Andrew Howie, MB ChB, Auckland, New Zealand
 Philip J. Candilis, MD, Washington, DE

PANEL DISCUSSION

4:15 PM – 6:15 PM

MARRIOTT BALLROOM ADDISON (4TH FLOOR)

T41 Balancing Assessment and Management in Older Sex Offenders – (Advanced)

(Sponsored by the Sexual Offenders and Geriatric Psychiatry and the Law Committees)

Kathryn Baseline, MD, Washington, DC
 Fatima Masumova, MD, Mullica Hill, NJ
 Abhishek Jain, MD, New York, NY
 Bradley Booth, MD, Ontario, Ottawa, Canada
 Carla Rodgers, MD, Bala Cynwyd, PA

SCIENTIFIC PAPER SESSION #1

4:15 PM – 6:15 PM

LOS ANGELES/MIAMI/SCOTTSDALE

T42 Ethics Dilemmas in Correctional Mental Health – (Advanced)

Graham Glancy, MB, Toronto, Ontario, Canada
 Kiran Patel, MD, Toronto, Ontario, Canada

T43 Assessing Racial Effects on Adjudicative Competence

Kelsey Hobart, MD, Arlington, VA
 Philip J. Candilis, MD, Washington, DC

T44 The Use of Electroconvulsive Therapy on Death Row

Arya Shah, MD, San Francisco
 Nathaniel P. Morris, MD, San Francisco, CA
 Dale E. McNeil, MD, San Francisco, CA (I)
 Renée Binder, MD, Mill Valley CA

T45 How Experts Advise Evaluating Pro Se Competence 15 Years Post Edwards

David S. Im, MD, Ann Arbor, MI
 Jay S. Witherell, PhD, Saline, MI (I)

AUDIOVISUAL SESSION

7:00 PM – 9:00 PM

CHICAGO BALLROOM E (5TH FLOOR)

T46 AAPL Goes to the Museum: Frida Kahlo “Heroine of Pain”

Salomon Grimberg, MD, Dallas, TX (I)
 James L. Knoll IV, MD, Syracuse, NY

**Your opinion of today’s sessions is very important:
 While it’s fresh in your mind, please complete the evaluation form
 in Guidebook for each session you attended.**

T1 CULTURAL BIAS IN SEXUAL ASSAULT: A POTENTIAL ITEM FOR ASSESSING RISK?

Ambra D'Imperio, MD, Geneva, Switzerland (I)

Neva Eloisa Suardi, MD, Chene-Bourg, Switzerland (I)

EDUCATIONAL OBJECTIVE

To provide insight into cultural bias in the field of forensic psychiatry, with a focus on sexual assault and violent behavior.

SUMMARY

Because of its variable and not yet measurable role, cultural bias is a very sensitive issue in the field of forensic psychiatry, especially when it comes to assessing criminal responsibility in cases of sexual assault and violent behavior. Several criticisms have been raised because cultural background is a source of incommensurability and incomparability. Nevertheless, the forensic psychiatrist is often required to provide an accurate and scientifically based opinion for the purpose of impartiality in court. In our poster we share our knowledge based on cases in which cultural factors played a role in determining criminal responsibility. Through praxeological and psychodynamic analysis, our goal is to demystify the stigma surrounding the so-called cultural legitimization of sexual assault behavior. We want to broaden the discussion of "cultural integration" as a key role in assessing dangerousness and risk of recidivism. Our project does not focus on a specific parametric tool, such as an actuarial rating scale, but further research is encouraged to develop a potential dynamic algorithm that can discern the impact of this new variable, such as precisely cultural integration, in determining risk prediction and treatability of offenders. Intensive international scientific collaboration will be required to support this type of investigation.

REFERENCES

Procentese F, Fasanelli R, Carnevale S, et al. Downside: The Perpetrator of Violence in the Representations of Social and Health Professionals. *Int J Environ Res Public Health*. 2020;17(19):7061. Published 2020 Sep 27. doi:10.3390/ijerph17197061

Jimeno-Feliu LA, Calderón-Larrañaga A, Díaz E, et al. The definition of immigrant status matters: impact of nationality, country of origin, and length of stay in host country on mortality estimates. *BMC Public Health*. 2019;19(1):247. Published 2019 Feb 28. doi:10.1186/s12889-019-6555-1

QUESTIONS AND ANSWERS

1. The Sexual Violence Risk 20 scale (SVR-20) considers the following items for forensic assessment:
- A. Cultural background
 - B. Migratory process
 - C. Low socioeconomic status
 - D. None of them

ANSWER: D

2. Which of the following factors is not necessarily associated with unsatisfactory cultural integration:
- A. Uncertainty about outcome of migration
 - B. Exposure to violence
 - C. Poor nutrition
 - D. Separation from caregiver
 - E. Psychiatric diseases

ANSWER: E

T2 CORRECTIONAL TELEPSYCHIATRY EXPOSURE FOR 3RD YEAR MEDICAL STUDENTS

Ibrahim Y. Z. Mohammad, MD, Toronto, Ontario, Canada (I)

Stephen F. Wood, MD, Ottawa, Ontario, Canada

EDUCATIONAL OBJECTIVE

To identify existing methods of measuring individual attitudes towards prisoners and their validity, including the modified Attitudes Towards Prisoners (ATP) scale, and to discuss the benefits of exposing medical student to correctional health, particularly correctional psychiatry early on in their training, and recognize the prevalence of Adverse Childhood Experiences (ACEs) in the prison population and the role of forensic psychiatrists in addressing their effects on inmates.

SUMMARY

Medical students have limited exposure to corrections, and their attitudes towards incarcerated individuals and the correctional system are varied. We wished to investigate their attitudes towards prisoners and whether exposure to a telecorrectional clinic with a focus on Adverse Childhood Experiences (ACEs) can improve their understanding and empathy towards inmates. One hundred thirty (130) third-year medical students at the University of Ottawa attended a one-hour lecture on Correctional Health and ACEs and subsequently observed a three-hour telecorrectional psychiatry clinic. Students completed pre-intervention and post-intervention questionnaires that included a 20-item modified Attitudes Towards Prisoners (ATP) scale and feedback questions. One hundred six (106) of 130 students completed the post-intervention questionnaire. Students' mean total ATP scores increased significantly from 72.785 to 78.415 ($p < 0.0001$) post-intervention, with a significant increase noted in 14 of 20 ATP items. Thematic analysis of qualitative feedback revealed a better understanding of the correctional system and increased empathy towards inmates. Scarce criticism included minimal interactivity and a desire for more sessions. Medical students benefitted from our intervention as reflected by an increase in their modified ATP scores and their feedback, showcasing an improved understanding and empathy towards inmates. Further studies are needed to assess reproducibility and clinical significance of findings.

REFERENCES

English, M., Sanogo, F., Trotzky-Sirr, R., Schneberk, T., Wilson, M. L., & Riddell, J. (2021). Medical Students' Knowledge and Attitudes Regarding Justice-Involved Health. *Healthcare (Basel, Switzerland)*, 9(10), 1302. <https://doi.org/10.3390/healthcare9101302> Tian, E. J., Venugopalan, S., Kumar, S., & Beard, M. (2021). The impacts of and outcomes from telehealth delivered in prisons: A systematic review. *PLOS ONE*, 16(5), e0251840. <https://doi.org/10.1371/journal.pone.0251840>

QUESTIONS AND ANSWERS

1. Which of the following scales originally designed to assess correctional officers' impressions of inmates was modified to assess healthcare professionals' attitudes?
 - A. Attitudes Towards Prisoners (ATP) scale
 - B. Attitudes of Imprisoned Individuals (AII) scale
 - C. Impression of Inmates (II) scale
 - D. Attitudes Towards Inmates (ATI) scale

ANSWER: A

2. Adverse Childhood Experiences (ACEs) are:
 - A. Less common in inmates than the general population
 - B. More common in male but not female inmates than the general population
 - C. More common in female but not male inmates than the general population
 - D. More common in inmates than the general population

ANSWER: D

T3 SMITS V. PARK NICOLLET AND THE CURRENT DUTY TO WARN LANDSCAPE

Katie K. McLaughlin, JD, MS, Hibbing, MN (I)
Chinmoy Gulrajani, MD, Minneapolis, MN

EDUCATIONAL OBJECTIVE

To demonstrate an understanding of the issues related to duty to warn and the diverse state-specific treatment of this issue in light of legal precedent.

SUMMARY

In this poster we present a recent opinion from the Minnesota Supreme Court and discuss its implications on clinical forensic psychiatry. After receiving outpatient mental health treatment at Park Nicollet Health Services for a period of approximately 3 months, Mr. Brian Short engaged in an act of murder-suicide in which he killed his wife and three teenage children before killing himself. His estate filed suit against Park Nicollet, presenting the central question: Was there foreseeable risk to Short's family members, where Mr. Short had no prior history of violence and had never threatened violence against his family members, such

that his mental health providers may be held liable? This poster examines how the Minnesota Supreme Court resolved the duty to warn question in this conflict and discusses the differential treatment this issue has recently received in various states (e.g. Washington). These recent cases are contextualized against the seminal case of *Tarasoff v. Regents of the University of California* and the underlying question of balancing duty to warn against patient confidentiality.

REFERENCES

Smits as Trustee for Short v. Park Nicollet Health Services, 979 N.W.2d 436 (Minn. 2022).

Tarasoff v. Regents of the University of California, 551 P.2d 334 (Cal. 1976).

QUESTIONS AND ANSWERS

1. In the event of a claim against a mental health professional in a duty to warn situation, which of the following would be important for the professional to have noted in their documentation?

- A. An assessment of the specific threat made by the patient
- B. An assessment regarding the identity of the potential victim
- C. An assessment regarding the ability of the patient to carry out the stated threat
- D. Details regarding attempts made to contact the potential victim (and law enforcement, if required)
- E. All of the above

ANSWER: E

2. As of 2023, there are a number of U.S. states that have neither statutes nor case law that establish a mandatory or permissive duty to warn. What is this number?

- A. 5
- B. 15
- C. 25
- D. 50

ANSWER: A

14 USING LITIGATION TO SOLVE THE EMERGENCY DEPARTMENT BOARDING CRISIS

Katie K. McLaughlin, JD, MS, Hibbing, MN (I)
Chinmoy Gulrajani, MD, Minneapolis, MN

EDUCATIONAL OBJECTIVE

To demonstrate an understanding of the legal issues and legal rights of patients and of health providers implicated in the boarding of mental health patients in hospital emergency departments.

SUMMARY

In this poster we present a recent opinion from the U.S. District Court for the District of New Hampshire and discuss its implications on the legal regulation of psychiatry and mental health services. In 2021, a class of plaintiff-patients prevailed in a federal action against the Commissioner of the New Hampshire Department of Health and Human Services (“Commissioner”), with the U.S. District Court holding that the patients’ due process rights were violated when they did not receive timely probable cause hearings while being boarded in emergency departments awaiting discharge or transfer for mental healthcare services. A group of New Hampshire hospitals (“Hospitals”) intervened, alleging that the Commissioner’s boarding of mental health patients in their emergency departments also violated the Hospitals’ rights, specifically their Fourth Amendment rights against unreasonable seizure. The U.S. District Court addressed this issue in 2023 in *Doe v. Commissioner*. As the crisis of emergency department boarding of patients with mental illness worsens, claims regarding the legal rights of patients and hospitals will surely become increasingly prevalent. This poster presents this recent federal decision alongside recent state court cases (e.g. Washington) as supportive of the principle that hospital litigation is a valuable tool in resolving the boarding crisis.

REFERENCES

Doe v. Commissioner, New Hampshire Department of Health and Human Services, 18-CV-1039-LM (D.N.H. 2023).

Detention of D.W. v. Department of Social & Health Services., 332 P.3d 423 (Wash. 2014).

QUESTIONS AND ANSWERS

1. Which of the following practices have been associated with reductions in attempted self-harm episodes for high-risk psychiatric patients being boarded in the emergency department setting?
 - A. 1:1 observation
 - B. Additional search of patient and/or belongings
 - C. Expedited psychiatric consultation
 - D. All of the above

ANSWER: D

2. Solving the emergency department boarding crisis will likely require which of the following:
 - A. Increasing the mental health workforce
 - B. Increasing capacity at state and private hospitals
 - C. Increasing community-based mental health services and supportive housing for people with mental illness
 - D. All of the above

ANSWER: D

T5 MANDATED REPORTEES – WHICH PERPETRATORS MUST BE REPORTED?

Samuel A. Rosenblatt, MD, Philadelphia, PA

EDUCATIONAL OBJECTIVE

To better understand mandated reporting requirement and the accompanying ethical challenges

SUMMARY

Child abuse is a significant problem that has a profound impact on the well-being of children. To combat child abuse, many states have mandated that certain individuals report suspected cases to the appropriate authorities. However, the definition of who is considered a perpetrator of child abuse, and therefore who must be reported, varies by state. Some states have a more limited reporting requirement, such as New York, Ohio, and South Carolina, which only require reporting if the perpetrator is a parent, guardian or Person Legally Responsible, excluding certain individuals like teachers. In contrast, other states such as Texas and California have a broader definition that includes anyone suspected of child abuse, regardless of their relationship to the child. This poster explores some of ethical and legal aspects of mandated reporting of child abuse, focusing on how different states define the perpetrator in terms of the reporting requirement. It also highlights the ethical challenges faced by psychiatrists as mandated reporters who are legally obligated to report suspected abuse while also having an ethical responsibility to maintain patient confidentiality and respect patient autonomy.

REFERENCES

California Penal Code section 11165

Ohio Revised Code section 2151.421

QUESTIONS AND ANSWERS

1. A 15-year-old male discloses to his treating psychiatrist that his teacher at school abused him at school. The patient requests that the psychiatrist not tell anyone. Which of the following is true about the psychiatrist's legal responsibility?
 - A. As a mandated reporter, he must report the suspected abuse to the appropriate authorities.
 - B. As the treating psychiatrist, he has a legal obligation to maintain patient confidentiality and to respect the patient's autonomy, and thus must not report the suspected abuse.
 - C. It is state-dependent whether the psychiatrist, as a mandated reporter, must break patient confidentiality and report the suspected abuse, given that the perpetrator is not a parent or legal guardian of the patient.
 - D. He does not have to report the suspected abuse because psychiatrists are not mandated reporters.

ANSWER: C

2. If a patient discloses abuse to a practicing psychiatrist but requests not to disclose the abuse to anyone, what ethical principles might compete with the obligation to report the abuse?
- A. Principle of Autonomy
 - B. Principle of Nonmaleficence
 - C. Principle of Veracity
 - D. Principle of Confidentiality
 - E. A & D

ANSWER: E

T6 DOES TESTIMONY VIA VIDEO VIOLATE DEFENDANTS' RIGHT TO CONFRONTATION?

Chinmoy Gulrajani, MD, Minneapolis, MN
Brianna Engelson, MD, St. Paul, MN

EDUCATIONAL OBJECTIVE

Audience will be able to demonstrate familiarity with the types of legal challenges that can be brought in cases where witness testimony is obtained via video-conference.

SUMMARY

Use of videoconference technology in the justice system expanded dramatically in the first half of 2020 with the advent of the COVID-19 pandemic. In Minnesota, courts suspended in-person proceedings and allowed proceedings via video-conferencing. In several courts, use of videoconferencing has persisted. But these remote proceedings are susceptible to unique legal challenges. In this poster we discuss a recent opinion from the Minnesota Supreme Court that has relevance to one such challenge. In *State v. Tate* (MNSC, 2023), the Supreme Court of Minnesota determined whether a criminal defendant's right to confrontation under the Sixth Amendment of the United States Constitution and Article I, Section 6, of the Minnesota Constitution is violated when a district court allows a witness to testify using live, two-way, remote video technology during a jury trial in the midst of the COVID-19 pandemic. We discuss implications for remote forensic practice, especially in scenarios where both examination and testimony are conducted via videoconference.

REFERENCES

State of Minnesota vs. Kim Marie Tate (MN Supreme Court, A21-0359 (2023))

Recupero J. Daubert Considerations in Forensic Evaluations by Telepsychiatry. *Journal of the American Academy of Psychiatry and the Law Online* December 2022, 50 (4) 517-528

QUESTIONS AND ANSWERS

1. The Sixth Amendment to the Constitution guarantees which right:
- A. Right to remain silent
 - B. Right to confront a Witness
 - C. Right to an attorney
 - D. Right to be free from unreasonable search and seizure

ANSWER: B

2. One of the following is not a Daubert criteria:
- A. Lack of general acceptance
 - B. Peer review and publication
 - C. Potential rate of Error
 - D. Whether a hypothesis is testable

ANSWER: A

T7 CREATING A MOUD PROGRAM IN THE NC PRISON SYSTEM BASED UPON AAPL GUIDANCE

Joseph B. Williams, MD, Raleigh, NC

THURSDAY**EDUCATIONAL OBJECTIVE**

To provide information about the process of developing and implementing policies and procedures related to providing medication treatment for opioid use disorder (MOUD) in the North Carolina state prison system, which have been based upon guidance offered in AAPL publications and AAPL courses.

SUMMARY

An estimated 15% of individuals who are incarcerated in America's prisons and jails meet criteria for an opioid use disorder (OUD). Historically, the vast majority of correctional facilities have not offered FDA-approved medications for treatment of opioid use disorder (MOUD), such as methadone, buprenorphine, and naltrexone, despite the high prevalence of OUD among the incarcerated population. In recent years greater attention has been paid to MOUD in corrections. Drivers of this change include increased awareness that opioid-related overdose mortality is a leading cause of death for individuals following release from incarceration, enforcement of the Americans with Disabilities Act and the protection it offers to individuals receiving MOUD, and recent judicial decisions supporting MOUD in correctional facilities. The North Carolina Department of Adult Correction (NC DAC) is currently in the process of devising policies and procedures for offering MOUD to individuals in the state prison system. The NC DAC advisory committee that was created to spearhead this project utilized guidance offered in AAPL publications and AAPL courses pertaining to MOUD in corrections. This poster provides information on NC DAC's endeavors in establishing a prison system-wide MOUD program, which can assist other correctional administrators and providers in creating their own MOUD programs.

REFERENCES

Tamburello A, Masumova F, Edelman K. Practice patterns in prescribing buprenorphine in the New Jersey Department of Corrections. *J Am Acad Psychiatry Law.* 2022; 50(2):252-262.

Kaplowitz E, Truong AQ, Berk J, et al. Treatment preference for opioid use disorder among people who are incarcerated. *J Subst Abuse Treat.* 2022;137:108690.

QUESTIONS AND ANSWERS

1. Which medication is NOT approved by the FDA for treatment of opioid use disorder?

- A. Buprenorphine
- B. Naltrexone
- C. Acamprosate
- D. Methadone

ANSWER: C

2. Barriers to offering MOUD in correctional facilities include all the following EXCEPT:

- A. Regulatory requirements
- B. Lack of effective medications
- C. Cost
- D. Stigma associated with MOUD

ANSWER: B

T8 THE INSANITY DEFENSE AT THE INTERNATIONAL CRIMINAL COURT

Zachariah O. Adham, MD, Portland, OR
Lee Hiromoto, MD, Portland, OR
Jennifer L. Darnell, MD, Portland, OR
Allegra Condiote, MD, Portland, OR (I)
Katie Chen, MD, Portland, OR (I)
Joseph Chien, MD, Portland, OR

EDUCATIONAL OBJECTIVE

Compare and contrast standards for the insanity defense at the International Criminal Court (ICC) to insanity defenses in domestic law.

SUMMARY

The insanity defense at the International Criminal Court (ICC) is codified in the treaty creating the court (the Rome Statute of 2002), but had not been tested until the recent case of Dominic Ongwen. Mr. Ongwen was captured by the Lord's Resistance Army (LRA) in Uganda at age nine and stayed with the LRA to become an adult commander. The ICC issued warrants for multiple LRA commanders, including Mr. Ongwen, based on the LRA's actions targeting civilians, including maiming and sexual crimes. Following arrest and transfer to the ICC, Mr. Ongwen stood trial on 70 counts. During his trial, the defense raised the insanity defense (based on Mr. Ongwen's childhood kidnapping) per Rome Statute 31(1)(a), the first time an accused at the ICC had invoked this defense. Nonetheless, he was convicted in 2021, with the ICC's Trial Chamber finding that Mr. Ongwen did not have mental illness. In December of 2022, the ICC's Appeal Chamber affirmed the conviction. This poster compares the ICC's insanity standard, destruction of capacity to appreciate or control conduct, to domestic applications of the insanity defense. The poster also discusses the somewhat ambiguous burden of proof of the insanity defense at the ICC.

REFERENCES

Chifflet P, Freckelton, I The Mental Incapacity Defence in International Criminal Law: Ramifications from the Ongwen Trial Judgment. *International Criminal Law Review*. 2022 June; 22(4):751-779. Available from <https://doi.org/10.1163/15718123-bja10138>

Hiramoto L, & Sparr, LF. Ongwen and Mental Health Defenses at the International Criminal Court. *J Am Acad Psychiatry Law*. 2023 January;51(1). Available from <https://doi.org/10.29158/JAAPL.220034-21>.

QUESTIONS AND ANSWERS

1. Which of the following best describes the ICC's standard for insanity defenses?
 - A. The accused's conduct was caused by psychiatric illness.
 - B. The accused could not distinguish right from wrong.
 - C. The accused's capacity to either appreciate the wrongfulness of their conduct or conform it to the law was destroyed by mental illness.
 - D. The accused's psychiatric illness prevented them from conforming their conduct to the law.

ANSWER: C

2. Which of the following best describes the burden of proof regarding the insanity defense at the ICC?
 - A. The accused must prove their insanity by clear and convincing evidence.
 - B. The accused must prove their insanity by preponderance of the evidence.
 - C. The prosecution must disprove, beyond a reasonable doubt, that the accused was insane
 - D. The prosecution must prove all elements of guilt beyond a reasonable doubt, including when an accused raises the insanity defense

ANSWER: D

T9 TRENDS IN LAW ENFORCEMENT FITNESS FOR DUTY EVALUATIONS

Alyssa N. Tran, DO, Aurora, CO
David Riedford, MD, Aurora, CO (I)
Andrea Johnson, MD, Aurora, CO (I)
Richard P. Martinez, MD, Aurora, CO

EDUCATIONAL OBJECTIVE

To help participants better understand the trends, implications, and utility of data in fitness for duty evaluations of law enforcement personnel.

SUMMARY

Trends in Fitness for Duty Evaluations (FFDEs) can provide valuable information about the health of a police department, provide insight into issues contributing to officer impairment, and guide wellness intervention efforts. There are many differences between department methods of completing FFDEs such as different thresholds for initiating FFDEs and different evaluators who each have their own style and format of report writing. FFDEs are often written in a narrative format, making data extraction tedious and time consuming. In this study we evaluate trends and potential insights from FFDEs in one large metropolitan police department.

REFERENCES

Price M. Psychiatric Disability in Law Enforcement Officers. *Behav Sci Law*. 2017;35(2):113-123.
Anfang SA, Faulkner LR, Fromson JA, Gendel MH. The American Psychiatric Association’s resource document on guidelines for psychiatric fitness-for-duty evaluations of physicians. *J Am Acad Psychiatry Law*. 2005;33(1):85-88.

QUESTIONS AND ANSWERS

1. In this study, what was one factor that increased the likelihood of officers being found unfit for duty?
 - A. Substance use
 - B. Extended leave of absence
 - C. History of military involvement
 - D. Chronic pain

ANSWER: A

2. In this study, what was one protective factor for being found fit for duty?
 - A. History of prior mental health treatment
 - B. Current healthy relationship
 - C. History of prior fitness for duty evaluation
 - D. History of substance use

ANSWER: B

T10 ATTORNEYS’ OBLIGATIONS TO CLIENTS WITH SUICIDAL THOUGHTS

Jennifer Piel, MD, JD, Seattle, WA

EDUCATIONAL OBJECTIVE

Understand competing ethical and legal principles for lawyers to alert others of their clients’ suicidal thoughts or behaviors. Appreciate jurisdictional variation in lawyers’ professional codes in permitting disclosure of confidences to prevent suicide.

SUMMARY

A difficult scenario for many attorneys is that of a client who expresses suicidal thinking or behaviors. Attorneys in this situation are commonly concerned about their client’s safety and wellbeing, but also concerned about their personal responsibilities under their professional code. Like psychiatrists, the protection of client confidences is one of the most important ethical and legal responsibilities for attorneys. Attorneys in this situation may be concerned that disclosing their client’s suicidal intent to others, absent their client’s consent, will violate their professional duty of confidentiality. The fact that assessment and counseling of clients with suicidal thoughts is beyond the training of most attorneys adds to their discomfort. Although the American Bar Association’s Model Rules of Professional Conduct permits breaking confidences “to prevent reasonably certain death or substantial bodily harm” (ABA Rule 1.6), this is an exception to attorney-client privilege that has not been adopted in all states. Where it has been adopted, the practicalities of defining what “reasonably certain” means is not clear cut, may vary by state, and has serious professional implications. This poster reviews jurisdictional variation in attorney professional codes and challenges in determining whether and how state codes authorize disclosures to prevent client suicide.

REFERENCES

American Bar Association: Model rules of professional conduct: Rule 1.6: Confidentiality of Information. American Bar Association (2020)

Piel J, Sheehy J: Criminal defense attorneys and suicide prevention. *International Association of Forensic Mental Health Services Newsletter*, Winter 2023

QUESTIONS AND ANSWERS

1. What resource should attorneys turn to for ethical guidance on exceptions to attorney-client confidentiality?
 - A. The Diagnostic and Statistical Manual of Mental Disorders
 - B. American Medical Association Code of Ethics
 - C. American Psychiatric Association’s Principles of Medical Ethics
 - D. State Code of Professional Responsibility

ANSWER: D

2. According to the Restatement (Third) of the Law Governing Lawyers, lawyers should consider which of the following in deciding whether the disclosure of confidential information is necessary to prevent reasonably certain death?
- A. The likelihood that the threatened harm will occur absent disclosure
 - B. Previous suicide attempts made by the client
 - C. Personal training in assessment and management of suicide risk
 - D. Availability of psychiatric care

ANSWER: A

T11 PRIMARY PSYCHOSIS VS. PERSISTENT METH-INDUCED PSYCHOSIS

Vincent R. Kennedy, DO, Harrisburg, PA
Sean S. Nutting, MD, Harrisburg, PA (I)

EDUCATIONAL OBJECTIVE

To highlight the existence of persistent methamphetamine-induced psychosis and to assist the forensic psychiatrist in distinguishing between this condition and primary psychosis.

SUMMARY

Distinguishing between mental disorders caused by abuse of a substance and those which are not caused by abuse of a substance is an important aspect of conducting forensic assessments of criminal responsibility. Methamphetamine abuse can result in psychotic symptoms which can in some cases persist for months or years after the most recent use of the drug. Both persistent methamphetamine-induced psychosis and primary psychotic illness such as schizophrenia can cause a wide range of symptoms. However, some studies have indicated differences in the frequency of specific symptoms between the two conditions, including non-auditory hallucinations, conceptual disorganization, negative symptoms of psychosis, loosening of associations, concrete thought process, and impairment in goal-directed thinking. Individuals with chronic methamphetamine-induced psychosis have performed comparably to those with schizophrenia on cognitive testing and demonstrate other psychotic symptoms such as auditory hallucinations at a similar rate. A forensic psychiatrist should exercise caution, however, in applying these general observations to specific cases. Research into this area is also complicated by the lack of a specific category in the DSM-5-TR to apply to persistent methamphetamine-induced psychotic disorder.

REFERENCES

Wearne TA, Cornish JL. A comparison of methamphetamine-induced psychosis and schizophrenia: a review of positive, negative, and cognitive symptomatology. *Front Psychiatry*. 2018 October; 9(491):1-19

Differences in the symptom profile of methamphetamine-related psychosis and primary psychotic disorders. *Psychiatry Research*. 2017 February; 251:349-354

QUESTIONS AND ANSWERS

1. Which of the following statements is INCORRECT regarding persistent methamphetamine-induced psychosis?
- A. Methamphetamine use can trigger psychotic episodes lasting multiple months after the most recent use of methamphetamine.
 - B. Persistent methamphetamine-induced psychosis can develop in the absence of other risk factors for primary psychotic illness.
 - C. Tests of cognition have been strongly demonstrated to differentiate between individuals with methamphetamine-associated psychosis and schizophrenia.
 - D. The risk of developing persistent psychotic symptoms associated with methamphetamine use is dose-dependent.

ANSWER: C

2. Which of the following signs or symptoms is MOST LIKELY to indicate persistent methamphetamine-induced psychosis rather than psychotic illness not associated with methamphetamine use?
- A. Absence of negative symptoms
 - B. Poor performance on cognitive testing
 - C. Presence of auditory hallucinations
 - D. Reduction in psychotic symptoms after administration of antipsychotic medication

ANSWER: A

T12 FORENSIC OUTPATIENT RESTORATION PROGRAM IN ARKANSAS: REPORT OF DATA

Ann-Marie F. Hayre, MD, Little Rock, AR
Lindsey A. Wilbanks, MD, North Little Rock, AR

EDUCATIONAL OBJECTIVE

The audience will be able to state the utility of performing competency restoration services in the outpatient setting.

SUMMARY

Across the country and in Arkansas, there is high demand for competency restoration services for clients with criminal charges who have or are suspected to have a mental illness. Historically, the process of restoration occurs inpatient, such as at the Arkansas State Hospital. Despite the high demand for restoration services, inpatient beds for these defendants are limited in availability, leading to a significant delay between the time a judge signs a court order to the client's inpatient admission. As a result, several states have faced lawsuits for violating patients' constitutional rights to speedy enactment of court-ordered services. In order to meet the demand for timely enactment of services, alternatives to inpatient have been explored, including jail-based and outpatient restoration programs. After a lawsuit from the American Civil Liberties Union, the Arkansas State Hospital instituted the Forensic Outpatient Restoration Program (FORP) in 2015 for defendants to receive restoration services outside the hospital setting if they can be managed in a lesser restrictive environment. This study will report data regarding defendant demographics, the number of clients at various stages of the FORP, and the degree of state-wide FORP clinic involvement to highlight the growth and overall performance of the outpatient restoration program.

REFERENCES

Bloom, Joseph D, et al. "Competency to Stand Trial, Civil Commitment, and Oregon State Hospital." *The Journal of the American Academy of Psychiatry and the Law*, vol. 50, 8 Dec. 2021, pp. 67-73., <https://doi.org/10.29158/JAAPL.210055-21>.

Danzer, Graham S, et al. "Competency Restoration for Adult Defendants in Different Treatment Environments." *The Journal of the American Academy of Psychiatry and the Law*, vol. 47, 8 Feb. 2019, <https://doi.org/10.29158/JAAPL.003819-19>.

QUESTIONS AND ANSWERS

1. What was the restoration rate (i.e. percent found competent) for clients who participated in the Arkansas FORP from January 2015 – August 2022?
- A. 12%
 - B. 30%
 - C. 54%
 - D. 81%

ANSWER: B

2. How many clients were referred to the Arkansas FORP from January 2015 – August 2022?
- A. 95
 - B. 367
 - C. 1562
 - D. 7998

ANSWER: C

T13 A STATE, COMMUNITY, AND JAIL PARTNERSHIP FOR COMPETENCE RESTORATION

Douglas R. Morris, MD, Logansport, IN

EDUCATIONAL OBJECTIVE

Upon completion of this activity, participants should be able to discuss a state, community, and jail partnership model for competence restoration.

SUMMARY

As the national demand for competence restoration services continues to grow, states have increasingly sought to develop alternatives to traditional inpatient restoration. Jail-based restoration programs have emerged as viable options for competence restoration with some advantages compared to inpatient and community-based programs. This presentation describes a unique state, community, and jail partnership for competence restoration. The partnership and coordination of the state mental health authority, state hospital, community mental health center, and jail is described. This model is particularly well suited for small and medium-sized counties and offers the opportunity to expand jail-based restoration services to smaller counties.

REFERENCES

Ash P, Roberts VC, Egan GL, et al: A jail-based competency restoration unit as a component of a continuum of restoration services. *J Am Acad Psychiatry Law* 48:43-51, 2020

Danzer GS, Wheeler EMA, Alexander AA, et al: Competency restoration for adult defendants in different treatment environments. *J Am Acad Psychiatry Law* 47:68-81, 2019

QUESTIONS AND ANSWERS

1. Which of the following factors makes jail-based restoration an attractive option for competence restoration?
 - A. Jailbased services are typically less costly that inpatient restoration.
 - B. Jail-based programs may initiate restoration services more quickly.
 - C. Jail environments may disincentivize malingering.
 - D. Restoration in a jail setting may facilitate development of a community-based treatment plan and diversion.
 - E. All of the above

ANSWER: E

2. Practical and ethical concerns regarding expansion of jail-based competence restoration include which of the following?
 - A. Jails may lack the statutory authority or willingness to administer involuntary medications.
 - B. Competence restoration in a jail setting may further criminalize mental illness.
 - C. Jails may lack the more comprehensive treatment individuals would receive in an inpatient setting.
 - D. Jails are less equipped to manage and treat more seriously ill individuals requiring longer-term hospital-level care.
 - E. All of the above

ANSWER: E

T14 CRIMINAL DEFENSE ATTORNEYS AND SUICIDE PREVENTION

Joellyn Sheehy, MD, Seattle, WA
Jennifer Piel, MD, Seattle, WA

EDUCATIONAL OBJECTIVE

To learn about the potential role of attorneys in suicide prevention

SUMMARY

Suicide is the leading cause of death in jails. Previous studies have identified recent arrest as a risk factor for suicide and may suggest that the period after arrest is a particularly vulnerable time for many detained persons. Roughly 80% of suicides in jail are completed by those awaiting trial and 40% occur within the first week of incarceration. In recent years, there has been increased attention to suicide in corrections, but questions remain about how to identify those at elevated risk who are not recognized by current screening

measures, and then how to mitigate that risk. This study looks at criminal defense attorneys and the role they could play in reducing suicide among defendants. Attorneys work with clients with multiple risk factors for suicide and may be in a position to help preserve the safety and life of their client. This poster summarizes the results of a survey study of criminal defense lawyers in the state of Washington. The study looks at attorneys’ perceptions of client suicide risk, efforts taken to mitigate risk, education on mental health conditions and suicide risk, familiarity with mental health and crisis resources, and barriers to disclosing confidences to mitigate risk of suicide.

REFERENCES

Carson EA. Mortality in Local Jails, 2000-2018 – Statistical Tables. April 2021, NCJ 256002. <https://bjs.ojp.gov/content/pub/pdf/mlj0018st.pdf>
Carson EA. Suicide in Local Jails and State and Federal Prisons, 2000–2019 – Statistical Tables. October 2021, NCJ 300731. <https://bjs.ojp.gov/library/publications/suicide-local-jails-and-state-and-federal-prisons-2000-2019-statisticaltables>

QUESTIONS AND ANSWERS

- 1. According to Carson (Oct 2021), what percentage of suicides are completed within the first week of incarceration?
 - A. 20%
 - B. 40%
 - C. 60%
 - D. 80%

ANSWER: B

- 2. What might be some concerns for lawyers about disclosing a client’s suicidal thoughts?
 - A. Breaking client privilege
 - B. Not knowing who to tell
 - C. Unaware of resources to help clients
 - D. All of the above

ANSWER: D

T15 DOES THE FIRST AMENDMENT PROTECT THREATS OF VIOLENCE WITHOUT INTENT?

Jonas Attilus, MD, MPH, Minneapolis, MN (I)
Laura Sloan, MD, Minneapolis, MN
Chinmoy Gulrajani, MD, Minneapolis, MN

EDUCATIONAL OBJECTIVE

To demonstrate the weight of intent and mental state when threats of violence are made

SUMMARY

In this poster we present a recent opinion from the Minnesota Supreme Court and discuss its implications on forensic psychiatry. After losing custody of her children, Ms. Mrozinski slid an envelope under the door of St. Louis County Children’s Protection Services. The envelope contained a threatening letter, and four toe tags, each with the name of a person associated with her child protection case. She was charged and convicted of four counts of threats of violence. Ms. Mrozinski challenged this finding, arguing that the Minnesota statute prohibiting threats of violence made in “reckless disregard” of the terror they may cause, was invalid under the First Amendment. The central question is: does the First Amendment protect threats of violence made without intent? The United States Supreme Court has addressed the conflict between free speech and threats of violence but has never clarified what mental state or intent is required for a threat to be considered a true threat. We examine how the Minnesota Supreme Court addressed the issues of intent and mental state for threats of violence as it relates to free speech. We discuss relevance to the practice of forensic psychiatrists who perform evaluations in cases of threats of violence.

REFERENCES

State v. Mrozinski, 971 N.W.2d 233 (Minn. 2022).
Virginia v. Black, 538 U.S. 343 (2003).

QUESTIONS AND ANSWERS

1. An example of protected speech is:

- A. Harassment
- B. True threats
- C. Political speech
- D. Defamation

ANSWER: C

2. Freedom of speech is protected by the:

- A. First amendment
- B. Fourth amendment
- C. Third amendment
- D. Fifth amendment

ANSWER: A

T16 THE DOBBS DECISION AND ITS IMPACT ON JUSTICE-INVOLVED POPULATIONS

Seher Z. Chowhan, MD, Saline, MI

W. Grover, MD, Saline, MI

Debra A Pinals, MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE

1) Describe the current legal status of abortion across the U.S.; 2) Compare specific states with legalized abortion, restricted abortion access, and those considering restricting abortion access; 3) Describe how the Dobbs decision potentially impacts justice-involved pregnant women seeking abortion within these states; and 4) Discuss what bearing the Dobbs decision has on correctional psychiatry patient care and service.

SUMMARY

In the landmark decision *Dobbs v. Jackson Women's Health Organization*, the Supreme Court overturned *Roe v. Wade* and held that the Constitution of the United States does not confer a right to abortion. As of 2022, individual states hold full jurisdiction in regulating abortion laws. While this decision impacts women across the U.S., justice involved women are a particularly vulnerable affected population and an important one for forensic psychiatrists working in correctional and community settings to consider. Pregnant women on probation/parole seeking abortion in states where abortion is illegal may face restriction of movement outside their state. Even if women can travel to a state where abortion is legal, time delays may result in abortion no longer being a viable option. Furthermore, those in legalized states may face other challenges in accessing care due to increased demand and longer wait times. The aim of this review is to provide an overview of the legal status of abortion across the U.S., to deepen our understanding of how Dobbs impacts justice-involved populations, and to discuss what bearing this may have on the role of forensic psychiatrists working with this population group.

REFERENCES

Friedman, SH, Landess, J, Ross, N, Kaempf, A. Evolving abortion law and forensic psychiatry. *J Am Acad Psychiatry Law*. 2022 Dec; 50(4):494–501

Advocacy and Research on Reproductive Wellness of Incarcerated People. ARRWIP's Reflections on the Supreme Court's Overturning of *Roe v. Wade* [Internet]; 2023. Available from: <https://arrwip.org/>. Accessed March 5, 2023.

QUESTIONS AND ANSWERS

1. What year was the U.S. Supreme Court's ruling in *Roe v. Wade*?

- A. 1965
- B. 1986
- C. 1973
- D. 1974

ANSWER: C

2. Which of the following will likely present as issues for justice-involved pregnant women seeking abortion?
- A. Restriction of movement out of state;
 - B. Time delays in obtaining care;
 - C. Limited access due to increased demands;
 - D. All of the above

ANSWER: D

T17 THE CLINICIAN STALKER: MEDICAL, BEHAVIORAL AND LEGAL TACTICS

Scott A. Gershan, MD, Chicago, IL
Justin Spring, MD, Chicago, IL

EDUCATIONAL OBJECTIVE

To review the phenomenon of physician stalking, appreciate emerging trends and knowledge gaps in existing literature and provide practical discussion points on how to appropriately address and teach this issue to clinicians through medical, legal and behavioral means.

SUMMARY

Stalking is a common behavioral phenomenon in the United States. Stalking by patients is a well-established problem for clinicians, and clearly exacerbated through growing methods of communication in the social media landscape. The definition of stalking has some variabilities within the medical literature and legal jurisdictions and overlaps with similar behavioral issues such as harassment and intimidation. Although this behavior has been described for centuries, appreciating it as a form of aberrant and criminal behavior is a relatively new legal construct. At its core, stalking is a pattern of unwanted and/or repeated surveillance by a person or group of people towards another. This type of surveillance in the clinical setting may be the precursor to type II workplace violence, and often leads to significant emotional distress or development of psychiatric symptoms. There is a paucity of established resources to assist victims of stalking. There is no national hotline, specific crisis centers or easily accessible professional guidance to address stalking behaviors. The purpose of this presentation is to underscore this highly consequential issue in medicine, help the clinician appreciate the boundaries of proper and improper communication, and propose a flowsheet presenting legal, medical and behavioral interventions for the stalked clinician.

REFERENCES

- Pathé M, Meloy JR: Commentary: Stalking by Patients – Psychiatrists’ Tales of Anger, Lust and Ignorance. *J Am Acad Psychiatry Law* 41: 200-205, 2013
- Nelson AJ, Johnson S, et al: The Prevalence of Physicians Who Have Been Stalked: A Systematic Review. *J AM Acad Psychiatry Law* 43: 177-182, 2015

QUESTIONS AND ANSWERS

1. Stalking behaviors by patients may be a precursor to what type of workplace violence?
- A. Type I
 - B. Type II
 - C. Type III
 - D. Type IV

ANSWER: B

2. A cautionary letter sent to an alleged wrongdoer describing the alleged misconduct and demanding that the alleged misconduct be stopped is a legal notice called a:
- A. Order of Protection
 - B. Notice by Employee
 - C. Cease and Desist Letter
 - D. Stalking Order

ANSWER: C

T18 SHIFTING LANDSCAPES: CLIMATE CHANGE AND THE FORENSIC PSYCHIATRIST

Scott A. Gershan, MD, Chicago, IL
Justin Spring, MD, Chicago, IL

EDUCATIONAL OBJECTIVE

To review and discuss existing literature regarding the impact of climate change on vulnerable psychiatric populations including but not limited to incarcerated persons, and highlight possible implications of climate change in the practice of forensic and correctional psychiatry.

SUMMARY

Climate change is a global crisis. There are ongoing efforts to characterize the downstream effects of climate change on mental health. While there is a growing body of literature discussing the impending impact of climate change on vulnerable psychiatric populations, there is little discussion in the literature of the impact of climate change on forensic psychiatric practice or the carceral system wherein mental health conditions are overrepresented. It is proposed that legal and healthcare systems will be uniquely challenged and shaped by climate change; how this will impact the landscape of forensic psychiatry warrants exploration and discussion. Forensic psychiatrists often work with vulnerable populations, including incarcerated individuals, asylum seekers, and refugees, all of whom are and will be disproportionately impacted by the effects of climate change. By conducting a targeted review of the literature across domains and proposing hypotheses on climate change corollaries within forensic psychiatric practice, this presentation seeks to educate colleagues about how the populations with whom they work may be affected by climate change and highlight gaps in knowledge to prioritize future research.

REFERENCES

- Cianconi, P., Betrò, S., & Janiri, L. (2020). The impact of climate change on mental health: a systematic descriptive review. *Frontiers in psychiatry*, 11, 74.
- Smith, A., Ogunwale, A., & Liebrez, M. (2022). The tip of the iceberg? Climate change, detention settings and mental health. *International journal of social psychiatry*, 68(7), 1303-1306.

QUESTIONS AND ANSWERS

1. Which of the following is a direct mechanism by which climate change may impact mental health?
- A. Extreme weather event
 - B. Displacement
 - C. Food scarcity
 - D. All of the above

ANSWER: A

2. Warmer temperatures have been associated with increased rates of:
- A. Aggression/violence
 - B. Attempted suicide
 - C. Substance use/abuse
 - D. All of the above

ANSWER: D

T19 SURVEY OF THE USE OF VIOLENCE RISK ASSESSMENT ACROSS STATE HOSPITALS

Meghan D. Rowland, PsyD, Ypsilanti, MI (I)
Nicole T. Kletzka, PhD, Detroit, MI (I)
Debra A. Pinals, MD, Ann Arbor, MI
Matthew Davis, MA, Detroit, MI (I)

EDUCATIONAL OBJECTIVE

At the end of this presentation, participants will be able to (1) describe trends in the use of violence risk assessments, (2) discuss the pros and cons of implementing violence risk assessment tools in state hospital settings, and (3) describe national survey results.

SUMMARY

Assessing violence is an important focus of forensic practice. Although violent behavior is rare, its outcomes are potentially costly and significant. Nevertheless, violence risk remains difficult to predict. Consequently, different, and evolving strategies have been developed to assess it, including structured professional judgment, actuarial assessments, and amnestic approaches. This research aims to better understand the approaches taken by state hospitals around the United States with the goal of informing the clinical application of violence risk assessment in public hospitals. To accomplish this, the researchers developed an 11-item questionnaire to gather data about violence risk assessment instruments routinely used by various state hospitals. The questionnaire was sent out to members of the National Association of State Mental Health Program Directors, who typically oversee their state hospital system. The directors were asked either to respond or to forward the questionnaire to the most appropriate person to respond. Data gathered and analyzed can be used to inform local practices and to help inform patterns of practices across the country about the current uses and value of different violence risk assessment strategies.

REFERENCES

Pinals DA: Violence risk assessment in clinical settings: enduring challenges and evolving lessons. Harv Rev Psychiatry 29(1):90-93, 2021

Buchanan A, Binder R, Norko M, Swartz M: Resource document on psychiatric violence risk assessment. Am J Psychiatry 2012; 169:340

QUESTIONS AND ANSWERS

1. Which of the following are violence risk assessment strategies used in state facilities across the United States?
 - A. Actuarial measures
 - B. Structured Professional Judgement
 - C. Amnestic methods
 - D. None of the above
 - E. All the above

ANSWER: E

2. Which are the most common questions that risk assessments are used to answer in forensic hospitals across the country?
 - A. <need answer choices>

ANSWER: A

T20 MENTAL HEALTH DIVERSION OUTCOMES: AN UPDATED LITERATURE REVIEW

Omotola K. Ajibade, MD, Brick, NJ
Adam J. Sagot, DO, Brick, NJ
Peter Ash, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE

Provide updated data on the efficacy of diversion programs.

SUMMARY

Prisons have long been the nation’s leading source of mental health treatment, yet incarcerated people continue to face structural barriers that lead to recidivism and worse healthcare outcomes. Jurisdictions are increasingly looking to mental health diversion programs to help reverse this trend, but this has been met with trepidation. Updated data is needed to demonstrate the utility of these programs in reducing recidivism and increasing access. A literature review was completed utilizing google scholar to gather literature on the topic. Selected articles were limited to those published within the United States between 2015 and 2020. Articles with specifically enumerated outcomes, data and experimental designs focused on recidivism, treatment outcomes, and economic impacts were prioritized in the selection process. Approximately 38 states have some form of Mental Health Diversion. Models vary based on types of eligible charges, program structure and graduation criteria. One analysis found reduced recidivism in 13 of the 15 studies examined. Diversion also has significant economic benefits and in some states has saved over \$200,000 per person per year. While there is high variability in how diversion programs are administered, a strong body of evidence suggests a benefit for such programs over incarceration.

REFERENCES

Canada, K., Barrenger, S., & Ray, B. (2019). Bridging mental health and criminal justice systems: A systematic review of the impact of mental health courts on individuals and communities. *Psychology, Public Policy, and Law*, 25(2), 73– 91. <https://doi.org/10.1037/law0000194>

Delgado, D., Breth, A., Hill, S., Warburton, K., & Stahl, S. M. (2020). Economics of decriminalizing mental illness: when doing the right thing costs less. *CNS Spectrums*, 25(5), 566–570. <https://doi.org/10.1017/S1092852919001792>

QUESTIONS AND ANSWERS

1. When compared with treatment in a forensic hospital, mental health diversion can lead to cost savings of

- A. \$25,000/person/year
- B. \$50,000/person/year
- C. \$75,000/person/year
- D. \$100,000/person/year
- E. \$200,000/person/year

ANSWER: E

2. Which of the following is true regarding Mental Health Courts (MHCs)?

- A. Graduates of MHC programs have lower recidivism rates than non-graduates.
- B. Recidivism rates are lower among participants with felony charges compared with misdemeanors.
- C. Participation in MHC programs for non-graduates results in cost savings of >\$7,600/person/year.
- D. Nearly 64% of MHC non-graduates have their cases dismissed when sent back to traditional courts
- E. All of the above

ANSWER: E

T21 POSTER WITHDRAWN

T22 NEW YORK STATE PRISONER PSYCHOLOGICAL AUTOPSIES: BEYOND SUICIDE NOTES

Stephanie Lilly, MD, Marcy, NY (I)
Jonathan S. Kaplan, MD, Poughkeepsie, NY
Meaghan Bernstein, MA, Marcy, NY (I)
Bethanie Sherwood, MSW, Marcy, NY (I)

EDUCATIONAL OBJECTIVE

This study will examine psychological autopsies of New York State prisoners contrasting those who left suicide notes to those who did not.

SUMMARY

Research on suicide in state prisons has not maintained pace with the increased number of suicides. Suicide note analysis is a critical source in the research of suicide prevention. Leenars Multidimensional Theory of Suicide and Joiner's Interpersonal Theory of Suicide have been utilized to evaluate suicide notes and suicide, respectively. Psychological autopsies are a valuable tool which contain many details of suicide notes and often incorporate evidence of the aforementioned suicide theories. The objective of the study is to examine psychological autopsies of New York State prisoners and contrast those who left suicide notes to those who had not. Evidence of Leenars and Joiner's suicide theories will also be explored. A blind review of 81 psychological autopsies will be conducted. Demographics and prison specific variables will be collected. Comparisons between prisoners who left suicide notes and those who did not will occur relating to demographics and specific prison variables. Additionally, themes found in suicide notes (presented AAPL, 2022) will be compared to those identified in psychological autopsies. Ultimately, the data will be incorporated into the enhancement of suicide prevention efforts in the correctional setting.

REFERENCES

Lang, A., Brieger, P., et al. (2021). Differences between suicide note leavers and other suicides: A German psychological autopsy study. *Journal of Psychiatric Research*, 137, 173-177.
Callanan, V., Davis, M. (2009). A comparison of suicide note writers with suicides who did not leave notes. *Suicide & Life-threatening Behavior*, 39(5), 558-568.

QUESTIONS AND ANSWERS

1. Which is not part of Leenaar’s Multidimensional Theory of Suicide?
- A. Unbearable psychological pain
 - B. Cognitive constriction
 - C. Chronic medical illness
 - D. Identification-egression

ANSWER: C

2. According to the literature, suicides notes are left in approximately what percent of suicides?
- A. 90%
 - B. 80%
 - C. 30%
 - D. 5%

ANSWER: C

T24 HUMAN TRAFFICKING AND THE COURTS: IDENTIFYING AND INTERVENING

Rachel N. Varadarajulu, MD, New York, NY
Merrill Rotter, MD, White Plains, NY

EDUCATIONAL OBJECTIVE

To recognize types of offenses victims of human trafficking get charged with, to learn about human trafficking courts and the role in mitigating risk factors for victims of human trafficking, and to discuss interventions such as training modules for staff who work within the judicial system.

SUMMARY

Human trafficking is a public health and social justice issue that has historically been addressed with criminal justice solutions. In efforts to enhance services for commercial sexual exploitation, specialty human trafficking courts were established. With the development of human trafficking courts providing alternatives to incarceration for victims of human trafficking, there has been an increasing demand to spread awareness about human trafficking amongst judges, lawyers and staff who work within the criminal justice system. However, in the last few years individuals are less likely to be arrested solely for prostitution, and so it is more challenging to identify victims of human trafficking, whose victimization may be indirectly related to their arrest. In this poster, we identify changing trends of victims of human trafficking within the criminal justice system, and discuss scope for interventions at the judicial, public policy and mental health levels. We describe the creation and implementation of a state-wide training project for identification and treatment referral.

REFERENCES

Cook, M.; Thomas, B.; Talbert, R. (2021). A longitudinal study of justice characteristics among girls participating in a sex trafficking court program. *Health Justice*, 9 (1), 1.
Key legislation. Human Trafficking. (2022, September 28). Available from <https://www.justice.gov/humantrafficking/key-legislation>

QUESTIONS AND ANSWERS

1. Which of the following statements are true?
- A. Victims of human trafficking are most likely to get arrested for prostitution.
 - B. Victims of human trafficking are usually underage women.
 - C. In the United States, labor trafficking is more common than sex trafficking.
 - D. Organ trafficking is a category of human trafficking in the United States.

ANSWER: A

2. What programs currently do not exist within the criminal justice system for victims of human trafficking?
- A. Human trafficking courts/diversion programs
 - B. Specialized peer advocacy support groups for justice-involved victims of human trafficking
 - C. Training for correctional officers to recognize red flags of human trafficking
 - D. Re-integration programs to assist internationally trafficked victims with obtaining special visas (U-visa, T-visa)

ANSWER: B

T24 PSYCHODIVERGENCE: A NEURODEVELOPMENTAL MODEL FOR PSYCHOPATHY

Loxley Godshall-Bennett, MD, Washington, DC
Cecily Lehman, DO, Rockville MD

EDUCATIONAL OBJECTIVE

Define psychopathy through a historical lens. Describe the modern relationship between psychopathy and antisocial personality disorder (ASPD). Illustrate psychopathy as a neurodevelopmental disorder.

SUMMARY

Historically, psychopathy has been viewed through a psychodynamic lens, leading to its classification as a variant of antisocial personality disorder (ASPD). However, this approach ignores neural, affective, and forensic distinctions. While studies show a strong comorbidity between psychopathy and ASPD, closer inspection reveals that the difference between psychopathy and ASPD may be more than a difference of degree; it may actually be a difference in kind. The conflation of psychopathy and ASPD has bred diagnostic confusion. Psychopathy exhibits many features of a neurodevelopmental disorder and may be better conceptualized on the spectrum of neurodivergence instead of an ill-defined moral deficiency. Historically, the provocative clinical descriptions of psychopathy have served as reflected manifestations of these individuals' negative impact on their environment. The stigma associated with psychopathy not only affects the individual, but also those in charge of their care. This new approach could result in improved diagnostic clarity as well as novel targets for mitigation and treatment. Approaching psychopathy as a neurodevelopmental disorder may allow for a balance of the negative countertransference that inhibits therapeutic alliance and forensic objectivity.

REFERENCES

Tina D. Wall, Dustin B. Wygant & Martin Sellbom (2015) Boldness Explains a Key Difference Between Psychopathy and Antisocial Personality Disorder, *Psychiatry, Psychology and Law*, 22:1, 94-105, DOI: 10.1080/13218719.2014.919627

Adrian Raine. Antisocial Personality as a Neurodevelopmental Disorder. *Annual Review of Clinical Psychology* 2018 14:1, 259-289

QUESTIONS AND ANSWERS

1. Which of the following features is NOT a diagnostic criterion for antisocial personality disorder?
- A. Pattern of disregard for, and violation of, the rights of others
 - B. Criminality
 - C. Impulsivity
 - D. Glibness / superficial charm

ANSWER: D

<NEED CLARIFICATION OF ANSWER CHOICES>

2. Which of the following features of neurodevelopmental disorders (such as ADHD and autism) is/are also seen in psychopathy?
- A. Manifestation in early childhood
 - B. Deficits or differences in brain processes
 - C. Impairments of personal, social, academic, or occupational functioning
 - D. All of the above

ANSWER: D

T25 SERIAL SEXUAL MURDER BY JUVENILES AND THE ROLE OF SEXUAL SADISM

Wade C. Myers, MD, Providence, RI

EDUCATIONAL OBJECTIVE

Of practical importance is gaining a better understanding of juvenile serial sexual homicide offenders, as research expanding our minimal knowledge regarding their amenability to rehabilitation, treatment outcomes, and likelihood of recidivism would be helpful in guiding courts and other oversight bodies involved in their disposition.

SUMMARY

This is a descriptive study of 21 cases of serial sexual murder by children and adolescents spanning nearly the past century and a half. No earlier cases worldwide were identified. Each of these youth committed two or more sexual homicides prior to age 18. Their psychopathological, psychosocial, crime scene behaviors, and offender-victim relationship characteristics are presented. Additionally, the role of sexual sadism and its measurement using the SADSEX-SH rating scale is addressed. Nearly all of the sample had conduct disorder, a paraphilic disorder, and sadistic fantasies, and two-thirds had sexual sadism disorder. Family dysfunction, serious school problems, and average or above IQ levels were typical. Their modus operandi generally reflected predatory behavior and direct contact methods of killing were most common. Two case reports are provided to illustrate the breadth and complexity of these offenders. Juvenile serial sexual homicide (JSSH) is an extremely rare but persistent phenomenon. Prognostic implications and future research directions are discussed.

REFERENCES

Myers, W. C. (2002). Juvenile Sexual Homicide. London: Academic Press.

Myers, W. C. (2004). Serial murder by children and adolescents. Behavioral Sciences & the Law, 22(3), 357-374.

QUESTIONS AND ANSWERS

1. Research topic of this presentation.
 - A. Serial sexual homicide by adults,
 - B. Serial sexual homicide by juveniles

ANSWER: B

2. Number of cases examined in this research.
 - A. 10 cases
 - B. 21 cases

ANSWER: B

T26 SEEKING BALANCE IN FORENSIC PSYCHIATRY

James L. Knoll IV, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

To be familiar with different ways in which balance is important to forensic psychiatry, learn how technology is already changing the practice of forensic psychiatry and understand the importance of teamwork and the values of civil discourse

SUMMARY

AAPL has stressed the virtue of balance in the preamble of its ethical guidelines, noting the importance of balancing competing obligations to individual and society. The forensic psychiatrist encounters the need for balance routinely and in a variety of areas. The challenge now faced by forensic psychiatry is data overflow and the data explosion. Information now flows too fast for a single individual to keep pace. This talk proposes that balance may be pursued by adapting and leveraging certain skills. During a time of substantial technological, social, and cultural change, the importance of balance, teamwork, and keeping up with technology will be discussed as vital options for AAPL to urgently consider.

REFERENCES

Glancy, G., Miller, D. The Greats: Perspectives on Excellence in Forensic Psychiatry. *Int J Risk Recov* 2021;4(1):43-50

Dietz, P. E. (1987). The forensic psychiatrist of the future. *Journal of the American Academy of Psychiatry and the Law*, 15(3), 217-227.

QUESTIONS AND ANSWERS

1. Areas to be balanced in forensic psychiatry include which of the following?

- A. Personal life and work
- B. Report writing
- C. Advocacy
- D. Retention by defense and prosecution
- E. All the above

ANSWER: E

2. Key values of civil discourse include which of the following?

- A. Honesty, objectivity
- B. Deconstructive dialogue
- C. Mutual respect, fairness
- D. Attentive listening
- E. All but b

ANSWER: E

127 HOW “EXTREME OVERVALUED BELIEF” DISCERNs THOUGHT, ACTION, AND BLAME

Tahir Rahman, MD, St. Louis, MO
Jeffrey S. Janofsky, MD, Baltimore, MD
Phillip J. Resnick, MD, Cleveland, OH
Philip J. Candilis, MD, Washington, DC
Ronald Schouten, JD, MD, Washington, DC,

EDUCATIONAL OBJECTIVE

To describe the development and application of “extreme overvalued beliefs” for distinguishing delusional from delusion-like thinking

SUMMARY

Research has shown that fixated beliefs are present in ~80% of targeted attacks. Forensic experts sometimes face difficulty in distinguishing between various fixated beliefs (delusions, obsessions, shared beliefs) which are critical to proper diagnosis. Delusions seen in disorders like schizophrenia can appear similar to shared belief systems (e.g., cults and conspiracy theories) that are the result of acculturation or indoctrination. Such shared beliefs are often relished, amplified and defended by attackers (e.g., the U.S. Capitol, 9/11, Breivik, Kaczynski, school shooters). Current DSM5 criteria that describe mental disorders are limited in their ability to describe the thinking or behavior of shared beliefs in cults or extremist groups. The term Extreme Overvalued Beliefs, derived from Carl Wernicke’s classic description, is proposed to fill this void. This panel will unpack the term and its potential application to targeted attacks such as mass shootings, terrorism, and assassinations. The historical legacy of Wernicke’s overvalued ideas will be reviewed alongside the cultural, clinical, legal, and ethical implications of pathologizing shared human experiences that can lead to violent behavior. The panel will present research informing the term from those who developed it as well as those who study targeted violence, including acts of violent extremism.

REFERENCES

Rahman T, Hartz SM, Xiong W, Meloy JR, Janofsky J, Harry B, Resnick PJ. Extreme Overvalued Beliefs. *J Am Acad Psychiatry Law*. 2020 Sep;48(3):319-326.

Pierre JM. Forensic Psychiatry versus the Varieties of Delusion-Like Belief. *J Am Acad Psychiatry Law*. 2020 Sep;48(3):327-334.

QUESTIONS AND ANSWERS

1. Which neuroscientist is credited for his work on sensory aphasia, alcoholic encephalopathy, and overvalued ideas?
 - A. Sigmund Freud
 - B. Carl Jung
 - C. Carl Wernicke
 - D. Paul Broca
 - E. Emil Kraepelin

ANSWER: C

2. A previously healthy young man reads about racism online and begins to identify with violent extremists. He purchases guns and selects targets for an attack to “stop Black people, transgendered people, and Jews from taking over America.” Which of the following best describes the next steps in threat assessment and management:
 - A. He is delusional, should be civilly committed, and forced to take antipsychotics
 - B. He is a free individual who can think and do as he pleases
 - C. He has extreme overvalued beliefs and law enforcement should be engaged as part of threat management
 - D. He has obsessional beliefs, should be prescribed an SSRI, and sent home

ANSWER: C

T28 BATTERY TO NUCLEAR POWER: BALANCING APPROACHES TO HOSPITAL VIOLENCE

(Sponsored by the Forensic Hospital Services Committee)

Cara A. Klein, MD, Bay Area, CA
 KyleeAnn Stevens, MD, Shakopee, MN
 Joy Stankowski, MD, Strongsville, OH
 Charles C. Dike, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

Service, e.g. treatment of forensic patients, development of service delivery systems and enhancement of consulting skills. Attendees will be able to delineate multiple complementary strategies for successful management of inpatient violence.

SUMMARY

Violence in psychiatric hospitals is ubiquitous, multifactorial, a major driver of staff burnout and injury, and a frequent cause of great morbidity and mortality among patients. Violence as a problem is also reflected in Joint Commission’s focus on workplace violence. Solutions to management of violence are many, yet seemingly elusive. The panelists will bring their experiences as state hospital leaders to discuss the variety of interventions available to address violence, balancing the very expensive and complex (nuclear) solutions with some that are less so (battery-powered) to achieve safe treatment and work conditions in hospitals. Nuclear options may include legislative approaches, such as changes to involuntary medication or civil commitment statutes, funding for physical plant changes, staffing enhancements, expanding assisted outpatient treatment, and others. However, a variety of less intense hydrogen fuel and battery powered approaches exist, including access to ECT and TMS, diversionary efforts, limiting access to substances of abuse, and providing effective staff training and support. By implementing several solutions along the continuum with fidelity and consistency, hospitals can limit the impact of violence in hospitals. The methods presented in this panel are in line with the Resource Document on Hospital Violence that will be produced by the Forensic Hospitals Committee.

REFERENCES

Stephen M. Stahl, Debbi A. Morrisette, Michael Cummings, Allen Azizian, Shannon Bader, Charles Broderick, Laura Dardashti, Darci Delgado, Jonathan Meyer, Jennifer O’Day, George Proctor, Benjamin Rose, Marie Schur, Eric Schwartz, Susan Velasquez and Katherine Warburton California State Hospital Violence Assessment and Treatment (Cal-VAT) guidelines. CNS Spectrums, Available on CJO 2014 doi:10.1017/S1092852914000376
 Warburton, K., & Stahl, S. (Eds.). (2016). Violence in Psychiatry. Cambridge: Cambridge University Press. doi:10.1017/9781316135839

QUESTIONS AND ANSWERS

1. Prevention and management of violence in psychiatric hospitals is multifactorial. The following solutions are demonstrated to be effective in the prevention and management of violence, except:
- A. Advanced psychopharmacological practice
 - B. Adequate risk assessment
 - C. Seclusion and/or restraints
 - D. Meaningful therapeutic engagement
 - E. Toxicology screenings

ANSWER: C

2. Clinical management of violent psychiatric patients faces a number of external barriers, including understaffing and legislative limitations. What legislative or regulatory solutions are available to hospitals to pursue to actively address safety in hospitals?
- A. Involuntary Medication Orders
 - B. Diversion programs
 - C. Outpatient/ambulatory commitment
 - D. Root cause analysis and morbidity/mortality reporting
 - E. All of the above

ANSWER: E

T29 COLLATERAL DAMAGE OF TAKING A LIFE

(Sponsored by the Trauma and Stress Committee)

Keith A. Caruso, MD, Brentwood, TN
Kevin D. Moore, MD, Stafford, VA
Jeffrey Guina, MD, Dearborn, MI
William D. Kenner, MD, Nashville, TN (I)

EDUCATIONAL OBJECTIVE

To review the emotional impact of using deadly force among police officers and drone fighters.

SUMMARY

Firearms training can teach one how to safely handle a weapon and to protect oneself in a situation calling for deadly force. However, there is little that can prepare one for the emotional impact of taking another person's life. We will present a case of a police officer who fatally shot a perpetrator. The subsequent investigation included viewing his body camera footage of the incident, and that officer developed an incapacitating case of PTSD. We will then turn to a review of the literature on the impact of taking a life and how this potential outcome has been addressed in law enforcement and military training. We will then turn to a discussion of drone fighters and the impact of fatal actions on these fighters before a discussion of commonalities and differences between these two populations and potential strategies for easing the impact of these momentous events.

REFERENCES

Grossman D. *On Killing: The Psychological Cost of Learning to Kill in War and Society*. New York: Back Bay Books, 2009.

McManus MJ. The management and treatment of postshooting trauma: administration and programs, in *Critical Incidents in Policing*, revised. Edited by Reese JT, Horn JM, Dunning C., Washington, DC: U.S. Dept. of Justice, Federal Bureau of Investigation, 1991, pp 191-197.

QUESTIONS AND ANSWERS

1. The loss of police officers involved in shootings was significantly decreased by:
- A. Discouraging discussion of the incident with other officers;
 - B. Introduction of formalized support systems for the officers involved;
 - C. Intensive emotive therapy for the officers involved;
 - D. Ignoring the involved officers’ feelings about the incident;
 - E. All of the above.

ANSWER: B

2. PTSD may result from:
- A. Shooting another person fatally;
 - B. Being wounded in a gunfight;
 - C. Viewing fatalities remotely in the line of duty;
 - D. Cumulative traumatic exposures;
 - E. All of the above.

ANSWER: E

T30 BALANCING LIFE, TRAUMA, AND BIAS TO DO OUR BEST WORK

(Sponsored by the Women’s Committee)

Sarah E. Baker, MD, Dallas, TX
 Jacqueline Landess, MD, JD, Mount Horeb, WI
 Ashley H. VanDercar, MD, JD, Northfield, OH
 Matthew Edwards, MD, Dallas, TX
 Cathleen A. Cerny-Suelzer, MD, Seven Hills, OH

EDUCATIONAL OBJECTIVE

Describe life events, such as parenthood and trauma, that have the potential to impact the evaluative work of forensic psychiatrists; Define vicarious traumatization and review how it relates to the practice of forensic psychiatry; Review types of cognitive bias that can influence evaluations and testimony; Reflect on how life events and vicarious trauma can contribute to biases that impact our work; Utilizing case-based small group discussion, identify ways to mitigate bias and balance personal identity with striving for objectivity in forensic work.

SUMMARY

As forensic evaluators, we are charged with doing unbiased evaluations to support well-reasoned and objective opinions. In reality, none of us come to the job free of bias. In addition to well-known and well-studied cognitive biases like confirmation and hindsight bias, our evaluations may also be influenced by our own life experiences, such as a personal history of trauma or previous clinical or forensic experiences. Furthermore, as forensic experts, we may also experience vicarious traumatization by repeatedly hearing tragic stories of human suffering and violence. Forms of unconscious bias related to gender or race may also influence our understanding of cases. In this workshop, speakers will discuss various forms of bias, including cognitive biases, vicarious trauma, personal experiences, gender, and race and their potential impact on forensic work. Speakers will also provide some tools for identifying and addressing bias. Then participants will split into small groups where they will be asked to consider potential sources of bias in case scenarios and consider how best to approach them. The group will then come together to explore strategies for mitigating bias. Together, participants will consider how best to balance personal identity while striving for objectivity in forensic work.

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Barros AJS, Teche SP, Padoan C, Laskoski P, Hauck S, Eizirik CL. Countertransference, Defense Mechanisms, and Vicarious Trauma in Work with Sexual Offenders. *J Am Acad Psychiatry Law.* 2020 Sep;48(3):302-314. doi: 10.29158/JAAPL.003925-20. Epub 2020 May 13. PMID: 32404359.

QUESTIONS AND ANSWERS

1. Which is an example of the availability heuristic?

- A. Believing a defendant has a high risk of recidivism, the forensic psychiatrist ignores the characteristics of the defendant that would indicate the defendant has a lower risk.
- B. Soon after a nurse on the unit where the forensic psychiatrist works is assaulted by a patient with schizophrenia, the forensic psychiatrist opines that a defendant with schizophrenia has a high risk of future violence
- C. After seeing a patient on the inpatient unit who, after discharge, does not follow-up with care, the psychiatrist says that they “always knew the patient would never follow-up.”
- D. The forensic psychiatrist believes that women are less dangerous than men so always provides favorable opinions of female clients.

ANSWER: B

2. Which of the following may be a symptom of vicarious trauma?

- A. Feeling emotionally numb
- B. Difficulty sleeping
- C. Distractibility
- D. All of the above

ANSWER: D

T31 THE LUCID INTERVAL IN TESTAMENTARY CAPACITY – NOT SUCH A CLEAR CONCEPT

Michael R. MacIntyre, MD, Santa Monica, CA

Mohan Naier, MD, Seal Beach, CA

Kimberly Clawson, MD, Los Angeles, CA

Piyush P. Nayyar, MD, Los Angeles, CA (I)

EDUCATIONAL OBJECTIVE

1. Understand how the concept of a lucid interval is relevant to assessment's of testamentary capacity. 2. Understand the natural course and progression of a variety of illnesses affecting neurocognition (including dementias, deliriums, and encephalopathies) including expected changes to alertness and higher level executive functions. 3. Formulate a method for assessing a testator's capacity during a lucid interval, both while alive and post-mortem.

SUMMARY

The relevance of the “lucid interval” is increasingly questioned in neurology and psychiatry as our understanding of neurocognition, dementia, and delirium gets clearer. However, it remains alive in the law with attorneys claiming a lucid interval justifies deathbed changes to one's will. Lucid intervals are often suggested because of a testator's congeniality, alertness, and lack of overt confusion, sometimes supported with simple cognitive tests. This concept is often tied to the phenomenon of cognitive fluctuations frequently seen in advanced diseases, potentially affecting multiple domains such as attention, vigilance, behavior, cognition, and functional abilities. However, factors defining cognitive fluctuations may not be relevant to testamentary capacity. Cognitive fluctuations typically present as changes to attention and arousal. They do not typically show as drastic improvements in memory or the higher-level executive brain functions at the core of testamentary capacity. Improved alertness alone is insufficient to regain previously absent capacities. In this talk, through the presentation of three cases, we will review the concept of lucid intervals, the cognitive fluctuations seen in a variety of neurocognitive disorders (including dementias and encephalopathy), and the forensic psychiatrist's assessment of whether one's lucid interval truly allowed them to form testamentary capacity at the end of life.

REFERENCES

Shulman, KI et. al. (2015) Cognitive fluctuations and the lucid interval in dementia: Implications for testamentary capacity 43(3):287-292

Mart, EG (2016) Neuropsychological assessment of testamentary capacity and undue influence. Archives of Clinical Neuropsychology 31(6):554-561.

QUESTIONS AND ANSWERS

1. The presence of which of the following neurocognitive functions would be most important to assess during a possible lucid interval to determine one's testamentary capacity?
 - A. An improvement in arousal
 - B. The ability to sustain attention
 - C. Improvement on objective neurocognitive testing
 - D. Object recognition
 - E. Demonstration of improvement in executive functioning

ANSWER: E

2. Which of the following helps best inform the assessment of a testator's lucid interval during a post-mortem assessment?
 - A. Caregiver's perspective on testator's mental state
 - B. Objective neurocognitive test results
 - C. Understanding of natural course of cognitive fluctuations in the testator's illness
 - D. Medical records documenting mental status exam.

ANSWER: C

T32 FORENSIC PRACTICE BEFORE AND AFTER THE TRIAL

Raymond Patterson, MD, Washington, DC

EDUCATIONAL OBJECTIVE

Participants will be able to identify and assess the stressors associated with Pre-trial and Post-trial evaluations by forensic psychiatrists and the shifts from evaluations to treatment, especially in carceral settings. He will discuss the availability of treatment services in carceral settings and the impact on staff, and prisoners living with mental illness.

SUMMARY

Dr. Patterson will draw from his experience as a clinician, administrator, and court appointed monitor to discuss the career challenges for forensic evaluators in performing pre-trial and posttrial evaluations and assessing the treatment provided for prisoners living with serious mental illness (SMI), personality disorders, and acute crises in carceral settings. He will discuss the stressors that may be experienced by individuals and teams working in carceral settings (i.e. clinicians, correctional staff and others) in attempting to provide treatment and management of these populations in carceral settings, including dual agency. He will also discuss realities of mass incarceration and its impact on mental health services delivery in these settings.

REFERENCES

Mental Health Care. *J m Acad Psychiatry Law* 46:140-146, 2018 the Mentally 111 Released from Correctional Institutions, in *Public Health Behind Bars*. Edited by Greifinger, R. New York: Springer Science+Business Media, LLC 2022.

QUESTIONS AND ANSWERS

1. In carceral settings, the treatment of persons living with chronic SMI, personality disorders, and acute mental health crises:
 - A. Are comparable to treatment in most communities
 - B. Are inadequate because of lack of clinical resources only
 - C. Are adequate when the numbers of correctional staff are sufficient
 - D. Vary by jurisdiction and improved by oversight via quality management measures

ANSWER: D

2. AAPL Ethical Guidelines as they apply to violent offenders in carceral settings are:
- A. The same as for any other person
 - B. Limited to non-violent pretrial offenders and insanity acquitees
 - C. Specific only for recommendations regarding prisoners sentenced to death
 - D. Specific for recommendations for conducting violence risk assessments.

ANSWER: A

T33 THE SILENT EXPERT

Michael A. Norko, MD, MAR, Durham, CT
Peter Ash, MD, Atlanta, GA
Richard Martinez, MD, MH, Aurora, CO
Alexander Westphal, MD, PhD, New Haven, CT
Michael K. Champion, MD, Honolulu, HI

EDUCATIONAL OBJECTIVE

Participants will be able to describe and contrast the experiences of multiple forensic psychiatrists in the practice of silent retreats, examine the processes by which those experiences enhance the experts' wellness, and appraise the potential value of such experiences in their own professional and personal lives.

SUMMARY

Much of the practice of forensic psychiatry is about language: interviews, record reviews, crafting of reports and narratives, and testimony. At times, the content, volume, and affect of the interpersonal communication can be stressful, painful, and potentially overwhelming. We seldom discuss these stresses, even though our training programs are required to promote the well-being of our trainees. The forensic psychiatrists on this panel will describe their experiences with the practice of silent meditation retreats, from weekend retreats to 30-day retreats, of a variety of religious, spiritual, and secular forms. They will discuss how they were first drawn to silence, what their prolonged silence was like, how repeated experiences evolved, the benefits they derived from these retreats, and how they have integrated (or struggled to integrate) the experiences of silent retreats into the reality of their often hectic, noisy, and chaotic lives and their practice of forensic psychiatry. We will incorporate a short breathing and silence experience into the presentation.

REFERENCES

Davis B: Silent retreat: seeking deeper meaning and purpose. HuffPost. 2013 Jun 15. https://www.huffpost.com/entry/silent-retreat_b_3064790

Scheepers RA, Emke H, Epstein RM, et al: The impact of mindfulness-based interventions on doctors' well-being and performance: a systematic review. Medical Education. 2020; 54(2):138-149

QUESTIONS AND ANSWERS

1. The evidence-based benefits of meditation practice include each of the following, EXCEPT:
- A. Reduction of stress
 - B. Enhanced emotional health
 - C. Enhanced self-awareness
 - D. Increased compassion
 - E. Reversal of bone density loss

ANSWER: E

2. Which of the following conditions are required for a fruitful silent retreat?
- A. Absence of interaction with other people
 - B. A remote physical location
 - C. Daily fasting and yoga
 - D. Cessation of routine activities
 - E. Study of spiritual writings

ANSWER: D

T34 THE OTHER DR. GILMER: RESTORING BALANCE THROUGH HUMANITY

Sherif Soliman, MD, Charlotte, NC
Benjamin Gilmer, MD, Asheville, NC (I)
Steve Buie, MD, Asheville, NC (I)

THURSDAY

EDUCATIONAL OBJECTIVE

The audience will learn the inspiring story of Dr. Benjamin Gilmer's quest to learn the truth about the murder committed by his predecessor in a rural family practice, Dr. Vincent Gilmer, leading to a surprising diagnosis of Huntington's Disease. The audience will learn about the forensic mental health assessments that occurred and the trial. The audience will discuss the implications of the Gilmer case for improving forensic mental health assessments.

SUMMARY

Dr. Benjamin Gilmer, author of the book *The Other Dr. Gilmer*, will be a special guest speaker to share firsthand his story. When he began working at a rural family practice clinic, he learned that he was preceded by Dr. Vincent Gilmer (no relation), who had been convicted of murdering his father, Dalton Gilmer. Dr. Benjamin Gilmer's curiosity led him to investigate further, culminating in him meeting Vince Gilmer in prison. This led to further investigation and a diagnosis of Huntington's Disease, made at the suggestion of Dr. Steve Buie, who will also be a panelist. Dr. Buie will discuss his role in the assessment and diagnosis. Dr. Benjamin Gilmer rallied a team of legal and scientific experts to advocate for Dr. Vince Gilmer's release, a fight that is ongoing in spite of a conditional pardon granted in January 2022. Dr. Soliman will discuss the role of forensic mental health in the case and offer reflections on improving these assessments. A key element of this case was the manner in which a label of malingering, applied by a forensic psychologist among others, likely colored the jury's view of Dr. Vince Gilmer's neuropsychiatric symptoms.

REFERENCES

Gilmer, B. (2022), *The Other Dr. Gilmer: Two Men, a Murder, and an Unlikely Fight for Justice*. Ballantine Books, New York

McDonnell KE, Brown BK, Hale L, Darby RR, Stovall J, Compas BE, Claassen DO. Medicolegal Aspects of Huntington Disease. *J Am Acad Psychiatry Law*. 2021 Dec;49(4):565-571. doi: 10.29158/JAAPL.210008-21. Epub 2021 Aug 2. PMID: 34341147.

QUESTIONS AND ANSWERS

1. Huntington's Disease acquired through:

- A. Autosomal recessive inheritance
- B. Autosomal dominant inheritance
- C. Exposure to heavy metals
- D. Non medelian inheritance
- E. None of the above

ANSWER: B

2. Which of the following is associated with criminal behavior in Huntington's Disease:

- A. Female gender
- B. Advanced age
- C. Decreased number of CAG repeats
- D. Male gender
- E. None

ANSWER: D

T35 FORENSIC PSYCHIATRY IMPLICATIONS OF MILD NEUROCOGNITIVE IMPAIRMENT

(Sponsored by the Forensic Neuropsychiatry Committee)

Dale E. Panzer, MD, Gladwyne, PA
Jacob Holzer, MD, Belmont, MA
Manish Fozdar, MD, Raleigh, NC
Vivek Datta, MD, MPH, San Francisco, CA
Timothy S. Allen, MD, Lexington, KY

EDUCATIONAL OBJECTIVE

Service: To enhance the consulting skills of forensic psychiatrists when assessing cognitive impairment in multiple forensic settings.

SUMMARY

Forensic psychiatrists are often asked to perform evaluations where the evaluatee's cognitive capacity is a central question. Mild Cognitive Impairment (MCI) or Mild Neurocognitive Disorder (MiND) are common diagnoses in these evaluations. This Workshop will address an overview of both conditions, emphasizing diagnosis, imaging, biomarkers for Alzheimer's disease, and related forensic implications. The Workshop will address forensic issues such as: (1) How these conditions impact competence to stand trial and/or criminal responsibility evaluations while considering the risks of malingering; (2) Ways in which MCI/MiND are factors in determining testamentary capacity and vulnerability to undue influence; (3) The Impact of MCI/MiND on determinations of disability and in workers compensation assessments; and (4) Assessment of MCI/MiND in older physicians with implications for medical board hearings and prognostication. The audience should take away a broad understanding of both conditions and practical skills for addressing questions of MCI/MiND in different forensic settings.

REFERENCES

Sabatino CP, Bonnie RJ. Criminal Justice and the Policy and Practice Challenges of Dementia: A Research and Policy Development Initiative. *Bifocal* Vol 42 Issue 5 May 2021, American Bar Association.

Ott, Stanley R, Aker J.B. Mannion, J.F. Anatomy of a Will Contest: Pennsylvania Conference of State Trial Judges-Mid-Annual Meeting Philadelphia, February 2002.

QUESTIONS AND ANSWERS

1. Which of the following statements is false?

- A. The most common clinical diagnoses in the elderly defendant referred for evaluation are alcohol-related disorders and cognitive disorders.
- B. Approximately 5% of elderly defendants referred for evaluation have a major neurocognitive disorder, and of those found clinically not competent to stand trial, 50% have a major neurocognitive disorder
- C. In the ability to work with an attorney, one needs processing speed, orientation, memory, sustained attention, ability to shift set, calculate, etc., equivalent with functioning complex attention and higher order executive functions.
- D. Re restorability of competence to stand trial, the likelihood of restorability is decreased if there is a major neurocognitive disorder > mild, older age, a burden of medical conditions, or a diagnosis of schizophrenia.

ANSWER: B

2. Which of the following is most accurate:

- A. Testators with Mild Neurocognitive Disorder lack testamentary capacity
- B. Mild Neurocognitive Disorder is a vulnerability to undue influence
- C. Mild cognitive impairment presents no vulnerability to undue influence
- D. Testators with intact testamentary capacity cannot have either Mild Cognitive Impairment or Mild Neurocognitive Disorder

ANSWER: B

T36 THE BAD SEED: CRIMINAL RESPONSIBILITY AND COMPETENCY IN CHILDREN – (CORE)

Savannah L. Woodward, MD, Portsmouth, VA
Graham Lambert, MD, Portsmouth, VA
Michael Ricciardi, MD, Portsmouth, VA

EDUCATIONAL OBJECTIVE

Understand the legal precedence in the context of psychosocial development in assessing competency and criminal responsibility in children.

SUMMARY

In early 2023 in Newport News, VA, a six-year-old child brought his mother's firearm to his elementary school. He threatened multiple children and left his teacher with a severe chest wound which required intensive care and necessitated her resignation from teaching so that she could complete months of rehabilitation. At the completion of the investigation, the Newport News Police Department declined to charge the child despite concluding that this was an intentional act citing impaired competency of the accused due to the child's age. This panel presentation will examine the case in depth, with particular attention paid to warning signs preceding the shooting and risk factors that increased this child's risk of violent behaviors. We will also review similar cases and address the legal precedence for prosecuting young children in violent crimes. Finally, we will examine psychosocial development of children and the particular role it plays in forensics and the juvenile system.

REFERENCES

Bath, E., and Gerring, J. (2014). National trends in juvenile competency to stand trial. *Journal of the American Academy of Child & Adolescent Psychiatry*. 53(3), 265–268. <https://doi.org/10.1016/j.jaac.2013.11.015>

Redding, R. E. (2003). The effects of adjudicating and sentencing juveniles as adults: Research and policy implications. *Youth Violence and Juvenile Justice*. 1(2), 128-155. <https://doi.org/10.1177/1541204002250875>

QUESTIONS AND ANSWERS

1. Which of these is not a risk factor for future violence in childhood violent offenders?

- A. History of Conduct Disorder
- B. History of sexual abuse
- C. Poor school performance
- D. Current substance use

ANSWER: C.

2. What factors can affect juvenile competency?

- A. Age
- B. Learning disability
- C. Psychiatric diagnoses
- D. Sex
- E. Developmental delay

ANSWER: A, B, C, AND E.

T37 CONSIDERATIONS FOR ECT IN INVOLUNTARY FORENSIC POPULATIONS

Matthew P. Lahaie, MD, JD, Bridgewater, MA
Christopher L. Myers, MD, Bridgewater, MA
Stephen H. Dinwiddie, MD, Chicago, IL

EDUCATIONAL OBJECTIVE

This panel aims to review the history of electroconvulsive therapy and its regulation, its treatment indications, and to inform attendees of the ethical and practical considerations for the future of electroconvulsive therapy in the treatment of patients in the correctional and forensic mental health system.

SUMMARY

Electroconvulsive Therapy (ECT) remains the gold standard for somatic treatment in psychiatry. Galvanizing both proponents and protesters alike, ECT achieves unparalleled results yet lies shrouded in stigma. Further compounding the challenge, incarcerated individuals comprise a population at the intersection of indigence and illness; often too severely impacted by circumstances to advocate for themselves or even agree to receive treatment. ECT is often an underutilized treatment modality which can be effectively implemented in even the most challenging of circumstances, and forensic hospital settings offer a unique environment with substantial potential for expanded scope of ECT implementation. The panel will review a history of the procedure itself as well as current legal regulation, followed by discussion of treating severe treatment-refractory patients at a forensic state hospital, and a practical account of logistical and administrative aspects of treatment-delivery. The panel will conclude with exploration of the ethical considerations in utilizing ECT in these populations, navigating the unique challenges of forensic correctional mental health care.

REFERENCES

The Practice of Electroconvulsive Therapy in US Correctional Facilities: A Nationwide Survey. Surya, Sandarsh MBBS; McCall, W. Vaughn MD, MS; Iltis, Ana S. PhD; Rosenquist, Peter B. MD; Hogan, Elizabeth MD. The Journal of ECT 31(3):p 150-154, September 2015.

Neurological Devices; Reclassification of Electroconvulsive Therapy Devices; Effective Date of Requirement for Premarket Approval for Electroconvulsive Therapy Devices for Certain Specified Intended Uses. Federal Register Vol. 83, No. 246, pp.66103-6124, <https://www.govinfo.gov/content/pkg/FR-2018-12-26/pdf/2018-27809.pdf> (accessed March 15th, 2023)

QUESTIONS AND ANSWERS

1. FDA risk reclassification of ECT devices from class III to class II applies to which of the following conditions?
 - A. Catatonia and Severe Major Depressive Episodes for treatment resistant patients over 12
 - B. Neuropsychiatric symptoms of dementia in geriatric populations
 - C. Major Depressive Episodes during pregnancy
 - D. Treatment refractory Schizophrenia and Schizoaffective Disorder

ANSWER: A

1. Which of the following represents an absolute contraindication to ECT?
 - A. There are no absolute contraindications to ECT
 - B. Epilepsy
 - C. Pheochromocytoma
 - D. Pregnancy, pacemakers, and pseudobulbar palsy

ANSWER: A

T38 TELLING THE WHOLE TRUTH: NEUROLOGICAL EVIDENCE IN THE COURTROOM

(Sponsored by the Judicial Action Committee)

William Connor Darby, MD, Los Angeles, CA
Octavio Choi, MD, PhD, Stanford, CA
Robert Weinstock, MD, Los Angeles, CA
R. Ryan Darby, MD, Nashville, TN (I)
Ciaran Considine, PhD, Nashville, TN (I)

EDUCATIONAL OBJECTIVE

Describe unique factors to consider when evaluating for common neurological disorders in criminal forensic settings; Describe how to recognize the limits of our qualifications in presenting certain neurological evidence (e.g., neuroimaging) and when it is most appropriate to consult, work in tandem, or refer to a forensic neurologist, neuropsychologist, or forensic neuropsychiatrist; Describe the competing ethics considerations to balance when applying neurological evidence to forensic opinions; Describe ethics and practical challenges to working in an interdisciplinary forensic team; Describe relevant case law pertinent to presenting on neurological evidence

SUMMARY

Neurological evidence (neurological diagnoses, neuroimaging, neuropsychological testing, and/or neurological exam findings) is increasingly used in forensic evaluations of defendants, having been introduced in over 8000 criminal cases in the United States in the last 12 decades. While forensic psychiatrists may be asked to opine on neurological evidence or neurological diseases, these opinions are typically outside their expertise unless they have had special training. The panel will present the unique factors and ethics challenges that forensic practitioners should consider when encountering common neurological diseases (e.g., TBI, focal brain lesions, dementia, sleep disorders, seizures, among others) and applying neurological evidence in their opinions. The panel, which includes a forensic neuropsychiatrist, forensic behavioral neurologist, forensic neuropsychologist, as well as general forensic psychiatrists, will use hypothetical and other case examples to illustrate how and when forensic psychiatrists should consult and coordinate their work with forensic neurologists and neuropsychologists. We will discuss the important role of forensic neurologists in relation to forensic psychiatrists despite there being no formal forensic training for neurologists. The panel will emphasize how an interdisciplinary approach to these forensic cases, balancing differing perspectives, approaches, and expertise between the specialties, is the best way to foster truth in these forensic settings.

REFERENCES

Deborah W. Denno, How Experts Have Dominated the Neuroscience Narrative in Criminal Cases for Twelve Decades: a Warning for the Future, 63 Wm. & Mary L. Rev. 1215 (2022), <https://scholarship.law.wm.edu/wmlr/vol63/iss4/5>

Darby, R. R. (2018). Neuroimaging abnormalities in neurological patients with criminal behavior. *Current neurology and neuroscience reports*, 18, 1-7.

QUESTIONS AND ANSWERS

1. Which of the following represents an ethics concern for applying neuroimaging and biomarkers for neurocognitive disorders in forensic evaluations?
 - A. The trier of fact may overvalue the significance of “objective” tests.
 - B. Informed consent issues regarding using data for forensic purposes.
 - C. Possible coercion for evaluatees to get these prognostic tests in forensic settings when they would otherwise wish not to know dementia risk.
 - D. All of the above
 - E. None of the above

ANSWER: D

2. It is estimated that between 37-57% of people with which neurological disorder have criminal behavior?
 - A. Huntington’s disease (HD)
 - B. Frontotemporal dementia (bvFTD)
 - C. Epilepsy
 - D. Traumatic Brain Injury (TBI)
 - E. REM sleep behavior disorder (RBD)

ANSWER: B

T39 PSYCHIATRISTS WORKING WITH PNPS – MORE OR LESS LIABILITY THAN WE THINK?

Ana Natasha Cervantes, MD, Amherst, NY
 Camille LaCroix, MD, Boise, ID
 Trent Holmberg, MD, Draper, UT

EDUCATIONAL OBJECTIVE

To provide concrete case examples of litigation and medical board consequences for psychiatrists who practice in systems where they are in a collaborative or supervisory arrangement with nurse practitioners. Panelists will discuss specific cases that highlight the risks to psychiatrists in these types of arrangements.

SUMMARY

Do psychiatrists have too many concerns, or not enough concerns about their liability when working alongside nurse practitioners? With the changing landscape of healthcare and the shortage of psychiatrists in most areas of the country, psychiatrists are increasingly expected to practice in systems that employ midlevel providers as part of the treatment team, and psychiatrists are often in supervisory or collaborative roles. Despite vast differences in training, nearly half of U.S. states have now granted full practice authority to nurse practitioners, making the roles in treatment as well as the malpractice exposure of psychiatrists in these settings less clear. The panelists will discuss outcomes of specific court cases involving claims against nurse practitioners, some of which also involve licensing boards, and highlight the legal risks psychiatrists undertake when working with nurse practitioners.

REFERENCES

Patients at Risk, The Rise of the Nurse Practitioner and Physician Assistant in Healthcare; Niran Al-Agba, M.D. and Rebecca Bernard, M.D., Universal Publishers, 2020

Bo Kyum Yang, Mehmet Burcu, Daniel J. Safer, Alison M. Trinkoff, and Julie M. Zito. Comparing Nurse Practitioner and Physician Prescribing of Psychotropic Medications for Medicaid-Insured Youths. *Journal of Child and Adolescent Psychopharmacology*. Apr 2018.166-172. <http://doi.org/10.1089/cap.2017.0112>

QUESTIONS AND ANSWERS

1. The minimum number of clinical hours required by Psychiatric Nurse Practitioner training programs is closest to:
 - A. 5,000
 - B. 2,500
 - C. 600
 - D. 10,000

ANSWER: C

2. Studies have shown all of the following EXCEPT:
 - A. In a study of nursing home residents with dementia, nurse practitioners and physician assistants prescribed more pain medications, including opioids, as well as a larger proportion of benzodiazepines than physicians
 - B. Psychiatric Nurse Practitioners were more likely than psychiatrists to prescribe psychotropic medication to children
 - C. Non-Psychiatric Nurse Practitioners were more likely than psychiatrists to prescribe psychotropic medication to children
 - D. Compared to Non-psychiatry physicians, nurse practitioners prescribed fewer psychiatric medications to children

ANSWER: D

T40 DOES FORENSIC KNOWLEDGE REQUIRE A NEW WAY OF THINKING

Susan Hatters-Friedman, MD, Cleveland, OH
Kiri Prentice, MBChB, Auckland, New Zealand
Andrew Howie, MBChB, Auckland, New Zealand
Philip J. Candilis, MD, Washington, DE

EDUCATIONAL OBJECTIVE

To describe tools of analysis, research, and cultural sensitivity that improve forensic practice

SUMMARY

The approach forensic practitioners use for their assessments, reports, and testimony balances multiple sources: research, observation, interview, experience, education, and training. All of these are affected by biases known to the field as cognitive, implicit, explicit, confirmation, hindsight, and a host of others. In the context of established social and racial effects on forensic outcomes (from differences in use of the least restrictive alternative, sentencing, and restraint, to medication over objection and legal disposition), forensic psychiatrists are faced by scientific uncertainty that requires a systematic approach to case analysis. Epistemology (understanding how we know what we know) offers exactly the kind of framework experts can use to balance the quality and certainty of information, from developing confidence in valid research methods to honing critical thinking that distinguishes true from artificial effects. This panel offers tools and perspectives from US and Maori cultures that practitioners can use to assess the quality of forensic information and thinking to minimize bias and account for cultural differences among forensic patients, evaluatees, experts, and systems.

REFERENCES

Hatters Friedman S. Searching for the whole truth: Considering culture and gender in forensic psychiatric practice, *J Am Acad Psychiatry Law Online* 2023; 51 (1) 23-34.

Scott CL. Believing doesn't make it so: forensic education and the search for truth. *J Am Acad Psychiatry Law.* 2013;41(1):18-32.

QUESTIONS AND ANSWERS

- 1. Epistemology is best defined as
 - A. The ideal balance of science and politics
 - B. The theory of knowledge, especially its methods and validity
 - C. Evidence-based practice
 - D. The study of bias
 - E. The systematic review of research

ANSWER: B

- 2. Challenges to forensic knowledge arise from which of the following?
 - A. Imperfect research design
 - B. Poor dissemination of information
 - C. Biases of race, sex, and crime severity
 - D. Inadequate understanding of cultural influences
 - E. All of the above

ANSWER: E

T41 BALANCING ASSESSMENT AND MANAGEMENT IN OLDER SEX OFFENDERS – (ADVANCED)

(Sponsored by the Sexual Offenders and Geriatric Psychiatry and the Law Committees)

Kathryn Baselice, MD, Washington, DC
Fatima Masumova, MD, Mullica Hill, NJ
Abhishek Jain, MD, New York, NY
Bradley Booth, MD, Ontario, Ottawa, Canada
Carla Rodgers, MD, Bala Cynwyd, PA

EDUCATIONAL OBJECTIVE

- 1. Describe etiologies of hypersexual and inappropriate sexual behavior unique to geriatric populations.
- 2. Analyze factors that may mitigate or exacerbate risk among a geriatric or aging sexual offender.
- 3. Communicate unique challenges faced by those caring for, treating, and supervising geriatric sexual offenders.
- 4. Describe how institutional policies and legal criteria may impact diagnostic, treatment, and placement considerations of older sex offenders.

SUMMARY

Older adults make up an increasing percentage of the US population. According to the United States Census Bureau, by the year 2030, one in five residents will be older than age 65. Geriatric populations and the evaluation and treatment of elderly sexual offenders pose unique challenges to forensic psychiatrists. This panel will provide insights into the phenomenology and management of sexual offending in the geriatric population. This will include an overview of sexual health and behavior among the elderly, with special attention to inappropriate sexual behavior associated with diseases of aging (e.g., dementia, Parkinson's Disease). We will discuss characteristics of older adults who sexually offend, with separate consideration of those who offended previously and are now aging and those who initially offended in their older years. We will discuss unique challenges and considerations for supporting an elderly sexual offender who is incarcerated, civilly committed, or under community supervision. Finally, we will provide guidance for unique issues of risk assessment and recidivism pertinent to this offender population. Audience members will be engaged through interactive case-based discussion and polling.

REFERENCES

Smethurst AJ, Bamford J, Tully RJ. A Systematic Review of Recidivism Rates of Older Adult Male Sex Offenders. *Applied Psychology in Criminal Justice*. 2021;16(1): 23-51.

Ghossoub E, Khoury R. Characteristics of older adult first-time sex offenders: Insights from the Missouri registry. *The American Journal of Geriatric Psychiatry*. 2021;29(3):230-238.

QUESTIONS AND ANSWERS

1. Which of the following medications is known to increase the risk of sexual disinhibition?

- A. Pramipexole
- B. Scopolamine
- C. Rivastigmine
- D. Tamsulosin

ANSWER: A

2. According to the US Bureau of Justice Report, across data from 1993 to 2013, at least ____ % of state prisoners age 55 or older were imprisoned for violent sexual offenses.

- A. 10%
- B. 15%
- C. 20%
- D. 25%

ANSWER: D

T42 ETHICS DILEMMAS IN CORRECTIONAL MENTAL HEALTH – (ADVANCED)

Graham Glancy, MB, Toronto, Ontario, Canada
Kiran Patel, MD, Toronto, Ontario, Canada

EDUCATIONAL OBJECTIVE

1. Participants will become familiar with an approach to ethics and corrections 2. Participants will be able to consider methods of resolving ethics dilemma and corrections 3. Participants will appreciate the progression of this ethical framework

SUMMARY

Traditional medical ethics are based on the principles of patient beneficence and non-maleficence. This involves striving to benefit the patient and above all to do no harm. It has been recognized that practitioners of forensic mental health straddle two different ethical worlds. They act both as treaters and as agents of the justice system. This complicates their relationship with the core principles of medical ethics. Correctional mental health is a growing field that has features of the field of general mental health delivery, but also some features analogous to forensic mental health. As this field develops, there is some recognition that the delivery of correctional mental health demands its own ethical perspective. In this article, we discuss the development of the ethics related to the delivery of mental health and the ethics of forensic mental health and develop a conversation about some issues that are distinct to correctional mental health. In doing so, we attempt to move closer to developing a guideline for resolving ethics dilemmas in correctional mental health.

REFERENCES

Glancy G, Simpson A. Ethics dilemmas in correctional institutions. In Griffith E, editor. *Ethics Challenges in Forensic Psychiatry and Psychology Practice.*: Columbia University Press. <http://www.jstor.org/stable/10.7312/grif18330.10>; 2018. p. 101–115.

Candilis P, Huttenbach E. Ethics in correctional mental health. In Trestman R, Appelbaum K, Metzner J, editors. *Oxford Textbook of Correctional Psychiatry.* Online edn ed. New York: Oxford Textbooks in Psychiatry; 2015.

QUESTIONS AND ANSWERS

1. Ethics and correctional mental health should be considered:

- A. The same as the ethical framework in general psychiatry
- B. The same as the ethical framework and forensic psychiatry
- C. There are no ethics and correctional mental health
- D. Separate set of ethics that borrows from the ethical framework of general and forensic psychiatry

ANSWER: D

2. Which of the following applies to informed consent and correctional mental health?

- A. Treater does not need to obtain informed consent and corrections
- B. Informed consent is only required for hospital patients
- C. Informed consent is required and corrections just as in general psychiatric treatment
- D. There is no such thing as informed consent in correctional mental health

ANSWER: C

T43 ASSESSING RACIAL EFFECTS ON ADJUDICATIVE COMPETENCE

Kelsey Hobart, MD, Arlington, VA
Philip J. Candilis, MD, Washington, DC

EDUCATIONAL OBJECTIVE

To identify factors influencing racial outcomes in competency restoration, underscore the importance of analyzing socioeconomic variables in the study of race and to describe a method institutions use to evaluate racially disparate outcomes.

SUMMARY

As racial influences on forensic outcomes are identified in every aspect of practice from the referral for adjudicative competence to the disposition after adjudication, scholars are exploring methods to disentangle race from its historical, economic, and attitudinal antecedents. Because jurisdictions vary like neighborhoods in these influences, definitions and data may differ among them, creating inconsistencies in analysis and policy. This study offers an approach to monitoring racial differences in forensic outcomes by exploring a wide range of socioeconomic, clinical, and forensic influences in a sample of 200 pre-trial defendants. Using a confirmatory approach to data collection and a statistical analysis based in logistic regression, results are placed in the context of the jurisdiction’s demographics and culture. Based in inpatient competence restoration and evaluation, the investigation may be expected to apply to other settings where race contributes to differential outcomes.

REFERENCES

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Massey D. Residential Segregation is the Linchpin of Racial Stratification. *City & Community.* 2016;15(1):4-7.

QUESTIONS AND ANSWERS

1. Studies of the racial determinants of competence restoration largely endorse which one of the following research approaches?
 - A. Distinguishing race from economic factors
 - B. Including numerous contributing variables
 - C. Avoiding regression and higher-order statistical analyses
 - D. Assuming the equal representation of groups in forensic and correctional settings
 - E. Equating neighborhood and national trends

ANSWER: B

2. Which of the following factors interferes with the study of racial determinants of forensic outcomes?
 - A. Diverse research samples
 - B. Complete economic data
 - C. Limited exposure to other races
 - D. A robust power analysis
 - E. Mitigation of selection bias

ANSWER: C

T44 THE USE OF ELECTROCONVULSIVE THERAPY ON DEATH ROW

Arya Shah, MD, San Francisco, CA
Nathaniel P. Morris, MD, San Francisco, CA
Dale E. McNeil, MD, San Francisco, CA (I)
Renée Binder, MD, Mill Valley CA

EDUCATIONAL OBJECTIVE

The learner will gain knowledge about the legal, ethical, and clinical considerations relevant to the provision of ECT to individuals sentenced to death. The learner will also gain an understanding of how ECT has played a role in legal outcomes, in both pre- and post-sentencing phases.

SUMMARY

Despite high rates of mental illness among incarcerated people in the United States, use of electroconvulsive therapy (ECT) remains limited in jails and prisons. There are some published guidelines regarding the provision of mental health care, including ECT, in U.S. correctional facilities, but little attention has been paid to the use of ECT for individuals sentenced to death. This article examines ECT within the context of the death penalty, including court consideration of ECT in capital cases and historical uses of ECT to facilitate execution of people on “death row.” Given the unique clinical, ethical, and legal considerations surrounding ECT for people sentenced to death, the authors call for greater attention to these practices and propose general guidelines regarding the use of ECT in this population.

REFERENCES

- Williams JB, Arvidson MM, Resource Document for Electroconvulsive Therapy in Adult Correctional Settings. *J ECT*. 2021 Mar; 37(1):18–23
- Livingston R, Wu C, Mu K, Coffey MJ. Regulation of Electroconvulsive Therapy: A Systematic Review of US State Laws. *J ECT*. 2018;34(1):60–8.

QUESTIONS AND ANSWERS

1. The issues of involuntary treatment for competency restoration and consent in institutional settings were addressed in which landmark cases, respectively?
 - A. *Sell v. United States*, *Kaimowitz v. Department of Mental Health for the State of Michigan*;
 - B. *Jackson v. Indiana*, *Estelle v. Gamble*;
 - C. *Washington v. Harper*, *Summerlin v. Shiro*;
 - D. *Sell v. United States*, *Jackson v. Indiana*;
 - E. *Jackson v. Indiana*, *Department of Mental Health for the State of Michigan*

ANSWER: A

2. How many of the 31 responding prisons systems in a recent survey of ECT utilization had utilized ECT in the preceding 5 years?
- A. 0
 - B. 15
 - C. 10
 - D. 4
 - E. 22

ANSWER: D

T45 HOW EXPERTS ADVISE EVALUATING PRO SE COMPETENCE 15 YEARS POST EDWARDS

David S. Im, MD, Ann Arbor, MI
 Jay S. Witherell, PhD, Saline, MI (I)

EDUCATIONAL OBJECTIVE

1) To provide attendees with a useful summary of recommendations published by legal and forensic mental health experts over the last 15 years, since the U.S. Supreme Court’s ruling in *Indiana v. Edwards* (2008), regarding the evaluation of competence to represent oneself (pro se competence) in criminal defendants. 2) To increase the confidence of forensic evaluators in conducting pro se competence evaluations in order to provide helpful guidance to courts regarding criminal defendants requesting to represent themselves.

SUMMARY

The challenge of achieving an acceptable balance between preserving the autonomy of criminal defendants by allowing them the right to self-represent, and protecting the integrity of the judicial process by limiting this right when mental illness symptoms impede such representation, has a long history. Although this balance has historically tipped in favor of allowing self-representation, a recognized ability of states to limit such rights was articulated by the U.S. Supreme Court in *Indiana v. Edwards* (2008). Because Edwards outlined no specific test for representational competence, numerous scholars have proposed criteria over the last 15 years to provide clarity, with variable frameworks and points of emphasis. We attempted to synthesize the published literature since Edwards on the evaluation of pro se competence. A search of electronic databases was conducted using relevant search terms, yielding 32 identified articles after review of titles, abstracts, full text articles, and reference lists. Overall, in evaluating pro se competence, experts advise assessing whether a defendant has the cognitive, communicative, and emotional abilities to adequately conduct a defense, can engage in constructive social intercourse, can provide a rationale reason for pursuing self-representation, and is willing to work with standby counsel. Implications for future research are discussed.

REFERENCES

Indiana v. Edwards, 554 U.S. 164 (2008)
 White MMS, Gutheil TG. A proposed model for assessing defendant competence to self-represent. *J Am Acad Psychiatry Law*. 2016; 44(4):425-436

QUESTIONS AND ANSWERS

1. Which of the following U.S. Supreme Court decisions has often guided rulings in federal circuit and state supreme courts over the last 15 years regarding claims related to pro se competence?
- A. *In re Gault*
 - B. *Barefoot v. Estelle*
 - C. *Jackson v. Indiana*
 - D. *Godinez v. Moran*
 - E. *Washington v. Harper*

ANSWER: D

2. Overall, most legal and forensic experts who have published on the topic of evaluation of pro se competence over the last 15 years agree that such competence should entail an ability to:
- A. Navigate courtroom procedures at an attorney level.
 - B. Demonstrate strong knowledge of legal concepts.
 - C. Display an absence of symptoms of mental illness.
 - D. Show at least 10th grade reading ability.
 - E. Have adequate communication skills.

ANSWER: E

T46 AAPL GOES TO THE MUSEUM: FRIDA KAHLO “HEROINE OF PAIN”

Salomon Grimberg, MD, Dallas, TX (I)
James L. Knoll IV, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

At the end of this program, participants will be able to understand the importance of art and art therapy to better understand and treat individuals with histories of severe trauma.

SUMMARY

Frida Kahlo (1907-1954) was a Mexican painter whose work is associated with the Mexican school of painting known as post-revolutionary iconography which followed the Mexican Revolution (1910-1921). Kahlo painted her abortions, loneliness, masochism, physical handicaps and her chaotic relationship with muralist Diego Rivera whom she married twice. In Mexico, Kahlo was referred to as the “heroine of pain.” She broke ground by painting instinctively, and in ways no one had before. Biographies of her life have theorized that she may have died by suicide. Kahlo’s work and fame grew, and she is now respected as an icon of Mexican culture, feminism, and the LGBTQ+ community. The talk will be presented by Salomon Grimberg, M.D. who is a noted art historian, curator and recognized as a leading expert on the life and work of Frida Kahlo. Dr. Grimberg is widely published in the field of Latin American art and has lectured on the subject internationally. Dr. Grimberg is also a child psychiatrist and writes on various aspects of the creative process.

REFERENCES

- Grimberg, S. (2008). *Frida Kahlo: Song of Herself*. Merrell Pub Limited.
- Hall, C. (2008) *The Role of Anger in Women who Cope by Self-harming*. In: *Art Therapy and Anger* (M. Liebman, Ed.), Chp. 9, Jessica Kingsley Publishers, London.
- Smeijsters, H., & Cleven, G. (2006). The treatment of aggression using arts therapies in forensic psychiatry: Results of a qualitative inquiry. *The arts in psychotherapy*, 33(1), 37-58.

QUESTIONS AND ANSWERS

1. Art therapy has been used in forensic psychiatric treatment to encourage which of the following?
- A. Allow patients to express emotions and strengthen social competencies
 - B. Develop reflective capacity to intercept destructive impulses
 - C. Learn to reflect upon and communicate difficult thoughts and emotions
 - D. All of the above

ANSWER: D

2. Art therapy can help women with histories of severe trauma in which of the following ways?
- A. Develop the capacity for developing an “observer self”
 - B. Express difficult emotions in ways that are less likely to damage the therapeutic alliance
 - C. Allows them to show important aspects of themselves and their experiences that would otherwise have remained hidden
 - D. All of the above

ANSWER: D

FRIDAY, OCTOBER 20, 2023

POSTER SESSION B

7:00 AM – 8:00 AM / 9:30 AM – 10:15 AM
CHICAGO BALLROOM F-G-H (5TH FLOOR)

F1 *The Competency Crisis: A Perfect Storm, Local and Systemic Responses*

Ashley Maestas, DO, Reno, NV (I)
Emmanuelle Garcia-Rider, MD, SMD, Reno, NV (I)
Sydney Soder, MD, Las Vegas, NV (I)
Melissa Piasecki, MD, Reno, NV
Hon. Egan Walker, Reno, NV (I)

F2 *SUNY Upstate Medical University Health Advocacy for the Incarcerated*

Elizabeth D. Lee, MD, Syracuse, NY (I)
Lorie S. Kim, MD, Syracuse, NY (I)
James L. Knoll IV, MD, Syracuse, NY

F3 *PTSD in IST Defendants: Addressing a Gender Imbalance*

Mary Maddox, MD, Atlanta, GA (I)
Brittany Clayton, MD, Atlanta, GA (I)
Tomina Schwenk, MD, Atlanta, GA (I)
Courtney Harhay, MD, Atlanta, GA (I)
Peter Ash, MD, Atlanta, GA

F4 *POSTER WITHDRAWN*

F5 *Comparison of Forensic Psychiatry in the United States and Nigeria*

Omagbemi A. Buwa, MD, MPH, MBA, Saline, MI
Debra A. Pinals, MD, Ann Arbor, MI
Matthew Grover, MD, Saline, MI

F6 *Evaluation of a Court-Ordered Injection Program*

John Henning, MD, Cincinnati, OH
Kristina Reinstatler, MD, Cincinnati, OH (I)

F7 *Dual Roles in Nevada: How Unique State Law Creates Ethical Complexity*

Jessica Arabski, MD, Las Vegas, NV (I)
Steven Zuchowski, MD, Sparks, NV
Isaac Wentz, MD, Sparks, NV (I)
Caitlin Chen, MD, Las Vegas, NV (I)
Matthew Christie, MD, Las Vegas, NV (I)

F8 *Frotteurism and Psychiatric Co-Morbidities: A Systematic Review*

Yarden Segal, MD, Bronx, NY
Gurtej Gill, MD, Bronx, NY
Garima Yadav, MD, Bronx, NY (I)
Hansini Kochhar, Bronx, NY (I)
Sasidhar Gunturu, MD, Bronx, NY (I)

F9 *Psychiatric Co-morbidities for Parricide: A Systematic Review.*

Gurtej Gill, MD, Bronx, NY
Yarden Segal, MD, Bronx, NY
Garima Yadav, MD, Bronx, NY (I)
Sasidhar Gunturu, MD, Bronx, NY (I)
Paulina Riess, MD, Bronx, NY

F10 *Chronic Traumatic Encephalopathy: The Forensic Psychiatrist's Role*

Daniel Jackson, MD, Syracuse, NY
Gurtej Gill, MD, Bronx, NY
Yarden Segal, MD, Bronx, NY
James L. Knoll IV, MD, Syracuse, NY

FRIDAY

- F11 Assessing Variance to Testamentary Capacity Using Cognitive Tools**
 Benjamin C. Brown, MD, San Antonio, TX
 Ethan D. Hinds, MD, San Antonio, TX
 Jason E. Schillerstrom, MD, San Antonio, TX (I)
- F12 Releasing Insanity Acquittees with Intellectual Disability**
 Dhruv Gupta, MD, Philadelphia, PA
 Danielle Barcak, MD, Philadelphia, PA
 Ken Weiss, MD, Bala Cynwyd, PA
- F13 Integrating Equity, Diversity, and Inclusion in Forensic Education**
 Shaheen A. Darani, MD, Toronto, Ontario, Canada
 Graham Glancy, MB, Toronto, Ontario, Canada
- F14 Assessing Trends in Arkansas Competency to Stand Trial Evaluations**
 Jacob K. Linna, MD, Little Rock, AK (I)
 Lindsey A. Willbanks, MD, Little Rock, AK
- F15 Barriers in Sexual Assault Victim Disclosures: A Forensic Checklist**
 Emmanuelle Garcia-Rider, MD, Reno, NV (I)
 Ashley Maestas, DO, Reno, NV (I)
 Sydney Soder, MD, Las Vegas, NV (I)
 Melissa Piasecki, MD, Reno, NV
- F16 From Community to Corrections: The TransInstitutional Model Applied**
 Melissa Piasecki, MD, Reno, NV
 John Packham, PhD, Reno, NV (I)
 Hon. Egan Walker, Reno, NV (I)
 Elizabeth R. Phelan, MD, Chicago, IL (I)
 Sydney Soder, MD, Las Vegas, NV (I)
- F17 The DUNDRUM Toolkit Using in Italian REMS**
 Fulvio Carabellese, MD, Bari, Italy
 Alan Felthous, MD, St. Louis, MO
 Lia Parente, MD, Bari, Italy (I)
 Donatella La Tegola, MD, Bari, Italy (I)
 Felice Carabellese, MD, Bari, Italy
- F18 Risk and Protective Factors to Treatment in Dangerous Offenders**
 Lia Parente, MD, Bari, Italy (I)
 Alan Felthous, MD, St. Louis, MO
 Fulvio Carabellese, MD, Bari, Italy
 Donatella La Tegola, MD, Bari, Italy (I)
 Felice Carabellese, MD, Bari, Italy
- F19 Personality Disorders and Schizophrenia: Forensic Treatment Paths**
 Anna Margari, MD, Bari, Italy (I)
 Luigi Buongiorno, MD, Bari, Italy (I)
 Felice Carabellese, MD, Bari, Italy
 Mandarelli Gabriele, MD, Bari, Italy (I)
 Catanesi Roberto, MD, Bari, Italy (I)
- F20 Effects of COVID on Outcomes of an In-Jail Restoration Program**
 Bradley A. Rosenkrantz, MD, Atlanta, GA
 Peter Ash, MD, Atlanta, GA
- F21 Mental Illness Stigma: Perspectives of Judges and Lawyers in Lebanon**
 Elias Ghossoub, MD, MSc, Beirut, Lebanon
 Nadia-Tina Dandan, PsyD, Beirut, Lebanon (I)
 Michele Cherro, MD, Beirut, Lebanon (I)
 Ghida Kassir, MD, Beirut, Lebanon (I)
 Rayan Mroue, MD, Beirut, Lebanon (I)

F22 After the Involuntary Hold: Clinical Outcomes & Patient Perceptions

Neva N. Lundy, MD, Miami Beach, FL (I)
 Roen M. Wheeler, MD, Miami Beach, FL (I)
 Brett S. Frank, MD, Miami Beach, FL (I)
 Adriana Baez, MD, Miami Beach, FL (I)
 Mousa Botros, MD, Miami Beach, FL (I)

F23 Predicting Competency Restoration Length with the RBANS

Ayanna D. Payne, MD, Atlanta, GA (I)
 Brandon R. Johnson, MD, Atlanta, GA (I)
 Glenn Egan, MD, Atlanta, GA (I)
 Tomina J. Schwenke, MD, Atlanta, GA (I)
 Peter Ash, MD, Atlanta, GA

F24 Risk Assessments, Social Media, and School Shootings

Kerry M. Sheahan, MD, Atlanta, GA
 Anoop S. Takher, MD, Chicago, IL

BUSINESS MEETING (AAPL MEMBERS ONLY) 8:00 AM – 10:00 AM
CHICAGO BALLROOM D (5TH FLOOR)

COFFEE BREAK 10:00 AM – 10:15 AM

PANEL DISCUSSION 10:15 AM – 12:00 PM
CHICAGO BALLROOM D (5TH FLOOR)

F25 Rebalancing the Mental Health-Criminal Justice Interface

Michael K. Champion, MD, Honolulu, HI
 Hon. Justice Loretta Rush, Indianapolis, IN (I)
 Hon. Judge Steve Leifman, Miami, FL (I)
 Scott A. Block, MA, Chicago, IL

WORKSHOP 10:15 AM – 12:00 PM
AVENUE BALLROOM (4TH FLOOR)

F26 Intelligent Use of Artificial Intelligence: Being Practical and Ethical

(Sponsored by the Technology Committee)

Andrew Nanton, MD, Newport Beach, CA
 Alan Newman, MD, Newport Beach, CA
 Michael Rogers, MD, El Cerrito, CA
 James Armontrout, MD, Palo Alto, CA

WORKSHOP 10:15 AM – 12:00 PM
MARRIOTT BALLROOM CLARK (4TH FLOOR)

F27 Balancing Ethical Dilemmas in Forensic Landmark Cases

Sanya A. Virani, MD, MPH, Westborough, MA
 Patricia Recupero, JD, MD, Providence, RI
 Richard Martinez, MD, Denver, CO
 Margarita Abi-Zeid Daou, MD, Worcester, MA

WORKSHOP	10:15 AM – 12:00 PM MARRIOTT BALLROOM ADDISON (4TH FLOOR)
F28 <i>Your Bite at the AAPL: Help Shape Our Organization's Future – (Advanced)</i> (Sponsored by the Membership, Engagement, Recruitment, and Retention – MERR – Task Force)	Abhishek Jain, MD, New York, NY Ariana Nesbit, MD, Durham, NC Britta Ostermeyer, MD, Oklahoma City, OK Ashley VanDercar, MD, Northfield, OH Tobias Wasser, MD, New Haven, CT Paul Arbisi, PhD, Minneapolis, MN (I)
SCIENTIFIC PAPER SESSION #2	10:15 AM – 12:00 PM CHICAGO BALLROOM A-B-C 5TH FLOOR)
F29 <i>The Meaning of Foreseeability in the Duty to Protect</i>	Alan R. Felthous, MD, St. Louis, MO
F30 <i>Advanced Neuroimaging and Mild TBI Litigation, Revisited</i>	Hal S. Wortzel, MD, Centennial, CO
F31 <i>The Forensic Mental Health Implications of Social Media Challenges</i>	Emily Asher, MD, San Francisco, CA Nathaniel P. Morris, MD, San Francisco, CA Dale E. McNeil, PhD, San Francisco, CA (I) Renée L. Binder, MD, San Francisco, CA
LUNCH (TICKET REQUIRED)	12:00 PM – 2:00 PM
F32 <i>How We Arrived Here: Cases that Influenced How We Respond to Violent Crime</i>	Steven R. Conlon, Quantico, VA (I)
PANEL DISCUSSION	2:15 PM – 4:00 PM CHICAGO BALLROOM D (5TH FLOOR)
F33 <i>A Multidimensional Approach to Radicalization and Extremism</i> (Sponsored by the Human Rights and National Security and Forensic Neuropsychiatry Committees)	Jacob C. Holzer, MD, Belmont, MA Anne Speckhard, PhD, Washington, DC (I) John Wyman, Special Agent (Ret.), FBI, Glen Allen, VA (I) Patricia Recupero, JD, MD, Providence, RI
PANEL DISCUSSION	2:15 PM – 4:00 PM AVENUE BALLROOM (4TH FLOOR)
F34 <i>Balancing Security and Rights in Asylum Evaluations</i> (Sponsored by the Human Rights and National Security Committee)	Mikel Matto, MD, Portland, OR Krista M. Ulisse, DO, Morgantown, WV Stephen N. Xenakis, MD, Philadelphia, PA Philip J. Candilis, MD, Washington, DC Reema Dedania, MD, Atlanta, GA

WORKSHOP	2:15 PM – 4:00 PM MARRIOTT BALLROOM CLARK (4TH FLOOR)
F35 <i>Autism and Aggression: Assessing the Spectrum of Violence</i>	Kathleen L. Kruse, MD, Ann Arbor, MI Camille Tastenhoye, MD, Pittsburgh, PA Anne McBride, MD, Sacramento, CA Charles Scott, MD, Sacramento, CA
WORKSHOP	2:15 PM – 4:00 PM MARRIOTT BALLROOM ADDISON (4TH FLOOR)
F36 <i>Claims of Disability due to PTSD</i>	Chinmoy Gulrajani, MD, Minneapolis, MN Paul Arbisi, PhD, Minneapolis, MN (I)
PANEL DISCUSSION	2:15 PM – 4:00 PM
F37 <i>The Effects of Social Media on Factitious Disorder and Malingering</i>	Paul Brindley, MD, Galveston, TX Ravali Poreddy, MD, Columbia, MO (I) Akriti Sinha, MD, Williamsburg, VA Tobias Wasser, MD, New Haven, CT Rocksheng Zhong, MD, Galveston, TX
COFFEE BREAK	4:00 PM – 4:15 PM CHICAGO FOYER
AUDIOVISUAL SESSION	4:15 PM – 6:15 PM CHICAGO BALLROOM D
F38 <i>DID for the Dubious: Video Examination for Insanity and Caselaw Review</i> <i>(Sponsored by the Trauma and Stress Committee)</i>	David Rosmarin, MD, Newton, MA
PANEL DISCUSSION	4:15 PM – 6:15 PM
F39 <i>A Precarious Balance: Autonomy, Religion, and Undue Influence</i> <i>(Sponsored by the Geriatric Psychiatry and the Law Committee)</i>	Lauren K. Robinson, MD, MPH, Chicago, IL Sherif Soliman, MD, Charlotte, NC Carla Rodgers, MD, Bala Cynwyd, PA Sanford Finkel, MD, Chicago, IL (I)
PANEL DISCUSSION	4:15 PM – 6:15 PM MARRIOTT BALLROOM CLARK (4TH FLOOR)
F40 <i>Forensic Reproductive Psychiatry: Practice Guidelines Review – (Advanced)</i> <i>(Sponsored by the Gender Issues Committee)</i>	Susan Hatters-Friedman, MD, Cleveland, OH Renée M. Sorrentino, MD, Weymouth, MA Jacqueline Landess, MD, Milwaukee, WI Joseph Penn, MD, Conroe, TX Patricia Westmoreland, MD, Aurora, CO

FRIDAY

PANEL DISCUSSION

4:15 PM – 6:15 PM

MARRIOTT BALLROOM ADDISON (4TH FLOOR)

F41 First Graders to High Schoolers: Finding Balance in Juvenile Court

(Sponsored by the Child and Adolescent Psychiatry Committee)

Anne McBride, MD, Sacramento, CA
Amanda Wallace, MD, New York, NY
Amanie Salem, DO, Sacramento, CA
Charles Scott, MD, Sacramento, CA
Britta Ostermeyer, MD, Oklahoma City, OK

PANEL DISCUSSION

4:15 PM – 6:15 PM

CHICAGO BALLROOM A-B-C (5TH FLOOR)

F42 Mind of the Mafia

Alan R. Felthous, MD, St. Louis, MO
Felice Carabellese, MD, Bari, Italy
Lia Parente, MD, Bari, Italy (I)
Fulvio Carabellese, MD, Siena, Italy (I)
Travaini Guido, MD, Milan, Italy (I)

***Your opinion of today's sessions is very important:
While it's fresh in your mind, please complete the evaluation form
in Guidebook for each session you attended.***

F1 THE COMPETENCY CRISIS: A PERFECT STORM, LOCAL AND SYSTEMIC RESPONSES

Ashley Maestas, DO, Reno, NV (I)
Emmanuelle Garcia-Rider, MD, SMD, Reno, NV (I)
Sydney Soder, MD, Las Vegas, NV (I)
Melissa Piasecki, MD, Reno, NV
Hon. Egan Walker, Reno, NV (I)

EDUCATIONAL OBJECTIVE

To define the competency crisis and the elements that contribute to it. To describe the responses to the competency crisis on a state, county, and court level. To identify potential solutions to the competency crisis.

SUMMARY

The majority of state hospitals maintain bed waitlists of defendants who have been court-ordered for competency to stand trial or restoration services. Prior to the pandemic, they were up six months or more for a forensic bed to become available, depending on the jurisdiction. During the pandemic, these wait times increased significantly, and in three states combined, there were over 3,000 people reportedly waiting in jail for a restoration bed. They are pre-trial defendants, sometimes charged only with misdemeanor offenses, all of whom are presumed innocent. Due to the prolonged wait times, many defendants spend far longer in jail or confined, than they would if they had plead guilty or were convicted of the underlying offense. There are many possible causes for the increasing numbers of defendants awaiting a forensic bed, which are not limited to an increase in referrals for psychiatric evaluations, increasing numbers of people adjudicated incompetent to stand trial and long wait lists for restoration services. This abstract will focus on identifying the elements that contribute to the competency crisis, local and systemic responses, and future potential solutions to this crisis.

REFERENCES

Leading Reform: Competence to Stand Trial Systems. National Judicial Task Force to Examine State Court's Response to Mental Health. 2021 Aug; volume 2: 1-23

Schwermer, Richard. SJI-Improving the Justice System Response to Mental Illness Competence to Stand Trial. National Center for State Courts Consultant and Retired Utah State Court Administration. 2020, May; 1-10

QUESTIONS AND ANSWERS

1. Which of the following is an element that contributes to increased waits for forensic beds?
 - A. Decreased rates of community policing
 - B. Forensic mental health workforce shortages
 - C. National changes in competency criteria
 - D. Increased restrictions on the use of Clozaril

ANSWER: B

2. Community responses to the "competency crisis" include all of the following except:
 - A. Specialized competency courts
 - B. Diversion of incompetent defendants into treatment programs
 - C. Jail-based competency restoration programs
 - D. Statutory changes in the Dusky standard to lower the bar to competency

ANSWER: D

F2 SUNY UPSTATE MEDICAL UNIVERSITY HEALTH ADVOCACY FOR THE INCARCERATED

Elizabeth D. Lee, MD, Syracuse, NY (I)
Lorie S. Kim, MD, Syracuse, NY (I)
James L. Knoll IV, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

Understand how to establish medical student opportunities to learn and work in correctional settings.

SUMMARY

Syracuse reflects the trend of mass incarceration seen throughout the nation. Syracuse, the fifth most populated city in New York, has a 4.7 times higher imprisonment rate within state prisons than New York City, the most populated city in New York. Until last year, SUNY Upstate Medical University, located in Syracuse, did not have a medical student interest group that focused on correctional healthcare. Health Advocacy for the Incarcerated (HAI) was created to address the healthcare needs of the incarcerated population, as well as to enhance recognition of this patient population within a medical school curriculum. In addition, HAI has been able to forge a partnership with a juvenile correctional facility – Hillbrook Juvenile Detention Center – a local county detention center housing youth. Our scientific poster will focus on the efficacy of our student interest group in bringing to the forefront the needs of the incarcerated population and promoting physicians' interest in correctional healthcare at a time when doctors are still early in their training. This will be investigated through feedback and evaluations from Upstate students and Hillbrook residents. We hope to explore the overarching boundaries of student advocacy and the balance of meeting community-identified needs while mitigating harm.

REFERENCES

- Abbott, P. A., Brooker, R., Hu, W., Hampton, S., & Reath, J. (2020). "I just had no idea what it was like to be in prison and what might be helpful": Educator and Learner Views On Clinical Placements in Correctional Health. *Teaching and Learning in Medicine*, 32(3), 259-270.
- Alsan, M., Yang, C. S., Jolin, J. R., Tu, L., & Rich, J. D. (2023). Health Care in US Correctional Facilities—A Limited and Threatened Constitutional Right. *New England Journal of Medicine*, 388(9), 847-852.

QUESTIONS AND ANSWERS

1. Approaches likely to facilitate medical student learning in a correctional healthcare setting include:
- A. Promotion of sustainability at the institutional level
 - B. Orientation to security arrangements, personal safety, management of anticipatory anxiety
 - C. Debriefing sessions by educators external to the correctional environment
 - D. Identification of tasks medical students can do within correctional health clinics which are more than mere observation
 - E. All the above

ANSWER: E

2. Medical University-Corrections partnerships often face which of the following challenges?
- A. Effective collaboration
 - B. Discontent by local politicians due to a misperception that inmates are receiving "Cadillac" healthcare
 - C. Exposure to a wide enough variety of medical illnesses
 - D. A and B only

ANSWER: D

F3 PTSD IN IST DEFENDANTS: ADDRESSING A GENDER IMBALANCE

Mary Maddox, MD, Atlanta, GA (I)
Brittany Clayton, MD, Atlanta, GA (I)
Tomina Schwenk, MD, Atlanta, GA (I)
Courtney Harhay, MD, Atlanta, GA (I)
Peter Ash, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE

Forensic mental health professionals have been assessing competency to stand trial and providing competence restoration for a very long time. However, if the scarcity of publications on the gender differences in competency restoration reflects the reality, there is little awareness among forensic professionals of how the gender of the defendant could influence the restoration process. There seems to be the expectation that the methods used to restore men will work equally well with women. This study seeks to expose the differences in male and female defendants found incompetent and to help inform those involved in competency restoration of factors related to gender that are not in balance.

SUMMARY

Emory’s Psychiatric and Law Service (PLS) performs court-ordered competency to stand trial evaluations of male and female in Fulton County, Georgia. In 2011, we created a male jail-based competency restoration program to address the long waitlists for hospital beds but lacked the resources for a female program. Females are just 15% of the Fulton Jail’s inmates, but the proportion of women found incompetent has been significantly higher than that of men. Research has found that women in prison have a greater incidence of post-traumatic stress disorder but the rates appear under reported in jails (Belet et al., 2020). We are starting a female competency restoration program and are exploring what this difference might mean for competency restoration. To understand the incidence of trauma in female defendants and to improve the restoration process, we are using the Primary Care PTSD Screen (PC-PTSD- 5) to identify the level of trauma in those who are evaluated for competency. Our results will be put in the context of the relevant research on the inequitable impact of trauma on women, including the negative health consequences they experience while involved in the criminal justice system. Suggestions for addressing PTSD as part of competency restoration will be included.

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QUESTIONS AND ANSWERS

1. The likelihood of female defendants being diagnosed as having PTSD is about:

- A. 2%
- B. 6%
- C. 12%
- D. 17%
- E. 21%

ANSWER: E

2. What percentage of females defendants evaluated for competency are likely to be found incompetent?

- A. 2%
- B. 5%
- C. 10%
- D. 15%
- E. 25% or greater

ANSWER: E

F4 POSTER WITHDRAWN

F5 COMPARISON OF FORENSIC PSYCHIATRY IN THE UNITED STATES AND NIGERIA

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 Debra A. Pinals, MD, Ann Arbor, MI
 Matthew Grover, MD, Saline, MI

EDUCATIONAL OBJECTIVE

To provide an overview of forensic psychiatry in Nigeria, including civil commitment and criminal forensic psychiatry; To compare how the current court and mental health systems in Nigeria and the United States address issues in civil commitment and criminal forensic psychiatry; and to describe current legislative efforts in Nigeria related to civil commitment and criminal forensic psychiatry that attempt to address challenges within the mental health and legal system.

SUMMARY

The COVID-19 pandemic has re-emphasized the importance of transnational collaboration in many areas of medicine, including forensic psychiatry. Both the United States and Nigeria rank in the top ten most populous countries and reviewing their mental health systems can provide opportunities to identify common challenges as well as areas for improvement. This poster will provide a comparison between Nigeria and the United States of several areas within forensic psychiatry, including civil commitment, correctional psychiatric care, competency to stand trial evaluations, criminal responsibility evaluations, and forensic psychiatry training. The poster will describe current efforts in Nigeria to address the ongoing challenges in addressing mental health needs with an emphasis on legislation. Although each country presents with a unique legal framework and mental health system, the poster will aim to identify opportunities for future collaboration and analysis.

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QUESTIONS AND ANSWERS

1. The history of correctional psychiatry in Nigeria can be traced to the 20th century when two important lines of 'asylums' were established under the Lunacy Ordinance by the British colonial administration in
 - A. 1900
 - B. 1916
 - C. 1960
 - D. 1963

ANSWER: B

2. Which of the following is/are notable challenge(s) affecting the provision of mental health care in prison settings in Nigeria?
 - A. Workforce shortage
 - B. Inadequate funding
 - C. Security and Safety
 - D. Ethical concerns
 - E. All of the above

ANSWER: E

F6 EVALUATION OF A COURT-ORDERED INJECTION PROGRAM

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EDUCATIONAL OBJECTIVE

To determine the impact of a community court order to treat injection program on hospitalizations and arrests.

SUMMARY

Long-acting injectable antipsychotics (LAIA) are a treatment cornerstone for psychotic disorders, particularly when insight is impaired. LAIA initiation often occurs during psychiatric hospitalization and pursuant to court order. Following LAIA initiation, psychiatric stability is contingent on maintenance treatment. To improve LAIA adherence, community agencies, the University of Cincinnati Medical Center (UCMC), and the Hamilton County Probate Court and Mental Health Board partnered to create the "Community Injection Program." The program, created in 2019, established a subset of individuals, already adjudicated as a mentally ill person subject to court order under the Outpatient Community Probate statute, who are monitored for LAIA adherence. Patients nonadherent to their LAIA may be legally conveyed by law enforcement to UCMC Psychiatric Emergency Services for physician assessment. The patient is hospitalized if necessary; otherwise, the physician reviews the LAIA for appropriateness, authorizes its administration, and the patient is discharged. We sought to evaluate if the Community Injection Program has decreased psychiatric hospitalizations and arrests among its participants. We compared arrests and hospitalizations of 48 individuals for the 12 months before and after beginning the program. The results suggest decreases in arrests and hospitalizations. Additionally, we discuss the legal and ethical considerations of establishing such a program.

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QUESTIONS AND ANSWERS

1. Which of the following is the strongest predictor of treatment adherence, irrespective of antipsychotic choice?

- A. Frequent follow up with the treatment team
- B. Remission of substance use disorders
- C. Affordability of pharmacotherapy
- D. Reduction in the Positive and Negative Syndrome Scale positive factor

ANSWER: D

2. Results of a patient questionnaire indicate those treated with LAIAs believe:

- A. LAIAs are less effective than oral antipsychotics
- B. Oral antipsychotics have less side effects than LAIAs
- C. LAIAs have better relapse prevention than oral antipsychotics
- D. LAIAs are extremely painful

ANSWER: C

F7 DUAL ROLES IN NEVADA: HOW UNIQUE STATE LAW CREATES ETHICAL COMPLEXITY

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Caitlin Chen, MD, Las Vegas, NV (I)

Matthew Christie, MD, Las Vegas, NV (I)

EDUCATIONAL OBJECTIVE

To understand the dual roles members of the Nevada forensic community face due to the unique wording of state competency restoration law.

SUMMARY

A forensic evaluator strives to avoid dual roles to the best of their abilities. In Nevada, however, this is not possible due to unique stipulations defining competency restoration law. Per Nevada Revised Statute (NRS), competency evaluations are written by treating members of an individual's inpatient treatment team. Typically such an arrangement would be perceived as a conflict of interest, but in Nevada, this is an expectation defined in state law. The situation presents both disadvantages and advantages, which this poster will explore. NRS specifically requires that individuals with felonies undergo three competency evaluations: two written by psychiatrist and psychologist from the treatment team, and a third by an independent evaluator outside the treatment team. There are few board certified forensic psychiatrists in the state, which in general faces a physician shortage. Individuals writing competency evaluations often lack formal forensic training and have employment elsewhere. At times, these dual roles can present ethical quandaries, such as when a prescriber at the county jail is also a psychiatrist at the state forensic hospital who writes competency evaluations. Providers must navigate the ethical complexities of managing dual relationships due to working in several roles.

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QUESTIONS AND ANSWERS

1. In Nevada, how is competency restoration law unique for an inpatient treatment team?
 - A. State law requires members of the inpatient treatment team to write a competency evaluation on their own patients.
 - B. State law prohibits members of the inpatient treatment to write a competency evaluation on their own patients.
 - C. State law explicitly says all evaluators must be “independent.”

ANSWER: A

2. In Nevada, how many competency evaluations are required for an individual charged with a felony who has been committed for competency restoration treatment?
 - A. One.
 - B. Two.
 - C. Three.

ANSWER: C

F8 FROTTEURISM AND PSYCHIATRIC CO-MORBIDITIES: A SYSTEMATIC REVIEW

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EDUCATIONAL OBJECTIVE

To understand the relationship between frotteurism with comorbid psychiatric disorders, the focus of treatment, paraphilic interest and behaviors, the prevalence of frotteurism in the community, potential legal implications and what education can be given to victims or the society.

SUMMARY

In our systematic review study, we conducted a qualitative synthesis to determine the relationship between frotteurism with comorbid psychiatric disorders, the focus of treatment, paraphilic interest and behaviors, and the prevalence of frotteurism in the community. A comprehensive systematic literature search was conducted in 2 electronic databases (PubMed and Scopus) with appropriate MeSH terms “frotteurism,” “frotteurism AND voyeurism,” “frotteurism AND forensic,” “frotteurism AND depression,” and “paraphilia,” either in the title or text. Twelve articles were included in the systematic review after critical appraisal. We observed high rates of frotteurism with depression. There is also an observed association of treatment with dopaminergic agents with frotteurism. Frotteurism is an underreported paraphilia, as it primarily exists as a nuisance in society and is generally not registered as a crime. Many factors are associated with it, including psychiatric comorbidities. Victims need to be aware of the legal implications of this disorder and encouraged to report it. Education and awareness in the community are necessary to facilitate early diagnosis and prompt treatment. However, there are currently no specific FDA-approved treatments for frotteurism. This systematic review highlights the need for further research to better understand the prevalence and management of frotteurism in the community.

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QUESTIONS AND ANSWERS

1. At which age group does frotteurism tend to typically present itself?
 - A. Late teens to early adulthood (15 - 25 years old)
 - B. Early childhood (2 - 7 years old)
 - C. Middle adulthood (45 -55 years old)
 - D. Geriatric (> 65 years old)

ANSWER: A

2. Which of the following definitions most accurately describes the act of frotteurism?
- A. Watching a person who is naked while they are in the process of undressing or engaging in sexual activity
 - B. Having compulsive sexual fantasies about exposing one's genitals (often male) to a stranger, usually either a woman or a child
 - C. Intense, repetitive sexual urges to touch and rub up against a non-consenting person or people, usually in crowded places
 - D. Deriving sexual pleasure or gratification from the psychological and physical suffering of other people

ANSWER: C

F9 PSYCHIATRIC COMORBIDITIES FOR PARRICIDE: A SYSTEMATIC REVIEW.

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EDUCATIONAL OBJECTIVE

To understand the risk factors, psychiatric comorbidities, and patterns of violence associated with parricide, and preventative or identification of risk factors earlier for prevention of Parricide.

SUMMARY

Parricide, a form of homicide, refers to killing one's father, mother, or other close relatives. It can have far-reaching effects on families, communities, and society as a whole. Although rare, this type of crime is usually committed by children against their parents. In the United States, there are 300 cases of parricide annually, less than 2% of all homicides. To understand the risk factors, psychiatric comorbidities, and patterns of violence associated with parricide, we conducted a systematic review by searching 3 databases for articles using the keywords "parricide," "matricide," and "patricide." We limited our search to human studies published in English between 2012 - 2023 and identified 133 articles, where 36 were included. Our findings show that parricide offenders are typically young, white males in their early 20s domiciled with their victims. Risk factors include a history of child abuse, antisocial personality, schizophrenia, and non-compliance with psychiatric medications. Most killings are spontaneous and involve using firearms or sharp objects. Parricide is a severe offense with significant psychological and social repercussions for individuals and their families. Further research is needed to identify efficient preventive measures to enhance the security and welfare of children and the wider society.

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QUESTIONS AND ANSWERS

1. What are some of the risk factors associated with parricide?
- A. History of drug abuse and alcoholism
 - B. A stable and supportive family environment
 - C. Compliance with psychiatric medications
 - D. A history of child abuse, antisocial personality, and schizophrenia

ANSWER: D

2. What percentage of homicides in the United States are estimated to be cases of parricide, according to the FBI?
- A. 5%
 - B. 10%
 - C. Less than 2%
 - D. More than 50%

ANSWER: C

F10 CHRONIC TRAUMATIC ENCEPHALOPATHY: THE FORENSIC PSYCHIATRIST'S ROLE

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EDUCATIONAL OBJECTIVE

We will primarily discuss the role of Forensic psychiatrists in Chronic traumatic encephalopathy (CTE) current applicability of a forensic psychiatrist may be for psychological autopsies, particularly a postmortem suicide risk assessment for those for whom the manner of their death is uncertain. We will also touch on the neuropsychiatric symptoms and the legal controversies due to the immense financial stakes from past legal action against the NFL.

SUMMARY

Chronic traumatic encephalopathy (CTE), formerly known as dementia pugilistica, or “punch drunk” is a progressive neurodegenerative syndrome caused by repeated head trauma that may or may not be sub-concussive in nature. Neuropsychiatric symptoms such as depression, attention and memory deficits, poor executive functioning, disinhibition, mood lability, executive functioning deficits, impulsivity, apathy, and aggression are purported to be sequelae of this condition. Much of the legal controversy is due to the immense financial stakes from past legal action against the NFL. While such controversy is relevant from a tort and workers’ compensation perspective, matters of criminal responsibility have been raised, with considerable medicolegal questions. The court may utilize the forensic psychiatrist’s evaluation, report, and expert testimony. CTE has currently diagnosed postmortem, and the current applicability of a forensic psychiatrist may be for psychological autopsies, particularly a postmortem suicide risk assessment for those for whom the manner of their death is uncertain. We will discuss the challenges inherent to its characterization and diagnosis. Furthermore, we will discuss the legal ramifications of this diagnosis from the vantage of criminal responsibility. Finally, we will propose what the forensic psychiatrist’s role as an expert consultant is in potential criminal proceedings against individuals with purported CTE.

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QUESTIONS AND ANSWERS

1. How is CTE currently diagnosed?
 - A. Through blood tests
 - B. Through imaging scans of the brain
 - C. Postmortem examination of the brain
 - D. Through behavioral assessments

ANSWER: C

2. Which of the following symptoms are associated with CTE?
 - A. Depression and anxiety
 - B. Attention and memory deficits
 - C. Poor executive functioning
 - D. All of the above

ANSWER: D

F11 ASSESSING VARIANCE TO TESTAMENTARY CAPACITY USING COGNITIVE TOOLS

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EDUCATIONAL OBJECTIVE

This study aims to gather normative data for the Testamentary Capacity Assessment Tool (TCAT) and examine its convergence with established cognitive tests.

SUMMARY

The demand for an impartial and consistent evaluation of testamentary capacity (TC) in people with dementing illnesses is on the rise. The development of a new instrument called the Testamentary Capacity Assessment Tool (TCAT) aims to address this need. However, its use in legal and clinical contexts has been limited due to the lack of validation and benchmark data. This study aims to gather normative data for the TCAT and examine its convergence with established cognitive tests. This study involved 28 (11 males and 17 female) elderly adults of varying ethnicity. Randomly selected patients enrolled in the geriatric psychiatry clinic at UTHSCSA were interviewed in one sitting. The TCAT was administered along with the Geriatric Depression Scale (GDS), the Mini-Mental State Examination (MMSE), the Executive Interview (EXIT 25), CLOX 1, CLOX 2, and the Memory Impairment Screen (MIS). Spearman's rank correlation with Bonferroni correction was computed to assess the relationship ($p=0.00238$). Among the cognitive assessments, there was only a significant positive correlation between TCAT and the MMSE ($r(28)=.68$, $p=.0017$). We hope our findings promote further awareness and use of the TCAT in clinical and forensic settings for the assessment of TC, however further research is needed.

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QUESTIONS AND ANSWERS

1. Criteria for testamentary capacity were outlined in what landmark case?
- A. US v. Comstock
 - B. Vacco v. Quill
 - C. Banks v. Goodfellow
 - D. District of Columbia v. Heller

ANSWER: C

2. Which of the choices listed refers to a person's ability to make a will in a clear and valid way?
- A. Testamentary capacity
 - B. Decision-making capacity
 - C. Estate planning
 - D. Advanced directive

ANSWER: A

F12 RELEASING INSANITY ACQUITTEES WITH INTELLECTUAL DISABILITY

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Ken Weiss, MD, Bala Cynwyd, PA

EDUCATIONAL OBJECTIVE

Participants will consider the unique challenges in the violence risk assessment of post-NGRI individuals with intellectual disability and acquire strategies to effectively address this static risk factor when planning for transitions in levels of care.

SUMMARY

Intellectual disability disorder (IDD) is a static risk factor when calculating violence risk. This case describes a 38-year-old man with IDD, schizophrenia, and cannabis use disorder. He allegedly brandished a household knife towards a crossing guard while experiencing paranoia and auditory hallucinations. He was found not guilty by reason of insanity (NGRI) and committed to a forensic institution until he “no longer pose[s] a danger to public safety.” Previous forensic evaluators recommended transfer to a non-forensic setting, but both opinions were rescinded following subsequent episodes of aggression. A violence risk assessment was recently conducted, identifying modifiable and non-modifiable risk factors, the latter including IDD. Such individuals are vulnerable to psychotic episodes and impairments in impulse control, executive functioning, and insight into their illness and treatment. This creates challenges in disposition planning for post-NGRI acquittees. By increasing coping and social skills, self-reliance, medication compliance (especially long-acting injectable antipsychotics), and investment in familial relationships, risk may be mitigated to a degree at which step-down to a non-forensic setting is considered appropriate.

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QUESTIONS AND ANSWERS

1. Intellectual disability predisposes individuals to psychosis. Which of the following psychotic symptoms has the highest likelihood of resulting in a violent action?
 - A. Auditory hallucinations
 - B. Visual hallucinations
 - C. Paranoid delusions
 - D. Grandiose delusions

ANSWER: C

2. Which of the following factors is not associated with a decreased risk for violence in individuals with intellectual disability?
 - A. Self-reliance
 - B. Social skills
 - C. Impulsivity
 - D. Improved insight

ANSWER: C

F13 INTEGRATING EQUITY, DIVERSITY, AND INCLUSION IN FORENSIC EDUCATION

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EDUCATIONAL OBJECTIVE

To discuss initiatives that have been included in training programs in forensic psychiatry in order to address these issues and promote cultural awareness, sensitivity, and humility in forensic psychiatry.

SUMMARY

There is an overrepresentation of diverse cultural groups in both the forensic mental health and criminal justice systems. Forensic psychiatrists therefore assess and treat patients who demonstrate increasing cultural diversity and indigeneity. It has been argued that forensic psychiatrists should be equipped to address cultural themes in assessment and rehabilitation. The University of Toronto, at the Centre for Addiction and Mental Health, have suggested a framework to promote health equity and to integrate equity, diversity, and inclusion into the planning, development, and implementation of educational treatment initiatives and psychiatric practice. This model recognizes health inequities and considers the needs of vulnerable and marginalized populations. The model uses the ADDIE model of instructional design. In this presentation we discuss initiatives that have been included in training programs in forensic psychiatry in order to address these issues and promote cultural awareness, sensitivity, and humility in forensic psychiatry.

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QUESTIONS AND ANSWERS

1. Mental health services should strive for the following in relation to patient experience:

- A. Cultural humility
- B. Cultural safety
- C. Cultural competence
- D. Cultural awareness

ANSWER: B

2. The following contributes to the overrepresentation of people of minority ethnicity in forensic mental health services

- A. Complex structural equities in society
- B. Complex structural inequities in society
- C. Bias against people of nonminority ethnicity in forensic mental health services
- D. Lack of culture competence among forensic mental health service providers

ANSWER: C

F14 ASSESSING TRENDS IN ARKANSAS COMPETENCY TO STAND TRIAL EVALUATIONS

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Lindsey A. Willbanks, MD, Little Rock, AK

EDUCATIONAL OBJECTIVE

Understanding trends in court-ordered Forensic Evaluations

SUMMARY

Incarceration rates within Arkansas have grown considerably within the last few decades, with a 52% increase in the jail population from 2000 to 2015 (1). With an estimated 2 of 5 people in jail having a history of mental illness, Arkansas is seeing a growth in court-ordered evaluations, leading to delays in both evaluation and subsequent treatment when needed (2). Here, we analyze monthly totals of competency to stand trial evaluation orders in Arkansas from 2019 to 2022, using linear modeling to demonstrate the significant increase in demand for these evaluations. While further research is needed to understand the, likely many, factors leading to delays in timely forensic psychiatric evaluation and treatment in Arkansas, this data suggests that the demand for forensic psychiatric evaluations is growing considerably each year, which is a nation-wide concern. We propose that this increase in demand without a proportional increase in supply of trained evaluators is of utmost concern and conclude by offering solutions to this issue.

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QUESTIONS AND ANSWERS

1. What percentage of inmates across the United States have a mental illness?

- A. 20%
- B. 30%
- C. 40%
- D. 50%

ANSWER: C

2. The state of Arkansas has seen what trend in the number of CST evaluations ordered?
- A. A Significant increase
 - B. No significant change
 - C. Significant decrease

ANSWER: A

F15 BARRIERS IN SEXUAL ASSAULT VICTIM DISCLOSURES: A FORENSIC CHECKLIST

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Sydney Soder, MD, Las Vegas, NV (I)

Melissa Piasecki, MD, Reno, NV

EDUCATIONAL OBJECTIVE

To recognize the myths and barriers surrounding victim conduct in sexual assault cases. To understand the importance of addressing myths and barriers in sexual assault cases. Describe potentially relevant factors for forensic experts to consider when dealing with sexual assault cases.

SUMMARY

Social media movements such as #MeToo have brought greater recognition to the magnitude of sexual abuse, harassment, and rape. However, despite this greater social awareness, myths about victim conduct continue. When victims disclose their assault, the validity of their statements and subsequent behavior is scrutinized by professionals, jurors, and laypeople, creating a potential bias that victims and the legal system must overcome. Research literature on sexual assault statement disclosure patterns have identified barriers and facilitators that impact many elements of disclosure. Examples include the age of the victim, available resources and the relationship between the victim and the abuser. We present a checklist of evidence-based, potentially relevant factors for forensic experts to consider in record reviews, interviews, reports, and testimony. Addressing these factors can inform the trier of fact in cases related to sexual assault victims.

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QUESTIONS AND ANSWERS

1. Which of the following is a common rape myth?
- A. Victims often know the perpetrator
 - B. Victims of acquaintance rape may have similar psychological experiences as victims of “stranger” rape
 - C. Victims typically provoke a rape through specific behaviors
 - D. Victim disclosure may occur over weeks, months or years.

ANSWER: C

2. Which is NOT a common reason for a delayed disclosure of sexual assault?
- A. Victims believe they may be blamed for the assault
 - B. Victims have delusional beliefs about law enforcement
 - C. Victims are concerned about the safety of other members of the household
 - D. Victims were threatened by the perpetrator

ANSWER: B

F16 FROM COMMUNITY TO CORRECTIONS: THE TRANSINSTITUTIONAL MODEL APPLIED

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Hon. Egan Walker, Reno, NV (I)
Elizabeth R. Phelan, MD, Chicago, IL (I)
Sydney Soder, MD, Las Vegas, NV (I)

EDUCATIONAL OBJECTIVE

Compare and contrast community factors and impact incarceration rates in two geographical areas. Identify a number of community factors that are associated with elevated rates of incarceration. Describe the overrepresentation of mentally ill people in correctional facilities.

SUMMARY

Although mental health systems of care and the criminal justice system are traditionally administered as separate government functions, they are inextricably linked through trans-institutionalization, the transfer of supervision and care for people with mental health disorders from health care systems to correctional systems. When communities close psychiatric hospital beds and limit community services for mental health and substance use disorders, jail populations rise with a disproportionate number of people with mental health problems being incarcerated. Increased rates of incarceration lead to large inequities in terms of health, mental health, mortality. This poster reviews the research-identified community factors that drive incarceration rates and predict the size of a county jail population (Ramezan, 2022). We also examine the published research on the impact of jail incarceration rates on the health and mental health of individuals and communities (Kajepeeta, 2021). We apply predictor variables for the size of jail populations from national studies to two case studies: a medium-sized county in the western US and another jurisdiction with a similar population size but dramatically different community factors and incarceration rates. Lastly, we discuss the evidence for programs and describe models to decrease this inequity.

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QUESTIONS AND ANSWERS

1. Which of the following is a community driver for lower rates of incarceration for people with mental health disorders?
 - A. The availability of office-based physician specialists and psychiatrists
 - B. Higher concentrations of police in the community
 - C. Smaller county population (<250,000)

ANSWER: B

1. High rates of incarceration in a community area are associated with which county-wide outcomes?
 - A. Decrease in crime rate
 - B. Decrease in suicide rates
 - C. Increase in all-cause mortality
 - D. Increase in birth rate

ANSWER: C

F17 THE DUNDRUM TOOLKIT USING IN ITALIAN REMS

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EDUCATIONAL OBJECTIVE

Not practicing forensic psychiatry at the highest level attainable based on current knowledge of the fundamentals of the field

SUMMARY

In Italy, treating psychiatric patients who committed crimes has significantly changed since the Prime Minister's decree of April 2008 transferred health responsibilities from the Ministry of Justice to the Ministry of Health. This change entailed the establishment in 2014 of the Residences for the Execution of the Safety Measurement (REMS) and transferring of all socially dangerousness patients. This study aims to examine this transformation's state of the art and whether the forensic inpatients received a correct level of security treatment with the DUNDRUM Toolkit. The DUNDRUM is a Toolkit consisting of four specific scales used with forensic patients for evaluation and treatment purposes for allocating forensic patients to higher or lower levels of therapeutic security. A sample was recruited throughout the national territory of over 250 offenders affected by mental disorders from different contexts: Italian REMS, prisoners, released offenders, offenders admitted to hospitals and/or forensic facilities, forensic patients in the communities, and patients placed on waiting lists. DUNDRUM Toolkit is shown to be single, composite, adaptable, and easy to use, which can assess many needs and main characteristics identified in the Italian forensic treatment model, which could be quickly adopted by all health professionals involved in the various forensic contexts.

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QUESTIONS AND ANSWERS

1. How many scales does the DUNDRUM Toolkit consist of?

- A. 4
- B. 3
- C. 2
- D. 1

ANSWER: A

2. The DUNDRUM Toolkit allows for the assessment of the level of therapeutic security needed for a psychiatric forensic patient?

- A. Yes
- B. No

ANSWER: A

F18 RISK AND PROTECTIVE FACTORS TO TREATMENT IN DANGEROUS OFFENDERS

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EDUCATIONAL OBJECTIVE

Not practicing forensic psychiatry at the highest level attainable based on current knowledge of the fundamentals of the field.

SUMMARY

The present survey investigates the forensic psychiatric treatment in Italy, evaluating treatments effectiveness and identifying risk and protective factors in reducing violence. Patients placed in Residencies for Execution of Security Measures (REMS) (n=26), inpatients on probation in the forensic facilities (n=40) and non-offending inpatients placed in general psychiatric facilities (n=60) were enrolled in different time point (T0: BPRS, GAF, PCL-R, SAPROF, T1 and T2: BPRS, GAF, T3: telephone interview after patient's discharge). The MOAS was carried out weekly. GAF scores were lower in REMS patients 47.3 (9.2) vs those in forensic facilities 54.5 (14.1), vs those in general psychiatric facilities 58.6 (14, 7) (p=0.01). PCL-R Factor 1 scores were higher in REMS patients 8.6 (3.1) vs those in forensic facilities 5.5 (3.7), vs general psychiatric facilities 4.7 (3.6) (p<0.001); SAPROF protection scores were lower in REMS patients than in other facilities (p=0.011). At T2 BPRS scores decreased from 48.5 (15.7) to 42.8 (17.8) (p<0.001). MOAS scores at T0 were higher in REMS patients. A progressive reduction in MOAS scores was observed. The Italian model allocates forensic patients at different level of therapeutic security according to need. Treatment in REMS and forensic facilities demonstrates effective reduction of the risk of violence.

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QUESTIONS AND ANSWERS

1. Mark the true statement among the following

- A. REMS patients presented with higher PCL-R Factor 1 scores, indicating a higher degree in selfish, callous and remorseless psychopathology
- B. REMS patients presented with higher GAF scores, indicating a less severe impact of the psychiatric illness on functioning compared to non-offending inpatients
- C. Non offending inpatients surprisingly showed higher selfish, callous and remorseless psychopathology, indicating a high risk to becoming offenders
- D. All of the previous answers are true

ANSWER: A

2. Which one is true about the outcome of the treatment in forensic settings in Italy?

- A. Treatment was not effective in reducing global symptomatology and aggression;
- B. There was a reduction in both BPRS and MOAS between t1 and t2 indicating reduction both in general symptomatology and in the risk of violence;
- C. There was a reduction in BPRS scores indicating an efficient treatment in general psychiatric symptomatology, but no reduction in MOAS, indicating inefficacy in reduction of the risk of violence;
- D. None of the previous answers is true

ANSWER: B

F19 PERSONALITY DISORDERS AND SCHIZOPHRENIA: FORENSIC TREATMENT PATHS

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EDUCATIONAL OBJECTIVE

Not practicing forensic psychiatry at the highest level attainable based on current knowledge of the fundamentals of the field.

SUMMARY

In Italy the Residencies for Execution of Security Measures (REMS) admit dangerous offenders acquitted due to criminal insanity and replaced forensic psychiatric hospitals. Schizophrenia spectrum disorders (SSD) (60%) and, personality disorders (PD) (32%) are the most frequent diagnoses among REMS patients. Despite SSD and PD differ in several clinical aspects, the legislator has not hypothesized the need for differentiated forensic treatment paths. This study focusses on differences between SSD and PD REMS patients. Secondary analyses were performed on a sample of 730 REMS patients extracted from an observational retrospective study in the 1-year period. PD group (n=173) comprised more females ($p<0.001$), with a medical history of substance abuse ($p<0.001$), than the SSD group (n=408). The SSD group was more frequently admitted in REMS due to homicide/attempted homicide ($p<0.001$), and violence against public officials ($p=0.044$) than PD patients. Among SSD patients we found a higher recognition of criminal irresponsibility ($p<0.001$). PD group engaged in violent behaviors in the last year ($p<0.001$) more frequently compared to SSD group. SSD patients were more likely to assume antipsychotic polypharmacy ($p=0.005$), and a higher dose of antipsychotic ($p<0.001$). These initial results provide empirical evidence to support the need of personalized forensic treatment paths.

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QUESTIONS AND ANSWERS

1. What are the crimes most frequently committed by patients with schizophrenia admitted to the Italian Residencies for Execution of Security Measures?

- A. Homicide/attempted homicide
- B. Sexual offenses
- C. Crimes correlated with weapons, drugs and evasion

ANSWER: A

2. How does the use of antipsychotics vary between REMS patients with schizophrenia and a with personality disorder?

- A. Patients affected by schizophrenia were more likely to assume antipsychotic polypharmacy compare to patients affected by personality disorders
- B. No significant difference of pharmacological treatment between patients with schizophrenia and with personality disorders.

ANSWER: A

F20 EFFECTS OF COVID ON OUTCOMES OF AN IN-JAIL RESTORATION PROGRAM

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Peter Ash, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE

To use the experience of how services were provided during COVID to better plan for how to provide optimal in-jail competency restoration services going forward.

SUMMARY

As with many psychiatric services, in-jail competency restoration services have been affected by the COVID pandemic. There have been limitations on allowing mental health professionals into the jail, less group activity to avoid contagion, loss of personnel, court delays, and major shifts to telehealth services. Since mid-2021, there has been a loosening of some restrictions, but practice has not returned to pre-COVID ways. A comparison of outcomes of the Fulton County Jail competency restoration unit in the pre-COVID period, maximum precautions period (March 2020 to May 2021), and follow-up period (May 2021 to present), shows that despite difficulties in providing services, restoration rates held steady or increased, although at a cost of increased length of stay.

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QUESTIONS AND ANSWERS

1. This study suggests that in jail restoration units that rely heavily on telehealth services:
 - A. Have worse outcomes than when using in-person services,
 - B. Are able to reduce length of stay.
 - C. Are able to continue to restore competency, although less efficiently than utilizing in-person services
 - D. Are able to continue to restore competency more efficiently than utilizing in-person services
 - E. Function similarly to in-person services

ANSWER: C

2. Restoring competency to stand trial in an In-jail competency restoration unit
 - A. Does not lead to cost savings.
 - B. Works well for defendants who refuse medication.
 - C. Should be seen as one step in a continuum of services for competency restoration.
 - D. Can provide care at the same level as a hospital inpatient unit.
 - E. From the time of referral, typically takes longer than referring the defendant to an inpatient unit.

ANSWER: C

F21 MENTAL ILLNESS STIGMA: PERSPECTIVES OF JUDGES AND LAWYERS IN LEBANON

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EDUCATIONAL OBJECTIVE

To provide information about mental health literacy and mental illness stigma among judges and lawyers in the Lebanese criminal justice system and to provide a basis to develop educational curricula about mental health to judges and lawyers.

SUMMARY

Judges, prosecutors and defense attorneys commonly come across cases involving mental illness in the criminal justice system and they may play a direct role in influencing the outcome of these cases. Forensic mental health services in Lebanon are scarce, despite the elevated proportion of individuals with mental illness who are incarcerated. Our knowledge of Lebanese judges and lawyers' attitudes regarding mental illness is limited. Therefore, we aim to assess the perspectives of lawyers and judges practicing in Lebanon towards mental illness and towards individuals with mental health issues. For this purpose, we surveyed Lebanese judges and lawyers via mass email. Our cross-sectional survey included a section on socio-demographics and the Reported and intended behavior scale (RIBS) and Perceived devaluation and discrimination scale (PDD). The results of the study will help advance our knowledge about the perception of mental illness among key actors within the Lebanese criminal justice system. By identifying the extent of mental health literacy and potential stigmatizing beliefs, our study can lend support to including mental health courses in law curricula to improve mental health awareness among judges and lawyers, and consequently promote criminal justice reform for defendants with mental illness.

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QUESTIONS AND ANSWERS

1. Which of the following is true regarding mental health literacy in the US criminal justice system?

- A. Judges are generally not interested in the testimony of mental health experts;
- B. Criminal law curricula tend to include several courses about mental health issues;
- C. Most judges do not have a significant education in social sciences and mental health;
- D. Mental health is rarely in issue in criminal practice

ANSWER: C

2. Forensic mental health services in Lebanon:

- A. Are limited in scope and resources;
- B. Include inpatient and outpatient services;
- C. Have an established sex offender treatment program;
- D. Include inpatient units for competency restoration

ANSWER: A

F22 AFTER THE INVOLUNTARY HOLD: CLINICAL OUTCOMES & PATIENT PERCEPTIONS

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Adriana Baez, MD, Miami Beach, FL (I)
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EDUCATIONAL OBJECTIVE

Educating medical students and practicing providers on the criteria for involuntary commitment while also exploring the clinical impact of involuntary psychiatric holds and the patient perceptions of the experience after the involuntary hold.

SUMMARY

Public health policy must balance preserving civil liberties with protecting community health. Involuntary psychiatric holds are a public health measure that markedly shifts the balance from respecting patient's rights in favor of protecting the patient from imminently harming themselves or others. A recent study evaluating trends in rates of psychiatric holds in 25 states unveiled a 13% annual increase in involuntary psychiatric hospitalization rates within a period of only a 4% increase in population size. In 2020, Florida alone saw 194,680 involuntary psychiatric evaluations. Policies allowing for short-term involuntary psychiatric commitment exist in every state, yet the data regarding their effectiveness in improving long-term mental health outcomes or exploring the patient perspective of the experience is limited. To better understand the impact of this policy in Florida, a case series is conducted on adults with multiple involuntary hold episodes at a safety net hospital in South Florida to explore clinical outcomes, including continuity of mental health care, subsequent suicide or homicide attempts, and future healthcare utilization. This study has the potential to improve data collection, and inform policy recommendations at the state and federal levels. This work should influence further research into the efficacy of involuntary psychiatric holds.

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QUESTIONS AND ANSWERS

1. What is the trend of involuntary psychiatric utilization?

- A. Stable with population growth
- B. Increasing compared to population growth
- C. Decreasing compared to population growth

ANSWER: B

2. In Florida, who can NOT initiate an involuntary hold?

- A. Health professional
- B. Police Officers
- C. Family/Friend
- D. Judge/ Court Ordered

ANSWER: C

F23 PREDICTING COMPETENCY RESTORATION LENGTH WITH THE RBANS

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EDUCATIONAL OBJECTIVE

This presentation aims to introduce forensic mental health professionals to a cognitive screening tool that allows for specific areas of functioning to be examined and not just a composite score. Most mental status tests act like a “cognitive blender” and produce just a total score, which may obscure the significant cognitive factor that causes the need for forensic services, such as competency restoration. Encouraging forensic professionals to examine the core cognitive issues could lead to the development of better tools for restoring competency, including psychiatric medications.

SUMMARY

Adequate cognitive functioning is essential for any individual to be competent to stand trial. Prior research has shown that patients who are often deemed incompetent and non-restorable are individuals who present with increased levels of cognitive impairment. Similarly, Ross and colleagues explored cognitive functioning and restorability using the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), a neurocognitive screening battery. They found that the RBANS total score was associated with a greater length of hospital stay required for competency restoration. However, their study did not examine the associations between hospital stay and specific RBANS cognitive domains. This study addresses whether scores on the RBANS domains of attention, immediate memory, and delayed memory are correlated with non-restorability and longer jail-based competency restoration in inmates treated in the Competency Restoration Program at the Fulton County Jail in Atlanta, Georgia, and whether the use of a screening tool that allows for analysis of specific cognitive domains can help predict the length of time a defendant is likely to require competency restoration services and eventually lead to the development of techniques to facilitate faster and more cost-effective treatments.

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QUESTIONS AND ANSWERS

1. In competency restoration programs, the greatest number of patients who display significant limitations in understanding the legal system have a diagnosis of:
- A. Intellectual Disability
 - B. Depression
 - C. Schizophrenia/Schizoaffective Disorder
 - D. Generalized Anxiety Disorder

ANSWER: C.

2. Which is not a domain the RBANS assess:

- A. Processing Speed
- B. Immediate Memory
- C. Delayed Memory
- D. Attention

ANSWER: A

F24 RISK ASSESSMENTS, SOCIAL MEDIA, AND SCHOOL SHOOTINGS

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EDUCATIONAL OBJECTIVE

Recommendations regarding risk assessments for social media comments about school shootings.

SUMMARY

The vast majority of mass school shooters who are themselves K-12 students in the school have told at least one person of their plans prior to shooting. With schools' increased vigilance about school shootings, concerning comments on social media or videogame chatrooms trigger a risk assessment of students who make such comments. For risk assessments regarding threats other than school shootings, literature review suggests videogame chat rooms and violent video games may play a role in predisposing individuals towards becoming numb to violent images. This can lead to decreased inhibition in sharing violent fantasies which may be expressed in group chats, leading to school administrators referring the student for a risk assessment. Studies suggest that most individuals who use video game chat rooms do not engage in reckless at-risk behavior, and the risk found during an assessment may be mitigated by monitoring children's online activity, promoting healthy social connections, and providing access to mental health services. In contrast to impulsive aggression, mass shootings are the product of careful planning, which has important implications for how the risk assessment should be conducted.

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QUESTIONS AND ANSWERS

1. Which of the following is a potential risk factor for school shootings?

- A. Telling someone their plan
- B. Researching how to obtain weapons
- C. Researching prior school shootings
- D. All of the above

ANSWER: D

2. What may violent video games play a role in for children?

- A. Numbness to violent images
- B. Increase school shootings
- C. Increase in bullying
- D. Increased engagement in schoolwork

ANSWER: A

F25 REBALANCING THE MENTAL HEALTH-CRIMINAL JUSTICE INTERFACE

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Hon. Justice Loretta Rush, Indianapolis, IN (I)
Hon. Judge Steve Leifman, Miami, FL (I)
Scott A. Block, MA, Chicago, IL

EDUCATIONAL OBJECTIVE

Describe the State Courts Leading Change Report and Recommendations and Behavioral Health Strategic Plans; Identify at least three ways forensic psychiatrists can (and should) utilize this Report and Recommendations and Plans to improve outcomes in legal, forensic, and clinical systems and the community; Identify at least two ways to engage local judges in the work of decriminalizing mental illness.

SUMMARY

The Chief Justices of all 50 states and all 50 State Court Administrators established a National Judicial Task Force Examining the State Courts' Response to Mental Illness. The Task Force has concluded, after issuing its final report and recommendations, and the next phase of its implementation work is now governed by the Conference of Chief Justices (CCJ) and the Conference of State Court Administrators (COSCA) Behavioral Health Committee. This session will provide an update on the Task Force's work and behavioral health strategic plans including opportunities for forensic psychiatrists to join in this work and use their expertise to improve outcomes for those involved in the criminal justice system. Developing collaborative partnerships with judges to impact system change will be emphasized. The Judges and Psychiatrists Leadership Initiative (JPLI), a project of The American Psychiatric Association Foundation and the Council of State Governments Justice Center, supports the development of these collaborative partnerships. A multidisciplinary presentation drawing upon the literature, findings, and the expertise of a panel of national court leaders and psychiatrists will be followed by discussion and Q and A regarding actionable steps that forensic psychiatrists can take in their jurisdictions to get involved with this important work.

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The National Judicial Task Force to Examine State Courts' Response to Mental Illness. Leading Change Report and Recommendations. National Center for State Courts; October 2022 MHTF_State_Courts_Leading_Change.pdf (ncsc.org)

QUESTIONS AND ANSWERS

1. What are three effective strategies to reduce the involvement of people with mental illness in the criminal justice system?
 - A. Law enforcement Crisis Intervention Team programs (prebooking diversion).
 - B. Diversion into treatment (post-booking diversion).
 - C. Limit the use of the CST process to cases that are inappropriate for dismissal or diversion.
 - D. All of the above

ANSWER: D

2. Incarceration is associated with negative effects on which of the following?
 - A. Mental health outcomes.
 - B. Housing stability.
 - C. Reintegration and successful tenure in the community.
 - D. All of the above.

ANSWER: D

F26 INTELLIGENT USE OF ARTIFICIAL INTELLIGENCE: BEING PRACTICAL AND ETHICAL

(Sponsored by the Technology Committee)

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Alan Newman, MD, Newport Beach, CA
Michael Rogers, MD, El Cerrito, CA
James Armontrout, MD, Palo Alto, CA

EDUCATIONAL OBJECTIVE

Forensic experts need to find a balance between the utility and potential technical and ethical pitfalls of artificial intelligence.

SUMMARY

Artificial intelligence (AI) is a branch of computer science that aims to create machines that can perform tasks that typically require human intelligence, such as recognizing speech, understanding natural language, and making decisions. This presentation will include an explanation of how some of the most relevant AI machine learning (ML) models work in order to understand their strengths and limitations. Practicing experts will obtain a basic understanding of the principles behind the technology, and an appreciation that the provided user interfaces to technologies such as ChatGPT are simulating but do not represent actual conversations with a generally intelligent virtual consciousness. The rest of the presentation will focus on potential applications of readily available AI tools and their implications for the practicing expert witness, including risk assessment instruments, writing tools, and primary literature search/summary. For the more technically adept, an example of how to setup, train, and run a local version of a large language model (LLM) will be provided. These kinds of local “agents” offer substantial possibilities for the automatic analysis of large volumes of text and images, and the output of condensed reports or summaries thereof. Their local nature eliminates some concern over uploading sensitive material to the “cloud.”

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QUESTIONS AND ANSWERS

1. According to a recent survey of VA providers who have worked with REACH VET the percentage who “Agree” or “Strongly Agree” that “The time I invest in REACH VET duties is well spent” was around:
 - A. 6%
 - B. 30%
 - C. 45%
 - D. 85%
 - E. 98%

ANSWER: A

2. When considering a highly trained predictive model, overfitting refers to:
 - A. Training the model on too much data, so that it becomes overwhelmed and its responses are too slow.
 - B. Training the model on too little data, so that its responses are too vague.
 - C. Training the model on too little data, so that its responses are too invariant.
 - D. Training the model on too much data, so that it becomes agile and its responses are quick.

ANSWER: C

F27 BALANCING ETHICAL DILEMMAS IN FORENSIC LANDMARK CASES

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Patricia Recupero, JD, MD, Providence, RI
Richard Martinez, MD, Denver, CO
Margarita Abi-Zeid Daou, MD, Worcester, MA

EDUCATIONAL OBJECTIVE

At the conclusion of this workshop, participants will be able to describe pertinent ethical principles as applied to several landmark cases in forensic psychiatry. Presenters will discuss ethical issues from the perspective of a forensic psychiatrist retained by one or both of the parties, while highlighting the duties they must balance, in cases selected for their relevance to specific ethical principles described by AAPL and APA.

SUMMARY

Forensic psychiatrists are expected to exercise the highest ethics in performing assessments and giving testimonies. However, many fellowship programs do not allot sufficient time for seminars devoted to ethics. We propose to use AAPL's landmark cases as a source for ethical analysis and learning. Presenters will analyze cases and provide examples of how ethics can be drawn into analyses of each major subject area identified in AAPL's Landmark Case document, including the Right to Die; Physician-Patient Relationship; Criminal Process; Emotional Harm/Disability/Workplace; and Duty to Protect. Discussants will demonstrate how landmark cases can draw from APA's Principles of Medical Ethics and AAPL's Ethics Guidelines, along with perspectives from various scholars who have contributed to forensic psychiatry ethics. Ethical dilemmas from more recent and prominent cases (US and other countries) will be presented as frameworks for discussion. Teaching materials will be drawn from multiple sources, including actual ethics advisory opinions, case law, films, novels, and other non-traditional sources, illustrating didactic techniques for diverse training and education settings to improve training in ethics for forensic psychiatrists. Participants will be asked to identify ethical challenges, explore possible solutions in highlighted landmark and other cases and develop active learning exercises to use while teaching fellows.

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Canada's Medically Administered Death (MAD) Expansion for Mental Illness: Targeting the Most Vulnerable (2022) 71(4) WMJ 72-82.

QUESTIONS AND ANSWERS

1. In *Cruzan v. Director, Missouri DMH* (1990), the U.S. Supreme Court utilized which constitutional principle to guide their decision?
 - A. Due process
 - B. Privacy
 - C. Liberty interest
 - D. Double jeopardy

ANSWER: C

2. Which of the following cases set the precedent for prohibiting discrimination against people with disabilities in state and local governments services, programs, and employment (Title II of Americans with Disabilities Act)?
 - A. *Olmstead v. L. C. ex rei. Zimring*
 - B. *U.S. v. Georgia*
 - C. *Kumho Tire Co., Ltd. v. Carmichael*
 - D. *Oncale v. Sundowner Offshore Services, Inc.*

ANSWER: B

F28 YOUR BITE AT THE AAPL: HELP SHAPE OUR ORGANIZATION'S FUTURE – (ADVANCED)

(Sponsored by the Membership, Engagement, Recruitment, and Retention – MERR – Task Force)

Abhishek Jain, MD, New York, NY
Ariana Nesbit, MD, Durham, NC
Britta Ostermeyer, MD, Oklahoma City, OK
Ashley VanDercar, MD, Northfield, OH
Tobias Wasser, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

1) Identify recent challenges faced by professional organizations in serving their members and patient populations; 2) Examine how AAPL has evolved, especially in the training of and clarifying the functions of forensic psychiatrists; 3) Explore future directions for AAPL, including in ethics, teaching, and research

SUMMARY

The 2021-2022 AAPL President's Membership, Engagement, Recruitment, and Retention (MERR) Task Force presents this lively interactive Workshop. The COVID-19 pandemic and events of the past three years forced us to reflect on our personal and professional values, from how we spend our time to broader societal and ethical concerns regarding culture, race, and gender. This has similarly been an inflection point for professional medical organizations, including AAPL. This presentation will review recent challenges faced by professional organizations (e.g., diversity and social justice), examine how AAPL and its membership have evolved over the past five decades, and summarize MERR Task Force findings. This includes findings from our October 2022 AAPL Members Survey, from which we received 341 responses (18.9% response rate) with useful AAPL membership perspectives and organizational needs. Audience polling will allow real-time feedback regarding future organizational directions and specific relevant topics (e.g., ethics, advocacy, education). The second half of the session will particularly allow small breakout groups for hands-on problem solving and opportunities to share views on training, teaching, and research needs. Focus will be on identifying how AAPL can optimize value for its membership, serve our patient populations and members, and enhance forensic psychiatric practice, knowledge, and research.

REFERENCES

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Cerny-Suelzer CA, Friedman SH. Be Woke, Choose Growth. Cathleen A. *J Am Acad Psychiatry Law*. 2022 Mar; 50(1):8-12

QUESTIONS AND ANSWERS

1. As of 2018, what percentage of AAPL membership is female?

- A. 65%
- B. 55%
- C. 45%
- D. 35%

ANSWER: D

2. In what year were the current AAPL "Ethics Guidelines for the Practice of Forensic Psychiatry" adopted?

- A. 1989
- B. 1997
- C. 2005
- D. 2013
- E. 2021

ANSWER: C

F29 THE MEANING OF FORESEEABILITY IN THE DUTY TO PROTECT

Alan R. Felthous, MD, St. Louis, MO

EDUCATIONAL OBJECTIVE

Participants will gain an understanding of 1) the seismic shift in the concept of foreseeability from the American Law Institute's Second Restatement of Torts to its Third Restatement. 2) how the development of violence risk assessment instruments has contributed to the changing concept of foreseeability. 3) how the Third Restatement and certain subsequent landmark cases have incorporated the duty of reasonable care into the duty to protect non-patients from the patient's violence. 4) implications of these changes in foreseeability for both clinical practice and public policy.

SUMMARY

Forensic psychiatrists and psychologists should be familiar with the diverse legal rules for establishing a duty to protect victims from the potential violence of their patients. Mental health clinicians in general should know which protective rule(s) govern their practice. These diverse rules of third-party liability share a commonality: They are almost all based upon foreseeability by the clinical tortfeasor. This core concept of foreseeability is different, depending upon whether the commissions or omissions are considered ordinary negligence, negligence based upon medical malpractice or public policy, and whether the duty is owed to one's own patient or to non-patients. Recent years have seen the development of another, broader concept of foreseeability shaping the duty to protect nonpatients, the duty of reasonable care. This analysis traces the evolution of changing legal concepts of foreseeability from the pre-Tarasoff era to the 21st century application of the concept of reasonable care in the protection of nonpatients.

REFERENCES

American Law Institute. Restatement (Second) of Torts. American Law Institute (1965).

American Law Institute. Restatement of the Law Third: Torts: Liability for Physical and Emotional Harm. Vol 2, sections 37-65. St. Paul, MN: American Law Institute, 2012.

QUESTIONS AND ANSWERS

1. An integral component of the "duty to protect" in the Second Restatement is the ability to:

- A. Influence the patient
- B. Treat the patient
- C. Warn the intended victim
- D. Control the patient.

ANSWER: D

2. Which of the following protective measures in the Third Restatement was not included in the California Supreme Court's Tarasoff Principle:

- A. Warning the identifiable victim
- B. Providing appropriate treatment to the patient
- C. Warning law enforcement
- D. Taking whatever other steps are necessary under the circumstances.

ANSWER: B

F30 ADVANCED NEUROIMAGING AND MILD TBI LITIGATION, REVISITED

Hal S. Wortzel, MD, Centennial, CO

EDUCATIONAL OBJECTIVE

Participants will learn the evidence regarding the use of various imaging techniques in the setting of mild TBI. Participants will learn about guidelines regarding the ethical presentation of neuroimaging evidence.

SUMMARY

Over a decade has now passed since publishing a brief series addressing advanced neuroimaging in the context of mild TBI litigation. That being the case, it seems like an appropriate interval to revisit these matters and consider the present landscape, to include appropriate uses and ethical reporting of advanced neuroimaging, as well as the ongoing potential for idiosyncratic applications, if not abuses. Much has

changed in the intervening decade in terms of various publications, guidelines, and position statements on the subject of neuroimaging in TBI, including its clinical and forensic applications. At the same time, implementation of these publications, guidelines, and position statements is lagging, and misapplications and misinterpretations continue to feature regularly in medicolegal matters involving claims of highly atypical, and medically improbable, negative outcomes after mild TBI. This presentation will offer an update on advanced neuroimaging and the best evidence for its use as informed by findings from the fields of neuroradiology, brain injury medicine, and neuropsychiatry, and will also explore the increasingly apparent need for greater involvement of forensically-trained physicians (i.e., forensic neuropsychiatrists) to serve as experts in such matters.

REFERENCES

Wortzel HS, Filley CM, Anderson CA. Forensic applications of cerebral single photon emission computed tomography in mild traumatic brain injury. *J Am Acad Psychiatry Law*. 2008 Sep; 36 (3):310–22

Wortzel HS, Kraus MF, Filley CM, et al. Diffusion tensor imaging in mild traumatic brain injury litigation. *J Am Acad Psychiatry Law*. 2011 Dec; 39(4):511–23

QUESTIONS AND ANSWERS

1. According to ACR Appropriateness Criteria, which of the following is usually appropriate for the evaluation of subacute or chronic head trauma?
 - A. fMRI
 - B. DTI
 - C. SPECT
 - D. MRI without contrast

ANSWER: D

2. The AMA Guide to the Evaluation of Disease and Injury Causation:
 - A. Is silent on the issue of malingering
 - B. Reports extremely low base rates of malingering in the setting of litigation
 - C. Mandates consideration for possible malingering
 - D. Discourages the use of the term malingering

ANSWER: C

F31 THE FORENSIC MENTAL HEALTH IMPLICATIONS OF SOCIAL MEDIA CHALLENGES

Emily Asher, MD, San Francisco, CA
Nathaniel P. Morris, MD, San Francisco, CA
Dale E. McNiel, PhD, San Francisco, CA (I)
Renée L. Binder, MD, San Francisco, CA

EDUCATIONAL OBJECTIVES

The learner will understand the new phenomenon of social media challenges and the role of forensic psychiatrists in evaluating individuals in related cases.

SUMMARY

Children and adolescents are increasingly spending time on social networking sites and can be exposed to “social media challenges.” These challenges are online dares or competitions and often involve participants recording themselves performing various activities to create a short video. Some of the activities have led to injury or death of the participants or other individuals. In this paper, the authors describe examples of these challenges and subsequent criminal charges and civil litigation. The authors describe a case where two children stabbed their friend as part of a social media challenge and the role of the forensic evaluator in helping the court determine culpability. The authors describe other potential roles of forensic evaluators who become involved in these type of cases. These include educating the Court about neurodevelopmental stages, the role of risk taking in adolescents, and determinations about whether behavior was accidental or related to intentional self-injury or suicide.

REFERENCES

Grant-Alfieri A, Schaechter J, Lipshultz SE. Ingesting and aspirating dry cinnamon by children and adolescents: the “cinnamon challenge”. *Pediatrics*. [Internet] 2013 [cited 2023 Mar 2] 131(5):833. Available from: doi: 10.1542/peds.2012-3418

Centers for Disease Control and Prevention. CDC Study Warns of Deaths Due to the Choking Game. [Internet] 2008 [cited 2023 Mar 2]. Available from: <https://www.cdc.gov/media/pressrel/2008/r080214.htm>

QUESTIONS AND ANSWERS

1. This challenge involves completing a series of steps that includes self-harm:
 - A. Kiki Challenge
 - B. Blue Whale Challenge
 - C. Skullbreaker Challenge
 - D. Orbeez Challenge

ANSWER: B

2. In *Anderson v. Tiktok*, the TikTok platform was sued on what grounds?
 - A. Wrongful death
 - B. Intentional infliction of emotional distress
 - C. Negligent infliction of emotional distress
 - D. Failure to provide the consumer adequate warning for safe use
 - E. Unfair trade practice

ANSWER: A

F32 HOW WE ARRIVED HERE: CASES THAT INFLUENCED HOW WE RESPOND TO VIOLENT CRIME

Steven R. Conlon, Quantico, VA (I)

EDUCATIONAL OBJECTIVES

To enhance the understanding that we continue to learn from each investigation. We can apply this new insight into our future work as we strive to identify not only what has occurred but also why the crime took place in the manner that it did.

SUMMARY

This presentation will examine and discuss criminal behavior observed in a variety of historical actions that involve different offenders and their motivations. Specific cases involving violence will be reviewed and the aspects of how each of these enhanced our insight will be discussed. The analysis of this information will be presented in a sequence that will include the aspects of the crime, offender information and motivation then concluding with the implications it has on how this can be beneficial in the application to future investigations.

REFERENCES

Campbell, J. H., & DeNevi, D. (2010). *Profilers*. Prometheus Books.

Douglas, J. E., Ann Wolbert Burgess, & Burgess, A. G. (2019). *Crime classification manual : a standard system for investigating and classifying violent crime*. Wiley.

QUESTIONS AND ANSWERS

1. Identify a case mentioned in the presentation where the motivation has not been validated?

ANSWER: *DC Sniper case, Mandalay Bay shooting in Las Vegas*

2. What city had the worst school disaster in the United States?

ANSWER: *Bath, Michigan (1927)*

F33 A MULTIDIMENSIONAL APPROACH TO RADICALIZATION AND EXTREMISM

(Sponsored by the Human Rights and National Security and Forensic Neuropsychiatry Committees)

Jacob C. Holzer, MD, Belmont, MA

Anne Speckhard, PhD, Washington, DC (I)

John Wyman, Special Agent (Ret.), FBI, Glen Allen, VA (I)

Patricia Recupero, JD, MD, Providence, RI

EDUCATIONAL OBJECTIVE

Service - increased understanding of those at risk of being radicalized, assessment and potential interventions to deradicalize; Teaching - a multi-factorial approach to up-to-date content on issues of radicalization and extremism, prominent current issues related to threats and violent behavior; Research - this panel presentation will discuss various potential research opportunities in clinical and forensic psychiatry.

SUMMARY

The radicalization process and extremist views and behavior have become prominent concerns in the U.S. and abroad, resulting in a heightened risk of violence based on political views, divisiveness, intolerance and racism. This panel presentation will discuss important topics underlying radicalization and extremism. Anne Speckhard, an authority in extremism, will discuss the radicalization and de-radicalization process, based on her work with the International Center for the Study of Violent Extremism. John Wyman will provide a broad overview of the federal law enforcement approach to extremism, including first amendment protections, mental health complications, juveniles, threat assessment and threat management/mitigation, based on his work as former Chief of the FBI's Behavioral Threat Assessment Center. Pat Recupero will discuss the impact of the internet and social media on the development of extremist ideology, including the roles of internet subcultures. Jacob Holzer will review key psychiatric and neuropsychiatric aspects of extremism based on recent research findings.

REFERENCES

Scrivens R, Wojciechowski TW, Freilich JD, Chermak SM, Frank R. Differentiating online posting behaviors of violent and nonviolent right-wing extremists. *Criminal Justice Policy Review* 2022; 33(9): 943–965; doi: 10.1177/08874034221095398

Shafi N. The Neuroscience of Terrorism: A Neuroscientific Approach to Understanding Cognitive-Behavioral Traits of Violent Extremists. *The New School Psychology Bulletin*, 2021, Vol. 18, No. 1; <http://www.nspb.net/index.php/nspb/article/view/335>

QUESTIONS AND ANSWERS

1. Individuals belonging to an internet subculture glorifying the perpetrator of the 2015 Charleston, SC church shooting refer to themselves by which moniker?
 - A. The Proud Boys
 - B. The Bowl Gang
 - C. The League of Supreme Gentlemen
 - D. The Boogaloo Boys
 - E. The Daily Stormers

ANSWER: B

2. Which of the following statements is not accurate?
 - A. A recent Dept. of Homeland Security National Terrorism Advisory Bulletin indicated there is an increased threat of domestic violent extremism
 - B. Research at Cambridge University has shown numerous neurocognitive findings in those holding right-wing, but not left-wing, extremist beliefs including dogmatic opinions, cognitive inflexibility, and a generic resistance to revising mistakes
 - C. Contemporary research supports an integrative approach to understanding extremism, including studying social psychology, personality, cognitive psychology and neuroscience
 - D. Research has shown that social exclusion is a strong indicator for risk of extremist violence motivated by either sacred values or money
 - E. Research at the U.S. Air Force Academy has shown that cadets with strong religious beliefs, as compared with those with lesser religious affiliation, take greater risks in virtual combat situations

ANSWER: B

F34 BALANCING SECURITY AND RIGHTS IN ASYLUM EVALUATIONS

(Sponsored by the Human Rights and National Security Committee)

Mikel Matto, MD, Portland, OR
Krista M. Ulisse, DO, Morgantown, WV
Stephen N. Xenakis, MD, Philadelphia, PA
Philip J. Candilis, MD, Washington, DC
Reema Dedania, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE

The learner will understand the new phenomenon of social media challenges and the role of forensic psychiatrists in evaluating individuals in related cases.

SUMMARY

Children and adolescents are increasingly spending time on social networking sites and can be exposed to “social media challenges.” These challenges are online dares or competitions and often involve participants recording themselves performing various activities to create a short video. Some of the activities have led to injury or death of the participants or other individuals. In this paper, the authors describe examples of these challenges and subsequent criminal charges and civil litigation. The authors describe a case where two children stabbed their friend as part of a social media challenge and the role of the forensic evaluator in helping the court determine culpability. The authors describe other potential roles of forensic evaluators who become involved in these type of cases. These include educating the Court about neurodevelopmental stages, the role of risk taking in adolescents, and determinations about whether behavior was accidental or related to intentional self-injury or suicide.

REFERENCES

Grant-Alfieri A, Schaechter J, Lipshultz SE. Ingesting and aspirating dry cinnamon by children and adolescents: the “cinnamon challenge”. *Pediatrics*. [Internet] 2013 [cited 2023 Mar 2] 131(5):833. Available from: doi: 10.1542/peds.2012-3418

Centers for Disease Control and Prevention. CDC Study Warns of Deaths Due to the Choking Game. [Internet] 2008 [cited 2023 Mar 2]. Available from: <https://www.cdc.gov/media/pressrel/2008/r080214.htm>

QUESTIONS AND ANSWERS

1. This challenge involves completing a series of steps that includes self-harm:

- A. Kiki Challenge
- B. Blue Whale Challenge
- C. Skullbreaker Challenge
- D. Orbeez Challenge

ANSWER: B

2. In *Anderson v. Tiktok*, the TikTok platform was sued on what grounds?

- A. Wrongful death
- B. Intentional infliction of emotional distress
- C. Negligent infliction of emotional distress
- D. Failure to provide the consumer adequate warning for safe use
- E. Unfair trade practice

ANSWER: A

F35 AUTISM AND AGGRESSION: ASSESSING THE SPECTRUM OF VIOLENCE

Kathleen L. Kruse, MD, Ann Arbor, MI
Camille Tastenhoye, MD, Pittsburgh, PA
Anne McBride, MD, Sacramento, CA
Charles Scott, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

Participants will identify the impact of an Autism Spectrum Disorder diagnosis in various aspects of juvenile and criminal justice system involvement, including the forensic evaluation, interventions and treatment in the justice system, specific criminal behaviors, and risk assessment.

SUMMARY

Autism Spectrum Disorder (ASD), first described in the 1940s and included in the DSM-III, has received increasing attention and awareness in recent years. Individuals with ASD represent 1% of the general population, but are overrepresented in criminal justice populations. A number of high-profile criminal cases, such as the Sandy Hook and Majorie Stoneman Douglas mass shootings, have led to increased attention to the potential relationship of ASD to criminal behavior. While child and adolescent psychiatrists are trained in diagnosis and treatment of ASD, forensic psychiatrists have varying familiarity and comfort with this disorder, structured assessments of ASD, and its relevance in forensic settings. This workshop will review the literature on ASD in justice-involved individuals, including prevalence and comorbid conditions in these settings. We will discuss ASD in the context of certain criminal acts, including sex crimes, impulse control, and the assessment of violence and recidivism risk. Finally, we will review important factors of ASD in forensic assessment, including the use of the Autism Diagnostic Observation Schedule (ADOS) and other commonly used assessment instruments to complement autism assessment. The evaluation for ASD in individuals without a documented history of the diagnosis and potential malingering of this disorder will also be highlighted.

REFERENCES

Heeramun R, Magnusson C, Hellner Gumpert C, et al . Autism and conviction for violent crimes: population-based cohort study in Sweden. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2017; 56(6):491-497.

Volkmar FR, Loftin R, Westphal A, Woodbury-Smith M, editors. *Handbook of Autism Spectrum Disorder and the Law*. Springer Nature, Switzerland. 2021.

QUESTIONS AND ANSWERS

1. What is the prevalence of Autism Spectrum Disorder in the general population?

- A. 1%
- B. 5%
- C. 10%
- D. 20%

ANSWER: A

2. Which of the following is not a diagnostic criterion of Autism Spectrum Disorder that may impact a defendant's Competence to Stand Trial?

- A. Nonverbal communication deficits
- B. Cognitive rigidity
- C. Repetitive or scripted speech
- D. Impulsive behavior
- E. Sensory processing problems

ANSWER: D

F36 CLAIMS OF DISABILITY DUE TO PTSD

Chinmoy Gulrajani, MD, Minneapolis, MN
Paul Arbisi, PhD, Minneapolis, MN (I)

EDUCATIONAL OBJECTIVE

At the end of this presentation, audience members will demonstrate knowledge of best practice standards for evaluating claims of PTSD.

SUMMARY

In the year after the murder of George Floyd, the number of Minnesota police officers and firefighters applying for disability retirement tripled. Seventy nine percent of disability applications were based on claims of job-related PTSD. Police and firefighters are eligible for both Worker's Compensation and the Minnesota Public Employees Retirement Association (PERA) retirement benefits. The claims are commonly disputed by the municipalities and an independent psychiatric/psychological evaluation (IPE) is undertaken. Presenters of this workshop are forensic mental health professionals who have extensive experience conducting IPEs to determine the presence of PTSD and whether the condition results in disability. The degree and duration

of disability, and whether a delayed onset of symptoms of PTSD has occurred are often in question. This workshop will cover the research database on symptoms of PTSD and best practice standards for evaluating claims of PTSD. A framework for assuring a reliable and valid diagnosis of PTSD that focuses on reaching an opinion regarding the presence of work-related PTSD that will withstand legal challenge will be presented. Additionally, four clinical vignettes will be provided to the audience members who will be asked to provide an opinion on the validity of the claim based on the vignette.

REFERENCES

Mikel M, McNeil DE and Binder RL. A Systematic Approach to the Detection of False PTSD. *J Am Acad Psychiatry Law* 47:325–34, 2019

Smith v. Carver County, 931 N.W.2d 390 (Minn. 2019)

QUESTIONS AND ANSWERS

1. For a DSM-5TR diagnosis of PTSD in adults, the duration of disturbance must be:

- A. Less than six months
- B. More than six months
- C. Less than one month
- D. More than one month

ANSWER: D

2. One of the following is not a qualifying Criterion A event for a DSM-5TR diagnosis of PTSD:

- A. Learning about loss of spouse in a driving accident
- B. Repeated exposure to human remains in first responders
- C. Being exposed to repeated gory violence in war movies
- D. Sexual assault under the effects of a date-rape drug

ANSWER: C

F37 THE EFFECTS OF SOCIAL MEDIA ON FACTITIOUS DISORDER AND MALINGERING

Paul Brindley, MD, Galveston, TX
Ravali Poreddy, MD, Columbia, MO (I)
Akriti Sinha, MD, Williamsburg, VA
Tobias Wasser, MD, New Haven, CT
Rocksheng Zhong, MD, Galveston, TX

EDUCATIONAL OBJECTIVE

To understand the impact of social media on the spread of misinformation and its effect on individuals with Tourette's Syndrome, Dissociative Identity Disorder, and ADHD. To identify online communities that have grown around specific diagnoses and their potential negative effects on individuals, including the spread of factitious disorder and malingering. To explore ways psychiatrists can navigate the ethical and legal implications of commenting on mental health diagnoses and offer recommendations for clinical practice in the age of social media.

SUMMARY

Forensic psychiatrists have a long tradition of assessing feigned or exaggerated symptoms of mental illness in medicolegal contexts. In the age of social media, forums such as TikTok and Reddit have given new life to this phenomenon, particularly with respect to Tourette's Syndrome, Dissociative Identity Disorder, and ADHD. Although social media has played an essential role in raising mental health awareness and reducing stigma, it enables the spread of misinformation, obscures evidence-based practices, and allows people to share tactics for feigning illness to achieve secondary gains. This panel presentation will address social media-influenced examples of factitious disorder and malingering. We will explore various online communities that have grown around specific diagnoses and share examples from former community members about their experiences and motivations, including the desire for attention, social pressures, and evading responsibility. Psychiatrists' debunking online misinformation, especially when shared by prominent individuals espousing their personal experiences, is complicated by the Goldwater Rule's restrictions on psychiatrists commenting on an individual's mental health without their permission or having conducted a personal examination. We will discuss the advantages and disadvantages of social media communities, weighing increased public awareness against the risks of misinformation, and conclude with implications and recommendations for clinical practice.

REFERENCES

Giedinghagen A. The tic in TikTok and (where) all systems go: Mass social media induced illness and Munchausen's by internet as explanatory models for social media associated abnormal illness behavior. *Clin Child Psychol Psychiatry*. 2023 Jan;28(1):270-278. doi: 10.1177/13591045221098522. Epub 2022 Apr 27. PMID: 35473358.

Matto M, McNiel DE, Binder RL. A Systematic Approach to the Detection of False PTSD. *J Am Acad Psychiatry Law*. 2019 Aug;47(3):325-334. doi: 10.29158/JAAPL.003853-19. Epub 2019 Jun 10. PMID: 31182437.

QUESTIONS AND ANSWERS

1. Which of the following is a common symptom presentation in individuals with factitious disorder?
 - A. Abrupt onset of symptoms
 - B. Symptoms that worsen with stress
 - C. Complaints of multiple somatic symptoms
 - D. Symptoms that are consistent across various health care providers

ANSWER: C

2. Which of the following is NOT a common motivation for individuals to feign illness online?
 - A. Desire for attention
 - B. Social pressure
 - C. Financial gain
 - D. Evading responsibility

ANSWER: C

F38 DID FOR THE DUBIOUS: VIDEO EXAMINATION FOR INSANITY AND CASELAW REVIEW

(Sponsored by the Trauma and Stress Committee)

David Rosmarin, MD, Newton, MA

EDUCATIONAL OBJECTIVE

Using extensive videos of an actual insanity evaluation, attendees will learn the relevant case law, forensic approach, FMRI evidence and pitfalls in DID insanity cases.

SUMMARY

Along with the repressed memory debates, the existence of DID is doubted by many psychiatrists, despite DSM-5 citing a community study that the prevalence is 1.5 percent. Forensic psychiatrists may lean towards skepticism as a defense against being snookered, as Richard Gere was famously in "Primal Fear." In the 1970's, the first American case resulting in insanity acquittal was William Milligan, the convicted Ohio rapist, kidnapper, and aggravated robber — with an improbable 24 distinct personalities ranging from Yugoslavian communist, to English hematologist, to shy lesbian rapist. Seeming iatrogenic cases, paralleling the surge in repressed memory cases, further pulled forensic psychiatrists into a stance best characterized as dubious. The approach to these cases is best done by video-taped examination, to memorialize the interactions of examiner and examinee. In the case (and other cases) to be presented, the first clues come from taking a careful developmental history. A history of severe, sustained abuse coupled with questions about concurrent dissociation as a child can lead to unexpected evidence for the etiology of the disorder. In this video-exam case, attendees can observe that process, the reluctance (as is typical in genuine cases) to switch personalities, and the personality switches. Be open-minded and decide for yourself.

REFERENCES

Farrell, H.M., Dissociative Identity Disorder: Medicolegal challenges, *J Am Acad Psychiatry Law*, 39:402-406, 2011

Schlumpf, Y, Reinders, A, Nijenhuis, E, et al, Dissociative part-dependent resting-state activity in dissociative identity disorder: a controlled FMRI diffusion study, *PLoS One*, 2014 Jun 12; 9(6): e 98795

QUESTIONS AND ANSWERS

1. Which of the following legal approaches have courts used in DID insanity cases:

- A. Host focus
- B. Alter focus
- C. Unified focus
- D. All three foci

ANSWER: D

2. Which of the following are true regarding forensic evaluations of defendants with DID:

- A. Important to get collateral information
- B. Important to have a topography of alters and functions
- C. Important to clarify which personalities have co-consciousness
- D. Important to assess the relevant capacities of the extant personality at the time of the crime
- E. All of the Above

ANSWER: E

F39 A PRECARIOUS BALANCE: AUTONOMY, RELIGION, AND UNDUE INFLUENCE

(Sponsored by the Geriatric Psychiatry and the Law Committee)

Lauren K. Robinson, MD, MPH, Chicago, IL
Sherif Soliman, MD, Charlotte, NC
Carla Rodgers, MD, Bala Cynwyd, PA
Sanford Finkel, MD, Chicago, IL (I)

EDUCATIONAL OBJECTIVE

At the end of the session, attendees will be able to perform comprehensive forensic evaluations for undue influence and testamentary capacity incorporating and differentiating the concepts of religion, vulnerability, and autonomy.

SUMMARY

Evaluations of testamentary capacity and undue influence require striking a balance between autonomy and protecting vulnerable people. With advances in medical care and the aging of the US population, older adults are the fastest growing demographic in the United States. With this, we can expect the creation of more wills and trusts and by extension, an increased demand for forensic assessments of undue influence and testamentary capacity. The impact of dementia and mental disorders are routinely assessed as part of these evaluations. In more recent years, we have seen an emphasis on the importance of incorporating a cultural formulation into one's opinions. Religion plays a central role in the lives of many, and it is critical to understand the role it plays in testamentary decision making. Distinguishing competent decision-making influenced by faith from manipulation under the guise of religion can be difficult and further complicated by the presence of mental disorders and dementia. Utilizing an interactive case example, our panel will discuss how to approach these complex cases, learning core components of the assessment and how to identify vulnerabilities while maintaining the ethical principle of respect for persons.

REFERENCES

- Shulman, Cohen, C. A., Kirsh, F. C., Hull, I. M., & Champine, P. R. (2007). Assessment of testamentary capacity and vulnerability to undue influence. *The American Journal of Psychiatry*, 164(5), 722–727. <https://doi.org/10.1176/appi.ajp.164.5.722>
- Peisah, Finkel, S., Shulman, K., Melding, P., Luxenberg, J., Heinik, J., Jacoby, R., Reisberg, B., Stoppe, G., Barker, A., Firmino, H., & Bennett, H. (2009). The wills of older people: risk factors for undue influence. *International Psychogeriatrics*, 21(1), 7–15. <https://doi.org/10.1017/S1041610208008120>

QUESTIONS AND ANSWERS

1. Which of the following is the role of the forensic psychiatrist in evaluating undue influence?
- A. Enumerate the vulnerabilities of the testator/testatrix and not the ultimate issue.
 - B. Definitively state one's opinion that they either were or were not unduly influenced.
 - C. Only focus on testamentary capacity.
 - D. Only assess the presence of either a neurocognitive disorder or psychiatric condition.
 - E. None of the above

ANSWER: A

2. What is the relationship between undue influence and testamentary capacity?
- A. They can be used interchangeably.
 - B. One must assess the presence of undue influence even if the testator/testatrix has testamentary capacity.
 - C. An individual must have both to have the will/trust invalidated by the law.
 - D. The law does not incorporate either concept into the invalidation of wills/trusts.
 - E. None of the above.

ANSWER: B

F40 FORENSIC REPRODUCTIVE PSYCHIATRY: PRACTICE GUIDELINES REVIEW – (ADVANCED)

(Sponsored by the Gender Issues Committee)

Susan Hatters-Friedman, MD, Cleveland, OH
Renée Sorrentino, MD, Weymouth, MA
Jacqueline Landess, MD, Milwaukee, WI
Joseph Penn, MD, Conroe, TX
Patricia Westmoreland, MD, Aurora, CO

EDUCATIONAL OBJECTIVE

At the end of this session, the attendee will have a fuller understanding of reproductive psychiatric topics that impact forensic evaluations, such that evaluations and testimony can reflect up-to-date understandings of topics ranging from postpartum psychosis in infanticide cases to issues for menopausal women in prison.

SUMMARY

The American Academy of Psychiatry and the Law's Practice Resource for Prescribing in Corrections describes the challenges of prescribing medications for mental health disorders to persons in jails and prisons, and a spinoff article provided further recommendations focusing on the unique challenges of prescribing for women in corrections through the lifecycle. This currently in-progress practice resource document regarding reproductive forensic psychiatry expands upon this by reviewing forensic issues particularly relevant to the female population and reproductive issues. It is important for forensic evaluators to recognize these gender-based differences in order to appropriately identify the treatment and risk management needs of women. Understanding whether gender-based differences are based on research or the product of bias is also important in formulating forensic opinions. This panel will review the fundamentals of reproductive psychiatry including related to menstruation, pregnancy, postpartum, and menopausal issues and their intersection with mental health. Forensic evaluations related to these will be discussed in detail as well, including neonaticide, filicide, kidnapping by Caesarean, parenting evaluations, risk assessment, mother-baby units, and special issues regarding women at both ends of the reproductive age range in corrections.

REFERENCES

Friedman SH, Kaempf A, Ross N. Reproductive Psychiatry. In *Malpractice and Liability in Psychiatry 2022* Mar 18 (pp. 191-200). Cham: Springer International Publishing.

Friedman SH, Reed E, Ross NE. Postpartum psychosis. *Current Psychiatry Reports*. 2023 Jan 13:1-8. Self Assessment Question #1 (Multiple Choice ONLY):

QUESTIONS AND ANSWERS

1. What percentage of women are pregnant on entry to the correctional system?

- A. 1%
- B. 5-10%
- C. 15-20%
- D. 25-30%

ANSWER: B

2. Why is the DSM-5 category of the ‘with peripartum onset’ (defined as the most recent episode occurring during pregnancy as well as in the four weeks after delivery) criticized?

- A. Pregnancy is a happy time with no depression
- B. Postpartum depression happens only in the first 2 weeks postpartum
- C. The first postpartum six months to year is considered the high risk period for depression
- D. There should not be a special diagnosis for women

ANSWER: C

F41 FIRST GRADERS TO HIGH SCHOOLERS: FINDING BALANCE IN JUVENILE COURT

(Sponsored by the Child and Adolescent Psychiatry Committee)

Anne McBride, MD, Sacramento, CA
 Amanda Wallace, MD, New York, NY
 Amanie Salem, DO, Sacramento, CA
 Charles Scott, MD, Sacramento, CA
 Britta Ostermeyer, MD, Oklahoma City, OK

EDUCATIONAL OBJECTIVE

In this panel, speakers will review the data on various stages of juvenile court to enhance skills of the consulting forensic psychiatrist.

SUMMARY

Multiple states have recently passed “Raise the Age” laws which allow minors previously processed as adults to be diverted to juvenile and family court. On the other end of the spectrum, 24 states in the U.S. lack minimum age legislation for prosecuting a child and other states range from ages 7 to 13 for the minimum age a child can enter the juvenile court system. Moreover, racial inequities persist at every stage of contact within the juvenile legal system. In this panel, speakers will walk the audience through the juvenile court system from entry to adjudication or transfer, including the role of the forensic psychiatrist in court. Attendees will acquire knowledge of current national trends in minimum age of juvenile jurisdiction and racial disparities within the juvenile court system; national trends in juvenile transfer to criminal court and common issues that impact transfer; and the role of the expert witness in evaluating school shooters and anticipated defenses that arise in expert testimony (e.g., developmental immaturity; autism spectrum disorder, fetal alcohol syndrome; depression/mood disorder; and conduct disorder). Clips from expert witness testimony will be used to demonstrate key points.

REFERENCES

Campbell J, McClendon J, Salem A, McBride AB. Spotlight on Juvenile Justice: How Did We Get Here? *J Am Acad Child Adolesc Psychiatry.* 2022; 61(9):1189-1193.

Tolliver DG, Bath E, Abrams LS, Barnert E. Addressing Child Mental Health by Creating a National Minimum Age for Juvenile Justice Jurisdiction. *J Am Acad Child Adolesc Psychiatry.* 2021 Nov;60(11):1337-1339.

QUESTIONS AND ANSWERS

1. The United Nations Convention to the Rights of a child has recommended nations increase their minimum age of criminal responsibility to at least the following age:

- A. 10 years old
- B. 11 years old
- C. 12 years old
- D. 13 years old
- E. 14 years old

ANSWER: E

2. Racial inequities persist at which stage of contact within the juvenile legal system:

- A. Arrest
- B. Intake
- C. Detention
- D. Adjudication
- E. Every stage of contact

ANSWER: E

F42 MIND OF THE MAFIA

Alan R. Felthous, MD, St. Louis, MO
Felice Carabellese, MD, Bari, Italy
Lia Parente, MD, Bari, Italy (I)
Fulvio Carabellese, MD, Siena, Italy (I)
Travaini Guido, MD, Milan, Italy (I)

EDUCATIONAL OBJECTIVE

Not practicing forensic psychiatry at the highest level attainable based on current knowledge of the fundamentals of the field. This panel discussion is submitted on behalf of the International Relations committee.

SUMMARY

Brutal mafia crimes are often striking and of high symbolic content. Mafia men could be considered as self-centered, cold, and emotionally detached people, who have no remorse and are unable to feel empathy or pity for others, even less for their victims, who they do not hesitate to plunder, break the law and kill. In a few words, this is the profile of a psychopath. The authors focus on the possible relationship between psychological/psychopathological profiles of men of the mafia and these men and especially the relationship of the psychopathic dimension in men and women of the mafia. In terms of differential diagnosis, it is important to distinguish antisocial, from dissocial, from psychopathy. In addition to traditional tasks, women play important roles in the criminal field, when their man is absent (arrested or fugitive). Women are then delegated temporary authority and are used in positions of command only because men need serve in. The forthcoming, massive investments of the European community in northern Italy will be discussing. Finally, the Foggia mafia is among the most ferocious and brutal criminal organizations in southern Italy. The origins this organization structure and its specific fields of interest will be debate.

REFERENCES

Carabellese F, Felthous AR, Kennedy HG, Montalbò D, La Tegola D, Coluccia A, Ferretti F, Carabellese F, Catanesi R. Women and men of mafia between traditional cultural contexts and new social roles. *Behav Sci Law*. 2021 Oct;39(5):567-582. doi: 10.1002/bsl.2533. Epub 2021 Aug 19. PMID: 34414597.

Carabellese F, Felthous AR, Montalbò D, La Tegola D, Carabellese F, Catanesi R. The psychopathic dimension in women of mafia. *Int J Law Psychiatry*. 2021 Jan-Feb;74:101600. doi: 10.1016/j.ijlp.2020.101600. Epub 2021 Jan 22. PMID: 33486393.

QUESTIONS AND ANSWERS

1. Do men and women have the same role in the mafia organization?

- A. Yes, they have the same role
- B. Women only temporarily replace men
- C. Women do not play any important role in the mafia organization.

ANSWER: B

2. What are the main characteristics of mafia men?

- A. Self-centered, cold, and emotionally detached
- B. Impulsive, frequent mood swings, and affective instability
- C. Unreasonably high sense of self-importance, interpersonal exploitative, and arrogant attitudes.

ANSWER: A

FRIDAY

SATURDAY, OCTOBER 21, 2023

POSTER SESSION

7:00 AM – 8:00 AM / 9:30 AM – 10:15 AM

CHICAGO BALLROOM F-G-H (5TH FLOOR)

S1 Poster Withdrawn

S2 *Balancing Rights to Conditional Release with Public Fears*

Aliana M. Abascal, MD, Morgantown, WV
Colleen M. Lillard, MD, Morgantown, WV (I)

S3 *Six Barriers to Forensic Psychiatric Research: A Systemic Review*

Amareen Dhaliwal, MD, MPH, Delray Beach, FL
Kenneth Zon, MD, Delray Beach, FL
Anthony Sanchez, MD, Delray Beach, FL
Kristian Hogue, MD, Delray Beach, FL

S4 *Do fMRI Studies Satisfy the Frye & Daubert Standards of Admissibility?*

Kristian M. Hogue, MD, Delray Beach, FL
Gavin Rose, MD, Fort Lauderdale, FL
Amareen Dhaliwal, MD, Delray Beach, FL

S5 *Bioethics and Violence Prosecution in Forensic Psychiatric Settings*

Grayson P. Holt, BA, Cleveland, OH (I)
Xavier F. Amador, PhD, Peconic, NY (I)

S6 *Pride & Prejudice: LGBTQI+ Competency in Sexual Offense Evaluations*

Chase A. Hiller, MD, Kankakee, IL
Charles P. Samenow, MD, Washington, DC (I)

S7 Poster Withdrawn

S8 *Commitment or Not? Legal Updates from the Bay State*

Paul E. Noroian, MD, Worcester, MA
Adeliza Olivero, MD, Boston, MA
Margarita Daou, MD, Worcester, MA

S9 *Psychiatric Risk Factors for Inmate Suicidality in a Large County Jail*

Catherine D. Agarwal, MD, Richardson, TX (I)
Luke P. Coffman, MD, Dallas, TX (I)
Christopher S. Kung, Dallas, TX (I)
Eunsol Park, MD, Dallas, TX (I)
Brianna Lacy, MD, Dallas, TX (I)
Hien Piotrowski, MD, Dallas, TX (I)
Waseem Ahmed, MD, Dallas, TX (I)
Mustafa M. Husain, MD, Dallas, TX (I)

S10 *Characteristics of Jail Inmates with a History of Psychiatric Care*

Krista N. Thompson, Dallas, TX (I)
Christopher S. Kung, Dallas, TX (I)
Eunsol Park, MD, Dallas, TX (I)
Brianna Lacy, MD, Dallas, TX (I)
Mustafa M. Husain, MD, Dallas, TX (I)

S11 *Mental Health Education to the Courts: An Underutilized Resource*

Yarden Segal, MD, Bronx, NY
Gurtej Gill, MD, Bronx, NY
Danielle Kushner, MD, Brooklyn, NY

SATURDAY

S12 Dual Diagnosis in Forensics and Corrections: A Systematic Review

Brandon M. Woolfson, MD, Toronto, Ontario, Canada (I)
Anna Katsev, MD, Toronto, Ontario, Canada (I)
John M. Bradford, MD, Hamilton, Ontario, Canada
Gary A. Chaimowitz, MD, Ancaster, Ontario, Canada
Andrew T. Olagunju, MD, Toronto, Ontario, Canada (I)

S13 Civil Commitment: Neurodevelopmentally Disabled in Florida

Christian T. Maxwell, MD, Delray Beach, FL
Allegra M. Condiotte, MD, MHA, Boca Raton, FL (I)
Richard L. Elliott, MD, PhD, Boca Raton, FL (I)
Gavin Rose, MD, Boca Raton, FL

S14 A New Frontier: Forensic Implications of Designer Benzodiazepines

Ashley Maestas, DO, Reno, NV (I)
Emmanuelle Garcia-Rider, MD, Reno, NV (I)
Melissa Piasecki, MD, Reno, NV

S15 Awareness of and Attitude Toward ERPO in Suicide Decedents' Next of Kin

James C Zinko, MD, Baltimore, MD
Aubrey DeVinney, BA, Baltimore, MD (I)
Matthew Kelly, PhD, Baltimore, MD (I)
Paul S. Nestadt, MD, Baltimore, MD (I)
Ling Li, MD, Baltimore, MD, (I)

S16 Treating for Two: Postpartum Mental Healthcare in Corrections

Parvaneh K. Nouri, MD, MPH, Aurora, CO
Jill Spice, MD, Aurora, CO
Sarah Nagle-Yang, MD, Aurora, CO (I)

S17 Fatale Femme: An Analysis of Women in NC's Forensic Treatment Program

Sara Banoo Feizi, MD, Hillsborough, NC
Nicole Wolfe, MD, Raleigh, NC
Stephanie Cripps, MD, Durham, NC

S18 Tools for Forensic Research: From Databases to Neuroprediction

Amareen Dhaliwal, MD, MPH, Delray Beach, FL
Anthony Sanchez, MD, Delray Beach, FL
Kenneth Zon, MD, Delray Beach, FL (I)
Kristian Hogue, MD, Delray Beach, FL

S19 Legal Considerations for the Use of Electrical Stimulation Devices

Micah Park, MD, Lubbock, TX
Joel Barrett, MD, Lubbock, TX
Astik Joshi, MD, Lubbock, TX

S20 The Black Box – Psychiatry vs. Primary Care Provider's Perceptions

Nicole M. Lentini, MD, Chicago, IL
Cara Angelotta, MD, Chicago, IL

S21 Effectiveness of Multisystemic Therapy with Recidivism in Juveniles

Ritvij Satodiya, MD, Atlanta, GA
Maxwell Miller, MD, Greenville, NC
Tapan Parikh, MD, Chicago, IL (I)
Peter Ash, MD, Atlanta, GA

S22 Balancing Resident Training – Early Exposure to Forensic Psychiatry

Shankar M. Nandakumar, MD, Houston, TX
Vinh-Son Nguyen, MD, Houston, TX (I)
Hira Hanif, MD, Houston, TX
Jeffrey Khan, MD Houston, TX
George Nadaban, MD, Houston, TX

S23 Teaching Core Principles to Residents with a Forensic Consult Clinic

Nicole M. Lentini, MD, Chicago, IL
Reuben Heyman-Kantor, MD, Chicago, IL
Juan Aparicio, MD, Chicago, IL (I)
Cara Angelotta, MD, Chicago, IL

S24 Incompetent to Stand Trial and Not Restorable: A Dilemma

Santanu Baghel, DO, Rochester, MN
Richard Ciccone, MD, Rochester, MN
Robert L. Weisman, DO, Rochester, MN
Nora Douglas, MD, Rochester, MN

PANEL DISCUSSION

8:00 AM – 10:00 AM

CHICAGO BALLROOM D (5TH FLOOR)

S25 Canadian Guidelines for Sexual Behaviour and Risk Assessments

Lisa Ramshaw, MD, Toronto, Ontario, Canada (I)
Treena Wilkie, MD, Toronto, Ontario, Canada
Graham Glancy, MB, Toronto, Ontario, Canada

PANEL DISCUSSION

8:00 AM – 10:00 AM

AVENUE BALLROOM (4TH FLOOR)

S26 When the Abyss Stares Back: Vicarious Trauma in Forensic Psychiatry

Layla Soliman, MD, Charlotte, NC
James C. Rachal, MD, Charlotte, NC (I)
John S. Rozel, MD, Pittsburgh, PA (I)
Lynneice Bowen, MD, Charlotte, NC (I)

S27 Presentation withdrawn

PANEL DISCUSSION

8:00 AM – 10:00 AM

MARRIOTT BALLROOM ADDISON (4TH FLOOR)

S28 Balance, Bias, Boundaries: Psychotherapy and Forensics

(Sponsored by the Diversity Committee)

Ren Belcher, MD, Cleveland, OH
Karen B. Rosenbaum, MD, New York, NY
Ryan Wagoner, MD, Tampa, FL
Anne Dailey, JD, Hartford, CT (I)

RESEARCH IN PROGRESS SESSION #1

8:00 AM – 10:00 AM

CHICAGO BALLROOM A-B-C (5TH FLOOR)

S29 Secure Recovery Care Education for Forensic Staff – A Narrative Review

(Sponsored by the Recovery Committee)

Shaheen A. Darani, MD, Toronto, Ontario, Canada
Elena Wolff, MD, Toronto, Ontario, Canada (I)
Amanda Jas, MD, Toronto, Ontario, Canada (I)
Alexander Simpson, MD, Toronto, Ontario, Canada

S30 Balancing Safety, Liberty and Effective Care in Conditional Release

Cara Klein, MD, Vallejo CA
Melinda DiCiro, PsyD, Represa, CA (I)
Melanie Scott, PsyD, Rocky Hill, CT (I)

S31 Understanding Deliberate Indifference to Suicide

Jennifer Piel, MD, JD, Seattle, WA
Carol Barnes, MD, Seattle, WA

SATURDAY

S32 Schizophrenia and Substance Use Disorders in Incarcerated Patients

Conchita Martin de Bustamante, Dallas, TX (I)
Christopher S. Kung, MD, Fort Worth, TX (I)
Eunsol Park, MD, Austin, TX (I)
Brianne Lacy, MD, Austin, TX (I)
Hien Piotrowski, MD, Austin, TX (I)

COFFEE BREAK

10:00 AM – 10:15 AM

CHICAGO FOYER (5TH FLOOR)

PANEL DISCUSSION

10:15 AM – 12:00 PM

CHICAGO BALLROOM D (5TH FLOOR)

S33 Crisis Negotiation – High Stakes Teamwork – (Advanced)

James L. Knoll IV, MD, Syracuse, NY
Gregg McCrary, MA, Fredericksburg, VA (I)
Detective Vance Ratcliff, Syracuse, NY (I)
Park E. Dietz, MD, MPH, PhD, Newport Beach, CA

PANEL DISCUSSION

10:15 AM – 12:00 PM

AVENUE BALLROOM (4TH FLOOR)

S34 Treating NGRI Acquittees on Conditional Release: An Update

Ren Belcher, MD, Cleveland, OH
Abhishek Jain, MD, New York, NY
Li-Wen Lee, MD, Albany, NY
Sara West, MD, Broadview Heights, OH
Stephen Noffsinger, MD, Cleveland, OH

PANEL DISCUSSION

10:15 AM – 12:00 PM

MARRIOTT BALLROOM CLARK (4TH FLOOR)

S35 Navigating the Digital World: Solutions to Develop Your Practice

(Sponsored by the Early Career Psychiatry Committee)

Gloria Osuruaka, MD, Arlington, VA
Beryl Vaughan, MD, San Rafael, CA (I)
Sanjay Adhia, MD, Sugar Land, TX
Dan Sandman, Esq., Orinda, CA (I)
Alan W. Newman, MD, San Francisco, CA

PANEL DISCUSSION

10:15 AM – 12:00 PM

MARRIOTT BALLROOM ADDISON (4TH FLOOR)

S36 From Marketing to Mayhem: Expert-Lawyer Agreements – (Advanced)

(Sponsored by the Private Practice Committee)

Jason Barrett, MD, Los Angeles, CA
Trent Holmberg, MD, Draper, UT
Steven H. Berger, MD, Reno, NV
William H. Reid, MD, Horseshoe Bay, TX

RESEARCH IN PROGRESS SESSION #2

10:15 AM – 12:00 PM

CHICAGO BALLROOM A-B-C (5TH FLOOR)

S37 Legislative Advocacy as Entry to Learning about Forensics

Jennifer Piel, MD, JD, Seattle, WA

S38 Using Education to Cultivate Confidence in Secure Recovery Practice

Shaheen A. Darani, MD, Toronto, Ontario Canada
Buthaina Almaskari, MD, Toronto, Ontario, Canada (I)
Alexander Simpson, MD, Toronto, Ontario, Canada
Stephanie Penney, MD, Toronto, Ontario, Canada (I)
Patti Socha, MD, Toronto, Ontario, Canada (I)
Faisal Islam, MD, Toronto, Ontario, Canada (I)
Remar Manaol, MD, Toronto, Ontario, Canada (I)
Treena Wilkie, MD, Toronto, Ontario, Canada

S39 Psychiatry Specific Firearm Anticipatory Guidance Curriculum

(Sponsored by the Forensic Training of Psychiatry Residents Committee)

Isabel Stillman, MD, Philadelphia, PA
Meghan Musselman, MD, Philadelphia, PA

LUNCH (TICKET REQUIRED)

12:00 PM – 2:00 PM

CHICAGO BALLROOM E (5TH FLOOR)

S40 A Forensic Psychiatrist's Journey

Park Dietz, MD, Newport Beach, CA

PANEL DISCUSSION

2:15 PM – 4:00 PM

CHICAGO BALLROOM D (5TH FLOOR)

S41 Legal Advocacy and Psychiatric Treatment: Can We Find Common Ground?

Christopher Lloyd Myers, MD, MPH, Marion, MA
Matthew Lahaie, MD, JD, Bridgewater, MA
Keellin Garvey, MD, Bristol, RI
Stephen Dinwiddie, MD, Chicago, IL

PANEL DISCUSSION

2:15 PM – 4:00 PM

AVENUE BALLROOM (4TH FLOOR)

S42 Drugs in "Controlled" Correctional Settings

(Sponsored by the Addiction Psychiatry and Correctional Forensic Psychiatry Committees)

Ashley VanDercar, MD, Northfield, OH
Abhishek Jain, MD, New York, NY
Adelle Schaefer, MD, Cleveland, OH
Sanya Virani, MD, MPH, Westborough, MA
Joseph Penn, MD, Conroe, TX

WORKSHOP

2:15 AM – 4:00 PM

MARRIOTT BALLROOM CLARK (4TH FLOOR)

S43 Female Sex Offenders: Psychotics, Pedophiles or Psychopaths?

Bethany Hughes, MD, Wichita Falls, TX
Charles Scott, MD, Sacramento, CA
Barbara McDermott, PhD, Sacramento, CA (I)

PANEL DISCUSSION

2:15 PM – 4:00 PM

MARRIOTT BALLROOM ADDISON (4TH FLOOR)

S44 What Have I Done??? The Self-Traumatized Perpetrator

(Sponsored by the Trauma and Stress Committee)

Juliette K. Dupre, MD, Toronto, Ontario, Canada
Celestine DeTrana, MD, Indianapolis, IN
Trent Holmberg, MD, Draper, UT

SATURDAY

PANEL DISCUSSION

2:15 PM – 4:00 PM

CHICAGO BALLROOM A-B-C (5TH FLOOR)

S45 *Involuntary Treatment in the Continuum of Forensic Settings*

Cara A. Klein, MD, Bay Area, CA
KyleeAnn Stevens, MD, Shakopee, MN
Christy Mulkerin, MD, San Luis Obispo, CA (I)
Melanie Scott, PsyD, Rocky Hill, CT (I)

COFFEE BREAK

4:00 PM – 4:15 PM

CHICAGO FOYER

PANEL DISCUSSION (AAPL MEMBERS ONLY)

4:15 PM – 6:15 PM

CHICAGO BALLROOM D (5TH FLOOR)

S46 *Peer Review of the Expert Witness in a High-Profile School Shooting*

(Sponsored by the Peer Review of Psychiatric Testimony Committee)

Ariana Nesbit, MD, Durham, NC
Charles Scott, MD, Sacramento, CA
Richard Frierson, MD, Columbia, SC
Richard Martinez, MD, Denver, CO

PANEL DISCUSSION

4:15 PM – 6:15 PM

AVENUE BALLROOM (4TH FLOOR)

S47 *Twenty Years Later, Still a Tough Sell?*

Sherif Soliman, MD, Charlotte, NC
Danita Bowling, PhD, JD, Morganton, NC (I)
Daniel Hackman, MD, Louisville, KY
Rabecca Stahl, PhD, Morganton, NC (I)
Alexis Glomski, MD, Louisville, KY

PANEL DISCUSSION

4:15 PM – 6:15 PM

MARRIOTT BALLROOM CLARK (4TH FLOOR)

S48 *Bail, Competency, Mental Health and Misdemeanors*

Emily Nash, MD, New York, NY
Elizabeth Ford, MD, New York, NY
Sela Dragich, MD, New York, NY (I)
Leah Pope, PhD, New York, NY (I)
Debra A. Pinals, MD, Ann Arbor, MI

PANEL DISCUSSION

4:15 PM – 6:15 PM

MARRIOTT BALLROOM ADDISON (4TH FLOOR)

S49 *Stimulants to Treat ADHD in Prison: Balancing Benefits and Risks*

Gunter Lorberg, MD, Penetanguishene, Ontario, Canada (I)
Martin Katzman, MD, Toronto, Ontario, Canada (I)
Tia Sternat, MD, Toronto, Ontario, Canada (I)

RESEARCH IN PROGRESS SESSION #3

4:15 PM – 6:15 PM

CHICAGO BALLROOM A-B-C (5TH FLOOR)

S50 A Functional MRI Study in First Episode Psychosis and Conduct Disorder – (Core)

Nathan J. Kolla, MD, PhD, Toronto, Ontario, Canada
Ryan Aloysius, BSc, Toronto, Ontario, Canada (I)
Colin Hawco, PhD, Toronto, Ontario, Canada (I)

S51 Balancing Parent and Adolescent Interests in Medical Decision Making

Marta L. Herger, MD, JD, Norwalk, CT

S52 Pictures Worth A Thousand Questions: Attorneys' Perspectives

Raina Aggarwal, MD, New York, NY
Madelon Baranoski, PhD, New Haven, CT (I)
Maya Prabhu, MD, New Haven, CT
Charles Dike, MD, New Haven, CT
Kathryn Thomas, JD, PhD, New Haven, CT (I)

S53 Cognitive Bias in Forensic Psychiatric Evaluation: A Scoping Review

Luigi Buongiorno, MD, Bari, Italy (I)
Federica Mele, MD, Bari, Italy (I)
Francesco Felice Carabellese, MD, Bari, Italy
Roberto Catanesi, MD, Bari, Italy (I)
Gabriele Mandarelli, MD, Bari, Italy (I)

***Your opinion of today's sessions is very important:
While it's fresh in your mind, please complete the evaluation form
in Guidebook for each session you attended.***

SATURDAY

S1 POSTER WITHDRAWN

S2 BALANCING RIGHTS TO CONDITIONAL RELEASE WITH PUBLIC FEARS

Aliana M. Abascal, MD, Morgantown, WV
Colleen M. Lillard, MD, Morgantown, WV (I)

EDUCATIONAL OBJECTIVE

Review the risk factors for recidivism of conditionally released forensic patients; review the rates of recidivism; recognize differences in recidivism rates of forensic patients based on type of conditional release placement; discuss the public perception of recidivism rates for forensic patients.

SUMMARY

Forensic patients found not guilty by reason of insanity are often initially hospitalized at psychiatric facilities. The purpose of conditional release is to gradually reintegrate forensic patients into the community, transitioning them out of inpatient hospitalization and into less restrictive environments, as appropriate. The goal is to provide services to continue their psychiatric care, maintain stability, and decrease their overall risk of reoffending. Research exploring the risk of recidivism for individuals conditionally released has shown low rates of recidivism. The goal of this study is to obtain a nationally represented sample of data regarding the public perception of the risks of reoffending when forensic patients are released into the community. We hypothesize that the public perception of recidivism risk is greater than actual rates of reoffending. We also hypothesize more reoffending in conditional release placements that are least restrictive (e.g., their own apartment) compared to more restrictive (e.g., forensic group home). We hypothesize that public perception will not differ based on type of placement. Finally, we will present placement recidivism data from one mid-Atlantic state forensic system. Future aims are to improve education of public stakeholders regarding these risks to improve growth and development of outpatient treatment programs.

REFERENCES

Novosad D, Banfe S, Britton J, et al.: Conditional Release Placements of Insanity Acquittees in Oregon: 2012-2014. *Behav Sci Law* 2016; 34:366–377

Gowensmith WN, Peters AJ, Lex IA, et al.: New Frontiers for Conditional Release: Applying Lessons Learned from Other Offenders with Mental Illness: *New Frontiers for Conditional Release* [Internet]. *Behavioral Sciences & the Law* 2016; 34:407–422[cited 2018 Aug 24] Available from: <http://doi.wiley.com/10.1002/bsl.2217>

QUESTIONS AND ANSWERS

1. What are the approximate rates of rehospitalization and revocation of conditional release for most jurisdictions?
 - A. 10%
 - B. 30%
 - C. 50%
 - D. 70%

ANSWER: B

2. Which of the following is not an empirically validated model for supervising/treating individuals with mental illness who have been released on Conditional Release?
 - A. Mental health court/ post booking jail diversion
 - B. Forensic assertive community treatment
 - C. Risk need responsivity
 - D. Supportive therapy

ANSWER: D

S3 SIX BARRIERS TO FORENSIC PSYCHIATRIC RESEARCH: A SYSTEMIC REVIEW

Amareen Dhaliwal, MD, MPH, Delray Beach, FL
Kenneth Zon, MD, Delray Beach, FL
Anthony Sanchez, MD, Delray Beach, FL
Kristian Hogue, MD, Delray Beach, FL

EDUCATIONAL OBJECTIVE

Enhances understanding of ethical considerations in forensic psychiatric research, including protection of participants' rights and responsibilities of IRBs. Develops methodological expertise for conducting research in complex contexts, such as applying appropriate study designs based on the research question. Fosters interdisciplinary collaboration and improves attitudes towards forensic psychiatric research by advocating for its significance and establishing collaborations with other stakeholders.

SUMMARY

Background: Forensic psychiatry research has the potential to improve understanding, assessment and treatment of mentally-disordered offenders - but many challenges can impede its progress. Methods: Using PRISMA guidelines, a comprehensive search was conducted across 5 electronic databases to identify studies examining obstacles that restrict forensic psychiatric advancement. 19 papers were eligible out of those found between 1990 and 2021; each study thoroughly analyzing various impediments encountered during development or implementation phases within this field. Results: Six categories of barriers to forensic psychiatric research were identified: (1) ethical considerations and procedural issues surrounding informed consent and confidentiality; (2) methodological challenges arising from complex clinical, legal and organizational contexts; (3) logistical constraints, including access to research participants, data, and appropriate settings; (4) resource limitations, such as insufficient funding, time, and personnel; (5) difficulties with interdisciplinary collaboration and the integration into clinical practice; (6) stigmatization and negative attitudes toward forensic psychiatric research held by various stakeholders. Discussion: Addressing these barriers will require multi-faceted strategies, including enhancing cross-disciplinary collaborations, improving research training and mentoring for forensic psychiatry staff, and developing rigorous methodologies to minimize biases and enhance the generalizability of research outcomes. Future research should focus on identifying specific strategies that effectively reduce barriers.

REFERENCES

Pedersen SH, Bergman H, Berlin J, Hartvigsson T. Perspectives on Recruitment and Representativeness in Forensic Psychiatric Research. *Front Psychiatry*. 2021 Jun 17;12:647450. doi: 10.3389/fpsy.2021.647450. PMID: 34220570; PMCID: PMC8247569.

Taylor, P.J. (2002), Challenges and successes in forensic psychiatric research. *Criminal Behav. Ment. Health*, 12: S59-S66. <https://doi.org/10.1002/cbm.520>

QUESTIONS AND ANSWERS

1. What is a significant barrier to forensic psychiatry research due to the ethical and legal implications of working with forensic populations?

- A. Lack of financial resources
- B. Inadequate number of qualified forensic psychiatrists
- C. Obtaining informed consent from participants
- D. Insufficient scientific literature on the topic

ANSWER: C

2. How does the heterogeneity of forensic psychiatric populations serve as a barrier to research in the field?

- A. It simplifies data interpretation and analysis
- B. It causes difficulties in recruiting research participants
- C. It limits the generalizability of research findings
- D. It reduces the need for multiple study groups

ANSWER: C

S4 DO FMRI STUDIES SATISFY THE FRYE & DAUBERT STANDARDS OF ADMISSIBILITY?

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Gavin Rose, MD, Fort Lauderdale, FL
Amareen Dhaliwal, MD, Delray Beach, FL

EDUCATIONAL OBJECTIVE

Understand both the Frye & Daubert Standards of evidence and how each applies to the admissibility of fMRI studies such as lie-detection based methods.

SUMMARY

Functional Magnetic Resonance Imaging (fMRI) presents great potential for elucidating the relationship between brain functionality and brain pathology. Its ability to produce detailed images of the brain on a functional and not strictly anatomic basis continues to generate interest in the scientific and legal communities as a tool with possible application to civil and criminal cases. Recent studies have focused on the application of fMRI to improve methods of lie detection. However, growing neuro-scientific evidence contains challenges regarding its admissibility and validity in court. This literature review considers how current fMRI studies fare against Frye and Daubert standards of evidence by utilizing keyword search terms on the following research databases– ResearchGate, Science Direct, Cochrane, PubMed, and Law Review Commons. The presentation will provide an overview of how fMRI's generate neuroimages as well as brief histories on the foundational cases that lead to the development of the Frye and Daubert Standards.

REFERENCES

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- Langleben, D. D., & Moriarty, J. C. (2013). Using Brain Imaging for Lie Detection: Where Science, Law and Research Policy Collide. *Psychology, public policy, and law : an official law review of the University of Arizona College of Law and the University of Miami School of Law*, 19(2), 222–234. <https://doi.org/10.1037/a0028841>

QUESTIONS AND ANSWERS

1. According to the Daubert Standard, scientific evidence must be both relevant and _____ to satisfy the criteria for admissibility

- A. Quantitative
- B. Qualitative
- C. Reliable
- D. Recent

ANSWER: C

2. What is the primary reason fMRI-based lie detection methods fail to satisfy the Frye standard?

- A. Ethical concerns
- B. Lack of general acceptance
- C. Cost Ineffectiveness
- D. Time consuming

ANSWER: B

S5 BIOETHICS AND VIOLENCE PROSECUTION IN FORENSIC PSYCHIATRIC SETTINGS

Grayson P. Holt, BA, Cleveland, OH (I)
Xavier F. Amador, PhD, Peconic, NY (I)

EDUCATIONAL OBJECTIVE

Describe the ethical complexities of prosecuting violent and aggressive behavior in forensic psychiatric settings based on competing beliefs about the diagnosis of antisocial personality disorder.

SUMMARY

Violent behavior in forensic psychiatric units is one of the most challenging problems facing forensic psychiatry with over 30% of patients committing at least one violent act during their hospitalization 1. One potential consequence of aggression is prosecution, an option most would agree is appropriate in the case of patients with antisocial personality disorder (ASPD) with histories of violence where mental health defenses were not pursued. The identification of these patients, however, raises various ethical concerns. Theoretically, accurate identification, which forensic settings may be in the best position to do given their unparalleled length of stay and access to patient information 2. Inaccurate identification, however, will lead to an inappropriate conditions of confinement that denies access to appropriate treatment. There are already consequences for violence in the forensic psychiatric setting such as restraints and seclusions along with documentation. That said, the experience of one of us (XFA), suggests that the over diagnosis of ASPD is fairly common in the case of psychotic disorders. In this instance, the history of preinstant offense psychosis is often overlooked in light of the crime(s) the patient has been charged with resulting in inaccurate assessment of relevant history needed to make a valid diagnosis of ASPD.

REFERENCES

Broderick, C., Azizian, A., Kornbluh, R., & Warburton, K. (2015). Prevalence of physical violence in a forensic psychiatric hospital system during 2011-2013: Patient assaults, staff assaults, and repeatedly violent patients. *CNS Spectrums*, 20(3), 319-330. doi: 10.1017/S1092852915000188.

Andreasson, H., Nyman, M., Krona, H., et al. (2014). Predictors of length of stay in forensic psychiatry: The influence of perceived risk of violence. *International Journal of Law and Psychiatry*, 37(6), 635-642. doi: 10.1016/j.ijlp.2014.02.038.

QUESTIONS AND ANSWERS

1. What percent of patients exhibit violent or aggressive behavior in forensic psychiatric hospitals?

- A. 10%
- B. 30%
- C. 50%
- D. 70%

ANSWER: B

2. What population do the authors believe should be prosecuted for violent and aggressive behavior?

- A. Patients with psychotic disorders
- B. Patients with substance abuse disorders
- C. Patients with mood disorders
- D. Patients with antisocial personality disorder with histories of violence where mental health defenses were not pursued

ANSWER: D

S6 PRIDE & PREJUDICE: LGBTQI+ COMPETENCY IN SEXUAL OFFENSE EVALUATIONS

Chase A. Hiller, MD, Kankakee, IL

Charles P. Samenow, MD, Washington, DC (I)

EDUCATIONAL OBJECTIVE

Develop LGBTQI+ literacy and best practices in conducting forensic evaluations of individuals who sexually offend.

SUMMARY

There is a long history of criminalization of LGBTQI+ people through institutional bias in laws, targeting by law enforcement, and prejudicial sentencing in the judicial system. A particular challenge is in the area of individuals who identify as LGBTQI+ and sexually offend. Much harm has been done to the LGBTQI+ community through false associations and morality-based arguments about sexual behaviors in this community. Despite more mainstream acceptance, LGBTQI+ individuals remain overrepresented in the criminal justice system, serve longer sentences for similar crimes as their cisgender and heterosexual counterparts, are more likely to end up on the sex offender registry, and suffer greater “collateral consequences” such as prison violence and mental health challenges. We will use case examples to develop

LGBTQ+ literacy and best practices in conducting forensic evaluations of individuals in this challenging population. A particular focus will be on preventing bias and distinguishing between diverse sexual practice and harmful sexual offending behavior. In the search for truth, forensic psychiatrists have a duty to evaluate LGBTQI+ individuals with an understanding of the unique psychodevelopmental, sociocultural, and behavioral characteristics of this population in a manner consistent with the AAPL Practice Guideline for the Forensic Assessment.

REFERENCES

Meyer IH, Bouton L, Maszak-Prato S, et al. LGBTQ people on sex offender registries in the US. Los Angeles, CA. The Williams Institute, UCLA School of Law; 2022 Friedman SH. Searching for the whole truth: Considering culture and gender in forensic psychiatric practice. J Am Acad Psychiatry Law. 2023 Feb; 51(1): 23-34

QUESTIONS AND ANSWERS

1. Lifetime suicidal ideation of LGBTQI+ individuals on sex offender registries is:

- A. 37%
- B. 57%
- C. 77%
- D. 91%

ANSWER: C

2. The highest proportion of LGBTQI+ identifying people are:

- A. Men in prison
- B. Men in jail
- C. Women in prison
- D. Women in jail

ANSWER: C

S7 POSTER WITHDRAWN

S8 COMMITMENT OR NOT? LEGAL UPDATES FROM THE BAY STATE

Paul E. Noroian, MD, Worcester, MA
Adeliza Olivero, MD, Boston, MA
Margarita Daou, MD, Worcester, MA

EDUCATIONAL OBJECTIVE

To review recent Massachusetts Supreme Judicial Court cases that dealt with issues of due process in civil and forensic psychiatric hospitalization and commitment. The cases include Massachusetts General Hospital v. C.R. (484 Mass 472, 2020) , Garcia v. Commonwealth (487 Mass 97, 2021), and K.J. v. Superintendent of Bridgewater State Hospital (488 Mass. 362, 2021).

SUMMARY

The Massachusetts Supreme Judicial Court recently decided three cases that involved the due process rights of individuals facing psychiatric commitment and hospitalization. Each case focused on unique aspects of the process by which individuals can be held on the basis of mental illness and dangerousness. In the case of Garcia v. Commonwealth, an NGRI acquittee challenged his commitment to a locked psychiatric facility for further evaluation arguing that no substantive issue of dangerousness had been raised at the time of NGRI finding. In K.J. v. Superintendent, the petitioner contested the facility (or superintendent) override of his court-ordered step down from the Department of Correction to a facility of the Department of Mental Health. Finally, in Mass General v. C.R., the court considered whether the time spent by a patient who is held in an emergency room when waiting for a psychiatric inpatient bed counts toward the time limit for an involuntary psychiatric admission. The poster will outline the facts of each case, the holdings of the Massachusetts Supreme Judicial Court, and the impact on psychiatric practice.

REFERENCES

Foucha v. Louisiana, 504 U.S. 71 (1992)
Lake v. Cameron, 364 F.2d 657 (1966)

QUESTIONS AND ANSWERS

1. In Foucha v. Louisiana, the US Supreme Court ruled that the commitment of an insanity acquittee must be based on which of the following factors:
- A. Dangerousness and lack of remorse
 - B. Dangerousness and antisocial personality
 - C. Mental illness and dangerousness
 - D. Failure to rehabilitate.

ANSWER: C

2. Lake v. Cameron introduced what concept into due process rights for individuals facing involuntary commitment to a psychiatric facility:
- A. Right to an attorney
 - B. Periodic review
 - C. Parens patriae
 - D. Least restrictive alternative

ANSWER: D

99 PSYCHIATRIC RISK FACTORS FOR INMATE SUICIDALITY IN A LARGE COUNTY JAIL

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Luke P. Coffman, MD, Dallas, TX (I)
Christopher S. Kung, Dallas, TX (I)
Eunsol Park, MD, Dallas, TX (I)
Brianne Lacy, MD, Dallas, TX (I)
Hien Piotrowski, MD, Dallas, TX (I)
Waseem Ahmed, MD, Dallas, TX (I)
Mustafa M. Husain, MD, Dallas, TX (I)

EDUCATIONAL OBJECTIVE

To better understand the underlying risk factors for suicidality and suicide precaution placement in an incarcerated population.

SUMMARY

Depression, PTSD, mania, and anxiety disorders are common diagnoses among mentally ill incarcerated persons and have been shown to elevate suicide rates. To our knowledge, no research on the relationship between psychiatric history and Columbia-Suicide Severity Rating Scale (C-SSRS) scores has been conducted in a U.S. incarcerated population. A retrospective chart review was performed evaluating 507 patients randomly selected from 1841 inmates seen by psychiatric providers in December 2020. Psychiatric history, C-SSRS scores, and suicide precaution orders were collected. Chi-Square values were calculated for MDD, schizophrenia, PTSD, bipolar disorder, and anxiety in SPSS version 29. Those with MDD or PTSD were more likely to have a C-SSRS score of greater than one compared to those that did not have these diagnoses ($p=0.001$ and $p = 0.014$, respectively), but there was no statistically significant difference in the rate of suicide precaution order placement among these groups. Schizophrenia diagnosis showed an increased likelihood for placement of suicide precaution orders ($p = 0.011$), but not C-SSRS scores. Anxiety or bipolar disorder diagnoses showed no significant correlation to either variable. These differences in relationships between C-SSRS score and suicide precaution placement highlight the unique challenges of screening and mitigating suicide risk in incarcerated populations.

REFERENCES

Reingle Gonzalez, J. M. & Connell, N. M. Mental health of prisoners: identifying barriers to mental health treatment and medication continuity. *Am J Public Health* 104, 2328-2333, doi:10.2105/ajph.2014.302043 (2014).
Posner, K. et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *Am J Psychiatry* 168, 1266-1277, doi:10.1176/appi.ajp.2011.10111704 (2011).

QUESTIONS AND ANSWERS

1. Which of the following statements summarizes the correlation between psychiatric diagnoses and C-SSRS scores in this study?
- A. All psychiatric diagnoses have a significant correlation to C-SSRS scores.
 - B. Anxiety and bipolar disorder were the biggest risk factors for high C-SSRS scores.
 - C. MDD and PTSD showed an increased likelihood of having a C-SSRS score of greater than one.
 - D. No psychiatric diagnoses showed a correlation to C-SSRS scores in an incarcerated population

ANSWER: C

2. Which of the following statements is false regarding psychiatric diagnosis and suicide precaution placement among incarcerated persons in this study?
- A. Schizophrenia diagnosis is correlated to suicide precaution placement but not a high C-SSRS score.
 - B. The same conditions that lead to a higher incidence of high C-SSRS scores also lead to suicide precaution placement.
 - C. An MDD diagnosis is correlated to a C-SSRS score of greater than one.
 - D. A PTSD diagnosis is correlated to a C-SSRS score of greater than one.

ANSWER: B

S10 CHARACTERISTICS OF JAIL INMATES WITH A HISTORY OF PSYCHIATRIC CARE

Krista N. Thompson, Dallas, TX (I)
Christopher S. Kung, Dallas, TX (I)
Eunsol Park, MD, Dallas, TX (I)
Brienne Lacy, MD, Dallas, TX (I)
Mustafa M. Husain, MD, Dallas, TX (I)

EDUCATIONAL OBJECTIVE

Identify patient demographic factors that may influence whether an inmate who presents to psychiatry has a history of prior psychiatric care; Explain one potential effect of prior psychiatric care amongst inmates

SUMMARY

Incarcerated individuals have a high mental health burden, yet many do not receive adequate psychiatric care. To better understand mental health care patterns within jails, we analyzed intake surveys of 471 inmates who received psychiatric care in December 2020. From this group, we compared inmates with and without prior psychiatric care. Of those who saw psychiatry, 67.7% had previously received inpatient psych care, outpatient psych care, substance abuse treatment, or detox treatment. A significantly higher percentage of women (74.3%) had received prior psychiatric care than men (64.6%; $p=0.034$). No correlation existed between an inmate's age, race, high school education, or homelessness status and psychiatric care history. Although race as a single variable was not predictive of prior psychiatric care, White men were less likely than other men to have received this care (57.2% vs. 70.7%; $p=0.012$). Inmates with previous psychiatric encounters were seen by psychiatry more quickly after jail intake on average (75 days vs. 97 days), though this difference was not statistically significant ($p=0.060$). This data suggests that certain groups in jail are more likely to have a psychiatric care history. Previous psychiatric encounters may result in quicker presentation for care in jail, though this assumption requires further validation.

REFERENCES

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- Butler A, Nicholls T, Samji H, Fabian S, Lavergne MR. Prevalence of Mental Health Needs, Substance Use, and Cooccurring Disorders Among People Admitted to Prison. *Psychiatr Serv*. 2022 July; 73(7):737-744

QUESTIONS AND ANSWERS

1. In this study population what demographic factor was predictive of prior psychiatric history amongst inmates who presented to psychiatry while incarcerated?
- A. Race
 - B. Age
 - C. Sex
 - D. Homelessness status

ANSWER: C

2. In this study population, what decreased amongst inmates who had prior psychiatric care?
- A. Time between jail intake and presentation to psychiatry
 - B. Columbia Suicide Screening Score
 - C. Days of jail psychiatric care utilization
 - D. Withdrawal symptoms

ANSWER: A

S11 MENTAL HEALTH EDUCATION TO THE COURTS: AN UNDERUTILIZED RESOURCE

Yarden Segal, MD, Bronx, NY
Gurtej Gill, MD, Bronx, NY
Danielle Kushner, MD, Brooklyn, NY

EDUCATIONAL OBJECTIVE

We will discuss the importance of understanding general concepts regarding mental health diagnoses and treatment that lawyers and other justice professionals in order to help support individuals with mental illness within the justice system. Mental health providers can play a role in educating lawyers and other individuals in the justice system about mental health issues, treatment that could potentially improve outcomes. We will explore already available programs and also briefly touch on the most common encountered psychiatric problems in incarceration.

SUMMARY

Individuals suffering from mental illness are overrepresented in the United States correctional system. According to a report from the Bureau of Justice statistics (2006), 56 percent of state, 45 percent in federal prison, and 64 percent of jail inmates have a mental health issue. Once in the Justice system, the main advocate for justice involved individuals are their lawyers, who advise, represent, and negotiate on their clients' behalf. In addition to providing legal advice, lawyers maybe the first person that notices change in psychiatric symptoms with their clients. Therefore, it is very important that lawyers and other criminal justice professionals understand general concepts regarding mental health diagnoses and treatment in order to help support individuals with mental illness within the justice system. Mental health providers can play a role in educating lawyers and other individuals in the justice system about mental health issues, treatment that could potentially improve outcomes. This poster presentation will discuss some approaches for the collaboration between mental health professionals and lawyers in the justice system, the implications and benefits of such actions, and the potential impact \care for individuals with mental illness involved in the justice.

REFERENCES

Perlin, M. L. (1976). The role of the lawyer in mental health advocacy.
<https://bjs.ojp.gov/content/pub/pdf/mhppji.pdf>

QUESTIONS AND ANSWERS

1. What percent of people are incarcerated with mental health problem in state prison?

- A. 55%
- B. 34%
- C. 69%
- D. 25%

ANSWER: A

2. What percent of people are incarcerated with mental health problem in federal prison?

- A. 45%
- B. 34%
- C. 69%
- D. 25%

ANSWER: A

S12 DUAL DIAGNOSIS IN FORENSICS AND CORRECTIONS: A SYSTEMATIC REVIEW

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Anna Katsev, MD, Toronto, Ontario, Canada (I)
John M. Bradford, MD, Hamilton, Ontario, Canada
Gary A. Chaimowitz, MD, Ancaster, Ontario, Canada
Andrew I. Olagunju, MD, Toronto, Ontario, Canada (I)

EDUCATIONAL OBJECTIVE

We will discuss the importance of understanding general concepts regarding mental health diagnoses and treatment that lawyers and other justice professionals in order to help support individuals with mental illness within the justice system. Mental health providers can play a role in educating lawyers and other individuals in the justice system about mental health issues, treatment that could potentially improve outcomes. We will explore already available programs and also briefly touch on the most common encountered psychiatric problems in incarceration.

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QUESTIONS AND ANSWERS

1. What percent of people are incarcerated with mental health problem in state prison?

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- B. 34%
- C. 69%
- D. 25%

ANSWER: A

2. What percent of people are incarcerated with mental health problem in federal prison?
- A. 45%
 - B. 34%
 - C. 69%
 - D. 25%

ANSWER: A

S13 CIVIL COMMITMENT: NEURODEVELOPMENTALLY DISABLED IN FLORIDA

Christian T. Maxwell, MD, Delray Beach, FL
Allegra M. Condiotte, MD, MHA, Boca Raton, FL (I)
Richard L. Elliott, MD, PhD, Boca Raton, FL (I)

EDUCATIONAL OBJECTIVE

(Applies to Service) 1. To increase awareness of how to prevent unnecessary hospitalization of individuals afflicted with neurodevelopmental disabilities.

SUMMARY

The Baker Act (BA) is the involuntary mental health hold in Florida for a person with a mental disorder who represents an acute danger to themselves or others. Individuals with neurodevelopmental disabilities (NDDs), such as autism or intellectual disability, may experience dysregulated behavior due to poor frustration tolerance. However, NDDs are excluded from the diagnosis of mental disorder as defined by the BA legislation. If NDDs alone are driving the disruptive behavior and not a co-morbid mental illness, then the individual's BA is rendered invalid, and they should be treated in a more appropriate setting. Unfortunately, the lack of adequate community services creates challenges for patients, their families, treating providers, and hospitals. Although there are more multidisciplinary and family focused services available to children and adolescents, unnecessary hospitalizations still occur due to inappropriate BA referrals. Avoidable hospitalizations persist with adults as well due to limited treatment services. This poster presentation will review a pertinent clinical case and discuss the implications of the landmark case *Olmstead v. L.C.* It will explore the ethical challenges around psychiatric hospitalization of individuals with NDDs, describe the shortcomings of the current infrastructure to support them, and discuss possible solutions to this structural issue.

REFERENCES

Pinals DA, Hovermale L, Mauch D, Anacker L. Persons with intellectual and developmental disabilities in the mental health system: part 1. Clinical considerations. *Psychiatr Serv.* 2022 March; 73(3):313–320
Lee G, Cohen D. Incidences of involuntary psychiatric detentions in 25 U.S. states. *Psychiatr Serv.* 2021 Jan; 72(1):61–68

QUESTIONS AND ANSWERS

1. What was the approximate number of all-ages emergency psychiatric detentions per 100,000 people in Florida in 2018?
- A. 266
 - B. 466
 - C. 866
 - D. 966

ANSWER: D

2. Which entity most often initiates a Baker Act on children in Florida?
- A. Mental Health Professional
 - B. School Administrator
 - C. Law Enforcement
 - D. Family Member

ANSWER: C

S14 A NEW FRONTIER: FORENSIC IMPLICATIONS OF DESIGNER BENZODIAZEPINES

Ashley Maestas, DO, Reno, NV (I)
Emmanuelle Garcia-Rider, MD, Reno, NV (I)
Melissa Piasecki, MD, Reno, NV

EDUCATIONAL OBJECTIVE

To define novel designer benzodiazepines (with a focus on Clonazepam). Describe the similarities and differences when compared to traditional benzodiazepines. To identify the potential forensic implications of novel benzodiazepines. To identify approaches to mitigate these implications

SUMMARY

Many psychiatrists are aware of the abuse potential of traditional benzodiazepines, but many are not aware of novel designer and synthetic benzodiazepines. Unless specifically screened for, these drugs are undetected and can be a source of diagnostic confusion alone or when mixed with other pharmaceuticals or abused substances. Although many forensic examiners are aware of the designer and synthetic drugs of abuse, such as synthetic THC ("Spice"), the designer benzodiazepines (DBZDs) are relatively unknown, undetected and create a potential "blind spot" in forensic assessments. This poster presents the emergence of DBZD in the US and global markets, with a specific focus on Clonazepam. We describe the challenges of detecting DBZDs, the potential for mischaracterization of substance-related behavior as well as the forensic implications these novel benzodiazepines. This poster will also discuss potential approaches to mitigate the diagnostic uncertainty posed by these drugs of abuse. We also present a forensic case example to illustrate the impact of these drugs on mental state and memory formation.

REFERENCES

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Moosmann B, Auwärter V: Designer benzodiazepines: Another class of new psychoactive substances. Handbook of Experimental Pharmacology, 383-410, 2018.

QUESTIONS AND ANSWERS

1. True or false. The structure of Clonazepam is a triazolo-analogue of clonazepam.

ANSWER: True

2. Identify which symptoms tend to be most prominent in novel benzodiazepines:

- A. CNS depression
- B. Bradycardia
- C. Miosis
- D. Involuntary muscle contractions

ANSWER: A

S15 AWARENESS OF AND ATTITUDE TOWARD ERPO IN SUICIDE DECEDENTS' NEXT OF KIN

James C Zinko, MD, Baltimore, MD
Aubrey DeVinney, BA, Baltimore, MD (I)
Matthew Kelly, PhD, Baltimore, MD (I)
Paul S. Nestadt, MD, Baltimore, MD (I)
Ling Li, MD, Baltimore, MD, (I)

EDUCATIONAL OBJECTIVE

Highlight the need for better public education surrounding risk-reduction legislation for its effective implementation.

SUMMARY

Background: Firearms were used in approximately 40% of suicides involving people aged <30 in Maryland between 2003 and 2019. In 2018, Maryland introduced the Extreme Risk Protective Order (ERPO) law allowing for the issuance of civil orders requiring individuals at risk of harming themselves or others to surrender firearms and ammunition and preventing them from purchasing firearms. Maryland is one of the few states that allows for filing by physicians. Prior research in Maryland has established low physician awareness of ERPOs but has not assessed public awareness.; Methods: We performed 11 semi-structured

psychological autopsies with friends and families of nine youth aged 17-21 who died from firearm related suicide. We assessed knowledge of Maryland's ERPO law, and whether the interviewee would have invoked it had they been aware of the risk of suicide.; Results: Nearly all interviewees (9/11) would have filed an ERPO were they aware of the risk of suicide. Two interviewees were aware of ERPOs, and two knew of the risk of suicide but were not aware of access to firearms.; Conclusion: While Maryland's ERPO law has the potential to reduce fatalities involving firearms, greater awareness of the law and suicide risk factors are needed for effective implementation.

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Frattaroli S, Hoops K, Irvin NA, McCourt A, Nestadt PS, Omaki E, Shields WC, Wilcox HC. Assessment of Physician Self-reported Knowledge and Use of Maryland's Extreme Risk Protection Order Law. *JAMA Netw Open.* 2019 Dec 2;2(12):e1918037. doi: 10.1001/jamanetworkopen.2019.18037. PMID: 31860108; PMCID: PMC6991220.

QUESTIONS AND ANSWERS

1. Maryland's ERPO law is unique in that it:

- A. Prevents purchasing of firearms
- B. Can only be filed by family members
- C. Can be filed by physicians
- D. Does not apply in situations of dangerousness towards others

ANSWER: C

2. This study demonstrated:

- A. Low knowledge of the ERPO law by next of kin
- B. Low awareness of suicide risk by next of kin
- C. Low awareness of firearm access by next of kin
- D. All of the above

ANSWER: D

S16 TREATING FOR TWO: POSTPARTUM MENTAL HEALTHCARE IN CORRECTIONS

Parvaneh K. Nouri, MD, MPH, Aurora, CO
Jill Spice, MD, Aurora, CO
Sarah Nagle-Yang, MD, Aurora, CO (I)

EDUCATIONAL OBJECTIVE

Improve understanding of unique challenges faced by postpartum parent/mother-child dyads in the correctional setting and how alternatives to early infancy separation may improve parental/maternal and child outcomes.

SUMMARY

Global incarceration rates of women have increased at an alarming rate over the last several decades. Incarcerated women have higher rates of psychiatric disorders than incarcerated men as well as women and men in the community. Each year, approximately 58,000 incarcerated women are pregnant at the time of admission, many with unplanned pregnancies. Contrary to popular belief, pregnancy is not protective against mental illness. Pregnancy and postpartum periods can be complicated by the onset of psychiatric symptoms or psychiatric decompensation. Although several organizations have proposed or developed treatment standards or guidelines, perinatal and postpartum care vary across correctional institutions. Postpartum psychiatric illness has been associated with negative outcomes of the infant and mother. Early separation has been associated with negative effects on breastfeeding, parent-infant bonding, maternal mental health, and infant mental health. This poster reviews data about postpartum care in the correctional setting, including the utilization of mother-baby units and community-based alternatives to incarceration, with particular emphasis on psychiatric care.

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Cohen LS, Altschuler LL, Harlow BL, Nonacs R, Newport DJ, Viguera AC, Suri R, Burt VK, Hendrick V, Reminick AM, Loughhead A, Vitonis AF, Stowe ZN. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *Jama*. 2006 February; 295(5):499-507.

QUESTIONS AND ANSWERS

1. Postpartum depression occurs in 12%-20% of postpartum people in the general community. Though limited, the data suggest postpartum depression has been reported as high as approximately what percentage of postpartum inmates?
 - A. 30%
 - B. 50%
 - C. 75%
 - D. 80%

ANSWER: D

2. Participation in programs allowing incarcerated birthing parents to co-reside with their infants postpartum (e.g. nurseries, mother-baby units) has NOT been shown to be associated with which of the following post-release outcomes?
 - A. Retained child custody
 - B. Increased matriculation into higher education
 - C. Reduced rate of substance use relapse
 - D. Reduced recidivism

ANSWER: B

S17 FATALE FEMME: AN ANALYSIS OF WOMEN IN NC'S FORENSIC TREATMENT PROGRAM

Sara Banoo Feizi, MD, Hillsborough, NC
Nicole Wolfe, MD, Raleigh, NC
Stephanie Cripps, MD, Durham, NC

EDUCATIONAL OBJECTIVE

To use this information to improve the accuracy of early detection of risk and prevention of violence in women with severe mental illness.

SUMMARY

There is a lack of research on the unique factors associated with women who end up forensically hospitalized. We sought to better understand violence risk assessment in women acquitted not criminally responsible or found incapable to proceed to trial by examining data from the past 25 years of patients admitted to the State of North Carolina's only Forensic Treatment Program. Women made up a minority of patients admitted from 1996-2022, however they showed a distinctly different clinical picture compared to male counterparts, including lower rates of substance use or prior violent offenses. Women were also more likely to be married, living with a partner, and/or have a child at the time of the offense. In many cases the child was the victim of the violent act for women. We further investigated the differences in risk factors and nature of violent offenses for women using a mixed methods qualitative analysis. Our goal is to use this information to improve the accuracy of early detection of risk and prevention of violence in women with severe mental illness.

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QUESTIONS AND ANSWERS

1. The presence of a psychotic disorder in women, particularly when paired with _____ that confer high aggressivity, fearlessness, and externalized behaviors, warrants a high degree of clinical surveillance for violence risk.

- A. Personality disorders and traits
- B. Substance Use Disorders
- C. Mood Disorder
- D. Severe Childhood Trauma

ANSWER: A

2. The victims of violence perpetrated by women are most often _____.

- A. Pets
- B. Children
- C. Intimate Partners
- D. Strangers

ANSWER: B

518 TOOLS FOR FORENSIC RESEARCH: FROM DATABASES TO NEUROPREDICTION

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EDUCATIONAL OBJECTIVE

Understand common diagnostic tools in forensic psychiatry, including structured clinical interviews, self-report questionnaires, and DSM/ICD systems. Review common forensic psychiatry assessment tools used in research including specialized instruments (RAGE-V, PCL-R, HCR-20). List resources and tools that support forensic psychiatry research such as data repositories, neurobiological methods, and neuroprediction.

SUMMARY

Forensic psychiatry research is in high demand, thus requiring resources and tools to support it. Diagnostic tools comprise structured clinical interviews, self-report questionnaires, and classification systems (DSM and ICD). Assessment techniques involve objective testing (neuropsychological and risk assessments) and subjective methods (clinical judgment and contextual analysis). Intervention strategies include evidence-based treatments, such as cognitive-behavioral therapy and pharmacotherapy, as well as multidisciplinary management approaches. A comprehensive literature review was conducted to identify the resources and tools used in forensic psychiatry research by searching academic databases, professional organizations' websites, and governmental resources. Data on the utility, validity, and reliability of these resources and tools were analyzed to determine their overall value to the field. Numerous resources and tools hold value for forensic psychiatry researchers and practitioners, such as data repositories like NACJD and WMHSI, neurobiological and neuro prediction tools such as MRI and AI, assessment instruments like the RAGE-V, PCL-R and HCR-20, and professional organization guidelines such as AAPL. Continued development, refinement, and validation of these resources are necessary to ensure their effectiveness, reliability, and usefulness. Building robust arsenals of high-quality resources will enhance the capacity to make significant contributions to mental health, the legal system, and public safety.

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QUESTIONS AND ANSWERS

1. What type of assessment instrument is the Hare Psychopathy Checklist-Revised (PCL-R), and what primary purpose does it serve in forensic psychiatry research?
 - A. A neuropsychological test to assess cognitive deficits related to criminal behavior
 - B. A self-report questionnaire designed to measure personality traits associated with criminality
 - C. A semi-structured interview and rating scale used to assess the presence and severity of psychopathic traits
 - D. A projective test used to uncover unconscious motives and conflicts related to criminal behavior

ANSWER: C

2. The use of functional magnetic resonance imaging (fMRI) in forensic psychiatry research is becoming increasingly popular due to its ability to effectively measure brain activity associated with specific cognitive tasks or emotional responses. Which major advantage does fMRI offer in comparison to other neuroimaging techniques such as electroencephalography (EEG) and positron emission tomography (PET)?
 - A. fMRI provides a less invasive method with improved spatial resolution
 - B. fMRI utilizes radioactive tracers for more accurate measurements
 - C. fMRI relies on electrical signals for real-time data analysis
 - D. fMRI is primarily focused on portraying static images of brain structures

ANSWER: A

S19 LEGAL CONSIDERATIONS FOR THE USE OF ELECTRICAL STIMULATION DEVICES

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Astik Joshi, MD, Lubbock, TX

EDUCATIONAL OBJECTIVE

1. Be able to discuss the controversy of the use of electrical stimulation devices for use in self-injurious behaviors
2. Summarize legal issues presented in the Judge Rotenberg Educational Center v. FDA

SUMMARY

Self-injurious behavior (SIB) and aggressive behavior are common problems for patients with neurodevelopmental disorders such as Intellectual Disability and Autism Spectrum Disorder. Management of SIB requires multimodal treatment approaches in both inpatient and outpatient settings, and despite best efforts, can be resistant to interventions. Because of this, electrical stimulation devices (ESD) have been used in the past to manage SIB via positive punishment. Judge Rotenberg Educational Center is the only residential treatment center in the U.S. to continue to employ a form of ESD, called Graduated Electronic Decelerator (GED). In 2020, the FDA banned the use of ESD, but in 2021, Judge Rotenberg Center sued the FDA and the U.S. Court of Appeals overturned the ban. This review presents the scientific literature that has been published on ESD, the history of the Judge Rotenberg Center, and the legal considerations of the 2021 case.

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QUESTIONS AND ANSWERS

1. According to the American Academy of Child and Adolescent Psychiatry Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities, the following are considerations when using therapeutic restraints except:
 - A. No other least restrictive treatment is appropriate.
 - B. The risk of airway obstruction.
 - C. Discretion of use in youths with histories of sexual abuse.
 - D. Positive punishment of oppositional and disruptive behaviors.
 - E. Institutional and departmental policies.

ANSWER: D

2. The U.S. Supreme Court's decision in *Washington v. Harper* (1990) allowed for the involuntary administration of psychotropic medications if an administrative process is followed. Which answer best describes this process?
- A. Judicial review.
 - B. Internal prison administrative committee, which includes a medical professional.
 - C. A hearing in accordance with the rules of evidence.
 - D. Medical professionals currently involved with the diagnosis and treatment.
 - E. Clinically indicated psychotropic medications can be involuntarily administered beyond periods of 72 consecutive hours.

ANSWER: B

S20 THE BLACK BOX – PSYCHIATRY VS. PRIMARY CARE PROVIDER'S PERCEPTIONS

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EDUCATIONAL OBJECTIVE

To understand differences between psychiatric and primary care providers' understanding of the black box warning on antidepressants in relation to their beliefs about the relative risk of antidepressant treatment (vs untreated depression) and their concerns about medicolegal risk associated with managing antidepressants; To evaluate the effectiveness of a brief educational intervention on increasing providers comfort in prescribing antidepressants in primary care settings.

SUMMARY

Public debate about a causal relationship between antidepressants and suicidal and / or violent behavior rose to national attention with a series of lawsuits against Eli Lilly and Prozac in the 1990s and culminated with the FDA's 2004 decision to require a black box warning on antidepressants for minors (later expanded to young adults). The FDA's decision to require this warning despite concerns about the original data, lack of evidence of a causal link, and lack of consensus within the psychiatric community as to clinical significance of the observed association was controversial and challenged by multiple professional organizations. Nevertheless, the warning has persisted and become, in itself, "evidence" that this relationship exists despite the relatively narrow conclusions that can be drawn from the original data. The warning had a series of unintended effects including decreasing diagnoses of depression and antidepressant treatment in adults and increasingly shifting treatment of depression out of primary care settings. The present study aims to compare psychiatry and primary care providers understanding of the black box warning in relation to their comfort utilizing antidepressant medications and their beliefs about the relative risk of antidepressant treatment (vs untreated depression) and perception of medicolegal risk of prescribing antidepressants.

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Fornaro, M., et al., The FDA "Black Box" warning on antidepressant suicide risk in young adults: more harm than benefits? *Front. Psychiatry*, 2019. 10:294

QUESTIONS AND ANSWERS

1. Which antidepressants carry a black box warning for suicidality?
- A. SSRIs
 - B. SSRIs & SNRIs
 - C. SSRIs, SNRIs, & TCAs
 - D. All antidepressant medications

ANSWER: D

2. What percentage of antidepressant prescriptions are managed by primary care providers?
- A. 40%
 - B. 60%
 - C. 80%
 - D. 90%

ANSWER: C

S21 EFFECTIVENESS OF MULTISYSTEMIC THERAPY WITH RECIDIVISM IN JUVENILES

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EDUCATIONAL OBJECTIVE

To conduct a systematic review of published studies assessing the effectiveness of MST with recidivism in juvenile population.

SUMMARY

Introduction: Multisystemic therapy (MST) is an intense, family-focused, community-based treatment designed to address social systems and individualized treatment for delinquent youth. **Objective** To conduct a systematic review of studies assessing the effectiveness of MST with recidivism in youth. **Methods:** A comprehensive search of published studies on “Multisystemic therapy” OR “Multisystemic family therapy” was conducted on PubMed, CINAHL Complete, APA PsychInfo, Cochrane Library, and Embase databases till January 3, 2022, using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines. Studies with control arm assessing the recidivism rates between MST and alternate interventions were screened by two independent reviewers. **Results:** Of 542 articles, 297 articles were screened for title and abstract after excluding duplicates resulted in 46 studies for full text analysis. 18 randomized controlled/controlled trials on MST, comprising 4774 juvenile offenders, were considered for final analysis. A descriptive table to inform study characteristics and demographic variables along with recidivism rates analysis comparing MST with alternate treatments will be presented in the poster. MST displayed favorable outcomes with recidivism rates in 13 studies with low re-arrest rates within various types of offenses and incarceration period. **Conclusion:** MST showed favorable results with recidivism rates relative to alternative treatments among juvenile offenders.

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QUESTIONS AND ANSWERS

1. In the evidence base, which of the following treatment modalities have the most indicated use for recidivism in juvenile population?
 - A. Cognitive Behavioral therapy
 - B. Insight-oriented psychodynamic psychotherapy
 - C. Multisystemic therapy
 - D. Family therapy

ANSWER: C

2. Which of the following best describes the multisystemic therapy approach for recidivism?
 - A. It is family-focused and is community-based
 - B. It is family-focused but not much emphasis on community engagement
 - C. It is community-centric and does not have family component
 - D. It operates on the principle that past trauma explains recidivism and trauma-informed care is the primary goal.

ANSWER: A

S22 BALANCING RESIDENT TRAINING – EARLY EXPOSURE TO FORENSIC PSYCHIATRY

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EDUCATIONAL OBJECTIVE

Justify having Forensic Psychiatry be a core rotation; 2. Defend the inclusion of Forensic Psychiatry experiences in earlier years of their residency program.

SUMMARY

Amongst the overall shortage of psychiatrists, there is a particular need in areas of forensic expertise (ie: corrections). However, it can be difficult to balance the ACGME core training requirements with early exposure to subspecialty work. At our program at Baylor College of Medicine, direct experience was via a PGY4 elective. This created a knowledge and exposure gap which could impact decisions related to fellowship training. Furthermore, residents who fast tracked to Child and Adolescent Psychiatry did not have this opportunity. We decided to increase exposure to Forensic Psychiatry by making this a core PGY2 rotation. This emphasized the importance of, and opportunities in, forensic psychiatry and improved balance in the program by placing it closer to other subspecialty rotations. In this poster, we will present the results of a residency-wide survey to assess the exposure, knowledge, and competency of Forensic Psychiatry skills in residents at the Baylor College of Medicine. We found that the majority felt that they had not had enough exposure in Forensics, were not comfortable writing Forensic reports, and felt that earlier Forensic Psychiatry exposure would be beneficial in their future career. All of these were improved in those who had done the core rotation.

REFERENCES

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Tobias Wasser et al., The benefits of required forensic clinical experiences in residency, 43 Academic Psychiatry 76–81 (2018).

QUESTIONS AND ANSWERS

1. Which of these does the ACGME NOT require as part of a resident's forensic psychiatry experience?
- A. Decisional capacity
 - B. Experience evaluating patients' potential to harm themselves or others
 - C. Writing a Forensic Report
 - D. Appropriateness for commitment.

ANSWER: C

2. What percentage of prison and jail inmates have psychiatric disorders that result in significant functional disability?
- A. 0-10%
 - B. 15-30%
 - C. 40-60%
 - D. Over 80%?

ANSWER: B

S23 TEACHING CORE PRINCIPLES TO RESIDENTS WITH A FORENSIC CONSULT CLINIC

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EDUCATIONAL OBJECTIVE

To present a novel forensic psychiatry course used to educate general psychiatry trainees by integrating residents into active forensic casework while teaching core forensic psychiatry concepts.

SUMMARY

Forensic psychiatry remains the only subspecialty area that doesn't have an ACGME-required clinical rotation during residency. Exposure to forensic concepts during general psychiatry training thus varies widely and may contribute to a lack of interest in forensic psychiatry among some trainees. In the face of increasing demand for both forensically trained psychiatrists and general psychiatrists comfortable working with justice-involved individuals, there has been increasing focus on best practices in teaching forensic psychiatry to residents. We describe a course recently introduced at Northwestern University that teaches forensic psychiatry to PGY4 residents via a forensic psychiatry clinic. The course was inspired by the Center on Wrongful Convictions at Northwestern's Pritzker School of Law and seeks to teach trainees about the field by integrating PGY4 residents into active real-world forensic consultation. During the longitudinal curriculum, residents assist a practicing forensic psychiatrist construct a forensic report by independently reviewing case documents, relevant psychiatric and forensic literature, and drafting an expert opinion. Throughout the course, residents receive didactics in core forensic concepts relevant to the case. This novel model could be replicated in other programs to increase knowledge of principles of forensic psychiatric practice among general psychiatrists and increase interest in the field.

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QUESTIONS AND ANSWERS

1. What percentage of general training programs currently require a forensic rotation?

- A. 25%
- B. 35%
- C. 45%
- D. 55%

ANSWER: B

2. How many states have at least one established fellowship program in forensic psychiatry?

- A. 47
- B. 35
- C. 26
- D. 20

ANSWER: C

S24 INCOMPETENT TO STAND TRIAL AND NOT RESTORABLE: A DILEMMA

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EDUCATIONAL OBJECTIVE

After a reviewing the case of a defendant facing charges without a statute of limitations, who was found not competent to stand trial and not restorable, we will present a description of the perplexing patchwork of approaches that states use when dealing with these individuals. We provide recommendations for a path forward to creating a consistent approach to individuals caught in this quandary.

SUMMARY

An individual was charged with murder in New York State (NYS), and found incompetent to stand trial (IST). Subsequently adjudicated not restorable, per *Jackson v. Indiana* (1972), the defendant was involuntarily committed to a civil hospital, converted to voluntary status, and then sought discharge. The District Attorney requested a reevaluation of competency to stand trial. Once again found IST, the defendant was recommitted to a forensic hospital for competence restoration. The defendant's NYS felony indictment did not have a statute of limitations and the time spent in a civil hospital did not count towards the 2/3rd of the maximum

sentence that an incompetent defendant could be held under NYS law. Over the 50 years that have passed since Jackson v. Indiana (1972) was decided, states have developed different approaches to these non-restorable defendants. In Montana and Missouri, their criminal charges are dismissed. Arkansas and Hawaii permit discretionary dismissal of their criminal charges. In Oregon, they are managed by a special board. In Arizona and California, they are more easily civilly committed. A 50-state survey would set the stage for developing guidelines that could provide a consistent, coherent approach to these individuals and protect their Constitutional rights.

REFERENCES

Morris DR, Parker GF. Indiana v. Davis: Revisiting Due Process Rights of Permanently Incompetent Defendants. J Am Acad Psychiatry Law. 2009 September; 37(3): 380-385

Bloom JD, Kirkorsky SE. Incompetent to Stand Trial, Not Restorable, and Dangerous. J Am Acad Psychiatry Law. 2020 June; 48(2): 237-243

QUESTIONS AND ANSWERS

1. What is due process?

- A. The government must provide a fair and consistent procedure
- B. Individuals must be given notice
- C. Individuals must have the opportunity to be heard
- D. The decision is to be rendered by a neutral decision maker
- E. All of the above

ANSWER: E

2. The Supreme Court held in Jackson v. Indiana that the Equal Protection and Due Process clauses of which Amendment were violated?

- A. Seventh Amendment
- B. Ninth Amendment
- C. Tenth Amendment
- D. Eleventh Amendment
- E. Fourteenth Amendment

ANSWER: E

S25 CANADIAN GUIDELINES FOR SEXUAL BEHAVIOUR AND RISK ASSESSMENTS

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Graham Glancy, MB, Toronto, Ontario, Canada

EDUCATIONAL OBJECTIVE

1. Upon completion of this educational activity, learners should be better able to understand the process and collaborative development of the Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing, and the content of the Sexual Behaviour and Risk of Sexual Offending guideline 2. Upon completion of this educational activity, learners should be better able to understand the utility of the guidelines as a resource in training and practice

SUMMARY

Using a national collaborative process, ten Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing, including the Sexual Behaviour and Risk of Sexual Offending guideline, were developed to enhance standards in training and practice. The Sexual Behaviour and Risk of Sexual Offending guideline provides a review of legal and psychiatric principles and offers detailed practical guidance to inform practice in the performance of third party evaluations, taking into account regional and legislative differences across Canada. They are intended to be used as a resource by forensic psychiatrists, other clinicians working in a forensic assessor role, and trainees, for education, reference, and self-assessment. We will review the development of the guidelines, and will focus on the structure and content reflecting best practices of sexual behaviour and risk of sexual offending assessments. Strategies to integrate the guidelines into training and as a resource in practice will be discussed. As well, the complexities and controversies, including terminology and labelling, diagnostic thresholds, sexological testing, and how the guidelines may be used in a legal setting will be reviewed.

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Ramshaw L, Wilke T, Chatterjee S, Tomita T, Glancy G. Canadian guidelines for forensic psychiatry assessment and report writing: general principles. 2022. Canadian Academy of Psychiatry & the Law. Available from: <https://www.caplacpd.org/wp-content/uploads/2022/06/01-Guidelines-FIN-EN-Web.pdf>.

Ramshaw L, Chatterjee S, Glancy G, Wilkie T. "Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Sexual Behaviour and Risk of Sexual Offending". Canadian Academy of Psychiatry and the Law, in press

QUESTIONS AND ANSWERS

1. All of the Canadian Guidelines for Assessment:

- A. Should include an introduction to the topic with case law and legislation, a section on assessment, and a section on report writing.
- B. Are intended as a review of all legal principles and case law.
- C. Offer practical All of the Canadian Guidelines for Forensic Psychiatry Assessments and Report Writing: guidance around expert testimony.
- D. Address treatment considerations.

ANSWER: A

2. According to the Canadian guidelines, you should include the following when writing a Court report for a sexual behaviors assessment:

- A. Safety and privacy considerations in the assessment
- B. Case law
- C. Descriptive language, rather than medical jargon
- D. The expert's cv

ANSWER: C

S26 WHEN THE ABYSS STARES BACK: VICARIOUS TRAUMA IN FORENSIC PSYCHIATRY

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EDUCATIONAL OBJECTIVE

Describe the signs of vicarious trauma; Discuss implications of vicarious trauma for expert and clinical work; Discuss the relationship between vicarious trauma, compassion fatigue, and burnout; Discuss strategies for managing vicarious trauma, including educating trainees.

SUMMARY

Psychiatrists experience vicarious trauma in several ways, including reviewing materials in forensic work, hearing patients' traumatic experiences, workplace violence, and adverse outcomes. While training on trauma-informed care has increased, physicians receive little education about approaching vicarious trauma, including its potential impact on how we experience compassion and countertransference. Nonetheless, clinicians and evaluators are called upon to strike a sometimes delicate balance between recognizing what our countertransference may be trying to tell us, objectivity, and maintaining our well-being. We present a review of the literature regarding the prevalence and presentation of vicarious trauma, varying perspectives on the experience/impact of such trauma, and proposed strategies for the management of vicarious trauma on an individual and systemic level. This will include a discussion of how vicarious trauma can influence objectivity in forensic work, as well as its potential impact on clinical work. Finally, the panel will explore considerations for educating trainees and directions for further investigation. Panelists include forensic psychiatrists doing a combination of expert and clinical work in inpatient and crisis settings, including first responder support after critical incidents, and a psychiatric residency training program director.

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QUESTIONS AND ANSWERS

1. Which of the following is true of vicarious trauma:

- A. It's an essential component of compassion fatigue
- B. It affects the majority of health care professionals across specialties and disciplines
- C. It refers specifically to secondary trauma from working with trauma survivors
- D. Countertransference can impact the scoring of the HCR-20

ANSWER: D

2. Which of the following describes the state of available interventions for vicarious trauma?

- A. There are no effective formalized interventions
- B. Addressing vicarious trauma requires structured trauma therapy, similar to that used in direct trauma
- C. Many interventions show promising preliminary results, but more randomized controlled trials are needed
- D. Peer support and cognitive behavioral interventions are the only evidence-based interventions for vicarious trauma

ANSWER: C

S27 PRESENTATION WITHDRAWN

S28 BALANCE, BIAS, BOUNDARIES: PSYCHOTHERAPY AND FORENSICS

(Sponsored by the Diversity Committee)

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Karen B. Rosenbaum, MD, New York, NY
Ryan Wagoner, MD, Tampa, FL
Anne Dailey, JD, Hartford, CT (I)

EDUCATIONAL OBJECTIVE

To enhance the consulting skills of forensic psychiatrists by presenting the benefits and risks of applying psychotherapeutic principles to the forensic psychiatry evaluation. Special emphasis is given to how psychotherapeutic ideas and skills can inform a comprehensive forensic evaluation and foster self-awareness, introspection, fairness, meaning, and balance in professional practice.

SUMMARY

Dr. Belcher will discuss how psychodynamic principles can help forensic psychiatrists “do better” in their pursuit of the whole truth. He will distinguish between considering psychoanalytic ideas in forensic evaluations (i.e., defense mechanisms, character organization, unconscious conflict) and the application of a psychotherapeutic stance to the forensic interview (i.e., neutrality, anonymity, empathy). Professor Dailey will present her theoretical foundation for the ways in which psychoanalysis has contributed to the law, including psychoanalytic challenges to engrained legal assumptions about free will, rationality, and guilt. She will discuss how theories of therapeutic action can inform the rehabilitative purpose of the judicial system. Dr. Rosenbaum will discuss how she balances her psychotherapeutic and forensic practices, with special emphasis on the professional responsibilities required when ‘switching hats.’ She will present a recent case where psychotherapeutic competency was central to her ability to serve as an expert witness. She will describe how occupying both roles has promoted personal balance. Dr. Wagoner will present the ethical implications and potential harms of applying a psychotherapeutic mindset to forensic evaluations. Referencing the forensic literature and AAPL practice guidelines, he will comment on the appropriate and inappropriate uses of psychotherapeutic skills, training, and perspectives in forensic work.

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Friedman SH. Culture, Bias, and Understanding: We Can Do Better. *J Am Acad Psychiatry Law* 45(2):136-139, 2017.

QUESTIONS AND ANSWERS

1. Which of the following is an example of a psychoanalytic technique and not a psychoanalytic idea?

- A. Defense mechanisms
- B. Unconscious conflict
- C. Neutrality in responding to evaluatee statements
- D. Character organization

ANSWER: C

2. Which of the following ethical principles must be considered when calling upon psychotherapeutic skills in the forensic evaluation?

- A. Distinguishing between clinical and forensic role of evaluator
- B. Awareness of countertransference
- C. Guarding against leading questions that limit responsiveness of evaluatee
- D. all of the above

ANSWER: D

S29 SECURE RECOVERY CARE EDUCATION FOR FORENSIC STAFF – A NARRATIVE REVIEW

(Sponsored by the Recovery Committee)

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Amanda Jas, MD, Toronto, Ontario, Canada (I)
Alexander Simpson, MD, Toronto, Ontario, Canada

EDUCATIONAL OBJECTIVE

To review the current literature on secure recovery education programs.

SUMMARY

Objective Recovery care empowers service users as active, collaborative participants in healthcare. Implementation can be challenging in forensic settings because patients are unwilling service users. There is limited research on the value of secure recovery education programs for forensic staff. As far as we are aware, there have been no prior reviews of this literature. A review was conducted of secure recovery care education programs for forensic staff to identify factors related to effectiveness. Methods: Medical and criminal justice databases were searched for articles describing recovery education for forensic staff. Studies with measurable outcomes were analyzed using an inductive approach. The review adhered to Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines for scoping reviews. Data were synthesized using Moore's 7 levels of outcomes for CPD education. Results: Of 1283 articles, 5 were included in final analysis. The programs achieved Moore's taxonomy level 6. Programs led to improvements in staff knowledge, skills, attitudes. Experiential teaching was preferred and themes related to programs' effectiveness included service user involvement, multimodal teaching methods, and relevance to forensic services. Conclusions: Our review suggests secure recovery care education programs are beneficial. Future programs should involve service users, incorporate experiential components, and address resistance.

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QUESTIONS AND ANSWERS

1. What is a central theme associated with recovery?

- A. Disconnection
- B. Pessimism and despair
- C. Meaning and purpose
- D. Life goals

ANSWER: C

2. The literature shows that effective secure recovery education includes the following:

- A. Incorporates service users as facilitators
- B. Incorporates service users only as guest speakers
- C. Incorporates didactic teaching components only
- D. Does not address staff resistance to secure recovery care

ANSWER: A

S30 BALANCING SAFETY, LIBERTY AND EFFECTIVE CARE IN CONDITIONAL RELEASE

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Melanie Scott, PsyD, Rocky Hill, CT (I)

EDUCATIONAL OBJECTIVE

Improving knowledge, skills, or performance in the following area: Service, e.g. treatment of forensic patients, and the development of service delivery systems

SUMMARY

Forensic hospital discharges require balanced considerations of public safety, patient liberty interests and continued effective treatment. The California Conditional Release Program (CONREP) is designed to reduce recidivism and improve patient outcome. To validate this premise for California's post-trial forensic patients transitioning to community, we compared the overall, violent, and sex crime rearrest rates of patients discharged directly to the community v. with those released to CONREP and examined the impact of key variables. The sample included 2613 patients with various commitment categories. We found the one, three, and five year fixed recidivism rates for CONREP Treated patients were significantly lower than those of Direct Discharge patients. For CONREP Treated patients overall re-arrest was seven to nine times less likely; for a violent crime, five to nine times less likely; and for a sex crime, six times less likely. CONREP treatment exerted most effects in commitment categories most prone reoffense. The effects of CONREP treatment lingers even after active CONREP treatment. Different group compositions partially explain the magnitude of the difference in rearrest rates and time to rearrest. Exploring these effects facilitates the careful balance of discharging patients following long hospital commitments.

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QUESTIONS AND ANSWERS

1. Which California commitment category is most likely to recidivate?

- A. Offender with Mental Disorder (OMD)
- B. Not Guilty by Reason of Insanity (NGI)
- C. Sexually Violent Predator (SVP)

ANSWER: A

2. What differences in group composition help explain higher recidivism rates in the Direct discharge group?
- A. Older Mean Age; Longer Hospital Stay; Non-Minority Status, Female Gender, and Psychotic Disorder
 - B. Younger Mean age; Minority Racial Status; Male Gender; Anti-Social Personality Disorder

ANSWER: B

S31 UNDERSTANDING DELIBERATE INDIFFERENCE TO SUICIDE

Jennifer Piel, MD, JD, Seattle, WA
Carol Barnes, MD, Seattle, WA

EDUCATIONAL OBJECTIVE

Understand recent legal cases with claims of deliberate indifference to suicide in corrections facilities to glean practice pointers for suicide risk management and education of corrections staff.

SUMMARY

Suicide is a leading cause of death in corrections facilities with rates of inmate suicide being notably higher than the national average. Suicide and attempted suicides may precipitate legal action against the facility, staff, and treating healthcare providers. In cases of a detainee's death or injury in a corrections facility, plaintiffs may bring legal action based on violations of the detainee's constitutional rights, separate from any tort claims. Specifically, plaintiffs may allege violations of detainees' Eighth or Fourteenth Amendment rights and assert that healthcare providers were deliberately indifferent to detainees' serious medical or psychiatric needs. With increased attention to suicide prevention in U.S. corrections facilities, the authors conducted a review of federal legal case decisions involving claims against healthcare providers for deliberate indifference to a detainee's serious illness or injury in the event of suicide or attempted suicide. The authors have identified themes from the cases and are exploring ways that the results can be used to address training needs and policy changes at local facilities. The cases provide a foundation for understanding suicides in corrections facilities and will be used to discuss practice pointers for healthcare providers in corrections facilities.

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Carson EA. Suicide in local jails and state and federal Prisons, 2000-2019 – Statistical tables [Internet]; 2021. <https://bjs.ojp.gov/library/publications/suicide-local-jails-and-state-and-federal-prisons-2000-2019-statistical-tables>.

Estelle v. Gamble, 429 U.S. 97 (1976).

QUESTIONS AND ANSWERS

1. According to Carson (2021), what was the suicide rate across jails and prisons in the United States in 2019?
- A. 0.49 per 100,000
 - B. 4.9 per 100,000
 - C. 49 per 100,000
 - D. 490 per 10000

ANSWER: C

2. What distinguishes claims of deliberate indifference from medical negligence?
- A. It involves allegations of a constitutional violation.
 - B. The plaintiff must prove that the defendant was aware of a detainee's serious medical or psychiatric need.
 - C. The plaintiff must establish that the defendant disregarded a known substantial risk of serious harm to the detainee.
 - D. All of the above

ANSWER: D

S32 SCHIZOPHRENIA AND SUBSTANCE USE DISORDERS IN INCARCERATED PATIENTS

Conchita Martin de Bustamante, Dallas, TX (I)
Christopher S. Kung, MD, Fort Worth, TX (I)
Eunsol Park, MD, Austin, TX (I)
Brianne Lacy, MD, Austin, TX (I)
Hien Piotrowski, MD, Austin, TX (I)

EDUCATIONAL OBJECTIVE

To conduct research in forensic psychiatry and develop a deeper understanding of Schizophrenia and substance use disorders in incarcerated patients.

SUMMARY

Schizophrenia is a serious mental illness amongst incarcerated inmates and is seldom the only disorder these patients suffer from. The prevalence of co-occurring schizophrenia and substance use disorder is markedly higher than for other mental disorders in the general population. The cohort consisted of 507 incarcerated patients at a large county jail who were evaluated by jail mental health providers in December 2020. A retrospective review was performed to evaluate associations between Schizophrenia, substance use disorders, and demographic variables. 15.2% of the cohort had a prior or current diagnosis of Schizophrenia (n = 77). Preliminary Chi-square analyses were performed to evaluate the co-occurrence of multiple substance use disorders, including marijuana, alcohol, cocaine, opioid, methamphetamine, benzodiazepine, and sedatives, with schizophrenia. Patients with a history of schizophrenia were significantly more likely to have comorbid opioid use disorder than those that did not. Schizophrenia was not significantly associated with any other substance use disorder. This suggests that Schizophrenia can predispose individuals to developing opioid use disorder. Determining the extent of these comorbid conditions within an incarcerated population can help determine better treatment plans for inmates moving forward, as addressing psychotic symptoms and substance use issues concurrently can lead to better outcomes for patients.

REFERENCES

Khokhar J, Dwiel L, Henricks A, Doucette W, Green A. The Link Between Schizophrenia and Substance Use Disorder: A Unifying hypothesis. *Schizophr Res.* 2018; 194: 78-85.

Baranyi G, Fazel S, Langerfeldt SD, Mundt Ap. The prevalence of comorbid serious mental illnesses and substance use disorders in prison populations: a systematic review and meta-analysis. *Lancet Public Health.* 2022 Jun;7(6):e557-e568. doi: 10.1016/S2468-2667(22)00093-7. PMID: 35660217; PMCID: PMC9178214.

QUESTIONS AND ANSWERS

1. Which substance use disorder was found to be most associated with a diagnosis of Schizophrenia?

- A. Cocaine
- B. Opioid
- C. Marijuana
- D. Alcohol

ANSWER: B

2. What was the prevalence of Schizophrenia within the cohort studied?

- A. 1%
- B. 7%
- C. 15%
- D. 50%

ANSWER: C

S33 CRISIS NEGOTIATION – HIGH STAKES TEAMWORK – (ADVANCED)

James L. Knoll IV, MD, Syracuse, NY
Gregg McCrary, MA, Fredericksburg, VA (I)
Detective Vance Ratcliff, Syracuse, NY (I)
Park E. Dietz, MD, MPH, PhD, Newport Beach, CA

EDUCATIONAL OBJECTIVE

Understand the importance and sophistication of crisis negotiation and how it can be used to reduce fatalities during high risk crises.

SUMMARY

Crisis negotiation (CN) has been described as one of the most of the most beneficial developments in law enforcement in last century. It utilizes psychological methods to resolve potentially violent crises without the use of force. CN is now taught and used by the FBI and other law enforcement agencies in a variety of scenarios such as mental health crises, domestic sieges or barricades, and hostage-taking. This panel will discuss the strengths of CN, as well as areas of CN that are in need of improvement. During the Waco Siege of 1993, former FBI agent Gregg McCrary supported crisis negotiations efforts and will describe real world challenges of CN. Dr. Park Dietz has been involved in many high profile CN scenarios, and was on scene at Ruby Ridge and Waco. He will also discuss his experience with corporate crisis negotiations. Detective Vance Ratcliff serves as Team Leader of the Syracuse Police Crisis Response Unit. He has peacefully resolved numerous volatile crises, helps train other officers and collaborates with mental health professionals.

REFERENCES

Seo, C., Kim, B., & Krus, N. E. (2021). Variation across police response models for handling encounters with people with mental illnesses: A systematic review and meta-analysis. *Journal of criminal justice*, 72, 101752.

Stokoe, E., & Sikveland, R. O. (2020). The backstage work negotiators do when communicating with persons in crisis. *Journal of Sociolinguistics*, 24(2), 185-208.

QUESTIONS AND ANSWERS

1. Research on the various police response models (PRMs) for resolving crises with people suffering from mental illness has concluded:
 - A. Crisis Intervention Team (CIT) training has shown the greatest success
 - B. The nature of police– community relationships has little impact
 - C. PRMs have been shown to be highly effective
 - D. PRMs appear to be moderately effective, but still in the early stages of research and development

ANSWER: D

2. During crisis negotiations, the secondary negotiator (or coach) can best assist the primary negotiator by which of the following?
 - A. Relaying important intel gathered by the team
 - B. Avoid disrupting the flow of negotiations
 - C. Paying attention to the emotional tone and linguistic interaction
 - D. Offer select, effective suggestions to the primary negotiator
 - E. All of the above

ANSWER: E

S34 INVOLUNTARY TREATMENT IN THE CONTINUUM OF FORENSIC SETTINGS

Cara A. Klein, MD, Bay Area, CA
KyleeAnn Stevens, MD, Shakopee, MN
Christy Mulkerin, MD, San Luis Obispo, CA (I)
Melanie Scott, PsyD, Rocky Hill, CT (I)

EDUCATIONAL OBJECTIVE

Improving knowledge, skills, or performance in the following area: Service, e.g. treatment of forensic patients, development of service delivery systems and enhancement of consulting skills

SUMMARY

Involuntary treatment statutes and case law exist to provide necessary and substantive treatment to patients who need it but whose illness impairs their capacity to consent to it. They also balance the ethical principles of respect for autonomy and beneficence, acknowledging that prompt, as well as continued, treatment is a key factor in prognosis. Across forensic settings, however, involuntary treatment is often not invoked or deployed, leading to, amongst others, consequences such as: recurrent cycle of criminalization and rehospitalization, prolonged hospitalization, inability to utilize pre-trial diversion programs secondary to lack of psychiatric stabilization, increased violence and injury in both correctional and hospital settings, and

poorer functional outcomes. We present here the real landscape of the use of involuntary treatment across forensic settings (i.e. corrections, forensic hospitals, community-based treatments), logistical and cultural barriers to implementation, and a concerted effort of outreach deployed to successfully address gaps in the provision of care due to medication refusal in forensic patients with impaired capacity to consent.

REFERENCES

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Am J Psychiatry Keers et al.; AiA: 1-8 “Association of Violence With Emergence of Persecutory Delusions in Untreated Schizophrenia”

QUESTIONS AND ANSWERS

1. What is the time period involuntary medications can be administered to a patient?
 - A. Involuntary medications can be administered indefinitely to a patient, even without a court order, if the prescribing professional find the medication necessary.
 - B. The administration of involuntary medications is time limited, often lasting only as long as the patient’s commitment or for a period set by the judge or State law.
 - C. Federal law dictates that involuntary medication can only be administered 2 times per day for 3 weeks.
 - D. Involuntary medication can be administered to a patient indefinitely because this determination is solely made by the patient’s treatment team.

ANSWER: B

2. Which of the following is NOT true?
 - A. The administration of involuntary medication in correctional settings requires coordination between multiple individuals, including mental health professionals, nursing, correctional staff, prescribing psychiatrists, court staff, and others.
 - B. Medications should be offered voluntarily on multiple attempts before they are administered involuntarily.
 - C. If the court’s involuntary medication order has been added to the medical record, no additional documentation is required by the health care team.
 - D. Procedures around involuntary medication orders must be consistent across the custody, mental health, and medical teams to ensure safety and consistency.

ANSWER: C

S35 NAVIGATING THE DIGITAL WORLD: SOLUTIONS TO DEVELOP YOUR PRACTICE

(Sponsored by the Early Career Psychiatry Committee)

Gloria Osuruaka, MD, Arlington, VA
Beryl Vaughan, MD, San Rafael, CA (I)
Sanjay Adhia, MD, Sugar Land, TX
Dan Sandman, Esq., Orinda, CA (I)
Alan W. Newman, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

Attendees will be armed with techniques and problem-solving tools to use digital platforms to develop a private practice in a manner ethical and consistent with best practices in Forensic Psychiatry. Techniques are taught to correct inaccuracies online. Attendees will learn ethical considerations in website development, and third-party affiliations.

SUMMARY

Increasingly, attorneys use the internet to seek qualified forensic psychiatrists. Forensic psychiatry fellows are largely untrained about how to develop a private practice and reputation online. This workshop will provide ethical, practical, and productive techniques to navigate practice development in a digital environment. Panelists will discuss overarching concerns about best practices and solutions to specific questions about websites, online directories, panel affiliations, and “matchmaking clearinghouses.” Panelists are specialists in

law, digital marketing best practices, ethics and internet data. Attendees will form small groups with focused tasks conducting internet research about their digital footprint using their own cell phone, or a tablet or laptop provided to them to identify top-ranking Google results an attorney will encounter in searching for a given expert. It is common for there to be mistakes and inaccuracies online. Group members will identify, and problem-solve how to correct outdated hospital and school affiliations, and contact information. Attendees will also review together websites of colleagues which appear in their test search. They will discuss ethical and practical concerns like content, scope, and cost in developing a website. During the workshop, groups will submit questions to panelists to answer before moving to the next task.

REFERENCES

Journal Article: Cook, Brian K., Goddard, Emily R., Werner, Tonia L., et al. The Risks and Responsible Roles for Psychiatrists Who Interact With the Media, *Journal of the American Academy of Psychiatry and the Law Online*. 2014 December, 42(4):459-468 Volume 42, Number 4, 2014

American Medical Association, Council on Ethical and Judicial Affairs. Advertising and Publicity, Opinion 9.6.1. American Medical Association Code of Ethics. June 2016. American Medical Association.

QUESTIONS AND ANSWERS

1. Is it ethical for a Forensic Psychiatrist to have a website for their forensic practice?

ANSWER: A

2. Is it unethical to pay for an advertisement with Google Ads?

ANSWER: C

S36 FROM MARKETING TO MAYHEM: EXPERT-LAWYER AGREEMENTS – (ADVANCED)

(Sponsored by the Private Practice Committee)

Jason Barrett, MD, Los Angeles, CA
Trent Holmberg, MD, Draper, UT
Steven H. Berger, MD, Reno, NV
William H. Reid, MD, Horseshoe Bay, TX

EDUCATIONAL OBJECTIVE

Service, e.g. treatment of forensic patients, development of service delivery systems and enhancement of consulting skills

SUMMARY

There are an estimated 45,000 psychiatrists that provide care to patients in the United States. Of these, approximately 1,500 hold an active board certification in forensic psychiatry. Yet the actual number of forensic psychiatrists conducting private evaluations as independent contractors is unknown. Medical schools, residencies, and forensic fellowships very often lack either formal courses or direct mentoring on the business of expert consultation. For forensic psychiatrists in private practice, suitable contracts are a key element to the success of their businesses. Panelists in this discussion will aid attendees seeking to find a balance between engaging in work as forensic experts and conducting business as competent professionals. A case will be presented that highlights elements of a contractual agreement from start to finish. Participants will review: 1. Marketing your private forensic practice 2. Dos and don'ts of the initial phone call with a lawyer 3. Elements of a private forensic contract/agreement 4. Fee agreements, billing, & collections 5. Navigating when things go wrong with payment and lawyer relations Attendees will be provided a handout of the panelists' suggestions for safeguarding their private practice. Attendees are also encouraged to come with questions for the panelists.

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Reid, W. H. (2013). *Developing a forensic practice: Operations and Ethics for experts*. Routledge, Taylor & Francis Group.

QUESTIONS AND ANSWERS

1. A colleague has recently decided to open a private forensic practice. They ask you for advice relative to fees and billing. Which of the following would be the most appropriate suggestion to your colleague regarding which fee and billing approach to use?
- A. Time-based
 - B. Package pricing
 - C. Contingency
 - D. Fee splitting
 - E. Letters of protection

ANSWER: A

1. A colleague informed you that he sent your name to an attorney about a case in your state. You anticipate the attorney will contact you. Which of the following would be a most appropriate conclusion for handling an initial call based on your discussion?
- A. Refer to another expert if appropriate
 - B. Offer an opinion from details obtained
 - C. Obtain no identifying information
 - D. Have the attorney setup a call with the litigant
 - E. Charge for time spent on the call

ANSWER: A

S37 LEGISLATIVE ADVOCACY AS ENTRY TO LEARNING ABOUT FORENSICS

Jennifer Piel, MD, JD, Seattle, WA

EDUCATIONAL OBJECTIVE

Attendees will gain awareness of ways legislative advocacy fosters training in basic legal concepts, how laws are made, working with lawyers and policymakers, and the influence of law on the practice of psychiatry.

SUMMARY

The presentation will focus on participation in a state psychiatric association as a way to learn about legislative advocacy and other broader concepts in psychiatry and law. Although advocacy is recognized as an important topic for medical education, educational programs and experiences in advocacy are varied. Legislative advocacy focuses on measures to introduce, implement, or change laws through the legislative process. This presentation will review results of a survey of trainees and professions who participated in state psychiatric association's government relations committee and their involvement in the 2023 state legislative session. The committee reviewed over 100 bills relevant to clinicians or consumers in behavioral health. Survey results shed light on ways that participation in legislative advocacy can foster increased knowledge in basic legal concepts, how bills are made, statutory interpretation, and the influence of law on psychiatric practice, as well as participants' attitude and competence in recognizing and participating in future activities at the intersection of psychiatry and the law.

REFERENCES

Piel JL: Legislative advocacy and forensic psychiatry training: model training elective and lessons learned, J Am Acad Psychiatry Law 46(2): 147-155, 2018

Bloom JD: Forensic psychiatry, statutory law, and administrative rules. J Am Acad. Psychiatry Law 39:418-21, 2011

QUESTIONS AND ANSWERS

1. Participants in legislative advocacy may learn which of the following related to concepts in psychiatry and the law?
- A. How bills become laws
 - B. Statutory interpretation
 - C. Influence of law on psychiatric practice
 - D. All of the above

ANSWER: D

2. Legislative advocacy may include which of the following activities?

- A. Drafting legislation
- B. Testifying in support of proposed legislation
- C. Lobbying
- D. All of the above

ANSWER: D

S38 USING EDUCATION TO CULTIVATE CONFIDENCE IN SECURE RECOVERY PRACTICE

Shaheen A. Darani, MD, Toronto, Ontario Canada
Buthaina Almaskari, MD, Toronto, Ontario, Canada (I)
Alexander Simpson, MD, Toronto, Ontario, Canada
Stephanie Penney, MD, Toronto, Ontario, Canada (I)
Patti Socha, MD, Toronto, Ontario, Canada (I)
Faisal Islam, MD, Toronto, Ontario, Canada (I)
Remar Manaoil, MD, Toronto, Ontario, Canada (I)
Treena Wilkie, MD, Toronto, Ontario, Canada

EDUCATIONAL OBJECTIVE

To describe forensic care providers' knowledge, skills, and education needs in relation to the practice of secure recovery at a large mental health hospital in Canada

SUMMARY

Recovery is the process of personal change leading to a satisfying, hopeful, contributing life, even within the limits of mental illness. Recovery-oriented care has become a dominant paradigm in mental health service provision and increasingly applied to forensic settings. There is limited evidence on forensic providers' knowledge, skills, education needs in this practice, and the challenges implementing recovery-oriented care in secure settings with consistency and fidelity. Kennedy (2022) calls for the development of a secure recovery curriculum to address this gap. A survey was administered to forensic staff at CAMH (n=300) to identify gaps in staff knowledge, skills and their education needs in secure recovery. Descriptive statistical techniques were used to analyze data and open-ended questions were analyzed thematically. Of 108 responses, 45% were nursing staff. Staff forensic experience ranged from 0 to 43 years with median of 5 years. Results showed 79% reported good or excellent knowledge in recovery-oriented principles, however, 44% were not, somewhat, or moderately confident in their skills in implementing recovery oriented care; 59% did not believe they received adequate education; 93% were interested in secure recovery education. Results will inform the development of a curriculum to increase confidence of forensic staff. Implications will be discussed.

REFERENCES

Eunson, H., Sambrook, S. & Carpenter, D. Embedding Recovery into Mental Health Training for Mental Health Practitioners. in Issues in Forensic Psychology (eds. Shuker, R., Drenna, G. & Alred, D.) vol. Secure Recovery 172–185 (Routledge, 2012).

Davidson, L. & White, W. The Concept of Recovery as an Organizing Principle for Integrating Mental Health and Addiction Services. *J Behav Health Serv Res* 34, 109–120 (2007).

QUESTIONS AND ANSWERS

1. Which of the following is most correct about recovery?

- A. Recovery is the process of personal change leading to a satisfying, hopeful, and contributing life, even within the limits of mental illness
- B. Recovery oriented care has not become a dominant paradigm in mental health service provision over the past decade
- C. Recovery oriented models of care have been fully adapted to forensic settings
- D. Recovery oriented models of care does not have health systems benefits

ANSWER: A

2. What are the benefits of recovery-oriented care from a health systems perspective?
- A. Allows services to alter resources to better meet users' self-identified needs
 - B. Has increased the use of physical restraints
 - C. Has decreased interprofessional staffs' work satisfaction
 - D. There is evidence for improved patient outcomes

ANSWER: A

S39 PSYCHIATRY SPECIFIC FIREARM ANTICIPATORY GUIDANCE CURRICULUM

(Sponsored by the Forensic Training of Psychiatry Residents Committee)

Isabel Stillman, MD, Philadelphia, PA

Meghan Musselman, MD, Philadelphia, PA

EDUCATIONAL OBJECTIVE

To share the development of a new longitudinal firearm safety curriculum for psychiatry residents that encompasses essential knowledge related to firearm safety, risk assessments and relevant legislation.

SUMMARY

Firearm use in aggressive and suicidal acts has become a crisis. However, there has been no firearm safety curriculum specific to psychiatric training. In the heated debate over gun control in which firearm violence is blamed on mental illness, a balance can be found in creating firearm safety curriculum for psychiatrists. The authors sought to develop a longitudinal curriculum for general psychiatry trainees that encompasses essential knowledge related to firearm safety, risk assessments and relevant legislation. The authors developed a six-lecture series with topics designed for each post graduate level of training and a Grand Rounds on basic firearm safety. The curriculum's impact on residents' attitudes to firearm safety guidance was measured using a pre- and post-lecture series questionnaire administered to all resident levels. The quantitative analysis was completed using paired t-test. Forty-seven residents participated. Twenty-seven respondents met inclusion criteria: attended minimum one lecture or the grand rounds, completed pre- and post-lecture surveys, and submitted their pre-lecture survey before their first lecture. There was a statistically significant increase ($p < 0.05$) in interest in firearm safety, and confidence in all areas surveyed. Areas of development include assessing the curriculum's impact on clinical practice and making the curriculum portable for other psychiatry departments.

REFERENCES

Pallin R, Teasdale S, Agnoli A, Spitzer S, Asif-Sattar R, Wintemute GJ, et al. Talking about Firearm Injury Prevention with patients: a Survey of Medical Residents. *BMC Medical Education*. 2022 Jan 3;22(1).

Albright TL, Burge SK. Improving Firearm Storage Habits: Impact of Brief Office Counseling by Family Physicians. *The Journal of the American Board of Family Medicine*. 2003 Jan 1;16(1):40-6.

QUESTIONS AND ANSWERS

1. Per the Federal Bureau of Investigations how many active shooter incidents were there in 2000 and how many in 2020?
- A. 3 in 2000 and 40 in 2020
 - B. 5 in 2000 and 30 in 2020
 - C. 2 in 2000 and 24 in 2020
 - D. 4 in 2000 and 52 in 2020

ANSWER: A

2. What is the leading method of Suicide in the U.S.?
- A. Suffocation
 - B. Firearm
 - C. Poisoning
 - D. Trauma from high impact fall

ANSWER: B

S40 A FORENSIC PSYCHIATRIST'S JOURNEY

Park Dietz, MD, Newport Beach, CA

EDUCATIONAL OBJECTIVES

This presentation will improve attendee competence and/or performance in the following way(s): (1) by encouraging forensic psychiatrists to explore adjacent disciplines, unfamiliar subcultures, and relevant institutions to better inform their understanding of the environments affecting those we evaluate and (2) by encouraging forensic psychiatrists to adopt the role of curious forensic scientist and to resist the pressures to serve as advocates for anything but their evidence-based opinions.

SUMMARY

This lecture synthesizes the journey of one psychiatrist toward an approach to forensic psychiatry emphasizing the collection and preservation of evidence; inquiry into the social and cultural contexts of the behavior at issue; efforts to integrate the understanding of diseases, dimensions, motivated behaviors, and life stories; and the role of forensic scientist. The presenter emphasizes the value of sub-specialization, the importance of playing an active investigative role, the need to continuously tap the literature of multiple disciplines, and the risks and rewards of accepting high-profile cases.

REFERENCES

Dietz, PE: The forensic psychiatrist of the future. *Bull Am Acad Psychiatry Law* 15:217-227, 1987.

Dietz, PE: The quest for excellence in forensic psychiatry. *Bull Am Acad Psychiatry Law* 24:153-163, 1996.

QUESTIONS AND ANSWERS

1. Questions forensic psychiatrists should ask themselves before accepting a case include:

- A. Do I have or can I rapidly acquire sufficient expertise in the diagnostic issues, legal issues, technical issues, social groups, and institutions central to this case?
- B. Will I have sufficient data, time, and resources to develop an evidence-based opinion on the referral questions?
- C. Would a well-prepared cross-examiner be able to discover impeachment material in my past writings, presentations, testimony, political donations, or advocacy activities?
- D. Should I exclude myself because the case implicates a social cause about which I have strong feelings?

ANSWER: *All of the above.*

2. Potential downsides of accepting high profile cases include:

- A. Usually involves intense scrutiny by retaining and opposing counsel and by the media
- B. May involve intrusive investigation of the expert and family members
- C. May attract threats, stalkers, or social media trolls
- D. More likely to provoke ad hominem attacks on the expert

ANSWER: *All of the above.*

S41 LEGAL ADVOCACY AND PSYCHIATRIC TREATMENT: CAN WE FIND COMMON GROUND?

Christopher Lloyd Myers, MD, MPH, Marion, MA

Matthew Lahaie, MD, JD, Bridgewater, MA

Keelin Garvey, MD, Bristol, RI

Stephen Dinwiddie, MD, Chicago, IL

EDUCATIONAL OBJECTIVE

Discuss the ways in which legal advocacy has shaped the legal regulation of and provision of psychiatric care in forensic psychiatric hospitals Describe legal, ethical and treatment issues that a psychiatric provider in a forensic setting may face when either working with or being investigated by legal advocates Describe ways in which legal advocates and psychiatric providers may be able to collaborate to better the lives of those with mental illness.

SUMMARY

Advocacy groups including state and federally funded Protection and Advocacy Systems along with nonprofit agencies have made substantial strides in advancing the humane treatment of mentally ill individuals, addressing issues such as conditions of confinement, treatment practices of psychiatrists and the preservation of patient autonomy. Despite often shared goals, advocates and psychiatric providers may differ in their views of treatment for debilitating symptoms, interpretations of state and federal law related to involuntary treatment for emergency behaviors, and their assessment of patients' needs and wishes when they are suffering from acute illness. Advocate investigations may lead to improvements in patient care but may also burden limited hospital administrative and clinical resources in addition to promulgating staff burnout and low morale related to media coverage from these investigations. This panel will provide a brief overview of mental health advocacy, present examples from two forensic psychiatric hospitals emphasizing viewpoints of both hospital staff and advocates, discuss the complex legal and ethical issues that may arise when these two entities intersect, and finally engage the audience in a discussion of ways to develop more collaborative relationships with these groups to further our shared goal of bettering the lives of those with serious mental illness.

REFERENCES

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Arrigo B, Williams C: The Ethics of Advocacy for the Mentally Ill: Philosophic and Ethnographic Considerations. *Seattle University Law Review* 24: 245-295, 2000

QUESTIONS AND ANSWERS

1. Which of the following receives Federal and State Funding to provide legal advocacy for mentally ill individuals?

- A. American Civil Liberties Union
- B. National Alliance on Mental Illness
- C. National Disability Rights Network
- D. Prisoner Legal Services

ANSWER: C

2. Which issues may be of particular concern to legal advocacy groups?

- A. Conditions of confinement
- B. Use of involuntary Psychotropic Medication in Behavioral Emergencies
- C. Use of Seclusion and Restraint
- D. All of the above

ANSWER: D

S42 DRUGS IN "CONTROLLED" CORRECTIONAL SETTINGS

(Sponsored by the Addiction Psychiatry and Correctional Forensic Psychiatry Committees)

Ashley VanDercar, MD, Northfield, OH

Abhishek Jain, MD, New York, NY

Adelle Schaefer, MD, Cleveland, OH

Sanya Virani, MD, MPH, Westborough, MA

Joseph Penn, MD, Conroe, TX

EDUCATIONAL OBJECTIVE

(1) To recognize the myriad of illicit substances that can be introduced, manufactured, or traded within "controlled" correctional settings; (2) To recognize systems-based challenges in preventing and monitoring illicit substances and contraband entering jails and prisons; (3) To identify management strategies, such as testing and indicators of substance use, particularly newer synthetic substances; (4) To understand the potential impact of illicit substances when treating an incarcerated individual and assessing a forensic evaluatee; (5) To appreciate the need to balance individual rights with maintaining custody and controlled setting, and the practical and economic implications this might have.

SUMMARY

In jails and prisons, illicit substance use is frequently encountered. For instance, in a 2017 review of the California Correctional Healthcare System, drug overdose was the fourth leading cause of death among the state's inmates. Trafficking and trading of contraband is common. Illicit substances can be introduced into penal settings in many ways – such as by visitors or staff, transported by drones, or hidden in mail. Illicit substances can be dissolved into crayons or other writing materials or, as with newer synthetic drugs, sprayed onto paper. Some correctional facilities have made efforts to combat this by photocopying or scanning incoming mail. Addressing the influx of illicit substances, while necessary, can be expensive and challenging. This co-sponsored panel, from the Addiction Psychiatry and Correctional Forensic Psychiatry Committees, will summarize various ways that contraband can be introduced into correctional settings. Potential constraints on detection methods will be detailed. We will discuss challenges in the treatment and evaluation of such individuals, especially with newer synthetic drugs that produce psychotic symptoms. Speakers will review published surveys of jail and prison policies, summarize relevant case law, and discuss practical experiences. Audience participation will include polling and case discussions.

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QUESTIONS AND ANSWERS

1. Which of the following is NOT a slang term used to describe synthetic cannabinoids?

- A. K2
- B. Spice
- C. Toonies
- D. Black Magic

ANSWER: C

2. When comparing regular cannabis to synthetic cannabinoids, which of the following statements is true?

- A. Synthetic cannabinoids are more easily detected in urine drug screens than regular cannabis
- B. Synthetic cannabinoids are full agonists at the CB1 receptor, whereas THC (the main psychoactive component of regular cannabis) is a partial agonist at the CB1 receptor
- C. Regular cannabis is more likely to cause psychosis than synthetic cannabinoids
- D. The effects of regular cannabis are more unpredictable than the effects of synthetic cannabinoids.

ANSWER: B

S43 FEMALE SEX OFFENDERS: PSYCHOTICS, PEDOPHILES OR PSYCHOPATHS?

Bethany Hughes, MD, Wichita Falls, TX

Charles Scott, MD, Sacramento, CA

Barbara McDermott, PhD, Sacramento, CA (I)

EDUCATIONAL OBJECTIVE

This workshop will provide an in-depth discussion describing female sex offenders (FSO). Attendees will understand statistics regarding epidemiology/prevalence of FSO, typologies with case vignette examples, risk assessment strategies, physiological approaches, treatment modalities and prognostic indicators.

SUMMARY

Female sex offenders (FSO) make up only about five percent of all known sex offenders. While much is unknown about this population, the literature indicates specific risk factors for sexual recidivism. Various typologies attempt to categorize FSO to assist evaluators in understanding pertinent historical factors, likely victim pool, type of abuse and motivation. The literature also provides information regarding potential treatment modalities as well as prognostic indicators specific to FSO. Dr. Bethany Hughes will discuss

epidemiology of FSO, various typologies in the literature and specific risk factors related to sexual recidivism. Dr. Barbara McDermott will describe the pros and cons as well as applicability of incorporating psychometric violence risk assessment tools in evaluation of FSO, with specific mention of including the PCL-R. Dr. Charles Scott will review physiological approaches including the use of polygraphy and sexual arousal testing, as well as potential treatment options. Example case vignettes will be woven throughout where audience participants will be asked to provide information regarding offender typology, risk for reoffending and prognostic indicators. Participants will be prompted to describe potential risk assessment modalities as well as treatment plan considerations.

REFERENCES

Mathews, R, Matthews, J, & Speltz, K: Female sexual offenders: An exploratory study. Vermont: Safer Society Press 1989

Vandiver, D, Kercher, G: Offender and Victim Characteristics of Registered Female Sexual Offenders in Texas: A Proposed Typology of Female Sexual Offenders. *Sexual Abuse: A Journal of Research and Treatment*, 16:121-137, 2004

QUESTIONS AND ANSWERS

1. Which of the following is not a known typology of female sex offenders?

- A. Teacher/lover
- B. Male coerced
- C. Revenge offender
- D. Female sexual predators

ANSWER: C

2. Which of the following statements is true regarding female sex offenders?

- A. Female sex offenders have similar levels of sexual recidivism risk compared to male sex offenders.
- B. Most violence risk assessment tools are not validated for use in evaluation of female sex offenders.
- C. There are no known options to assist in the long-term treatment of female sex offenders.
- D. Female sex offenders exclusively offend against child victims.

ANSWER: B

S44 WHAT HAVE I DONE??? THE SELF-TRAUMATIZED PERPETRATOR

(Sponsored by the Trauma and Stress Committee)

Juliette K. Dupre, MD, Toronto, Ontario, Canada
Celestine DeTrana, MD, Indianapolis, IN
Trent Holmberg, MD, Draper, UT

EDUCATIONAL OBJECTIVE

1. Participants will describe the current status of perpetrator trauma in the literature and the DSM-V-TR. 2. Participants will identify the relevance of perpetrator trauma in forensic evaluation.

SUMMARY

There is increasing recognition of the impact of witnessing and experiencing violence in the development of both mental and physical ill-health. However, there has been a paucity of research and attention on self-traumatization through one's own violent act(s). An introduction to the topic will include a historical perspective on the development of the DSM-V-TR diagnosis of posttraumatic stress disorder, with particular attention paid to the role of combat related violent acts and their status as incident traumas (Aldridge et al., 2020). The ambiguous ethical status of various archetypes of self-traumatized perpetrators will be explored using a moral dialectic approach as opposed to moral dualism. This panel will then discuss the epidemiological data with respect to self-traumatization and how it is distinct from exposure to other traumatic events (Maguen et al., 2009). Research on how self-traumatization is considered in forensic assessments and sentencing will be reviewed, as this is an area that is often overlooked. Two case studies will be presented to elicit audience participation and highlight the nuances of the forensic evaluation of perpetrator trauma, including a case of a woman who attacked and nearly killed her baby while in a psychotic episode and a case of traumatic amnesia.

REFERENCES

Aldridge, V., Scott, H., & Paskell, R. Post-Traumatic Stress Disorder and Killing in Combat: A Review of Existing Literature. *Journal of Military and Veterans' Health*. 2020 December; 28(4): 46–59

Maguen, S., Metzler, T. J., Litz, B. T., Seal, K. H., Knight, S. J., & Marmar, C. R. (2009). The impact of killing in war on mental health symptoms and related functioning. *Journal of Traumatic Stress*. 2009 October; 22(5): 435–443

QUESTIONS AND ANSWERS

1. What is the status of perpetrator-induced PTSD in the DSM-V-TR?

- A. It is explicitly excluded under the Criteria A definition of traumatic stressor
- B. It only applies to military personnel
- C. It only applies to cases of psychotically motivated violence
- D. It is not addressed by the DSM-V-TR

ANSWER: B

2. How do symptoms of perpetrator-induced PTSD differ from other causes of traumatization?

- A. The symptoms of PTSD are less severe overall
- B. Hypervigilance is less severe
- C. Rates of comorbid alcohol and cocaine use disorder are lower
- D. Intrusive imagery is more prominent

ANSWER: D

345 TREATING NGRI ACQUITTEES ON CONDITIONAL RELEASE: AN UPDATE

Ren Belcher, MD, Cleveland, OH
Abhishek Jain, MD, New York, NY
Li-Wen Lee, MD, Albany, NY
Sara West, MD, Broadview Heights, OH
Stephen Noffsinger, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

1. Summarize recent legal history and court cases regarding the management of individuals adjudicated not guilty by reason of insanity (i.e., insanity acquittees) 2. Identify how criteria and procedures for the conditional release of insanity acquittees vary by jurisdiction 3. Appraise new evidence and key literature updates regarding the management of insanity acquittees in the community 4. Recognize the opportunities and challenges of clinical risk assessment and treatment of insanity acquittees This session is appropriate for learners new to the topic as well as those with experience treating patients on CR.

SUMMARY

In June 2022, John Hinckley Jr. tweeted: “After 41 years 2 months and 15 days, FREEDOM AT LAST!!!” The infamous attempted assassin of President Reagan, acquitted as NGRI, had been conditionally released since 2016 following a 34-year-long hospitalization. His unconditional freedom last year has brought professional and popular attention to the management of insanity acquittees. This panel will provide an evidence-based update regarding criteria and procedures for the Conditional Release (CR) of insanity acquittees. This will include a discussion of the wide jurisdictional variation in the management and monitoring of defendants adjudicated NGRI, the legal foundations of CR, and recent court cases featured in the JAAPL Legal Digest (1,2) that add to the AAPL landmark cases *Foucha v. Louisiana* and *Jones v. US*. Evidence for the effectiveness of CR, including recent studies of the rates of recidivism and revocation of CR (3), and program-specific and individual-specific factors associated with success (4), will be outlined. Best practices for the psychiatric treatment of patients on CR will be summarized. Composite examples of both a successful and unsuccessful CR plan will be highlighted. The need for future investigation to enhance clinical practice and legal outcomes will be examined.

REFERENCES

Lamplsey SF and Obikoya KA. Outpatient Conditions of Release Following NGRI Acquittal. *J Am Acad Psychiatry Law* 49(3): 436-439, 2021.

Ahmad A and Martinez R. Mental Illness Without Dangerousness in Conditional Release. *J Am Acad Psychiatry Law* 48 (4): 549-552, 2020.

QUESTIONS AND ANSWERS

1. In longitudinal studies, approximately what percentage of NGRI acquttees granted Conditional Release maintain their CR privileges for the first 5-10 years without revocation?

- A. 0-20%
- B. 20-40%
- C. 40-60%
- D. 60-80%
- E. 80-100%

ANSWER: D

2. Which of the following requirements is NOT a common requirement for NGRI acquttees granted Conditional Release?

- A. Sobriety from drugs
- B. Medication adherence
- C. Periodic reassessment of eligibility for the NGRI defense
- D. Structured and supervised housing
- E. Attendance at treatment appointments

ANSWER: C

S46 PEER REVIEW OF THE EXPERT WITNESS IN A HIGH-PROFILE SCHOOL SHOOTING

(Sponsored by the Peer Review of Psychiatric Testimony Committee)

Ariana Nesbit, MD, Durham, NC
Charles Scott, MD, Sacramento, CA
Richard Frierson, MD, Columbia, SC
Richard Martinez, MD, Denver, CO

EDUCATIONAL OBJECTIVE

1) Understand the ethical controversy and challenges associated with evaluating a defendant charged with a high profile capital crime; 2) Review the components of effective expert testimony; 3) Consider the line between serving as an effective expert and advocate.

SUMMARY

On February 14, 2018, Nikolas Cruz carried out the deadliest high school shooting in the United States at Marjory Stoneman Douglas High School in Parkland, Florida. He pled guilty to 17 counts of murder and 17 counts of attempted murder; however, the question as to whether he would be sentenced to death remained. Dr. Charles Scott served as the state's forensic psychiatric expert. In this panel, Dr. Nesbit will describe the purpose and principles of peer review and provide a summary of the case. Dr. Scott will describe factors he considered when deciding whether or not to provide expert consultation in a capital case. He will also share his own self-assessment of his evaluation and testimony, including challenges that other AAPL members should anticipate if they are hired to evaluate a high profile capital defendant. Videoclips of Dr. Scott's testimony will be shared with the audience. Drs. Frierson and Martinez will review Dr. Scott's testimony and consider several questions, including supportive evidence for Dr. Scott's opinion, the role of the forensic psychiatrist in a capital case, how to maintain the ethical balance between serving as an effective expert and advocate, and Dr. Scott's manner of communicating with the jury.

REFERENCES

Perlin ML, Lynch AJ. The death penalty. In Rosner R, Scott CL, editors. Principles and Practice of Forensic Psychiatry. Boca Raton, FL: CRC Press; 2017. p. 91-98.

Frierson RL. Chapter 20: Psychiatry and the Death Penalty. In Gold FH, Frierson RL, editors. Textbook of Forensic Psychiatry, 3rd edition. Arlington, VA: American Psychiatric Association Publishing; 2018. P. 297-312

QUESTIONS AND ANSWERS

1. Which of the following statements about the death penalty is true?
- A. Executing individuals with any mental health disorder violates the 8th amendment
 - B. Executing individuals with intellectual disability violates the 8th amendment
 - C. Executing juveniles does not violate the 8th amendment if the defendant is charged with murder
 - D. Victim impact statements violate the 8th amendment because there is too much risk that the jury may impose the death penalty in an arbitrary and capricious way

ANSWER: B

2. Which of the following statements about psychiatric evaluations in capital cases is true?
- A. The World Psychiatric Association and World Health Organization have declared that psychiatrists should participate in competence to be executed evaluations
 - B. AAPL ethical guidelines prohibit testimony in competence to be executed evaluations
 - C. The American Medical Association declared that competence to be executed evaluations should be considered participation in executions
 - D. No United States professional guideline prohibits evaluating and/or testifying in competency to stand trial or NGRI cases of capital defendants

ANSWER: D

S47 TWENTY YEARS LATER, STILL A TOUGH SELL?

Sherif Soliman, MD, Charlotte, NC
Danita Bowling, PhD, JD, Morganton, NC (I)
Daniel Hackman, MD, Louisville, KY
Rabeca Stahl, PhD, Morganton, NC (I)
Alexis Glomski, MD, Louisville, KY

EDUCATIONAL OBJECTIVE

The audience will review the holding in *Sell v. United States*, 539 U.S. 166 (2003), discuss its significance, and learn how courts have applied *Sell* in selected cases. The audience will be able to discuss the contemporary literature regarding the efficacy of psychological and pharmacotherapeutic interventions in competency restoration. The audience will be able to discuss the balance between multiple competing interests including patient autonomy, beneficence, and the government's interest in pursuing criminal prosecution. The audience will be able to discuss how the *Sell* Court balanced these interests as well as how subsequent case law has interpreted *Sell*. The audience will have the opportunity to consider their own opinion of where the balance should lie.

SUMMARY

In 2003, the Supreme Court considered the unusual case of Dr. Charles Sell, who was incompetent to stand trial due to delusional beliefs. The Court held that involuntary medication to restore competence in a non-dangerous individual who was competent to refuse was permissible in limited cases. The Court's standard included consideration of the relevant state interest, the likelihood of the medication to restore competence, the likelihood of side effects that could affect the defendant's ability to assist in their defense, and the efficacy of less intrusive means to restore competence. The panel will examine the effect of the *Sell* decision twenty years later. Dr. Soliman will review the case and its implications. Dr. Bowling, who holds both a J.D. and a Ph.D., will discuss how courts have applied the *Sell* holding. Dr. Hackman will discuss contemporary studies about the efficacy of involuntary medication to restore competence, particularly regarding delusions. Dr. Stahl, a psychologist with forensic experience, will discuss the efficacy of psychological approaches to delusions in the context of competency restoration. Dr. Glomski will discuss the role the *Sell* case played in select high profile cases.

REFERENCES

Sell v. United States, 539 U.S. 166 (2003)

Appelbaum, P. S. (2003). Law & Psychiatry: Treating Incompetent Defendants: The Supreme Court's Decision Is a Tough Sell. *Psychiatric Services*, 54(10), 1335-1341.

QUESTIONS AND ANSWERS

1. Which of the following is not part of the Sell criteria?
- A. The medication must be substantially likely to restore competence to stand trial.
 - B. The medication must be substantially unlikely to have side effects that could render the defendant unable to assist their attorney.
 - C. The defendant must be dangerous.
 - D. Less intrusive means must be considered.
 - E. All of the above are part of the criteria

ANSWER: C

2. Which of the following Sell criteria can be determined without the assistance of psychiatric expertise?
- A. The medication must be substantially likely to restore competence to stand trial.
 - B. There must be an important governmental interest at stake.
 - C. The medication must be substantially unlikely to have side effects that could render the defendant unable to assist their attorney.
 - D. All of the above require psychiatric testimony to establish.
 - E. None of the above require psychiatric testimony.

ANSWER: B

S48 BAIL, COMPETENCY, MENTAL HEALTH AND MISDEMEANORS

Emily Nash, MD, New York, NY
Elizabeth Ford, MD, New York, NY
Sela Dragich, MD, New York, NY (I)
Leah Pope, PhD, New York, NY (I)
Debra A. Pinals, MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE

To identify national trends in statutory law and real-world practice related to the impact of mental illness on judicial decisions regarding pre-trial detention.

SUMMARY

In more than half of states, statutes governing bail and pretrial release or competency to stand trial evaluations may allow judges to remand a person to jail because they have a mental illness, which exposes individuals to the potential physical and emotional harms in jail. The statutory purpose of pretrial detention is to detain those who are at risk of failing to appear at their court hearing or pose an unacceptable risk of dangerousness in the community. However, it is unclear if or how mental illness – in and of itself – impacts someone’s ability to appear at court or their risk for community violence in the time between pretrial release and their next court hearing. The limited research that does exist is not generalizable, includes small sample sizes, and does not distinguish different mental illnesses. Presenters will discuss a summary of literature, a summary of relevant national bail statutes, and a description of real-world practice gained from key informant interviews with criminal court judges and state forensic mental health directors. The primary purpose is to better understand the impact of mental illness on judicial decision-making at the early stages of an individual’s involvement in the criminal legal system.

REFERENCES

Criminal Justice Policy Program, Harvard Law School. Moving beyond money: A primer on bail reform [Internet]; 2016. Available from: <https://www.prisonpolicy.org/scans/cjpp/FINAL-Primer-on-Bail-Reform.pdf>. Accessed March 3, 2023

Gehring, K. S., & Van Voorhis, P. Needs and pretrial failure: Additional risk factors for female and male pretrial defendants. *Criminal Justice and Behavior*. 2014 Aug; 41(8):943-970.

QUESTIONS AND ANSWERS

1. Although state law varies, which of the following describes general procedures around remand to jail?
 - A. The prosecutor can decide to remand someone to jail based on the charges.
 - B. The prosecutor can decide to remand someone to jail based on a risk the defendant will not show up to court.
 - C. A judge may remand someone to jail if there is a significant risk a defendant will miss their court date or they will be dangerous (or commit a serious crime) in the community during their pretrial period.
 - D. Judges have full discretion on whether or not someone should be remanded to jail.

ANSWER: C

2. Which of the following accurately describes the existing literature around mental illness and the risk of missing a court appearance or risk of becoming violent during the pretrial period?
 - A. People with chronic psychotic disorders are very unlikely to show up to their court date.
 - B. Defendants with chronic psychotic disorders charged with felonies have a high risk of missing their court date, but defendants with chronic psychotic disorder charged with misdemeanors have a small risk.
 - C. A robust literature shows no connection between mental illness, failing to appear in court, or risk of dangerousness.
 - D. Though some literature suggests a relationship between mental illness and missing court appearances, more research is needed in this area to inform policy.

ANSWER: D

S49 STIMULANTS TO TREAT ADHD IN PRISON: BALANCING BENEFITS AND RISKS

Gunter Lorberg, MD, Penetanguishene, Ontario, Canada (I)
Martin Katzman, MD, Toronto, Ontario, Canada (I)
Tia Sternat, MD, Toronto, Ontario, Canada (I)

EDUCATIONAL OBJECTIVE

This panel discussion aims to discuss the risks and benefits associated with using psychostimulants in correctional facilities as a treatment for ADHD as well as the necessary cautionary steps to attain a balance between the two. This panel discussion will also review the neurobiology of ADHD, specifically relating to hedonic tone, and how that may contribute to the development of criminality.

SUMMARY

ADHD is common in the prison setting. Research has demonstrated that prisoners with adult ADHD display more aggressive and extreme behavior, and have higher infraction rates. While psychostimulants have been considered as first-line treatment for ADHD, there are unique risks and challenges associated with their use in prisons. Historically, concerns regarding diversion, substance abuse, and dependence have prohibited and/or limited the use of psychostimulants within the prison population. Moreover, potential side effects such as increased aggression, abnormal behavior, alterations in mood, and psychosis are of particular concern for this population. Thus, considerable caution and effort is required when initiating a psychostimulant protocol in the prison setting; is all the effort and risk-taking worth it? This panel discussion will assess the role of hedonic tone in ADHD and its contribution to the development of externalizing behavior and criminality. The speakers will discuss the neurobiology of criminality and ADHD, and how psychostimulants target low hedonic tone. They will also discuss the balance between the benefits and risks associated with prescribing psychostimulants within the prison environment. Finally, the speakers will review current research, preliminary findings, and future directions of this research.

REFERENCES

- Sternat, T., & Katzman, M. A. (2016). Neurobiology of hedonic tone: the relationship between treatment-resistant depression, attention-deficit hyperactivity disorder, and substance abuse. *Neuropsychiatric disease and treatment*, 12, 2149–2164. <https://doi.org/10.2147/NDT.S111818>
- Tully, J. (2022). Management of ADHD in prisoners—evidence gaps and reasons for caution. *Frontiers in Psychiatry*, 13. <https://doi.org/10.3389/fpsy.2022.771525>

QUESTIONS AND ANSWERS

1. Which of these is LESS OF a concern associated with proceeding with psychostimulant treatment within prison settings?
- A. Risk of Diversion
 - B. Mood Lability and Aggression
 - C. Risk of Exacerbation of Psychosis
 - D. Loss of appetite

ANSWER: D

2. What is low hedonic tone?
- A. Inability to regulate emotions
 - B. Reduced ability to feel pleasure
 - C. Reduced learning capacity
 - D. Increased impulsive actions

ANSWER: B

S50 A FUNCTIONAL MRI STUDY IN FIRST EPISODE PSYCHOSIS AND CONDUCT DISORDER – (CORE)

Nathan J. Kolla, MD, PhD, Toronto, Ontario, Canada
Ryan Aloysius, BSc, Toronto, Ontario, Canada (I)
Colin Hawco, PhD, Toronto, Ontario, Canada (I)

EDUCATIONAL OBJECTIVE

The objective of this project is to characterize the neurobiology of first episode psychosis with comorbid conduct disorder assessed using functional magnetic resonance imaging (fMRI). At the end of this talk, attendees will develop a better understanding of the neural correlates underpinning impulsive responding in males with first episode psychosis and conduct disorder.

SUMMARY

To better understand the neurobiological factors contributing to conduct-disordered behavior in some individuals with first episode psychosis (FEP), we employed fMRI during a Go/No-Go impulsivity paradigm with 50 male participants: 17 FEP, 15 FEP + CD (first-episode psychosis with comorbid conduct disorder) and 18 HC (healthy controls). Wholebrain functional images were analyzed via a general linear model in a two-level process. Four event-related predictors – Go-Correct (GC), No-go-Correct (NC), Go-Incorrect (GI), and No-go-Incorrect (NI) – were defined and convolved with a hemodynamic response. Two contrasts of interest in our first-level analysis (GC > NC; GI > NI) were compared between groups in our second-level analysis in a pairwise manner (FEP vs FEP+CD; FEP vs HC; FE+CD vs HC). The average age of the sample was 24.2 years (range 17-34 years). Results revealed no behavioral task differences between groups, but differences in neural activity between the GC versus NC contrast were found between FEP and FEP+CD groups in frontal regions. These preliminary results suggest unique alterations in the neural networks involved in higher attention, motor control, and impulse control in FEP+CD.

REFERENCES

- Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R: Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. *Arch Gen Psychiatry* 60:709-17, 2003.
- Schiffer B, Leygraf N, Muller BW, Scherbaum N, Forsting M, Wiltfang J, Gizewski ER, Hodgins S: Structural brain alterations associated with schizophrenia preceded by conduct disorder: a common and distinct subtype of schizophrenia? *Schizophr Res* 39:1115-28, 2013.

QUESTIONS AND ANSWERS

1. In a prominent prospective investigation that followed a birth cohort to age 26 years, what percentage of the cohort who had developed a schizophreniform disorder displayed conduct disorder prior to age 15 years?
- A. 10%
 - B. 20%
 - C. 40%
 - D. 70%

ANSWER: C

1. Which of the following is true regarding the Go/No-Go fMRI study presented?
- A. The analyses controlled for IQ
 - B. All FEP+CD participants had a history of violent offending
 - C. The sample was medication-free
 - D. The behavioral paradigm employed the Wisconsin Card Sorting Task

ANSWER: A

S51 BALANCING PARENT AND ADOLESCENT INTERESTS IN MEDICAL DECISION MAKING

Marta L. Herger, MD, JD, Norwalk, CT

EDUCATIONAL OBJECTIVE

After this presentation, audience members will be able to: describe the ethical principles underlying adolescent confidentiality; consider developmental factors related to medical decision-making; and understand the often competing interests between parents and adolescents in medical decision-making and confidentiality.

SUMMARY

While the ethical principle of autonomy promotes confidentiality between adolescents and medical providers, in most situations, parents retain medical decision-making authority over their teenage children. The transitional period between the parental protections of childhood and the full autonomy of adulthood exposes a tension between parents' and adolescents' interests. Federal law sets a general floor for confidentiality of medical records but does not control the flow of information from providers of adolescent health care to parents. A review of the laws of 50 states revealed significant variability from state to state in approaches to consent and confidentiality for adolescent patients. State laws differ in their approaches to emancipation and "mature minors," exceptions for specific areas of health care (including psychiatric services, substance treatment, and reproductive care), and the ages at which exceptions may be considered. The laws and policies controlling adolescent medical confidentiality and consent remain complicated and may not reflect current understandings of adolescent development. Providers must be aware of state-specific laws and appreciate the often-competing interests between adolescent patients and their parents.

REFERENCES

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Pathak PR, Chou A. Confidential care for adolescents in the U.S. health care system. *J Patient Cent Res Rev*. 2019 Jan; 28;6(1):46-50.

QUESTIONS AND ANSWERS

1. In medical decision-making, compared to adults, adolescents are more likely to:
- A. Appreciate long-term outcomes of their decisions.
 - B. Value peer influence.
 - C. Avoid risk.
 - D. Communicate a choice.

ANSWER: B

1. In the United States, parents exercise medical decision-making authority over their adolescent children based primarily on:
 - A. State laws, which vary significantly and may exempt certain medical conditions.
 - B. State laws, which are uniform across jurisdictions.
 - C. Federal laws, which exempt mental health decision-making.
 - D. Federal administrative policy, which exempts mental health decision-making.

ANSWER: A

S52 PICTURES WORTH A THOUSAND QUESTIONS: ATTORNEYS' PERSPECTIVES

Raina Aggarwal, MD, New York, NY
Madelon Baranoski, PhD, New Haven, CT (I)
Maya Prabhu, MD, New Haven, CT
Charles Dike, MD, New Haven, CT
Kathryn Thomas, JD, PhD, New Haven, CT (I)

EDUCATIONAL OBJECTIVE

By the end of the session, participants will be familiar with survey data assessing forensic evaluators' and attorneys' views regarding review of graphic material; be able to examine the implications of this data for forensic practice; and be able to discuss how consideration of potential for vicarious traumatization could be incorporated into both forensic and legal practice and training.

SUMMARY

The impact of reviewing graphic digital evidence and potential for vicarious traumatization are just now being considered. To explore this topic, we conducted a survey of over 250 members of forensic psychiatry and psychology associations. Survey respondents described their decision-making around reviewing images if serving as experts on fictionalized cases. But what are attorneys' perspectives on viewing graphic images? How do those hiring experts perceive the potential for vicarious traumatization? We are conducting a survey of attorneys assessing their views on experts reviewing graphic images in the same fictionalized cases. We will present data from both the survey of forensic experts and of attorneys, then compare how views differ and how each profession prepares its practitioners to consider the potential for vicarious traumatization. We will examine the following questions across both professions: (1) How do psychiatry experts and attorneys determine when viewing graphic images is required? (2) How does the potential for vicarious traumatization affect decision-making across both professions? (3) How do other factors like gender, age, years of practice, and professional training affect these considerations? The results will inform our discussion of standards of practice and ethical obligations for educators, professional societies, and AAPL in both law and psychiatry.

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Bradford JMW, de Amorim Levin GV. Vicarious trauma and PTSD in forensic mental health professionals. *J Am Acad Psychiatry Law*. 2020 Sep; 48(3):315-318

QUESTIONS AND ANSWERS

1. Which of the following terms is considered a diagnosis in the DSM-5?
 - A. Vicarious traumatization
 - B. Secondary traumatic stress
 - C. Compassion fatigue
 - D. None of the above

ANSWER: D

2. Which of the following is not listed in the DSM-5 as one of the ways in which a PTSD exposure can occur?
- A. Directly experiencing the traumatic event(s)
 - B. Witnessing, in person, the event(s) as it occurred to others
 - C. Viewing video footage or images of the traumatic event
 - D. Learning that the traumatic event(s) occurred to a close family member or close friend
 - E. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)

ANSWER: C

553 COGNITIVE BIAS IN FORENSIC PSYCHIATRIC EVALUATION: A SCOPING REVIEW

Luigi Buongiorno, MD, Bari, Italy (I)
Federica Mele, MD, Bari, Italy (I)
Francesco Felice Carabellese, MD, Bari, Italy
Roberto Catanesi, MD, Bari, Italy (I)
Gabriele Mandarelli, MD, Bari, Italy (I)

EDUCATIONAL OBJECTIVE

1. Service: enhancement of consulting skills.

SUMMARY

Evidence of bias affecting subjective decision-making in forensic disciplines and debiasing strategies has been reported. Despite the American Academy of Psychiatry and the Law (AAPL) attempt to draw up forensic evaluation and reporting guidelines, several studies in different countries have shown a disagreement among forensic psychiatric reports that assessed the same case. In forensic psychiatric practice, multiple sources of cognitive bias were identified, possibly favored by the absence of methodological standardization of expert evaluations. This study aims to describe and synthesize scientific literature on cognitive bias in forensic psychiatrists to improve awareness of this field and de-biasing strategies. A scoping review was conducted by searching PubMed and Scopus, for full-text articles in English published until May 2022 which included forensic psychiatry and cognitive bias keywords. Another search was carried out among references of the selected articles. Of the 672 articles found, 101 met the inclusion criteria. Finally, 15 main biases were grouped according to their characteristics and summarized by reporting the description of bias, the subcategories, or consequential biases, the first mention of each one, and the group of related articles. Our review highlighted possible debiasing solutions and illustrates the complexity of bias influence in expert witness activities.

REFERENCES

Glancy GD, Ash P, Bath EP, Buchanan A, Fedoroff P, Frierson RL, Harris VL, Hatters Friedman SJ, Hauser MJ, Knoll J, Norko M, Pinals D, Price M, Recupero P, Scott CL, Zonana HV. AAPL Practice Guideline for the Forensic Assessment. *J Am Acad Psychiatry Law*. 2015 June; 43(2 Suppl):S3-53

Kacperska I, Heitzman J, Bak T, Lesko AW, Opio M. Reliability of repeated forensic evaluations of legal sanity. *Int J Law Psychiatry*. 2016 Jan-Feb; 44:24-9

QUESTIONS AND ANSWERS

1. Which of the following is a cognitive bias?
- A. Negative bias
 - B. Anchoring
 - C. Illusion of control
 - D. None of the above
 - E. All of the above

ANSWER: E

2. What kind of bias is “the tendency of people with low ability in a specific field to overestimate their ability”?
- A. Blindspot
 - B. Availability bias
 - C. Framing
 - D. Dunning-Kruger effect
 - E. None of the above

ANSWER: D

SATURDAY

SUNDAY, OCTOBER 22, 2023

PANEL DISCUSSION

8:00 AM – 10:00 AM

CHICAGO BALLROOM A-B (5TH FLOOR)

Z1 *Balancing Limited Resources in Forensic Psychiatry*

(Sponsored by the Ethics Committee)

Ariana Nesbit, MD, Durham, NC
Jacob Appel, MD, New York, NY
Richard Martinez, MD, Denver, CO
Bipin Subedi, MD, Brooklyn, NY
Michael Champion, MD, Honolulu, HI

PANEL DISCUSSION

8:00 AM – 10:00 AM

CHICAGO BALLROOM C (5TH FLOOR)

Z2 *Retraumatized in Court: Victim Impact and Special Victim Advocacy*

(Sponsored by the Trauma and Stress Committee)

Keith A. Caruso, MD, Brentwood, TN
Katelyn Csjerer, MD, Johnson City, TN
Grace Cho, MD, Philadelphia, PA
Andrew P. Levin, MD, Hartsdale, NY
Kevin D. Moore, MD, Stafford, VA

WORKSHOP

8:00 AM – 10:00 AM

DENVER/HOUSTON (5TH FLOOR)

Z3 *To Engage or Not To: Interfacing with the Media*

(Sponsored by the Early Career Development Committee)

Isabel Stillman, MD, Philadelphia, PA
Maria Lapchenko, MD, Reading, PA
Ian C. Lamoureux, MD, Scottsdale, AZ
Meghan A. Musselman, MD, Philadelphia, PA
Marianela Rosales Gerpe, MD, Philadelphia, PA (I)

PANEL DISCUSSION

8:00 AM – 10:00 AM

KANSAS CITY (5TH FLOOR)

Z4 *Forensic Mental Health Legislation: Balancing our Obligation*

(Sponsored by the Government Affairs Committee)

Danielle B. Kushner, MD, Brooklyn, NY
Karen Rosenbaum, MD, New York, NY
Michael K. Champion, MD, Honolulu, HI
Christopher Thompson, MD, Los Angeles, CA
Joseph Penn, MD, Conroe, TX

WORKSHOP

8:00 AM – 10:00 AM

CHICAGO BALLROOM F-G (5TH FLOOR)

Z5 *A Death in the Family: Forensic Evaluations in Parricide and Filicide*

Patricia R. Recupero, JD, MD, Providence, RI
Efraim J. Keisari, MD, Plainville, NY
Jennifer Kim, JD, MD, MPH, New York, NY
Uche Ugorji, DO, JD, Providence, RI

COFFEE BREAK

10:00 AM – 10:15 AM

SUNDAY

WORKSHOP

10:15 AM – 12:00 PM

CHICAGO BALLROOM A-B (5TH FLOOR)

Z6 *Big Data and Racial Bias in Forensic Risk Assessment*

William Connor Darby, MD, Los Angeles, CA
Melinda DiCiro, PsyD, Represa, CA (I)
Shoba Sreenivasan, PhD, Malibu, CA (I)
Robert Weinstock, MD, Los Angeles, CA

WORKSHOP

10:15 AM – 12:00 PM

CHICAGO BALLROOM C (5TH FLOOR)

Z7 *Forensic Perspectives on Transgender Well Being*
(Sponsored by the Gender Issues Committee)

Renée Sorrentino, MD, Weymouth, MA
Ariana Nesbit, MD, Durham, NC
Juliette Dupre, MD, Toronto, Ontario, Canada

PANEL DISCUSSION

10:15 AM – 12:00 PM

DENVER/HOUSTON (5TH FLOOR)

Z8 *Applying CBT to the Treatment of Psychosis in the Forensic Setting*

Steven J. Zuchowski, MD, Sparks, NV
Byron Czerniski, MD, Sparks, NV (I)
Isaac Wentz, MD, Reno, NV
Ashley D. Maestas, DO, Reno, NV
Lorenzo Capannolo, MD, Reno, NV (I)

WORKSHOP

10:15 AM – 12:00 PM

KANSAS CITY (5TH FLOOR)

Z9 *When They Go Low, We'll Go High: Responding to Unethical Behavior*

Jeffrey Khan, MD, Houston, TX
Sara West, MD, Broadview Heights, OH
Edward Poa, MD, Houston, TX
Ian C. Lamoureux, MD, Scottsdale, AZ

PANEL DISCUSSION

10:15 AM – 12:00 PM

CHICAGO BALLROOM F-G (5TH FLOOR)

Z10 *Core Forensic Training for General Residents: How Do We Fill in the Gap?*

Katherine Michaelsen, MD, Seattle, WA
Tobias Wasser, MD, New Haven, CT
George D. Annas, MD, MPH, Syracuse, NY

***Your opinion of today's sessions is very important:
While it's fresh in your mind, please complete the evaluation form
in Guidebook for each session you attended.***

SUNDAY, OCTOBER 22, 2023

Z1 BALANCING LIMITED RESOURCES IN FORENSIC PSYCHIATRY

(Sponsored by the Ethics Committee)

Ariana Nesbit, MD, Durham, NC
Jacob Appel, MD, New York, NY
Richard Martinez, MD, Denver, CO
Bipin Subedi, MD, Brooklyn, NY
Michael Champion, MD, Honolulu, HI

EDUCATIONAL OBJECTIVE

1) Understand the impact that COVID-19 has had on forensic psychiatric resources and the concept of scarcity in forensic ethics; 2) Consider how forensic psychiatric resources should be ethically distributed across jails, forensic hospitals, and state mental health systems; 3) Explore inequities in access to forensic psychiatric evaluations and ways to reallocate these limited resources; 4) Understand the concepts of robust professional identity and forensic psychiatry as a social good.

SUMMARY

Resource allocation discussions in the beginning of the pandemic primarily focused on medical equipment and treatments, including N-95 masks and ventilators. As medical supplies have normalized and COVID-related deaths have decreased, the focus has shifted to health care staffing shortages. The topic of pandemic-driven resource scarcity is particularly relevant to forensic psychiatry because individuals involved in the criminal justice system are, at baseline, subject to structural bias and inequity. During this panel, Dr. Nesbit will explore resource allocation at forensic hospitals in the setting of staffing shortages, reduced community resources, and longer-than-ever waitlists for admission. Dr. Subedi will discuss resource allocation and corrections, with a focus on the New York City jail system. Dr. Champion will discuss resource allocation across a state mental health system. Dr. Appel will explore questions of resource allocation and equity with regards to expert witness work, asking audience members to consider why some forensic psychiatrists may devote their limited energies to particular evaluations at the expense of others, and whether resources should be allocated to serve broader forensic needs of their communities. Dr. Martinez will relate the concept of forensic psychiatry as a social good with overarching goals and purposes that should drive the profession morally.

REFERENCES

Appel JM. Resource allocation and forensic ethics. *J Am Acad Psychiatry Law*. 2023 January; 51(1): online. DOI: 10.29158/JAAPL.220033-21

Martinez R, Candilis P. Ethics in the time of injustice. *J Am Acad Psychiatry Law*. 2020 December; 48(4): 428-430

QUESTIONS AND ANSWERS

1. What percentage of American federal judges have appointed an expert under Federal Rule of Evidence 706?
 - A. 9%
 - B. 19%
 - C. 39%
 - D. 59%
 - E. 69%

ANSWER: B

2. What is Martinez and Candilis' concept of robust professional identity based on?
 - A. Objectivity and truth-telling
 - B. Beneficence and non-maleficence
 - C. Cultural competence, the narrative of vulnerable people and values, and the centrality of moral relationships
 - D. Honesty and respect for persons

ANSWER: C

Z2 RETRAUMATIZED IN COURT: VICTIM IMPACT AND SPECIAL VICTIM ADVOCACY

(Sponsored by the Trauma and Stress Committee)

Keith A. Caruso, MD, Brentwood, TN
Katelyn Csjerer, MD, Johnson City, TN
Grace Cho, MD, Philadelphia, PA
Andrew P. Levin, MD, Hartsdale, NY
Kevin D. Moore, MD, Stafford, VA

EDUCATIONAL OBJECTIVE

To review the emotional impact of sexual assault and retraumatization of victims in court proceedings with special attention to interventions promoted by the U.S. Military to lessen the impact and protect victims' rights.

SUMMARY

Sexual assault victims are more likely to suffer from PTSD than even combat veterans. Childhood sexual assault victims are at increased risk of later sexual victimization and domestic violence in adulthood. Many cases go unreported due to the extreme stress of the intrusiveness and length of the legal process, from the forensic gynecological examination, to recounting the trauma in police interviews, to facing one's perpetrator and testifying in court. This panel will open with an illustrative case presentation of an adolescent girl who decompensated under the strain of the court process. We then will review PTSD in sexual assault victims with particular attention to children and adolescents. We will then summarize the literature on retraumatization before turning to a discussion of the U.S. Military's recognition of the scope the problem of sexual assault within the ranks, which led to the development of Special Victim's Advocacy (SVA) and Special Victim's Counsel (SVC) programs by a former Navy Commanding Officer and forensic psychiatrist tasked with deployment of these programs. Finally, we will present some of the benefits and fallout from the practical applications of these programs and discuss victim's rights in local civilian courts.

REFERENCES

Katirai N.: Retraumatized in Court. *Arizona Legal Studies*, Discussion Paper No. 19-10, *Arizona Law Review* 2020; 62: 81-124.

United States Department of Defense Sexual Assault Prevention and Response. <https://sapr.mil/svc-vlc>, 2021.

QUESTIONS AND ANSWERS

1. The SVC program:

- A. Provides legal counsel to victims making a restricted report.
- B. Provides legal counsel to victims making an unrestricted report.
- C. May provide legal counsel to victims who have not made an official report.
- D. Maintains a victim's confidentiality.
- E. All of the above.

ANSWER: E

2. PTSD in rape victims:

- A. Is uncommon
- B. Is seldom severe
- C. Is transitory
- D. Is much less common than in combat veterans
- E. Has been reported to be as high as 80%.

ANSWER: E

Z3 TO ENGAGE OR NOT TO: INTERFACING WITH THE MEDIA

(Sponsored by the Early Career Development Committee)

Isabel Stillman, MD, Philadelphia, PA
Maria Lapchenko, MD, Reading, PA
Ian C. Lamoureux, MD, Scottsdale, AZ
Meghan A. Musselman, MD, Philadelphia, PA
Marianela Rosales Gerpe, MD, Philadelphia, PA (I)

EDUCATIONAL OBJECTIVE

To prepare forensic psychiatrists to make well informed decisions as to whether to engage with the media and, if so, how to communicate with the media most effectively.

SUMMARY

Media inclusion of, and public interest in, psychiatric topics has recently experienced a meteoric rise with the advent of the ‘true crime’ genre. Unfortunately, the often-misinformed way the media covers mental health topics informs public opinion and contributes to stigmatization. An unintended, especially harmful, consequence of media misrepresentation is its influence on the criminal justice system where bias can skew outcomes. The John Hinckley Jr. case epitomizes public opinion’s power to shape legislation. This workshop’s purpose is to prepare forensic psychiatrists to operate in today’s media-heavy legal landscape. Thoughtful engagement with the media should strike a balance between competing interests such as educating the public by dispelling misinformation, maintaining neutrality, and addressing the media’s need to be topical. We will examine the interplay between media, public opinion, and legislation; media’s effect on public opinion and how it has impacted specific legal cases; ethics of communicating with the media, including confidentiality and the Goldwater Rule; and how to interface with the media in practice. In small groups, participants will discuss how to best address hypothetical scenarios involving communicating with the media that they may encounter in their practice, ethical dilemmas, and pitfalls. Small groups’ opinions will then be discussed collectively.

REFERENCES

Cohen SN, Kolla NJ. Media and mental illness in a post-truth era. *Journal of the American Academy of Psychiatry and the Law*. 2019 Jun 1;47(2):144-9.

Cooke BK, Goddard ER, Werner TL, Cooke EO, Griffith EE. The risks and responsible roles for psychiatrists who interact with the media. *Journal of the American Academy of Psychiatry and the Law*. 2014 Dec 1;42(4):459-68.

QUESTIONS AND ANSWERS

1. In APA’s 2017 clarification of the Goldwater rule, what justification did they give for rendering an opinion without examining an individual in certain forensic cases?
 - A. Court authorization; Work uses an evaluative framework including how and where the information may be used or disseminated; Departures from evaluation must identify methods used and their limitations.
 - B. Court authorization; No other option; Work uses an established framework for this scenario.
 - C. Court authorization; Work uses an established framework for this scenario.
 - D. Court authorization; Greater good; Work uses an established framework for this scenario.

ANSWER: A

2. Which medical and psychiatric professional bodies mandate to thoughtfully engage and collaborate with the media?
 - A. World Psychiatric Association and American Psychiatric Association.
 - B. American Academy of Psychiatry and the Law, and American Psychiatric Association.
 - C. American Psychiatric Association, American Medical Association and American Psychiatric Association.
 - D. World Psychiatric Association, American Psychiatric Association and American Medical Association.

ANSWER: D

Z4 FORENSIC MENTAL HEALTH LEGISLATION: BALANCING OUR OBLIGATION

(Sponsored by the Government Affairs Committee)

Danielle B. Kushner, MD, Brooklyn, NY
Karen Rosenbaum, MD, New York, NY
Michael K. Champion, MD, Honolulu, HI
Christopher Thompson, MD, Los Angeles, CA
Joseph Penn, MD, Conroe, TX

EDUCATIONAL OBJECTIVE

To educate about current and proposed state and national legislation impacting the field of forensic psychiatry and encourage further audience involvement.

SUMMARY

The COVID 19 pandemic, socioeconomic stressors, and political divisions has exacerbated a worldwide mental health crisis. Now more than ever forensic psychiatry expertise is needed to help educate legislators and the public regarding mental health and forensic issues. Currently there is proposed legislation restricting forensic testimony, developing standards for youth prosecuted in adult court, hospitalizing homeless individuals, restricting transgender treatment and access, enhancing court ordered mental health services, increased funding for forensic psychiatry training programs and loan payment programs. Additionally, there has been litigation resulting in court monitoring/oversight in correctional and public psychiatry systems in several states. AAPL membership and Government Affairs committee is in a strong position to educate and work with the APA and the Council of Psychiatry and Law to educate and advocate for important forensic issues. The AAPL Government Affairs committee members will present updates on new and proposed state and federal legislation relevant for forensic psychiatrists with a focus on California, New York, Hawaii, and Texas. We will discuss how the lack of specific forensic psychiatric advocacy can adversely impact the field and patients. In addition, the panel will discuss how participants can become more involved and impact the development of forensic mental health legislation.

REFERENCES

Gulrajani, C. Realmuto, GM. Role of Forensic Psychiatry in Legislative Advocacy. *J Am Acad Psychiatry Law*. 46(2): 155-157, 2018.

Piel J: Legislative advocacy and forensic psychiatry training. *J Am Acad Psychiatry Law* 46:147-54, 2018

QUESTIONS AND ANSWERS

1. Psychiatrists can become involved in legislative and policy discussions for issues at the ____ level.
- A. Federal
 - B. State
 - C. City
 - D. Hospital
 - E. All of the above

ANSWER: E

2. Forensic Psychiatrists can provide legislators education on:
- A. Insanity defense
 - B. Involuntary medications
 - C. Jail based treatment
 - D. Child custody
 - E. All of the above

ANSWER: E

Z5 A DEATH IN THE FAMILY: FORENSIC EVALUATIONS IN PARRICIDE AND FILICIDE

Patricia R. Recupero, JD, MD, Providence, RI
Efraim J. Keisari, MD, Plainville, NY
Jennifer Kim, JD, MD, MPH, New York, NY
Uche Ugorji, DO, JD, Providence, RI

EDUCATIONAL OBJECTIVE

At the conclusion of this workshop, participants will be able to describe the history of forensic psychiatric evaluations in cases of infanticide, parricide, and filicide, describe pertinent psychiatric aspects of prominent recent cases of infanticide, parricide, and filicide, and improve their approach to forensic mental health assessments in cases involving domestic violence.

SUMMARY

The recent case of the Clancy family in Duxbury, Massachusetts has reinvigorated discourse surrounding cases of filicide and parricide and the role of forensic psychiatrists in evaluating the perpetrators of such tragic events. Presenters in this workshop will review the medicolegal history of peripartum murder; prominent cases of family annihilators who committed filicide or parricide and the role of forensic mental health professionals in such cases; the performance of dangerousness risk assessments during the peripartum period (including standardized tools to assess risk); and the assessment of perpetrators in cases of fratricide, with a particular focus on individuals who kill their younger siblings. During this interactive workshop, participants will be asked to respond to hypothetical questions about cases, utilizing real cases (such as the Menendez brothers and the case of Andrea Yates) as well as hypothetical scenarios. Presenters will illustrate important ethics questions raised by infanticide, parricide, and filicide cases and the particular legal and ethical responsibilities and dilemmas faced by psychiatrists tasked with performing evaluations or treating the perpetrators of such crimes or individuals at heightened risk for committing violent offenses against family members.

REFERENCES

Weiss KJ. Arsenic, familicide, and female physiology in Nineteenth-Century America. *J Am Acad Psychiatry Law* 2020 (May); 48(3): 1-9; doi: 10.29158/JAAPL.003927-20

Nau ML, McNiel DE, Binder RL. Postpartum psychosis and the courts. *J Am Acad Psychiatry Law* 2012 (Sept); 40(3):318-325.

QUESTIONS AND ANSWERS

1. Approximately what percentage of women with postpartum psychosis are estimated to commit filicide?
- A. 0.5%
 - B. 1%
 - C. 2%
 - D. 4%
 - E. 6%

ANSWER: D

1. Approximately what percentage of deaths among male parricide offenders are attributable to suicide?
- A. 10%
 - B. 25%
 - C. 33%
 - D. 50%
 - E. 66%

ANSWER: C

Z6 BIG DATA AND RACIAL BIAS IN FORENSIC RISK ASSESSMENT

William Connor Darby, MD, Los Angeles, CA
Melinda DiCiro, PsyD, Represa, CA (I)
Shoba Sreenivasan, PhD, Malibu, CA (I)
Robert Weinstock, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE

Describe the impact of big data on racial bias in forensic risk assessments; Describe how to mitigate systemic bias and clinician implicit bias in violence risk assessments

SUMMARY

The workshop will address the impact of big data on racial bias in forensic risk assessment. Algorithms that classify criminal recidivism, including commonly used actuarial instruments by forensic evaluators, rely on Big Data, or large datasets. The intent is to provide fair and unbiased assessment. However, risk algorithms emphasize prior criminal history. Bureau of Justice surveys repeatedly demonstrate that Black males are arrested and incarcerated at higher rates than white males across all age bands. A Black offender is more likely to receive a higher score on risk algorithms than a white offender. Consequently, risk prediction which relies on prior criminality has been criticized as reflecting systemic injustice; that it is inherently biased against Blacks as it confounds who is likely to engage in harmful conduct with who is likely to be arrested and incarcerated. Others argue that unvalidated and unstructured approaches are harmful to disadvantaged groups as they are vulnerable to evaluator's implicit biases. Practical guidance to mitigating systemic bias and implicit bias in risk assessment will be provided. Presenters will navigate the audience through four violence and sexual violence risk assessment scenarios to practice identifying systemic biases that erroneously elevate risk and employing ways to ethically mitigate bias.

REFERENCES

Sreenivasan, S, DiCiro, M, Rokop, J, Weinberger, L. Addressing systemic bias in violence risk assessment. *J Am Acad Psychiatry Law*. 2022. 50(4) online, 2022. DOI:10.29158/JAAPL.220031-21.

Vincent CM, Viljoen JL. Racial algorithms or systemic problems? Risk assessments and racial disparities. *Crim Just & Behav*. 2020; 47(12):1576–84

QUESTIONS AND ANSWERS

1. In what ways can structural biases elevate risk classifications?

- A. Greater likelihood of detection and conviction, and history of these factors elevating risk classification.
- B. Apparent accuracy of risk instruments reflects bias instrument outcomes.
- C. Cultural factors affect manifestations and meaningfulness of risk factors.
- D. All of the above.

ANSWER: D.

2. Which is a way to mitigate bias in risk assessment?

- A. Strict adherence to scoring rules in actuarial and structured professional judgment instruments.
- B. Consider upstream systemic biases; applicability of risk factors, inequities in juvenile sanctions; developing awareness of bias blind spots, environmental factors, and developing culturally informed practices.
- C. Ignore scoring rules and structure and rely on wise intuition.
- D. All of the above

ANSWER: C.

Z7 FORENSIC PERSPECTIVES ON TRANSGENDER WELL BEING

(Sponsored by the Gender Issues Committee)

Renée Sorrentino, MD, Weymouth, MA
Ariana Nesbit, MD, Durham, NC
Juliette Dupre, MD, Toronto, Ontario, Canada

EDUCATIONAL OBJECTIVE

1. Participants will be familiar with the legal framework from which the forensic referral questions related to transgender individuals arise. 2. Participants will understand approaches to the identified forensic referral questions.

SUMMARY

An estimated 1.4 million adults in the U.S. identify as transgender (Flores et al, 2016). While there currently are no known systematic efforts to identify transgender individuals within US prisons, recent estimates suggest that 16% of transgender individuals have been incarcerated (Grant et al, 2011). Transgender individuals are a vulnerable group subject to significant mistreatment and human rights violations. This may relate, in part, to their higher rates of trauma, suicide, and self-harm than those experienced by the cisgender population (Bromdal et al, 2019). Attempts to improve the well-being of transgender individuals have led to systemic changes in the healthcare of such individuals as well as legal reform. With the evolving landscape, forensic psychiatrists may be consulted on a variety of questions related to transgender individuals. In this workshop we will explore the following forensic issues: transgender law in the US and internationally, litigation in the correctional setting, civil claims including psychiatric harm, disability evaluations and SDP evaluations, diagnosing malingering of transgender orientation and conceptualizing reasonable accommodations for transgender individuals. The presenters will provide both a legal framework by outlining relevant legal opinions, as well as guidelines to conducting such forensic evaluations. Audience participation will be solicited through case presentations.

REFERENCES

Bromdal A, Clark KA, Hughto JMW, Debattista J, Phillips TM, Mullens AB, Gow J, Daken K: Whole-incarcerationsetting approaches to supporting and upholding the rights and health of incarcerated transgender people. *International Journal of transgenderism* 20(4): 341-350, 2019

Glezer A, McNeil DE, Binder R: Transgendered and incarcerated: A review of the literature, current polices and laws, and ethics. *J Am Acad Psychiatry Law*. 2013;41(4): 551-559

QUESTIONS AND ANSWERS

1. What is the most common reason for malingering a transgender orientation?

- A. To gain access to alternative housing
- B. To increase the likelihood of discharge from a sexually violent predator civil commitment.
- C. To gain access to medical care
- D. Unknown as this has never been studied

ANSWER: D

2. Transgender individuals have a higher rate of which behavior compared to cisgender individuals?

- A. Self injury
- B. Suicidal ideation
- C. Self injury and suicidal ideation
- D. Anxiety disorders

ANSWER: C

Steven J. Zuchowski, MD, Sparks, NV
Byron Czerniski, MD, Sparks, NV (I)
Isaac Wentz, MD, Reno, NV
Ashley D. Maestas, DO, Reno, NV
Lorenzo Capannolo, MD, Reno, NV (I)

EDUCATIONAL OBJECTIVE

Attendees will be able to: 1) Identify common thinking errors in psychosis pertinent to the forensic setting 2) Describe therapeutic approaches to working with psychosis in forensic settings 3) Explain the barriers to therapeutic interventions for psychosis in the forensic setting 4) Discuss the potential risks and benefits of therapeutic interventions for psychosis in the forensic setting

SUMMARY

Cognitive behavioral treatment modalities are increasingly being applied to psychosis in non-forensic populations and considered in the forensic context. Psychotic symptoms are a major barrier to competency restoration, a common forensic evaluation in the United States. Secure forensic facilities may provide an opportunity for treatment of persistent psychotic symptoms that insufficiently respond to medication management alone. Overcoming the barriers in psychological treatment of psychosis, including common limitations of standard forensic environments, may prove beneficial toward the goal of achieving adjudication. This panel will begin with a discussion of the common thinking errors in psychosis and how these psychological factors could prevent restoration of competency for forensic populations. Existing approaches in treating psychosis in the general and forensic populations (e.g. CBTp, metacognitive training) will be discussed with attention to their efficacies and barriers to implementation. Finally, case examples will be used to emphasize practical barriers and experience of these approaches.

REFERENCES

Grossi, Cabeldue, M., & Brereton, A. (2021). Cognitive Behavior Therapy for Psychosis (CBT-p) as an Adjunct to Competency Restoration. *Journal of Forensic Psychology Research and Practice*, 21(4), 317–337. <https://doi.org/10.1080/24732850.2021.1877022>

Wright, N. P. (2014). *Treating psychosis: a clinician's guide to integrating acceptance & commitment therapy, compassion-focused therapy, and mindfulness approaches within the cognitive behavioral therapy tradition*. New Harbinger Publications, Inc.

QUESTIONS AND ANSWERS

1. Of the reasons for applying psychological interventions, which of the following is least specific to a competency restoration environment:
 - A. Preventing defendants from becoming non-compliant with medications prior to adjudication
 - B. Reducing the need for Sell orders
 - C. Helping to differentiate their specific symptoms and reality as related to their charge
 - D. Improving access to treatments the defendant would not have otherwise

ANSWER: D

2. When working with a defendant who was experiencing psychosis at the time of the alleged offense, the best time to challenge his or her experience is:
 - A. When defendants say they are ready
 - B. After developing rapport
 - C. A decision of the clinician's best professional judgement
 - D. When maximal therapeutic benefit from psychotropics has been achieved

ANSWER: C

Z9 WHEN THEY GO LOW, WE'LL GO HIGH: RESPONDING TO UNETHICAL BEHAVIOR

Jeffrey Khan, MD, Houston, TX
Sara West, MD, Broadview Heights, OH
Edward Poa, MD, Houston, TX
Ian C. Lamoureux, MD, Scottsdale, AZ

EDUCATIONAL OBJECTIVE

Analyze perilous situations related to forensic practice; Weigh responses to these situations; Act to protect themselves professionally and personally

SUMMARY

A retaining party threatening future cases and blacklisting, an attorney in another case intimidating an expert in a related case, a live-streamed trial leading to hate mail and streamed unprofessional behavior, a patient making threats after declining disability paperwork – what do we do to navigate perilous situations and protect ourselves, professionally and personally? While some of the basics ring true – report to a licensing agency or board, report to the police for harassment, etc. – these often may not address the acute situation at hand or larger issues such as protecting a professional reputation or our own licensure. In this workshop, presenters will discuss recent challenging situations that they have faced and how these were navigated. From these, we will discuss a framework for approaching challenging dilemmas in forensic practice and ways to protect ourselves, professionally and personally

REFERENCES

Norris DM, Gutheil TG. Harassment and intimidation of forensic psychiatrists: an update. *Int J Law Psychiatry*. 2003 Jul-Aug;26(4):437-45. doi: 10.1016/S0160-2527(03)00042-6. PMID: 12726815.

Leavitt N, Presskreischer H, Maykuth PL, Grisso T. Aggression toward forensic evaluators: a statewide survey. *J Am Acad Psychiatry Law*. 2006;34(2):231-9. PMID: 1684480

QUESTIONS AND ANSWERS

1. If a party brings a lawsuit, board complaint, or other adverse actions towards a forensic evaluator, what should the evaluator do first?
 - A. Call complainant to try to resolve the issue.
 - B. Contact their risk management team.
 - C. Buy a gun for self-defense.
 - D. Alert police about the threatening behavior.

ANSWER: B

2. What is the most common form of aggression towards clinicians?
 - A. Harassment or intimidation
 - B. Verbal or physical threats
 - C. Physical aggression without a weapon or object
 - D. Physical aggression with a weapon or object

ANSWER: A

Z10 CORE FORENSIC TRAINING FOR GENERAL RESIDENTS: HOW DO WE FILL IN THE GAP?

Katherine Michaelsen, MD, Seattle, WA
Tobias Wasser, MD, New Haven, CT
George D. Annas, MD, MPH, Syracuse, NY

EDUCATIONAL OBJECTIVE

Describe the ACGME requirements for forensic psychiatry training for general psychiatry residents, including the new milestones. Identify core and advanced topics recommended for teaching in AAPL's Practice Resource for Forensic Training in General Psychiatry Residency Programs. Discuss the pros and cons of using online training modules to incorporate forensic training into general psychiatry training

SUMMARY

Educating psychiatric residents on the core aspects of forensic psychiatry has always been a challenge. Some programs lack access to forensic faculty, some don't integrate existing faculty into the residency curriculum, and others struggle with competing curricular demands. To provide guidance for training programs, the American Academy of Psychiatry and the Law published a resource document identifying ten "core topics" for forensic training in general psychiatry (2019) and the ACGME updated the milestones for forensic training in general residency (2021). We will briefly review the above recommendations and identify ways in which programs can adopt best practices in forensic training, with a focus on those identified in AAPL's Practice Resource. The discussion will also include some common barriers to forensic training and new creative ways to address these – especially with an eye toward programs lacking direct access to experienced forensic faculty. We will review the state of a current project to develop online teaching modules that target the competencies identified in AAPL's Practice Resource. Finally, we will discuss data on national dissemination of existing modules.

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QUESTIONS AND ANSWERS

1. Which of the following is an ACGME core forensic requirement in general psychiatry residencies?
 - A. Experience with providing testimony in court
 - B. Experience with drafting a forensic report for the court
 - C. Experience with assessing patients' decision-making ability
 - D. At least one month dedicated to Forensic Psychiatry
 - E. Experience in treating those in incarcerated/correctional settings

ANSWER: C

2. Which of the following may be a barrier to forensic education in general psychiatry residencies?
 - A. Only requiring one month FTE dedicated to Forensic Psychiatry
 - B. Lack of a minimum FTE dedicated to Forensic Psychiatry
 - C. Residents having little interest in Forensic Psychiatry
 - D. Safety concerns in forensic settings
 - E. The level of comprehensive forensic training in medical school, making additional training in residency redundant

ANSWER: B

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