American Academy
Of
Psychiatry and the Law

49th Annual Meeting

October 25-28, 2018
Austin, Texas

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

Forty-ninth Annual Meeting
American Academy of Psychiatry and the Law
October 25-28, 2018
Austin, Texas

OFFICERS OF THE ACADEMY

Christopher R. Thompson, MD
President

Richard Frierson, MD
President-Elect

Liza Gold, MD
Vice President

Barry Wall, MD
Vice President

Michael A. Norko, MD
Immediate Past President

William Newman, MD
Secretary

Stuart Anfang
Treasurer

Charles C. Dike, MD, FRCPsy
Councilor

John Paul Fedoroff, MD
Councilor

Anna Glezer, MD
Councilor

Trent Holmberg, MD
Councilor

Reena Kapoor, MD
Councilor

Richard B. Krueger, MD
Councilor

Britta Ostermeyer, MD
Councilor

Karen Rosenbaum, MD
Councilor

Hal S. Wortzel, MD
Councilor

PAST PRESIDENTS

Michael A. Norko, Md	2016-17	Larry H. Strasburger, MD	2001-02	J. Richard Ciccone, MD	1986-87
Emily A. Keram, MD	2015-16	Jefrey L. Metzner, MD	2000-01	Selwyn M. Smith, MD	1985-86
Graham Glancy, MB	2014-15	Thomas G. Gutheil, MD	1999-00	Phillip J. Resnick, MD	1984-85
Robert Weinstock, MD	2013-14	Larry R. Faulkner, MD	1998-99	Loren H. Roth, MD	1983-84
Debra Pinals, MD	2012-13	Renée L. Binder, MD	1997-98	Abraham L. Halpern, MD	1982-83
Charles Scott, MD	2011-12	Ezra E. H. Griffith, MD	1996-97	Stanley L. Portnow, MD	1981-82
Peter Ash, MD	2010-11	Paul S. Appelbaum, MD	1995-96	Herbert E. Thomas, MD	1980-81
Stephen B. Billick, MD	2009-10	Park E. Dietz, MD, PhD, MPH	1994-95	Nathan T. Sidley, MD	1979-80
Patricia R. Recupero, MD, JD	2008-09	John M. Bradford, MB	1993-94	Irwin N. Perr, MD	1977-79
Jeffrey S. Janofsky, MD	2007-08	Howard V. Zonana, MD	1992-93	G. Sarwer-Foner, MD	1975-77
Alan R. Felthous, MD	2006-07	Kathleen M. Quinn, MD	1991-92	Seymour Pollack, MD	1973-75
Robert I. Simon, MD	2005-06	Richard T. Rada, MD	1990-91	Robert L. Sadoff, MD	1971-73
Robert T.M. Phillips, MD, PhD	2004-05	Joseph D. Bloom, MD	1989-90	Jonas R. Rappeport, MD	1969-71
Robert Wettstein, MD	2003-04	William H. Reid, MD, MPH	1988-89		
Roy J. O'Shaughnessy, MD	2002-03	Richard Rosner, MD	1987-88		

2018 ANNUAL MEETING CO-CHAIRS

Jessica Ferrante, MD and William Newman, MD

EXECUTIVE OFFICES OF THE ACADEMY

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

Jeffrey Janofsky, MD
Medical Director

Jacquelyn T. Coleman, CAE
Executive Director

CALL FOR PAPERS 2019

The 50th Annual Meeting of the
American Academy of Psychiatry and the Law will be held in
Baltimore, MD – October 24-27, 2019

AAPL AT 50: TEACHING AND ADVOCATING FOR FORENSIC PSYCHIATRY

Inquiries may be directed to Dr. Susan Hatters Friedman

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, 2019

FUTURE ANNUAL MEETING DATES and LOCATIONS

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

52nd Annual Meeting
October 28-31, 2021 – Vancouver, BC, Canada

53rd Annual Meeting
October 27-30, 2022 – New Orleans, LA

GENERAL INFORMATION

Table of Contents

REGISTRATION DESK
(Lone Star Foyer)

Hours of Operation

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

AAPL BOOKSTORE
Lone Star Foyer

NOETIC FILMS
Lone Star Foyer

PRESENTATION CODES

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

SUPPORT THE AIER!
American Academy of Psychiatry and the Law Institute for Education and Research (AIER)

The AIER was developed to stimulate educational and research activities, provide educational resources and activities, and to aid education and research by encouraging tax-exempt contributions to forensic education and research programs.

MERCHANDISE FOR SALE

All proceeds used to fund AIER grants.

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

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

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

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

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

The American Academy of Psychiatry and the Law's Institute for Education and Research, Inc., is exempt from federal income taxes as a public charity under IRS Section 501(c) (3).

A MESSAGE TO PHYSICIAN ATTENDEES CONTINUING MEDICAL EDUCATION

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

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

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

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

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

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

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

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

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

Thank you in advance.

Richard Frierson, MD, and Liza Gold, MD
Co-chairs, Education Committee

AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW
Continuing Medical Education Mission Statement

The Bylaws of the American Academy of Psychiatry and the Law place education first among the purposes for which the Academy exists.

Purpose: Through the education process, the Academy desires to: promote the exchange of ideas and experiences that enrich the field of psychiatry and the law, provide practical knowledge for members and others with an interest in this area, foster the development of future psychiatrists in this field, and encourage research.

Target Audience: Our target audience includes members and other psychiatrists interested in forensic psychiatry.

Content areas: Each educational offering of the Academy shall have as content areas subjects that improve skills in at least one of the following: 1) practice, including treatment of forensic patients and forensic examinations in the criminal and civil context, development of service delivery and risk management strategies, and enhancement of consultative abilities at the interface of psychiatry and the law; 2) teaching, including developing new and improving existing methods of forensic training of psychiatrists; and 3) research, including the development and application of scientific data in areas that form the basis for practice of the discipline. The scope of the Academy's educational activities includes forensic psychiatric aspects of civil, criminal, and correctional issues, and other related topics.

Types of activities: The Academy carries out its educational mission through the Annual Meeting, the Semiannual Meeting, the Forensic Review Course, the *Journal of the American Academy of Psychiatry and the Law*, the AAPL Newsletter, the Learning Resource Center, the website, committees and ethics and practice guidelines.

Results: The Academy expects the results of its CME program to be improvement in competence or performance.

Adopted: September 5, 2008

FINANCIAL DISCLOSURE/CONFLICT OF INTEREST

It is the policy of the American Academy of Psychiatry and the Law (AAPL) to ensure balance, independence, objectivity, and scientific rigor in all its individually sponsored or jointly sponsored educational programs. In order to comply with the ACCME's Updated Standards for Commercial Support, the American Academy of Psychiatry and the Law requires that anyone who is in a position to control the content of an educational activity disclose all relevant financial relationships with any commercial interest pertaining to the content of the presentation. Should it be determined that a conflict of interest exists as a result of a financial relationship of a planner of the CME activity, the planner must recuse himself or herself from the planning for that activity or relevant portion of that activity. Should it be determined that a conflict of interest exists as a result of a financial relationship of a proposed presenter at a CME activity, the proposed presenter and the Education Committee must agree on a method to resolve the conflict. Refusal to disclose a conflict or the inability to resolve an identified conflict precludes participation in the CME activity.

The ACCME definition of a commercial interest is "…any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients." The ACCME does not consider providers of clinical services or publishers to be commercial interests.

All speakers have been advised of the following:

- Slides, posters, and handouts may not contain any advertising, trade names or product group messages of any commercial entity.

- If a presentation describes the use of a device, product, or drug that is not FDA approved or the off-label use of an approved device, product, or drug, it is the speaker's responsibility to disclose this information during the presentation.

- Presentations must give a balanced view of therapeutic options. Use of generic names contributes to this impartiality. If the content of a presentation includes trade names, where possible, trade names from several companies should be used.

- Recommendations involving clinical medicine in a CME activity must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients. All scientific research referred to, reported or used in CME in support or justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collection and analysis.

Instances of bias or failure to conform to any of the above instructions should be reported to the Education Committee by means of the evaluation form. Please be as specific as possible in reporting.

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

FINANCIAL DISCLOSURES

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

SPEAKERS/PRESENTERS

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

Abi Zeid Daou, M.; Abukamil, R.; Albassam, A.; Ali, A.; Alvarez-Toro, V.; Anacker, L.; Anderson, T.; Annas, G.D.; Antonius, D.; Aoun, E.; Appel, J.M.; Appelbaum, P.S.; Arabski, J.; Armbruster, M.; Arnold, J.A.; Ash, P.; Asheinheim, D.; Bailey, R.; Banayan, D.; Baranoski, M.; Barnett, B.; Bauschka, M.; Beaman, J.; Bechtel, D.; Becker, S.; Beizer, N.; Belfi, B.; Bell, G.; Berger, A.; Berrettini, W.H.; Berry, W.; Bertsch, I.; Bevin, S.; Bhullar, D.; Binder, R.L.; Black, L.; Blum, I.; Bresler, S.; Brown, J.; Bunker, A.; Burch, E.E.; Calhoun, D.; Candilis, P.J.; Carabellese, F.; Caruso, K.A.; Casey-Leavell, B.; Cerny-Suelzer, C.; Cervantes, A.N.; Chaimowitz, G.; Champion, M.; Chan, E.; Cheng, J.C.; Chien, J.; Cleary, S.D.; Coffman, K.L.; Cohen, M.A.; Colavita, M.; Collins, T.; Collis, E.; Concordia, M.; Cooke, B.; Crowley, B.; Curry, S.; Dailey, L.; D'Alessandro, E.; Darby, W.C.; Datta, V.; Davis, G.; Delgado, D.; Deqiang, G.; Dessin, C.; Dike, C.; Dinwiddie, S.H.; Ditter, S.; Dornfeld, B.; Drogin, E.Y.; Dukes, C.; Dunn, M.H.; Durst, P.; Dvoskin, J.; Elizondo III, P.M.; Elkhatib, R.; Elmaghraby, R.; Farrell, H.; Fayer, S.; Felthous, A.R.; Ferguson, E.; Fischer, C.; Fisher, K.; Flo, J.; Foellmi, M.; Ford, E.; Ford, A.; Forman, H.; Freitas, C.; Frierson, R.L.; Frizzell, W.; Gable, M.; Gage, B.; Gallo, L.; Garvey, K.; Gashi, M.; Gershan, S.; Ghossoub, E.; Gilbo, N.; Gill, R.; Glass, O.M.; Glezer, A.; Gowensmith, N.; Gold, L.H.; Green, D.; Greenspan, M.; Greenwald, M.; Grover, M.; Guina, J.; Gulrajani, C.; Gundersen, D.C.; Gupta, N.; Gutheil, T.G.; Gutman, A.R.; Hackman, A.; Hall, J.; Hall, R.C.W.; Halls, A.; Hamalian, G.; Hanson, A.; Harding, L.; Hargadon, J.; Harry, B.; Hatters Friedman, S.; Healey, L.; Heekin, R.D.; Herman, S.P.; Hiller, C.; Hirschtritt, M.E.; Hoge, S.K.; Holbreich, R.; Holmberg, T.C.; Holoyda, B.; Holzer, J.; House, S.; Howel, T.; Iannuzzi, G.; Immel, M.; Isidore, M.; Izenberg, J.; Jain, A.; Janofsky, J.S.; Johnson, N.R.; Jorgensen, C.; Joshi, K.G.; Judd, S.; Kaempf, A.; Kaliebe, K.; Kambam, P.; Kapoor, R.; Karns, R.; Kaufman, H.; Keisari, E.J.; Kelly, B.; Keram, E.; Kerwin, J.; Khadivi, A.; Khan, J.; Khan, M.; Khin Khin, E.; Khoury, R.; Kikorsky, S.; King, I.; Kingston, A.; Kline, R.; Knoll, J.L.; Knowles, A.; Kolla, N.; Korenis, P.; Krueger, R.; La Tegola, D.; Lahaie, M.P.; Lamoureux, I.; Landess, J.; Lavach, B.; Leahy, R.; Lembke, A.; Levin, A.P.; Lian, N.Z.; Lopez, S.; Lopez-Leon, M.; Manocha, P.; Marasa, L.; Marett, C.; Marks, J.A.; Martell, D.A.; Martin, P.S.; Martinez MD, R.; Martinez, R.; Mathias, M.; Matos, F.; Matto, M.; McBride, A.; McCoy, B.; McCrary, G.; McDermott, B.E.; McIntyre, K.; McKenzie Cassidy, A.M.; McKenzie, J.B.; McNeil, D.E.; Mela, M.; Melia, A.M.; Metzner, J.; Michaelsen, K.; Mills, K.; Mistry, A.; Montazeralghaem, D.; Morel, J.; Mott, B.; Mufti, M.; Mujdaba, T.M.; Muller, M.; Naidoo, Y.; Negron-Munoz, R.E.; Nesbit, A.; Newman, W.; Nissan, D.; Noesner, G.; Noffsinger, S.; Noor, S.; Norko, M.A.; Noroian, P.; Odom, C.; Okwerekwu, J.; Ortiz, P.; Ostermeyer, B.; Ozdoba, A.; Patel, R.; Patel, K.; Petaia, L.; Piel, J.; Pigott, T.; Pinals, D.A.; Pozios, V.K.; Prabhu, M.; Prat, S.S.; Rafla-Yuan, E.; Rahman, T.; Ramachandran, G.; Ramya, V.; Rani, P.; Ravven, S.; Recupero, P.R.; Redinger, M.; Reeves, R.; Reimers, K.; Resnick, P.J.; Riess, P.; Ritchie, E.C.; Riyaz, S.; Rogers, M.; Rosenbaum, K.; Rosmarin, D.; Rotter, M.; Rozel, J.; Ruppert, P.; Sabitha, V.; Sadacharan, R.; Sahi, S.; Salaria, S.; Saleh, A.; Gondim Sales, P.M.; Salgado, C.; Saxton, A.; Schoelerman, R.; Schouten, R.; Schwarz, L.; Scott, C.L.; Secarea, C.M.; Seth, H.; Shand, J.P.; Shelton, C.; Simpson, S.; Simpson, J.R.; Sita, E.E.; Skimming, K.; Sloan, L.; Soliman, S.; Solis, O.L.; Sonnier, L.; Sorrentino, R.M.; Srinivasaraghavan, J.; Stolar, A.G.; Stoner, T.; Stowe, Z.; Straka, T.; Subedi, B.; Sundararaj, D.; Sussman, N.; Swartz, M.; Tabriz, K.; Tamburello, A.; Tewari, S.; Thomas, T.; Thompson, C.R.; Trestman, R.L.; Tucker, D.; Tyndall, M.; VanDercar, A.; Vanderpool, D.; Vargas, S.; Vats, D.; Vaughn, M.S.; Vega, I.; Velsor, S.; Viswanathan, R.; Wagoner, R.C.; Wall, B.; Walyzada, F.; Wang, A.; Warburton, K.; Wasser, T.; Watson, C.; Watts, J.; Way, B.; Weinstock, R.; Weisman, R.L.; Weiss, K.J.; West, S.; Westmoreland, P.; Wettstein, R.; Wilk, C.; Williams, M.M.; Williams, J.; Willis, L.; Wolfe, N.; Xenakis, S.N.; Xiong, W.; Yarnell-MacGrory, S.; Yates, K.A.; Zahedi, S.; Zarzar, T.

The following speaker made declarations of financial relationships. The conflict for his presentation *Clinical Assessment of Malingering: A Continuing Journey for Advancing Forensic Practice* was resolved by review of the materials by the Chairs of the Education Committee.

Richard Rogers, PhD Royalties for SAMA Measures and SIRS-2

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 relationship with any commercial interests:

Anacker, L.; Ash, P.; Billick, S.; Chaimowitz, G.; Champion, M.; Coleman, J. (staff).; Dike, C.; Ferguson, E.; Ferranti, J.; Frierson, R.; Gold, L.; Guina, J.; Gulrajani, C.; Hanson, A.; Henry, S.; Holoyda, B.; Holzer, J.; Johnson, N.; Kaempf, A.; Kapoor, R.; Kaye, N.; Keram, E.; Klein, C.; Knoll, J.; Krueger, R.; Lee, L.; Lewis, R.; Michaelsen, K.; Newman, A.; Newman, W.; Noffsinger, S.; Ong, H.; Ostermeyer, B.; Parker, G.; Pinals, D.; Prabhu, M.; Preven, D.; Price, M.; Rai, S.; Reichlin, S.; Resnick, P.; Rosmarin, D.; Ryan, E.; Schiffman, E.; Scott, C.; Silberberg, J.; Srinivasaraghavan, J.; Subedi, B.; Tamburello, A.; Thompson, C.; Weinstock, R.; Wills, C.

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

Gary Chaimowitz: Received speaker honoraria from Lundbeck and Pfizer Pharmaceuticals.

J. Paul Federoff: Stockholder with Canopy Corporation.

Andrea Stolar: Received consulting fee from MetLife Disability Company.

SPECIAL EVENTS

WEDNESDAY, OCTOBER 24, 2018	TIME	PLACE
AIER Board Meeting	7:00 a.m. – 8:30 a.m.	Lone Star Ballroom A, Level 3
Council Meeting	8:45 a.m. – 1:00 p.m.	Lone Star Ballroom A, Level 3
Council with Committee Chairs	6:00 p.m. – 7:00 p.m.	Room 310, Level 3
Committee Reception and Dinner (ticket required)	7:00 p.m. – 10:00 p.m.	Lone Star Ballroom E, Level 3

THURSDAY, OCTOBER 25, 2018	TIME	PLACE
Past President's Breakfast	7:00 a.m. – 8:00 a.m.	Room 301, Level 3
ADFPF Reception (for fellowship program faculty, fellows and potential applicants)	6:00 p.m. – 7:00 p.m.	Lone Star Ballroom E, Level 3
President's Panel	7:00 p.m. – 9:00 p.m.	Lone Star Ballroom D, Level 3
Women of AAPL Reception	9:00 p.m. – 10:00 p.m.	Lone Star Ballroom H, Level 3

FRIDAY, OCTOBER 26, 2018	TIME	PLACE
Research Breakfast	7:00 a.m. – 8:00 a.m.	Room 303, Level 3
Rappeport Fellows Breakfast	7:00 a.m. – 8:00 a.m.	Room 304, Level 3
AAPL Business Meeting	8:00 a.m. – 9:30 a.m.	Lone Star Ballroom D, Level 3
Reception for Meeting Attendees	6:00 p.m. – 7:30 p.m.	Lone Star Ballroom E, Level 3

SATURDAY, OCTOBER 27, 2018	TIME	PLACE
ECP and Fellows Breakfast (for those in the first seven years after training and current fellows)	7:00 a.m. - 8:00 a.m.	Rooms 301-302, Level 3
Midwest AAPL Chapter Meeting (Chapter meetings by request only, please contact AAPL staff)	6:00 p.m. – 7:00 p.m.	Room 301, Level 3

COFFEE BREAKS WILL BE HELD IN THE LONE STAR FOYER

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

JW MARRIOTT AUSTIN

PLEASE

BE COURTEOUS TO YOUR FELLOW ATTENDEES.

TURN CELL PHONES OFF OR SET THEM TO VIBRATE.

HOLD YOUR PHONE CONVERSATIONS OUTSIDE THE MEETING ROOM.

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

(SESSION MODERATORS HAVE BEEN ASKED TO ENFORCE THESE POLICIES)

American Academy of Psychiatry and the Law
Forty-ninth Annual Meeting

OPENING CEREMONY

Thursday, October 25, 2018
8:00 a.m. - 10:00 a.m.

WELCOME AND INTRODUCTIONS
Christopher R. Thompson, MD
President

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

Viviana M. Alvarez-Toro, MD
University of Maryland

Selena R. Magalotti, MD
University Hospitals Cleveland Medical Center

Robert A. Ellis, MD, JD
Medical University of South Carolina

Meghan A. Musselman, MD
Massachusetts General Hospital

Alexandra Junewicz, MD
Child Study Center at NYU Langone Medical Center

Hassan Naqvi, MD
Emory University School of Medicine

AWARD PRESENTATIONS
Jeffrey L. Metzner, MD

Red Apple Award
Barry W. Wall, MD

Golden Apple Award
Graham D. Glancy, MB, ChB

Award for Outstanding Teaching in a Forensic Fellowship Program
Kaustubh G. Joshi, MD

Seymour Pollack Award
Debra A. Pinals, MD

Young Investigator Award
Elias Ghossoub, MD

2017 Poster Award
Joseph Cheng, MD, PhD

AAPL INSTITUTE FOR EDUCATION AND RESEARCH
Debra A. Pinals, MD

OVERVIEW OF THE PROGRAM
Jessica Ferranti, MD
William J. Newman, MD
Co-Chairs, *Program Committee*

INTRODUCTION OF THE PRESIDENT
Charles L. Scott, MD

PRESIDENT'S ADDRESS
Christopher R. Thompson, MD

ADJOURNMENT
Jessica Ferranti, MD
William J. Newman, MD
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.

BARRY W. WALL, MD

Barry Wall, MD, is the recipient of the 2018 outstanding service award (Red Apple), which is awarded in recognition of service to AAPL.

AAPL has been Barry Wall, MD's professional home since 1994. He has served as Councilor and Secretary and is currently a Vice President. He has been a member of the Liaison with Forensic Psychology Committee, Peer Review of Psychiatric Testimony Committee, Private Practice Committee, Ethics Committee and Program Committee. He has co-chaired the Program Committee and currently co-chairs the Media & Public Relations Committee.

Dr. Wall served as a member for the Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial as well as for the Practice Guideline for the Forensic Evaluation of Psychiatric Disability. He chaired the Competence to Stand Trial Practice Guideline revision in 2017. He has presented at ten annual meetings and has published articles in both JAAPL and in the newsletter.

Dr. Wall is AAPL's Delegate to the AMA. Leading AAPL's AMA Delegation requires collaboration with the American Psychiatric Association and several other psychiatric specialty organizations.

He is a Clinical Professor in the Department of Psychiatry and Human Behavior at the Alpert Medical School of Brown University.

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.

GRAHAM D. GLANCY, MB, CHB

Dr. Glancy completed his MB, ChB and post-graduate training at Manchester University in England. After moving to Canada, he served as post-graduate director and chief of Forensic Service at the Clarke Institute of Psychiatry (1989-1991), now the Centre for Addiction and Mental Health (CAMH). While there, he also founded the Clarke Institute Sex Offender Treatment Program.

Dr. Glancy served as president of the Canadian Academy of Psychiatry and the Law from 1993 to 1997. Dr. Glancy was president of AAPL from 2014-2015.

Dr. Glancy is an associate professor in the Department of Psychiatry at the University of Toronto, where he is the co-head of the Division of Forensic Psychiatry. He has authored over 100 scholarly articles and chapters focusing on the assessment of high-risk offenders, legal decisions that influence forensic mental health, and raising the standard of practice of forensic psychiatry.

Dr. Glancy is chair of the Forensic Psychiatry Examination Committee of the Royal College of Physicians and Surgeons and has been designated a founder of Forensic Psychiatry by the College.

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.

KAUSTUBH G. JOSHI, MD

Kaustubh G. Joshi, MD is the 2018 recipient of the Award for Outstanding Teaching in a Forensic Fellowship Program, which recognizes excellence in teaching forensic psychiatry.

Dr. Joshi completed his fellowship at the University of South Carolina (USC) while serving in the U.S. Air Force. Dr. Joshi received several Outstanding Faculty Awards for excellence in teaching while in the military. Dr. Joshi was selected to lead the forensic evaluation for Nidal Hasan, the Army psychiatrist who killed 13 and wounded 32 military personnel at Ft. Hood, TX in November 2009.

He joined the USC faculty as Assistant Training Director in 2015, where he has been a tremendous asset to the fellowship and residency training program. Dr. Joshi is currently an associate clinical professor of psychiatry.

Qualities exhibited by Dr. Joshi include his dedication to teaching and mentoring of trainees. His supporting letters described teaching as Dr. Joshi's passion. He has spent countless hours preparing lectures and spending extra time in supervision with the fellows. Dr. Joshi has a keen interest in mentoring others in their academic development. He has co-authored publications with four of the five fellows he has supervised and is working on a research project with the fifth.

SEYMOUR POLLACK AWARD

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

DEBRA A. PINALS, MD

The Seymour Pollack Award recognizes distinguished contributions to the field of forensic psychiatry. This year's awardee is Debra A. Pinals, MD, who has multiple titles, including Clinical Professor of Psychiatry in the Department of Psychiatry at University of Michigan, where she is Director, Program in Psychiatry, Law and Ethics and Director, Forensic Evaluation Service, and Medical Director, Behavioral Health and Forensic Programs for the Michigan Department of Health and Human Services Center for Forensic Psychiatry.

Dr. Pinals' career has focused on forensic and correctional psychiatry as well as the treatment of substance use disorders at the interface of corrections and communities. Her research interests include violence risk assessment and treatment of complex populations, forensic and public mental health systems, and integration of behavioral health and criminal justice treatment approaches. She is currently the principal or co-investigator of two major grants regarding these topics.

Her CV summarizes her extensive leadership positions within AAPL and APA such as being a past president of AAPL and serving as the current chair of APAs' Council on Psychiatry and the Law.

Not surprisingly, Dr. Pinals has an extensive list of publications that includes peer reviewed journals, book chapters, and two books.

DISTINGUISHED LECTURERS

Thursday, October 25, 2018

RICHARD ROGERS, PHD

Clinical Assessment of Malingering: A Continuing Journey for Advancing Forensic Practice

Richard Rogers, PhD, ABPP, is a Regents Professor of Psychology at the University of North Texas. His past academic appointments included both the disciplines of psychiatry and psychology at Rush University and the University of Toronto. In addition, Dr. Rogers continues to consult on prominent cases and is often called specifically as a malingering expert. His research on malingering and related response styles spans more than three decades and 60 refereed articles. In 1988, he edited *Clinical Assessment of Malingering and Deception (CAMD)*, which was nationally recognized by AAPL and APA with the Manfred S. Guttmacher Award. A fully revised 4th edition of CAMD was released in the spring of 2018. Dr. Rogers is also the principal author of the *Structured Interview of Reported Symptoms (SIRS)* and its second edition (SIRS-2). The SIRS/SIRS-2 is often considered the premier measure for feigned mental disorders. In 2011, Dr. Rogers became only the third psychologist in the history of APA to receive APA awards for Distinguished Professional Contributions to both Applied Research and Public Policy.

Friday, October 26, 2018

ANNA LEMBKE, MD

The Opioid Epidemic: How We Got Here, Where We Are Now, and How to Get Out

Dr. Lembke was one of the first in the medical community to sound the alarm regarding opioid overprescribing and the opioid epidemic. In 2016, she published her best-selling book on the prescription drug epidemic, *Drug Dealer, MD – How Doctors Were Duped, Patients Got Hooked, and Why It's So Hard to Stop*, that combines case studies with public policy, cultural anthropology, and neuroscience to explore the complex relationship between doctors and patients around prescribing controlled drugs, the science of addiction, and the barriers to successfully addressing prescription drug misuse and addiction.

The success of *Drug Dealer, MD* has had an impact on public policy makers and legislators across the nation in the wake of the ongoing opioid epidemic. Dr. Lembke testified before Congress, consulted with governors and senators from Kentucky to Missouri to Nevada, was a featured guest on *Fresh Air with Terry Gross*, and appeared on *MSNBC with Chris Hayes*, the *Today Show with Dr. Oz*, the *Megyn Kelly Show* on CBS, and numerous other media broadcasts.

Using her teaching/academic position and her public platform, Dr. Lembke continues to advocate for people with addiction and educate health care professionals, policymakers, and the public on a wide variety of addiction-related topics.

Saturday, October 27, 2018

RANGER RAMIRO "RAY" MARTINEZ

Confronting an Active Shooter: Perspectives on the UT Tower Shooting 50 Years Later

Ranger Martinez spent over thirty years in law enforcement, serving with the Austin Police Department, Texas Department of Public Safety as a Narcotics Agent and as a Texas Ranger. He was involved in the University of Texas Tower sniper incident on August 1, 1966. Ranger Martinez received the Austin Police Medal of Valor for his role in bringing the tragedy to an end. Later, as a Texas Ranger, he participated in rooting out corruption and white-collar crimes in South Texas, which reached from the county court house to the White House. He is a graduate of the FBI National Academy. Upon his retirement, Ranger Martinez served as a Justice of the Peace in Comal County, Texas. He authored two books, *They Call Me Ranger Ray* and *Creating the Professional Texas Lawman*. He serves on the Board of Directors for the Former Texas Ranger Association and the Former Texas Ranger Foundation. He has been featured on CBS News Sunday Morning, the BBC, Texas Monthly magazine, and the award-winning documentary, "Tower," which was featured on PBS. He has made presentations before active assailant conferences, first responders training conferences and community colleges. He was recognized by the Texas Senate, in Senate Proclamation No.635, for his actions on August 1, 1966.

THURSDAY, OCTOBER 25, 2018

POSTER SESSION A — 7:00 AM - 8:00 AM / 9:30 AM - 10:15 AM — **LONE STAR FOYER**

T1 ***Forensic Psychiatry Fellowship Recruitment Process***
Seth Judd, MD, Columbia, SC
Richard L. Frierson, MD, Columbia, SC
Kaustubh G. Joshi, MD, Columbia, SC

T2 ***Endrew v. Board of Education and Its Impact on Special Education Law***
Mary Gable, MD, Los Angeles, CA
Ilaina Blum, MA, MFT, Los Angeles, CA

T3 ***Millennials & Technology "Residents": Forensic Education Gets a Re-Boot***
Tobias Wasser, MD, Middletown, CT
Stephanie Yarnell-MacGrory, MD, PhD, New Haven, CT
Katherine Michaelsen, MD, MASc, New Haven, CT

T4 ***Child and Adolescent Fellows' Conducting Youth Violence Risk Assessments Before and After a Case Guided Didactic***
Kathryn Skimming, MD, MA, Baltimore, MD
Viviana Alvarez-Toro, MD, Baltimore, MD
Christopher Wilk, MD, Baltimore, MD

T5 ***Who Are You? Case Studies of Violence by Patients with Capgras Syndrome***
Olaya Lizette Solis, MD, San Antonio, TX

T6 ***Recognizing and Reducing Risk of Violence Toward Forensic Practitioners***
J.P. Shand, MD, Lancaster, PA
Clarence Watson, MD, JD, Philadelphia, PA
Mustafa Mufti, MD, New Castle, DE

T7 ***Managing Confessions of a Serial Murderer***
Eric Chan, MD, San Francisco, CA
Tara Collins, MD, MPH, San Francisco, CA
Mikel Matto, MD, San Francisco, CA
Jacob Izenberg, MD, San Francisco, CA

T8 ***The Concurrent Validity of the Psychological Inventory of Criminal Thinking Styles-Simplified Version (PICTS-SV)***
Margot M. Williams, MS, Denton, TX
Richard Rogers, PhD, Denton, TX

T9 ***Implicit Amnestic Disorders: Forget What you Learned!***
Rami Abukamil, MD, Cincinnati, OH
Eric Rafla-Yuan, MD, San Diego, CA

T10 ***Prison Changed Me: Early Medical Student Exposure to Correctional Psychiatry***
Samantha Sahi, San Francisco, CA
Vivek Datta, MD, MPH, San Francisco, CA

T11 ***Tattoo Removal-Necessary Treatment in a Forensic Hospital?***
Kayla Fisher, MD, JD, Riverside, CA

T12 ***A Tale of Two Psychiatrists, Forensic and Transplant***
Scott Gershan, MD, Chicago, IL
David Banayan, MD, Chicago, IL

T13 ***Variables in Forensic Settings that Impact Health Measures***
Gowri Ramachandran, MD, Washington, DC

T14 ***White Coats Aren't Superhero Capes***

Darmant Bhullar, MD, New York, NY
Felix Matos, Bronx, NY
Panagiota Korenis, MD, Bronx, NY

T15 ***Female Arsonists: A Systematic Review***

Alick Wang, BSc, Hamilton, ON, Canada
Yedishtra Naidoo, MD, Hamilton, ON, Canada
Sebastien Prat, MD, Hamilton, ON, Canada

T16 ***Commonwealth v. Eldred: Probationers Incarcerated for Relapsing?***

Paul Noroian, MD, Worcester, MA
Margarita Abi Zeid Daou, MD, Worcester, MA
Amam Saleh, MD, Worcester, MA

T17 ***The Prevalence of Adverse Childhood Experiences (ACE) in Florida Youth Referred to the Department of Juvenile Justice***

Greg Iannuzzi, MD, Tampa, FL
Mark Greenwald, PhD, Tallahassee, FL
Kristopher Kaliebe, MD, Tampa, FL

T18 ***The Collaborative Model For Capacity Assessment: A New Model in Residency Training***

Jarrod A. Marks, MD, Boston, MA
Jacob M. Appel, MD, JD, New York, NY

T19 ***Application of Genetics and Genomics in Forensic Psychiatry***

Naomi Z. Lian, MD, PhD, Syracuse, NY
George David Annas, MD, MPH, Syracuse, NY
Bruce Way, PhD, Syracuse, NY
James L. Knoll, IV, MD, Syracuse, NY

T20 ***Competency Restoration on a Jail-Based Unit Compared to a State Hospital Forensic Unit***

Michael Armbruster, MD, Atlanta, GA
Peter Ash, MD, Atlanta, GA

T21 ***Autism, Violent Fantasies and Duty to Warn***

Deepika Sundararaj, MD, Springfield, MA
Sonia Riyaz, MD, Springfield, MA

T22 ***Firearm Background Checks: A Military Loophole***

Christopher Jorgensen, MD, Leon Valley, TX
Belinda Kelly, MD, San Antonio, TX

T23 ***Use of Evidence-Based Risk and Protective Factors for Violence by Non-Forensic Outpatient Clinicians***

Nadia Gilbo, MD, Bronx, NY
Ashley Ford, MD, Bronx, NY
Karishma Patel, MD, Bronx, NY
Sarah Becker, MD, Bronx, NY
Adam Knowles, MD, Bronx, NY
Laurie Gallo, PhD, Bronx, NY
Howard Forman, MD, Bronx, NY
Ana Ozdoba, MD, Bronx, NY

T24 ***Non-Biased Approach in Assessing Patients Who are Under Arrest***

Myriane Isidore, MD, Richmond Hill, NY
Sadaf Noor, MD, Brooklyn, NY
Manuel Lopez-Leon, MD, Brooklyn, NY

OPENING CEREMONY 8:00 AM – 10:00 AM **LONE STAR D**

T25 ***A Seat at the Table: AAPL's Potential Role in Shaping 21st Century Forensic Mental Health Policy and Law***

Christopher R. Thompson, MD, Los Angeles, CA

COFFEE BREAK **10:00 AM – 10:15 AM** **LONE STAR FOYER**

DEBATE — 10:15 AM - 12:00 PM — **LONE STAR A**

T26 Forensic Psychiatrists and Social Justice: Should We Take A Stand?

Merrill Rotter, MD, Bronx, NY
Reena Kapoor, MD, New Haven, CT
Debra Pinals, MD, Ann Arbor, MI
Sandy Simpson, MD, Toronto, ON, Canada

PANEL — 10:15 AM - 12:00 PM — **LONE STAR D**

T27 An Autopsy of Mass Shootings

James L. Knoll, IV, MD, Syracuse, NY
Philip Candilis, MD, Alexandria, VA
Karen Rosenbaum, MD, New York, NY
Corina Freitas, MD, Oxon Hill, MD
Dennis Bechtel, Fayetteville, NC

WORKSHOP — 10:15 AM - 12:00 PM — **LONE STAR F**

T28 Mental Illness and the Right to Bear Arms: Assessments for Restoration of Rights

Joseph R. Simpson, MD, PhD, Hermosa Beach, CA
Liza H. Gold, MD, Arlington, VA
Michael A. Norko, MD, New Haven, CT

WORKSHOP — 10:15 AM - 12:00 PM — **LONE STAR G**

T29 Guns in K-12: The Role of the Forensic Psychiatrist in Gun Violence Education and Reduction Interventions

Drew Calhoun, MD, Seattle, WA
Ian Lamoureux, MD, Scottsdale, AZ
Jeffrey Khan, MD, Houston, TX
Charles Scott, MD, Sacramento, CA

WORKSHOP — 10:15 AM - 12:00 PM — **LONE STAR B-C**

T30 Refusal of Life-Saving Medical Treatment Due to Suicidal Motivation

Ramaswamy Viswanathan, MD, Brooklyn, NY
Paul S. Appelbaum, MD, New York, NY
Paulo Marcelo Gondim Sales, MD, Brooklyn, NY

LUNCH (TICKET REQUIRED) — 12:00 PM – 2:00 PM — **LONE STAR E**

T31 Clinical Assessment of Malingering: A Continuing Journey for Advancing Forensic Practice

Richard Rogers, PhD, Denton, TX

PANEL — 2:15 PM - 4:00 PM — **LONE STAR D**

T32 Threatening the President: When Hate Trumps Love

Charles L. Scott, MD, Sacramento, CA
Mary Gable, MD, Sacramento, CA
Scott Kikorsky, MD, Sacramento, CA
Andrea Bunker, MD, Sacramento, CA
Lauren Marasa, MD, Sacramento, CA

PANEL — 2:15 PM - 4:00 PM — **LONE STAR A**

T33 ***Forensic Mental Health Legislation: A Primer and Update***

Tobias Wasser MD, Middletown, CT
Debra Pinals, MD, Ann Arbor, MI
Michael Champion, MD, Honolulu, HI
Richard Krueger, MD, New York, NY
Melissa Immel, Washington, DC
Beth Lavach, Washington, DC
Christopher R. Thompson, MD, Los Angeles, CA

WORKSHOP 2:15 PM - 4:00 PM **LONE STAR F**

T34 ***Submitting Successful Research Grant Applications to AIER***

Nathan Kolla, MD, PhD, Toronto, ON, Canada
Robert L. Trestman, PhD, MD, Roanoke, VA

WORKSHOP 2:15 PM - 4:00 PM **LONE STAR G**

T35 ***Working with Lawyers: The Good, the Bad, and the Ugly***

Patricia Westmoreland, MD, Denver, CO
Brian Crowley, MD, Washington, DC
Trent C. Holmberg, MD, Draper, UT
Ana Natasha Cervantes, MD, Buffalo, NY
Katayoun Tabriz, MD, Durham, NC

COURSE (TICKET REQUIRED) 2:15 PM - 6:15 PM **LONE STAR B-C**

T36 ***#MeToo In Court: Psychiatric Evaluation in Sexual Harassment Employment Litigation***

Liza H. Gold, MD, Arlington, VA
Patricia R. Recupero, MD, JD, Providence, RI
Philip Durst, JD, Austin, TX

COFFEE BREAK **4:00 PM – 4:15 PM** **LONE STAR FOYER**

FLASH TALK SESSION #1 4:15 PM – 6:15 PM **LONE STAR A**

T37 ***Gina's Got a Gun***

Sohrab Zahedi, MD, Farmington, CT
E.J. Keisari, MD, Farmington, CT

T38 ***Risk-Based Gun Removal Laws: An Overview of Five States***

William Frizzell, MD, Portland, OR
Joseph Chien, DO, Portland, OR

T39 ***Using Threat Assessment Practices for School-Based Threats in Emergency Settings***

Matthew P. Lahaie, MD, JD, Boston, MA

T40 ***From Fun to Felony: Child Pornography***

Nicole Sussman, MD, Cambridge, MA

T41 ***PROGRAM WITHDRAWN***

T42 ***Under the Influence: DWI Courts in the United States***

R. David Heekin, MD, Houston, TX
Andrea Gail Stolar, MD, Houston, TX

T43 ***Involuntary Psychiatric Holds During Pregnancy: Providers' Perspectives***

Samuel House, MD, Little Rock, AR
Jason Beaman, DO, Tulsa, OK
Tiffany Howel, PhD, Little Rock, AR
Zachary Stowe, MD, Madison, WI

T44 ***Citizenship and Social Justice: Voting by People with Mental Illness***

Jennifer Okwerekwu, MD, Cambridge, MA
James B. McKenzie, DO, MBA, Cambridge, MA
Katherine A. Yates, BS, Cambridge, MA
Renée M. Sorrentino, MD, Weymouth, MA
Susan Hatters Friedman, MD, Cleveland OH

PANEL — 4:15 PM -6:15 PM — **LONE STAR D**

T45 ***Serial Killers and Psychiatry: From Pursuit to Trial***

Ryan C. Wagoner, MD, Tampa, FL
Charles L. Scott, MD, Sacramento, CA
Phillip Resnick, MD, Cleveland, OH

PAPER SESSION #1 — 4:15 PM - 6:15 PM — **LONE STAR F**

T46 ***Forensic Aspects of Kratom Use***

Stephen P. Herman, MD, New York, NY

T47 ***The Relationship Between Child Pornography and Contact Offending***

Matthew Hirschtritt, MD, MPH, San Francisco, CA
Douglas Tucker, MD, Berkeley, CA
Renée L. Binder, MD, San Francisco, CA

T48 ***Cyberstalking Directed at Youth***

Paul M. Elizondo, III, DO, San Francisco, CA
Renée L. Binder, MD, San Francisco, CA
Dale E. McNiel, PhD, San Francisco, CA

T49 ***When do Internet Communications Become Criminal?***

Rami Abukamil, MD, Cincinnati, OH
Jennifer Piel, JD, MD, Seattle, WA

WORKSHOP — 4:15 PM -6:15 PM — **LONE STAR G**

T50 ***Developing Expertise in Miranda Consultations***

Richard Rogers, PhD, Denton, TX

PANEL — 7:00 PM – 9:00 PM — **LONE STAR D**

T51 ***Dazed and Confused: How the Opioid Epidemic has Challenged Physicians, Attorneys and Law Enforcement***

Anna Lembke, MD, Stanford, CA
James A. Arnold, MA, Washington, DC
Donna Vanderpool, MBA, JD, Arlington, VA

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

T1 FORENSIC PSYCHIATRY FELLOWSHIP RECRUITMENT PROCESS

Seth Judd, MD, Columbia, SC
Richard L. Frierson, MD, Columbia, SC
Kaustubh G. Joshi, MD, Columbia, SC

EDUCATIONAL OBJECTIVE

To provide background on the current forensic psychiatry fellowship application process; to identify the strengths and weaknesses of the current system as perceived by applicants and program directors through a survey; and to offer suggestions to help facilitate positive changes in the application process.

SUMMARY

Since the inception of the first forensic psychiatry training program in the late 1960s, the specialty has grown to 45 accredited fellowships. The fellowship application process has been characterized by decentralization, unlike other residency and fellowship specialty programs, which follow the National Resident Matching Program (NRMP). In 1952 the NRMP changed the application process from a chaotic endeavor into a structured one. Additionally, the NRMP Specialties Matching Service (SMS) provides services for 25 separate matches (63 subspecialties), including match programs for child and adolescent psychiatry and psychosomatic psychiatry. Although the NRMP existed for nearly two decades prior to the first forensic psychiatry fellowship program, forensic fellowships haven't participated in the NRMP SMS. This raises two important questions: (1) is the current recruitment process fair to applicants and directors?, and (2) should forensic fellowships participate in the NRMP SMS? To investigate these questions, a survey was distributed to current forensic fellows (N=80) and program directors (N=45) with response rates of 56.3% and 64.4%, respectively. The goals of this study are to examine the potential benefits and pitfalls of a decentralized application process and to determine whether the forensic fellowship should strongly consider utilizing a match system.

REFERENCES

The National Resident Matching Program. Available at http://www.nrmp.org. Accessed on March 24, 2018.

Kelly M, Hearn J, McBride A, et al: A guide for applying to forensic psychiatry fellowship. Acad Psychiatry, in press.

QUESTIONS AND ANSWERS

What percentage of fellowship directors see no disadvantages under the current system?

a. 3%
b. 23%
c. 43%
d. 63%
e. 83%
ANSWER: a

What percentage of fellowship directors would prefer to participate in the NRMP?

a. 22%
b. 32%
c. 52%
d. 62%
e. 72%
ANSWER: c

T2 ENDREW V. BOARD OF EDUCATION AND ITS IMPACT ON SPECIAL EDUCATION LAW

Mary Gable, MD, Los Angeles, CA
Ilaina Blum, MA, MFT, Los Angeles, CA

EDUCATIONAL OBJECTIVE

To understand the significance of the Endrew v. Board of Education decision and its impact on special education.

SUMMARY

The Supreme Court's decision in Endrew F. v. Douglas County School District RE-1 (2017) is the most significant special education decision in over 35 years, since that of Board of Education of the Hendrick Hudson Central School District v. Rowley (1982). In Rowley, the court ruled that the Individuals with Disability Education Act (IDEA) did not require schools to provide disabled students an equal educational opportunity relative to students without disabilities, but rather that services had to "convey some educational benefit" without clarifying what might

constitute the latter. Yet in Endrew the court rejected that a de minimis standard can be adequate if the goal of grade-level advancement as outlined in IDEA is to be pursued, and instead it stresses that the focus on a particular child is critical and that IDEA "requires an educational program reasonably calculated to enable a child to make progress appropriate in light of a child's circumstances." This poster will provide practical guidance on what constitutes the four key components of the Endrew decision: educational program, reasonably calculated, progress, and the child's circumstances. It will additionally examine how the decision impacts student assessment and evaluation in developing an individualized education plan.

REFERENCES

Turnbull HR, Turnbull AP, Cooper DH: The Supreme Court, Endrew, and the appropriate education of students with disabilities. Exceptional Children 84(2):124-140, 2018

Crawford L: The role of assessment in a response to intervention model. Preventing School Failure 58:230-236, 2014

QUESTIONS AND ANSWERS

The Endrew v. Board of Education decision, at its core, is intended to do which of the following?

a. Use a standard for all students that an individualized education plan (IEP) must set out a program that is "reasonably calculated to enable the child to receive educational benefits"
b. Use a standard for all students that an IEP "requires an educational program reasonably calculated to enable a child to make progress"
c. Use a standard for all students that an IEP "requires an educational program that invites de minimis progress from year to year"
d. Use a standard for all students that an IEP that is "reasonably calculated to allow the student to achieve passing marks"

ANSWER: b

The Endrew v. Board of Education decision:

a. Does not require educators to address a student's level of achievement and disability
b. Alters the purpose of the Individuals with Disabilities Education Act (IDEA)
c. Places new requirements on student evaluations and assessments
d. Probably does not have implications for developing Individualized Education Plan (IEP) goals

ANSWER: c

T3 MILLENNIALS & TECHNOLOGY "RESIDENTS": FORENSIC EDUCATION GETS A RE-BOOT

Tobias Wasser, MD, Middletown, CT
Stephanie Yarnell-MacGrory, MD, PhD, New Haven, CT
Katherine Michaelsen, MD, MASc, New Haven, CT

EDUCATIONAL OBJECTIVE

To demonstrate example modules for forensic education which employ adult learning theory in a modern user-friendly interface; to identify advantages of interactive, case-based format for teaching forensic psychiatry; to discuss opportunities and challenges of implementing online modules; and to appreciate the importance of effective forensic education for general psychiatrists and trainees.

SUMMARY

Though general psychiatry residencies must provide training in forensic psychiatry, many meet this requirement only via general psychiatry rotations and classroom-based activities. To most effectively train future general psychiatrists "and attract forensic fellows" we need to improve the quality and consistency of forensic education. Toward this goal, we developed a case-based curriculum anchored in adult learning theory, which can be used either in the classroom or at-home as complement to classroom or clinical activities.

The authors used AIER funding to develop two interactive online tutorials introducing trainees to core forensic concepts: Confidentiality and Duties to Third Parties. In the tutorials, clinical vignettes synthesized from relevant legal cases introduce each topic in an engaging and clinically relevant format. Resident knowledge is tested with pre- and post-tutorial assessments. We disseminated the modules nationally to residency programs via the American Association of Directors of Psychiatric Residency Training. Our presentation will review the tutorials' development and the results of the initial roll-out, including the number of programs, participants, and preliminary information on their impact on residents' forensic education (based on pre-/post-test results and resident feedback). We will conclude by exploring challenges with the modules and future directions.

REFERENCES
Lewis CF: Teaching forensic psychiatry to general psychiatry residents. Acad Psychiatry 28(1):40-6, 2004

Williams J, Elbogen E, Kuroski-Mazzei A, Training directors' self-assessment of forensic education within residency training. Acad Psychiatry 38(6):668-71, 2014

QUESTIONS AND ANSWERS
The Accreditation Council of Graduate Medical Education (ACGME) requires that all psychiatry residents have an experience in forensic psychiatry lasting:

a. 2 weeks
b. 4 weeks
c. 8 weeks
d. No specified duration
ANSWER: d

Adult learning theory indicates that the following approach to teaching medical trainees is LEAST effective:

a. Lectures
b. Interactive, case-based format
c. Problem-based learning
d. Team-based learning
ANSWER: a

T4 CHILD AND ADOLESCENT FELLOWS' CONDUCTING YOUTH VIOLENCE RISK ASSESSMENTS BEFORE AND AFTER A CASE-GUIDED DIDACTIC

Kathryn Skimming, MD, MA, Baltimore, MD
Viviana Alvarez-Toro, MD, Baltimore, MD
Christopher Wilk, MD, Baltimore, MD

EDUCATIONAL OBJECTIVE
Forensic Psychiatrists will learn how to effectively educate and lead discussions in the medical field and general public about risk assessment and mitigating factors for rampage shootings among juveniles.

SUMMARY
Deadly school rampage shootings and shootings in other public places by juveniles have raised attention in the medical field and the general public. Forensic psychiatrists are uniquely positioned in this social issue given their expertise in risk assessment and mitigating risk factors for violence. How can forensic psychiatrists best disseminate this clinical knowledge to various stakeholders?

This poster aims to teach methods of educating both medical providers and the general public. Presenters will draw on their own experience and perspective to dialogue about effective education techniques and platforms. Discussions will be centered around guidance for various stakeholders, including child and adolescent psychiatrists, pediatricians, emergency medicine physicians, parents, schools, and school resource officers. Ethical issues of predicting youth violence will also be addressed.

REFERENCES
Bushman BJ, Newman K, Calvert SL, et al. Youth violence: what we know and what we need to know. Am Psychol 71:17-39, 2016

Resnick MD, Ireland M, Borowsky I. Youth violence perpetration: what protects? what predicts? findings from the national longitudinal study of adolescent health. J Adolesc Health 35:424.e1e424.e10, 2004

QUESTIONS AND ANSWERS
Which of the following is NOT a family risk factor for youth violence?

a. Harsh and rejecting parents
b. Inter-parental violence
c. Child abuse and neglect
d. Consistent discipline
ANSWER: d

Which of the following interventions has been NOT been suggested to help create a climate where students feel engaged and feel a sense of belonging in schools?

a. Equal access to all academic and extracurricular opportunities
b. Restorative justice program
c. Zero tolerance policy
d. Development of social trust between youth and adults
ANSWER: c

T5 WHO ARE YOU? CASE STUDIES OF VIOLENCE BY PATIENTS WITH CAPGRAS SYNDROME

Olaya Lizette Solis, MD, San Antonio, TX

EDUCATIONAL OBJECTIVE

To improve knowledge regarding psychotic symptoms that can increase a patient's risk of harm to others and therefore warrant closer monitoring.

SUMMARY

In the aftermath of mass shootings, there is a tendency by the general public and policymakers alike to assume that the perpetrator had a mental illness. Research has overwhelmingly shown that only 1-3% of violent crime is attributable to persons with serious mental illness. However, there are certain conditions which may increase the risk for violence by persons with mental illness. The Delusional Misidentification Disorders (DMSs) are a group of disorders in which patients mistake the identity of people they know. The most common and best known of these is Capgras syndrome, which is the delusional belief that a close friend or relative has been replaced by a "double" whose original has disappeared. The "double" is often viewed with hostility by the patient. In persons with mental illness, this delusion is most commonly seen in patients with paranoid schizophrenia. The author will present two cases of violent behavior by persons with Capgras syndrome. In both cases, the subjects of delusions were family members, and the delusions grew more intense with time. These cases highlight the need for more frequent risk assessment in patients with particular types of delusions.

REFERENCES

Silva JA, Leong GB, Weinstock R, et al: Capgras syndrome and dangerousness. J Am Acad of Psychiatry Law 17(1):5-14, 1989

Klein CA, Hirachan S: The masks of identities: who's who? delusional misidentification syndromes. J Am Acad of Psychiatry Law 42(3):369-378, 2014

QUESTIONS AND ANSWERS

What percentage of violent crime is perpetrated by persons with serious mental illness?

a. Greater than 50%
b. Between 10% and 20%
c. Between 1% and 3%
d. Between 5% and 10%
ANSWER: c

Which of the following are factors that increase the risk for violence by patients with Capgras syndrome?

a. The patient is male.
b. The misidentified person lives with the patient.
c. The misidentified person is viewed with hostility and suspicion, as an "evil" person, by the patient.
d. All of the above.
ANSWER: d

T6 RECOGNIZING AND REDUCING RISK OF VIOLENCE TOWARD FORENSIC PRACTITIONERS

J.P. Shand, MD, Lancaster, PA
Clarence Watson, MD, JD, Philadelphia, PA
Mustafa Mufti, MD, New Castle, DE

EDUCATIONAL OBJECTIVE

To improve knowledge and appreciation of risks for personal injury in the practice of forensic psychiatry and to improve comprehension of ways that are practical and logical to help keep practitioners safe.

SUMMARY
Accurately assessing violence risk is a challenging, if not impossible, task. This becomes particularly relevant to a clinician when he or she has to evaluate the risk to one's own safety. Patients threatening their physicians is a common occurrence, with assault being not uncommon, while murder of a physician by a patient makes headlines. Many clinicians at some point fear for their own safety from their patients. Psychiatrists have great interest in how they can improve their own safety and decrease their risk. In addition to becoming familiar with literature and recommendations on the topic, insights have been aided by working with an individual who executed a detailed plan to kill their psychiatrist and was subsequently adjudicated Guilty But Mentally Ill. The authors discuss ways in which psychiatrists can improve their safety, including how to make address and home information difficult to find, more secure home locks, and security features that act as deterrents. In addition to home safety, the authors discuss specific examples of ways in which prior cases of assaults may have been avoided by using real-world examples.

REFERENCES
Binder R, Garcia P, Johnson B, et al: Identifying and mitigating risk of violence in the scientific workplace. J Am Acad Psychiatry Law 45(4):400-403, 2017

Farnham FR, James DV, Cantrell P: Association between violence, psychosis, and relationship to victim in stalkers. Lancet 355:199, 2000

QUESTIONS AND ANSWERS
What percentage of physicians were subject to severe violence?

a. 12%
b. 26%
c. 38%
ANSWER: c

The most common causes of violence towards physicians were dissatisfaction with which of the following?

a. Treatment or diagnosis
b. Services
c. Fees
ANSWER: a

T7 MANAGING CONFESSIONS OF A SERIAL MURDERER

Eric Chan, MD, San Francisco, CA
Tara Collins, MD, MPH, San Francisco, CA
Mikel Matto, MD, San Francisco, CA
Jacob Izenberg, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE
Using a real-life case example to explore the legal and ethical concerns that arise when a patient or evaluee reports a history of serial murder, the potential motivations for such disclosure, limits of confidentiality and Tarasoff, and related case law.

SUMMARY
This poster uses a real-life case example in which a patient presents to a community mental health clinic and reveals a past history of committing serial murder, and current stalking behaviors in the community. As the case is presented, the authors discuss how to best manage similar situations, taking into account existing statutes and case law regarding privacy, confidentiality, and the risk of misprision (active concealment of a crime). Special considerations for such confessions made by forensic evaluees or patients in the correctional system will be discussed. The ethical and legal issues that arise when a psychiatrist weighs protection of the public against the potential rupture of alliance when involving police in a treatment relationship will be detailed, as will the Tarasoff duties that may not be clear in situations with vaguely identified future targets. Finally, the authors will also explore literature on the potential motivations for an individual to disclose past commissions of crimes, particularly if such disclosure is actually false.

REFERENCES
Appelbaum P S, Meisel A:. Therapists' obligations to report their patients' criminal acts. Bull Am Acad Psychiatry Law 14(3):221-30, 1986

Walfish S, Barnett J, Marlyere K, et al: Doc, there's something I have to tell you: patient disclosure to their psychotherapist of unprosecuted murder and other violence. Ethics & Behavior 20(5):311-323, 2010

QUESTIONS AND ANSWERS
What is the definition of "misprision"?

a. Concealment of one's knowledge of a crime and/or failure to report it to authorities
b. Erroneous imprisonment of an innocent individual
c. Intentional misrepresentation of facts in a police report
ANSWER: a

Self-reported false confessors have been found to score higher on measures for all scales on:

a. Depression
b. Anxiety
c. Intraversion
d. Psychoticism
Answer: c

T8 THE CONCURRENT VALIDITY OF THE PSYCHOLOGICAL INVENTORY OF CRIMINAL THINKING STYLES-SIMPLIFIED VERSION (PICTS-SV)

Margot M. Williams, MS, Denton, TX
Richard Rogers, PhD, Denton, TX

EDUCATIONAL OBJECTIVE
To provide initial research data assessing the utility of the recently developed PICTS-SV for assessing criminal thinking in offenders.

SUMMARY
Building on the work of Yochelson and Samenow (1976), forensic psychiatrists and allied disciplines have long been interested in understanding criminal thinking styles. More recently, Walters (1995) developed an approach to systematically measure these styles with the Psychological Inventory of Criminal Thinking Styles (PICTS). Offenders' PICTS profiles identify proactive (planned harm motivated by gain) and reactive (impulsive, emotionally driven action) thinking styles, which have proven relevant to treatment planning and management. They also aid risk assessment, contributing incremental predictive validity beyond static historical variables (Walters, 2012b). To address the typically low reading levels among offenders, Disabato et al. (2016) developed the PICTS-Simplified Version (PICTS-SV), lowering the reading grade level to 5.5. The first goal of this presentation is to inform forensic psychiatrists about the clinical utility of the PICTS-SV. The second goal is to present new data on its comparability with the PICTS in a very common population for forensic practitioners: offenders with severe substance use involved in court-mandated treatment. Our initial findings demonstrate the efficacy of the PICTS-SV with this population. Overall, the PICTS-SV is an easily-used measure that may assist in improving patient management and forensic assessment of risk.

REFERENCES
Walters GD: The Psychological Inventory of Criminal Thinking Styles (PICTS). Part I: Reliability and preliminary validity. Criminal Justice and Behavior 22:307-325, 1995

Disabato DJ, Folk JB, Wilson J, et al: Psychometric validation of a simplified form of the PICTS for low-reading level populations. Journal of Psychopathology and Behavioral Assessment 38(3):456-464, 2016

QUESTIONS AND ANSWERS
Most psychological risk assessment measures focus on:

a. Static risk factors
b. Dynamic risk factors
c. Protective factors
d. All of the above
ANSWER: a

Concurrent validity results indicate:
a. PICTS and PICTS-SV scores are comparable only among males
b. PICTS-SV scores correlate highly with PICTS scores, indicating concurrent validity
c. PICTS-SV scores are consistently higher than PICTS scores
d. Correlations between the two versions were generally equivalent to or higher than PICTS test-retest values
e. both b and d
ANSWER: e

T9 IMPLICIT AMNESTIC DISORDERS: FORGET WHAT YOU LEARNED!

Rami Abukamil, MD, Cincinnati, OH
Eric Rafla-Yuan, MD, San Diego, CA

EDUCATIONAL OBJECTIVE

To distinguish between causes of implicit and explicit memory impairments and to familiarize the audience with available memory screening tools.

SUMMARY

Memory processing involves three stages: encoding, consolidation, and retrieval, with retrieval including both recall and recognition. Amnesia refers to memory impairment that goes beyond ordinary forgetting. Common causes of amnesia include traumatic brain injury, psychogenic amnesia, and dementia. Amnesia can be classified as retrograde amnesia and focal amnesia.

Because implicit memory does not require a conscious effort and is based on a previously learned skill, understanding implicit memory and how it relates to amnesia is crucial when examining memory. In individuals with impairments in explicit memory, implicit memory, particularly procedural memory, is often preserved. Accordingly, claims of implicit memory impairment often raise concern for feigned symptoms, especially when it occurs in the absence of explicit memory impairment. However, it remains important for psychiatrists to understand causes of implicit memory deficits as to not mistakenly label an individual a malingerer.

This poster will present case examples of neuropsychiatric conditions which feature genuine implicit memory impairment, including Parkinson's disease and subthalamic stroke. The poster will also review available psychometric screening tools which may be utilized in amnesia cases including the MMSE, MoCA, the Verbal Fluency Test (VST), Serial Reaction Time (SRT), and Serial Interception Sequence Learning (SIRL).

REFERENCES

Scott L: Evaluating amnesia for criminal behavior: a guide to remember. Psychiatr Clin North Am 35(4):797-819, 2012

Landrum RE, Radtke RC: Degree of Cognitive Impairment and the Dissociation of Implicit and Explicit Memory. The Journal of General Psychology 117(2):187-96, 1990

QUESTIONS AND ANSWERS

Which of the following tools is most useful for implicit memory testing?

a. Test of Memory and Malingering (TOMM)
b. Montreal Cognitive Assessment (MoCA)
c. Serial Interception Sequence Learning (SISL)
d. Structured Interview of Reported Symptoms (SIRS)
ANSWER: c

Which of the following is least likely to result in implicit memory impairment?

a. Parkinson's disease
b. Subthalamic stroke
c. PTSD
ANSWER: c

T10 PRISON CHANGED ME: EARLY MEDICAL STUDENT EXPOSURE TO CORRECTIONAL PSYCHIATRY

Samantha Sahi, San Francisco, CA
Vivek Datta, MD, MPH, San Francisco, CA

EDUCATIONAL OBJECTIVE

To explore the benefits of early exposure of medical students to correctional psychiatry from the perspective of educational value and ability to recruit future providers.

SUMMARY

Recruiting psychiatrists into correctional settings has proved a Sisyphean task, which has led to an interest in providing psychiatry residents with exposure to correctional psychiatry rotations to stimulate interest in this area. However, beginning exposure to correctional psychiatry during medical school could also prove beneficial to attracting medical students into psychiatry in general, and correctional psychiatry in particular. Here, we describe a first year medical student's experience of a preceptorship in correctional psychiatry at San Quentin State Prison. Her experience documents the ability of correctional exposure to improve patient communication skills before

entering the clinical phase of training. Furthermore, correctional populations can expose students to highly diverse populations such as former gang members, death row inmates, and sex offenders, which can deepen understanding of the complexity of correctional psychiatry issues and careers. Finally, correctional settings epitomize the tensions between providing care as a patient advocate and maintaining objectivity with difficult patients, an otherwise neglected topic in undergraduate medical education. This experience provides a perspective on how the unique setting of correctional psychiatry can both pique medical student interest and enrich medical student education. This preceptorship can serve as a model for early exposure to correctional psychiatry for medical students.

REFERENCES

Holoyda BJ, Scott CL: Psychiatric education in the correctional setting: challenges and opportunities. International Review of Psychiatry 29:11-20, 2016

Filek H, Harris J, Koehn J, et al: Students' experience of prison health education during medical school. Medical Teacher, 35:938-943, 2013

QUESTIONS AND ANSWERS

Which of the following court cases can lead to restrictions on the ability of psychiatric residents to practice as first line providers in California correctional settings?

a. Tarasoff v. Regents of the University of California
b. Brown v. Board of Education
c. Coleman v. Brown
d. Brown v. Plata
ANSWER: c

Which of the following is not an achievable learning objective for a pre-clinical medical student on a correctional psychiatry rotation?

a. Acknowledging additional intricacies of suicide risk assessment in the setting of a high prevalence of malingering
b. Understanding assessment of recidivism risk for mentally ill offenders
c. Learning alternatives to addictive substances with creative use of psychotropic medications
d. Appreciating multidisciplinary models of therapy in limited resource settings
ANSWER: b

T11 TATTOO REMOVAL–NECESSARY TREATMENT IN A FORENSIC HOSPITAL?

Kayla Fisher, MD, JD, Riverside, CA

EDUCATIONAL OBJECTIVE

This poster examines the benefits of providing tattoo removal in the forensic hospital setting, along with the treatment considerations in determining which patients should have access to this procedure.

SUMMARY

Tattoos, once thought to be linked to drug abuse and deviant behavior, have assumed a place in middle America, with 30% of those surveyed in 2017 reporting at least one tattoo. Likewise, the patient population of forensic hospitals increasingly wear ink. For some patients, these tattoos bind them to a past they strive to rid themselves of. Such is particularly the case with tattoos reflecting gang affiliation. As forensic hospitals endeavor to provide treatment to patients to lower their risk of future dangerousness, some have embraced the treatment of tattoo removal in certain situations. Patients have reported that tattoo removal decreases anxiety and increases their ability to dissociate from a problematic past. Treatment considerations for tattoo removal include the substance of the tattoo, tattoo placement, and patient's symptoms flowing from the tattoo. Risks of medical complications and possible delays in discharge dates must be weighed against the benefits in determining whether this treatment should be provided to a forensic patient.

REFERENCES

Armstrong ML, Stuppy DJ, Gabriel DC, et al: Motivation for tattoo removal. Arch Dermatol. 132(4):412-416, 1996

Khunger N, Molpariya A, Khunger A: Complications of tattoos and tattoo removal: stop and think before you ink. J Cutan Aesthet Surg 8(1):30-36, 2015

QUESTIONS AND ANSWERS
Patients who seek tattoo removal often are experiencing the following as a result of the tattoo:

a. Feelings of low self esteem
b. Stigmatization
c. Anxiety
d. All of the above
ANSWER: d

Patients reported which of the following after tattoo removal:

a. Increased ability to dissociate from the past
b. Sense of loss
c. Depression
d. Both a and b
ANSWER: a

T12 A TALE OF TWO PSYCHIATRISTS, FORENSIC AND TRANSPLANT

Scott Gershan, MD, Chicago, IL
David Banayan, MD, Chicago, IL

EDUCATIONAL OBJECTIVE
To review and discuss forensic-related risk factors and ethical considerations in organ transplant evaluations to enhance consultation skills.

SUMMARY
Transplant psychiatrists face an abundance of challenging factors in qualifying graft recipients appropriate for a scarce resource. A comprehensive appreciation of psychiatric illness and substance use is standard practice for transplant evaluations, but forensic patients - those currently within the criminal justice system, with histories therein or engaging active criminal behavior - add another layer of complexity. Validated assessment tools that assist clinicians in identification of both risk and protective factors can help with risk stratification. However, at present, there is no instrument that directly accounts for forensic-related risk factors.

Transplant candidates with psychiatric histories are often stigmatized, and this bias can ripple through the multidisciplinary transplant evaluation. Beyond standardized tools, transplant psychiatrists are afforded a quality of subjective interpretation of absolute and relative contraindications based on at-risk behavioral patterns. It is less clear how forensic issues impinge upon and possibly confound the transplant evaluation or organ procurement trends. There is a scarcity of literature exploring this relationship. Inter-rater variability, inter-institution disparities and a lack of any standardized review process further complicates this ethically sensitive landscape. This project tasks to review the practice of transplant psychiatry in a forensic context and with legal and bioethics aspects considered.

REFERENCES
Katharine S, Elisa JG, Min WS, et al: National survey of provider opinions on controversial characteristics of liver transplant candidates. Liver Transplantation 19:395-403, 2013

Shawna, LE: Ethical analysis and consideration of health behaviors in organ allocation: focus on tobacco use. Transplantation Reviews 22:171-177, 2008

QUESTIONS AND ANSWERS
Which transplant assessment tools assess for forensic-related risk factors?

a. Stanford Integrated Psychosocial Assessment for Transplant (SIPAT)
b. Transplant Evaluation Rating Scale (TERS)
c. Psychosocial Assessment of Candidates for Transplant (PACT)
d. Structured Interview for Renal Transplantation (SIRT)
e. All of the above
f. None of the above
ANSWER: f

The ethical model of Utilitarianism is best defined as:

a. God has endowed humans the rational capacity to derive ethical rules from observations of the empirical facts of the world we live in.
b. What makes an ethical code right is that compliance with it produces the greatest good for the greatest number of persons.
c. An ethical code is right because people adhere to it have always regarded it as right.
d. Emphasizes the relationship between duty and the morality of human actions.
ANSWER: b

T13 VARIABLES IN FORENSIC SETTINGS THAT IMPACT HEALTH MEASURES

Gowri Ramachandran, MD, Washington, DC

EDUCATIONAL OBJECTIVE

To explore variables in forensic hospitalizations, such as long-term atypical antipsychotic use, dietary options, and physical activity, that may have a tangible impact on health measures.

To investigate the clinical significance of such variables.

To consider if any policy changes can be undertaken to improve health measures.

SUMMARY

The purpose of this study is to consider the health implications of extensive antipsychotic use in the controlled setting of a long-term forensic psychiatric unit with limited dietary and physical activity options, where medication compliance can be monitored more strictly and health measures can be regularly assessed over time. Many of the second generation, or atypical, antipsychotics are associated with improved outcomes in the treatment of schizophrenia, including increased life expectancy, but are simultaneously associated with negative sequlae including metabolic syndrome. Little attention has been given to how the restrictions imposed by inpatient forensic units may further impact those negative sequelae that have been found to result from long-term antipsychotic use. Thus, our question of interest is: within an inpatient forensic psychiatric unit, where patients may have finite access to physical activity, as well as select nutritional options, are there clinically significant changes in measures of wellbeing (such as BMI, blood glucose, HBA1C, lipid levels) when patients are exposed to long-term antipsychotic use? We will furthermore examine what differences, if any, are notable across gender and years of hospitalization.

REFERENCES

Tiihonen J, Lönnqvist J, Wahlbeck K, et al: 11-year follow-up of mortality in patients with schizophrenia: a population-based cohort study (FIN11 study). The Lancet 374(9690):620-627, 2009

Dickerson FB, Brown CH, Daumit GL, et al: Health status of individuals with serious mental illness. Schizophrenia Bulletin 32(3):584-589, 2006

QUESTIONS AND ANSWERS

Side effects associated with the use of atypical antipsychotic use include all of the following EXCEPT:

a. Hyperlipidemia
b. Weight gain
c. Weight loss
d. Hyperglycemia
e. QTc prolongation
ANSWER: c

Comorbidities often complicate the course of schizophrenia and complicate treatment. These comorbidities include which of the following:

a. Substance use
b. Anxiety
c. Depression
d. All of the above
e. None of the above
ANSWER: d

T14 WHITE COATS AREN'T SUPERHERO CAPES

Darmant Bhullar, MD, New York, NY
Felix Matos, Bronx, NY
Panagiota Korenis, MD, Bronx, NY

EDUCATIONAL OBJECTIVE

To teach, including new methods of training forensic psychiatrists and clarification of the functions of a forensic psychiatrist.

ABSTRACT:

The mean rate of non-fatal assaults against doctors in the United States is on the rise; currently 8.3 per 10,000 doctors are victims to workplace attacks. Caring for violent psychiatric patients presents with difficult clinical challenges, complicating the efforts of caregivers. The emotional trauma of caring for someone who responds by violence should not be underestimated and it has been shown to have a significant impact, particularly on residents in training. Psychiatry residents are particularly vulnerable to this phenomenon in the emergency department and wards, due to the acuity of patients' presentation and lack of experience and training managing violent patients. Research shows that psychiatry residents who have been assaulted have reactions that range from decreased self-esteem to diminished working capacity, enhancing physician burnout. Literature review demonstrated the inadequacies regarding identification of violent and pre-violent behaviors, but also the lack of understanding physicians have regarding re-evaluating treatment plans based on violence risk assessments. This abstract aims to provide a basic understanding of violence, with an emphasis on prevention and developing a brief educational intervention focused on violence risk assessment and corresponding management options.

REFERENCES

Schwartz TL, Park TL: (1999, March). Assaults by patients on psychiatric residents: a survey and training recommendations. Psychiatr Serv. 50(3):381-3, 1999

Hostiuc S, Dermengiu D: Violence against physicians in training. a Romanian perspective. J Forensic Leg Med. 27:55-61, 2014

QUESTIONS AND ANSWERS

What is the rate of physicians assaulted in United States in the workplace?

a. 15-25%
b. 30-45%
c. 50-70%
d. 80-90%
ANSWER: c

How are residents effected from being involved in work place violence?

a. Increased dedication to resolve this issue i.e. getting involved in committees targeting this issue
b. Minimal impact on work productivity
c. Increased number of missed workdays
d. Visits to mental health professionals after the event
ANSWER: c

T15 FEMALE ARSONISTS: A SYSTEMATIC REVIEW

Alick Wang, BSc, Hamilton, ON, Canada
Yedishtra Naidoo, MD, Hamilton, ON, Canada
Sebastien Prat, MD, Hamilton, ON, Canada

EDUCATIONAL OBJECTIVE

To perform a systematic review of the literature on female arsonists and to determine whether there has been any evolution in our understanding of this topic since 2010.

SUMMARY

Background: Despite key differences between male and female arsonists, there are relatively few studies directly investigating female arsonists or gender-related differences among fire-setters. At present there is only one review article on this topic, published in 2010. We aim to perform a systematic review of the literature and determine whether there has been any evolution in our understanding of this topic since 2010.

Methods: The databases MEDLINE and Web of Science were searched for studies on female arson, fire-setting, and pyromania until January 2018. Study selection, data analysis, and reporting were conducted according to the PRISMA guidelines.

Results: A total of 320 articles were identified and 44 were selected; 13 were published on or after 2010. Female arsonists are often victims of abuse, family disorganization and low socioeconomic status. Studies published prior to 2010 describe depression and psychosis as key psychopathologies. More recent studies demonstrate a high proportion of substance abuse and personality disorders among female arsonists.

Conclusions: Female arsonists are a unique patient population, distinct from both male arsonists and non-arsonist female offenders. There has been some evolution in our understanding of female arsonists since 2010.

REFERENCES

Gannon TA, Pina A: Firesetting: psychopathology, theory and treatment. Aggression and Violent Behavior 15(3):224-238, 2010

Doley R, Fineman K, Fritzon K, et al: Risk factors for recidivistic arson in adult offenders. Psychiatry, Psychology and Law 18(3):409-423, 2011

QUESTIONS AND ANSWERS

Female arsonists are more likely to be victims of which of the following:

a. Previous abuse
b. Family disorganization
c. Low socioeconomic status
d. All of the above
ANSWER: d

Female arsonists are more likely to suffer from:

a. Depression
b. Personality disorders
c. Substance abuse
d. All of the above
ANSWER: d

T16 COMMONWEALTH V. ELDRED: PROBATIONERS INCARCERATED FOR RELAPSING

Paul Noroian, MD, Worcester, MA
Margarita Abi Zeid Daou, MD, Worcester, MA
Amam Saleh, MD, Worcester, MA

EDUCATIONAL OBJECTIVE

To review a Massachusetts Supreme Judicial Court case in which the incarceration of a probationer for substance use relapse was challenged as unconstitutional.

SUMMARY

In Commonwealth v. Eldred, the Massachusetts Supreme Judicial Court heard an 8th Amendment challenge to the incarceration of a probationer who had been jailed following substance use relapse. At issue is whether substance use by a probationer is a punishable offense, if it is recognized as part of a medical disorder that prevents the afflicted individual from meeting the conditions of probation. The case has been the subject of numerous amicus briefs by medical and psychological organizations, as well as the ACLU. The authors will outline the arguments for and against the punishment of substance use as a criminal act, and the implications of the court's holding for psychiatry and criminal justice.

REFERENCES

Robinson v. California, 370 U.S. 660 (1962)

Powell v. Texas, 392 U.S. 514 (1968)

QUESTIONS AND ANSWERS
In which case did the US Supreme Court hold that punishment of individuals for the status of drug addiction is in violation of the 8th Amendment?

a. Ake v. Oklahoma
b. Powell v. Texas
c. Barefoot v. Estelle
d. Robinson v. California
ANSWER: d

In which case did the US Supreme Court opine that a Texas law that made public intoxication a criminal offense was not in violation of the 8th Amendment?

a. Addington v. Texas
b. Ake v. Oklahoma
c. Powell v. Texas
d. Estelle v. Gamble
ANSWER: c

T17 THE PREVALENCE OF ADVERSE CHILDHOOD EXPERIENCES (ACE) IN FLORIDA YOUTH REFERRED TO THE DEPARTMENT OF JUVENILE JUSTICE

Greg Iannuzzi, MD, Tampa, FL
Mark Greenwald, PhD, Tallahassee, FL
Kristopher Kaliebe, MD, Tampa, FL

EDUCATIONAL OBJECTIVE
To educate the forensic community about the relationship between Adverse Childhood Experiences (ACE) and anti-social behavior by comparing the prevalence of ACE in Florida youth referred to the Department of Juvenile Justice over a five-year period.

SUMMARY
The Positive Achievement Change Tool (PACT) is an evidence-based actuarial risk assessment developed and implemented by the the Florida Department of Juvenile Justice (FDJJ) used to identify youth at high risk for recidivism. The PACT assesses protective and risk factors including Adverse Childhood Experiences (ACE) such as emotional, physical, and sexual abuse; emotional and physical neglect; family violence; household substance abuse; household mental illness; parental separation or divorce; and household member incarceration. These ACE have been shown to correlate strongly with antisocial behavior and risk to reoffend. Youth who score as high-risk to reoffend are referred for focused intervention to target risk factors with the goal to reduce antisocial behaviors and recidivism. Information obtained through PACT screening is stored in the Juvenile Justice Information System (JJIS), a comprehensive database maintained by the FDJJ. The purpose of this poster is to analyze the prevalence of the above ACE among juvenile offenders referred to FDJJ. Prevalence data obtained last year (2017) will be compared to youth who were referred five years prior (2012).

REFERENCES
Baglivio MT: The assessment of risk to recidivate among a juvenile offending population. J Crim Just 37(6):596-607, 2009

Baglivio MT, Epps N, et al: The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. OJJDP JOJJ (3):1-23, 2014

QUESTIONS AND ANSWERS
Exposure to abuse or household dysfunction during childhood has been shown to significantly increase the odds of developing which of the following medical comorbidities?

a. Ischemic heart disease
b. Cancer
c. Chronic lung disease
d. Skeletal Fractures
e. Liver Disease
f. All of the above
ANSWER: f

Exposure to which of the following childhood risk factors predicts antisocial and delinquent outcomes up to age 32?

a. Parental divorce
b. Parental imprisonment
c. History of substance use
d. History of mental health disorder
e. Male Gender
ANSWER: b

T18 THE COLLABORATIVE MODEL FOR CAPACITY ASSESSMENT: A NEW MODEL IN RESIDENCY TRAINING

Jarrod A. Marks, MD, Boston, MA
Jacob M. Appel, MD, JD, New York, NY

EDUCATIONAL OBJECTIVE

To provide educational benefit for both psychiatric residents and consulting residents from non-psychiatric residencies. The approach is designed to maximize patient autonomy while improving patient outcomes.

SUMMARY

When a patient's capacity stands in question, psychiatry residents at many general hospitals are frequently called upon to perform assessments of decision-making capacity. Although the primary physician is usually best suited to make such an assessment, lack of familiarity and facility with the criteria used in capacity assessments frequently necessitates consulting the psychiatry service. We have developed a novel collaborative model for performing capacity assessments that attempts to teach medical and surgical residents the principles of capacity assessments at the bedside, while simultaneously guiding them through a capacity assessment of their own patient. The results of this new collaborative model have been overwhelmingly positive and have resulted in more accurate capacity assessments and improved patient care. Our presentation describes this collaborative model and delineates the multiple benefits that may arise from its utilization vis-a-vis the psychiatric resident, the consulting resident, and the patient. Possible barriers to implementation of the model will also be explored. Further research will involve surveying various specialties to better understand how a collaborative approach to capacity assessment can be better tailored to their field and daily work flow.

REFERENCES

Appelbaum PS: Clinical practice. Assessment of patients' competence to consent to treatment. N Engl J Med 357:1834-40, 2007

Lewis C: Teaching forensic psychiatry to general psychiatry residents. Academic Psychiatry 28(1):40-46, 2004

QUESTIONS AND ANSWERS

Which of the following is a benefit of the collaborative model for capacity assessment?

a. Clarification of role of psychiatric consultant
b. Increased validity of capacity assessments
c. Better continuity of patient care
d. Provides education of fundamental forensic principles
e. All of the above
ANSWER: e

Possible barriers to implementation of the collaborative model for capacity assessment include which of the following?

a. State law regarding capacity assessments
b. Hospital policy regarding capacity assessments
c. Primary team reluctance to engage in a collaborative model
d. Time constraints
e. All of the above
ANSWER: e

T19 APPLICATION OF GENETICS AND GENOMICS IN FORENSIC PSYCHIATRY

Naomi Z. Lian, MD, PhD, Syracuse, NY
George David Annas, MD, MPH, Syracuse, NY
Bruce Way, PhD, Syracuse, NY
James L. Knoll, IV, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

To discuss the implications of the new and powerful molecular genetic techniques for forensic psychiatry.

SUMMARY

The application of the genetic techniques in forensic psychiatry had been limited as a result of complex ethical issues and legislative rules, in addition to inefficient technologies. With the completion of the Human Genome Project and Encode Project, especially the development of sophisticated technologies of deep sequencing and genome-wide association study (GWAS), forensic psychiatrists can now identify and record genomic and epigenetic elements' contribution to the mental illnesses in forensic population. For example, biomarker identification studies have suggested an association between antisocial, aggressive, and delinquent behavior and the short variant of the serotonin transporter gene polymorphism (5-HTTLPR). Recently, a GWAS study of broad spectrum of antisocial personality disorder (ASD) identified three promising loci on chromosome 1, 11, and X with close association of ASD, those genomic elements also shared genetic origin with conduct problems in certain population. The application of advanced genomics and genetics methodology increases the ability to treat and study mental diseases in forensic psychiatry. We explore the dramatic changes being made in forensic psychiatry through identifying genetic markers, applying faster, more accurate and less expensive DNA sequencing, and other cutting edge technologies.

REFERENCES

Tielbeek JJ, Karlsson Linnr R, Beers K, et al: Meta-analysis of the serotonin transporter promoter variant (5-HTTLPR) in relation to adverse environment and antisocial behavior. Am J Med Genet B Neuropsychiatr Genet. 171(5):748-60, 2016

QUESTIONS AND ANSWERS

Scientists are getting closer to understanding the genetic roots of crime. According to the recent meta-analysis on data from 24 genetically informative studies demonstrated, up to what percent of the total variance in aggressive behaviors can be explained by genetic influences:

a. less than 5 %
b. 30 %
c. 50%
d. 90%
ANSWER: c

Which gene (s) are associated with acts of serious physical violence and aggression:

a. DRD2/DRD4
b. GATA1/GATA 2
c. CEBPA
d. RET
ANSWER: a

T20 COMPETENCY RESTORATION ON A JAIL-BASED UNIT COMPARED TO A STATE HOSPITAL FORENSIC UNIT

Michael Armbruster, MD, Atlanta, GA
Peter Ash, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE

To examine long-term outcomes of different types of competency restoration programs.

SUMMARY

This study compares long-term outcomes of two different types of competency restoration services: a jail-based restoration unit and state hospital forensic units. The sample consists of defendants from one county assessed as incompetent to stand trial (IST), and compares rates of recidivism and rehospitalization in the 3 years following discharge from hospital or, if subsequently sentenced, from jail. The analysis controlled for severity of the offense (misdemeanor, felony, violent felony) and number of charges and hospitalizations in the previous 5 years.

REFERENCES
Rice K, Jennings JL. The ROC program: accelerated restoration of competency in a jail setting journal of correctional health care. J Correct Health Care 20(1):59-69, 2014

Fogel MH, Schiffman W, Mumley D, et al: Ten year research update (2001-2010): evaluations for competence to stand trial (adjudicative competence). Behav Sci Law 31(2):165-91, 2013

QUESTIONS AND ANSWERS
In this study, which intervention diverted significantly more defendants out of the criminal justice system and into the mental health system?

a. Jail-based unit restoration
b. State hospital forensic unit
c. No significant differences
ANSWER: a

Jail-based competency restoration units now exist in how many states?

a. Less than a quarter
b. Between a quarter and half
c. More than half, but not in all
d. All states
ANSWER: a

T21 AUTISM, VIOLENT FANTASIES AND DUTY TO WARN

Deepika Sundararaj, MD, Springfield, MA
Sonia Riyaz, MD, Springfield, MA

EDUCATIONAL OBJECTIVE
To increase awareness of factors that can contribute to homicide risk in patients with autism and violent fantasies, and consider when it is appropriate to issue third party warning.

SUMMARY
Mental health professionals, including psychiatrists, are expected to evaluate patients for dangerousness as part of their mental status exam. Violent fantasies are a form of homicidal ideation which can present in a wide continuum, with the majority being harmless thoughts. Studies have shown that these fantasies are common and may serve some form of psychological function. We describe a patient with a previous diagnosis of schizophrenia who was admitted for homicidal ideation, specifically wanting to become a school shooter. Further evaluation suggested a more likely diagnosis of underlying autism spectrum disorder with psychotic features. Patient had a history of physical aggression and killing animals. During his evaluation, he listed various hypothetical scenarios of harm to several people he knew. We were confronted with determining discharge-readiness, a potential duty to warn, and possible legal risk in the context of recent school mass shootings and media attention. This poster will explore factors to analyze when assessing violent fantasies, particularly in patients with autism spectrum disorders.

REFERENCES
Palermo MT, Bogaerts S: Violent fantasies in young men with autism spectrum disorders: dangerous or miserable misfits? duty to protect whom? International Journal of Offender Therapy and Comparative Criminology 61(9):959-974, 2017

Gellerman DM, Subbath R: Violent fantasy, dangerousness, and the duty to warn and protect. Journal of the American Academy of Psychiatry and the Law 33(4):484-495, 2005

QUESTIONS AND ANSWERS
Of the risk factors (listed below) for risk of violence, which should be given highest priority?

a. Presence of major mental health disorder
b. History of violence
c. Substance use
d. History of impaired impulse control
ANSWER: b

Which of the following characteristics of violent fantasies should be considered in an assessment of risk?

a. Endurance of fantasy
b. Compulsiveness towards action
c. Level of Distress related to Fantasies
d. Nature of fantasy
e. All of the above
ANSWER: e

T22 FIREARM BACKGROUND CHECKS: A MILITARY LOOPHOLE

Christopher Jorgensen, MD, Leon Valley, TX
Belinda Kelly, MD, San Antonio, TX

EDUCATIONAL OBJECTIVE

To identify which patients with mental illness can legally purchase firearms. Enhancement of consulting skills by increasing knowledge of gaps in mandated reporting to NICS.

SUMMARY

In the wake of frequent mass shootings throughout the US over the past century, there have been numerous attempts by Congress to regulate firearm access in an effort to prevent future tragedies while maintaining citizens' 2nd amendment right to bear arms. Whether warranted or not, the public perception that mental illness can lead to gun violence has resulted in regulations that prohibit "mental defectives" and persons who have been committed to a mental institution from possessing, shipping, transporting, and receiving firearms and ammunition. As a forensic psychiatrist it is important to know exactly who may meet this criteria and how the relevant information is reported. A loophole exists in reporting procedures for the NICS background check system, through which certain active duty service members and veterans circumvent the intent of the law. Military members who are involuntarily hospitalized for psychiatric reasons, receive punishment under an article 15, are addicted to controlled substances, or are placed on no-contact orders for domestic violence are not reported to the NICS database, providing a loophole through which potentially dangerous persons may legally acquire firearms.

REFERENCES

U.S. Congressional Research Service, Liu EC: Submission of mental health records to NICS and the HIPAA privacy rule (R43040; Apr. 15, 2013), in LexisNexis® Congressional Research Digital Collection. Available at https://fas.org/sgp/crs/misc/R43040.pdf. Accessed March 24, 2018.

Gun Control Act of 1968, 18 USC ch. 44 § 921

QUESTIONS AND ANSWERS

Which legal authority oversees involuntary psychiatric hospitalization of servicemembers in DOD hospitals?

a. Local mental health court of the state where the DOD facility is located
b. The mental health court of the service member's county of residence
c. The Joint Service Committee on Military Justice
d. Under Command authority as advised by a privileged psychiatrist or medical officer, IAW DODI 6490.04
ANSWER: d

Which of the following servicemembers would have an application to purchase a firearm denied?

a. Army SSG with repeated DUIs on base and failure of substance abuse treatment program who is subsequently discharged under other than honorable conditions
b. Air Force Capt. on a no-contact order from command for alleged domestic violence
c. Trainee who experienced a psychotic break on day 3 of basic training and has been refusing medications, leading to prolonged involuntary hospitalization
d. A Navy seaman who did not report for morning PT, deserted his duty station for several months and subsequently dishonorably discharged for desertion
ANSWER: d

T23 USE OF EVIDENCE-BASED RISK AND PROTECTIVE FACTORS FOR VIOLENCE IN NON-FORENSIC OUTPATIENT CLINICIANS

Nadia Gilbo, MD, Bronx, NY
Ashley Ford, MD, Bronx, NY
Karishma Patel, MD, Bronx, NY
Sarah Becker, MD, Bronx, NY
Adam Knowles, MD, Bronx, NY
Laurie Gallo, PhD, Bronx, NY
Howard Forman, MD, Bronx, NY
Ana Ozdoba, MD, Bronx, NY

EDUCATIONAL OBJECTIVE
To demonstrate the level of knowledge and confidence of non-forensic outpatient clinicians in performing violence risk assessments.

SUMMARY
With the ongoing political dialogue regarding mental illness and dangerousness, mental health professionals in the outpatient setting are increasingly required to perform violence risk assessments. Most of these professionals lack formal forensic training. This project aimed to assess the confidence level and knowledge base of non-forensic outpatient clinicians. Outpatient clinicians (n=35) at an urban academic center were surveyed on their level of knowledge and degree of confidence regarding evidence-based violence risk assessment. Questions were drawn from the HCR-20 for risk factors and the Structured Assessment for Protective Factors (SAPROF) for protective factors. Only 18% of clinicians reported consistently feeling comfortable obtaining an effective violence history. Although most clinicians were able to identify common historical, clinical, and risk-management factors, notable deficiencies were identified in areas such as employment problems, negative attitudes towards authority, and poor response to treatment. In an effort to decrease knowledge gaps and increase confidence levels, an educational session was designed using the framework of the HCR-20 and SAPROF to inform clinicians about evidence-based violence risk and protective factors. Preliminary results from a post-survey suggest increased knowledge and degree of confidence in performing risk assessments in the outpatient setting.

REFERENCES
De Vogel V, de Ruiter C, Bouman Y, et al: SAPROF. Guidelines for the assessment of protective factors for violence risk. English version. Forum Educatief. Utrecht, The Netherlands, 2009

Douglas KS, Hart SD, Webster CD, et al: HCR-20V3: Assessing risk for violence: user guide. Burnaby, BC, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University, 2013

QUESTIONS AND ANSWERS:
Which of the following risk factors did non-forensic outpatient clinicians have difficulty identifying?

a. Employment problems
b. History of substance use
c. Stress
d. Impulsivity
ANSWER: a

Which of the following is an evidence-based risk assessment instrument for protective factors?

a. GAD-7
b. MSSI-SA
c. SAPROF
d. PCL-C
ANSWER: c

T24 USING A NON-BIASED APPROACH IN ASSESSING PATIENTS WHO ARE UNDER ARREST

Myriane Isidore, MD, Richmond Hill, NY
Sadaf Noor, MD, Dallas, TX
Manuel Lopez-Leon, MD, Brooklyn, NY

EDUCATIONAL OBJECTIVE
To educate psychiatric residents on how to write a forensic report, assessing for imminent danger to self or others and understanding how the law intercepts with mental health.

SUMMARY
Suicide has become a detrimental and pervasive public health problem in the United States and around the world. Men are more likely to use violent methods in order to achieve their goal in committing suicide while women are more prone to use a nonviolent approach in attempting suicide. According to Fazel, Grann, Kling, & Hawton, 2011, suicide rates are substantially higher in prison inmates when compared to the general population.

The purpose of this study is to uncover our own biases toward patients who are under arrest that report suicidal ideation in the psychiatric emergency room. Our hypothesis suggests the majority of patients who were under arrest when evaluated in the psychiatric emergency room were more likely to be discharged back into police custody than patients who arrived via ambulance who weren't under arrest. Our preliminary data supported our hypothesis and showed patients who were not under arrest and arrived to the emergency room via ambulance were 50% more likely to be admitted to the inpatient unit than patients who arrived in handcuffs. However, patients who arrived under police custody were 98% more likely to be discharged rather than transferred to a forensic unit at a general psychiatric hospital.

REFERENCES
Nock MK, Wedig MM, Holmberg EB, et al: Emotion reactivity scale: psychometric evaluation and relation to self-injurious thoughts and behaviors. Behav Ther, in press.

Nock MK, Borges G, Bromet EJ, et al. Cross-national prevalence and risk factors for suicidal ideation, plans, and attempts in the WHO World Mental Health Surveys. Br J Psychiatry 192:9-105, 2008

QUESTIONS AND ANSWERS
Based on the results of the questionnaire, staff were more inclined to discharge patients who were under arrest with a chief complaint of suicidal ideation from the psychiatric emergency room because

a. They believed patients will be supervised in the precinct, therefore the probability of patients committing suicide is low
b. They believed patients were malingering to avoid booking or pre-arraignment
c. They were reluctant to admit patients to the hospital because of hospital policy
d. They believed patients weren't in imminent danger of committing suicide
ANSWER: a
The most common method of failed suicide is

a. Self-Mutilation: cutting, burning, or head banging
b. Hanging
c. Drug overdose
d. Use of a firearm
ANSWER: c

T25 A SEAT AT THE TABLE: AAPL'S POTENTIAL ROLE IN SHAPING 21ST CENTURY FORENSIC MENTAL HEALTH POLICY AND LAW

Christopher R. Thompson, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE
To explain the rationale for forensic psychiatrists' and AAPL's involvement in shaping policies and law around forensic mental health issues; to review selected current issues and future developments that might provide opportunities for AAPL and its members to provide collective and/or individual expertise and input; to discuss new means by which AAPL and AAPL members can have increased involvement in tracking (and potentially shaping) policy and law involving forensic mental health issues; and to briefly update attendees on some of the activities of the newly formed committees (i.e., Government Affairs Committee and Consortium of Forensic Science Organizations [CFSO], Judicial Action Committee, and Media and Public Relations Committee).

SUMMARY
Since the release of the 2009 National Academy of Sciences' report "Strengthening Forensic Science in the United States: A Path Forward," the country's forensic science system has come under fire. In the not-too-distant future, new standards and certification processes likely will impact forensic psychiatrists, in addition to other forensic science disciplines. Forensic psychiatrists should be involved in developing these standards.

Concurrently, components of many current pressing societal issues are in need of forensic psychiatric input (e.g., the opioid epidemic, PDMP and "standard of care" issues, increased focus prevention/early intervention programs to decrease juvenile delinquency, and new technologies' impact on youth's mental health and behavior [e.g., suicidality, violence]). And on the horizon, new technologies will require significant forensic psychiatric input so that they are utilized appropriately (e.g., fMRI for deception of deception/aberrant sexual preference, predictive

analytics/algorithms for risk assessment, non-invasive brain stimulation (NIBS) to enhance moral reasoning).

Current and future opportunities for individual AAPL members and/or the organization to expand their educational mission by providing input on the above to legislative bodies, executive agencies, the judicial system, the media, and the public will be explored (e.g., AAPL's joining the Consortium of Forensic Science Organizations [CFSO]). Attendees will be apprised of some of the activities of the new committees to date.

REFERENCES

Hurley D: Can an algorithm tell when kids are in danger? New York Times Magazine. January:MM30, 2018
Youyou W, Kosinski M, Stillwell D: Computer-based personality judgments are more accurate than those made by humans. Proc Natl Acad Sci 112(4):1036-40, 2015

QUESTIONS AND ANSWERS

According to a study published in the Procedures of the National Academy of Sciences in 2015, computer models needed to analyze how many Facebook "likes" in order to outperform spouses in accurately evaluating the "Big 5" personality traits (i.e., openness, agreeableness, extraversion, conscientiousness, neuroticism)?

a. 300
b. 1,000
c. 5,000
d. 10,000
e. 100,000
ANSWER: a

The majority of studies related to the impact of NIBS on moral reasoning focus on which area of the brain?

a. Nucleus accumbens
b. Amygdala
c. Dorsolateral prefrontal cortex (DLPFC)
d. Right temporal-parietal junction (TPJ)
e. Basal ganglia
ANSWER: c

Which one of the other organizational members of the Consortium for Forensic Science Organizations has members who are forensic psychiatrists?

a. The American Society of Crime Lab Directors (ASCLD)
b. The National Association of Medical Examiners (NAME)
c. The Society of Forensic Toxicologists and American Board of Forensic Toxicology
d. The American Academy of Forensic Sciences (AAFS)
e. The International Association of Identification (IAI)
ANSWER: d

T26 FORENSIC PSYCHIATRISTS AND SOCIAL JUSTICE: SHOULD WE TAKE A STAND?

Merrill Rotter, MD, Bronx, NY
Reena Kapoor, MD, New Haven, CT
Debra Pinals, MD, Ann Arbor, MI
Sandy Simpson, MD, Toronto, ON, Canada

EDUCATIONAL OBJECTIVE

To understand arguments for and against psychiatrists wading into discussion and advocacy about social issues that drive mental health and criminal justice outcomes.

SUMMARY

The social determinants that are shared drivers of health, mental health and criminal justice outcomes are increasingly recognized by researchers and public policy decision-makers. The consequences of such deeply rooted problems of poverty, racism and related challenges are being incorporated as important targets for individual treatment and population treatment. The relevance of these factors to recovery and public safety is a critical area of knowledge for the forensic clinician. However, what role if any should psychiatrists play in addressing the underlying social conditions that create or exacerbate these determinants? Some suggest that these are public health issues, with clear behavioral health sequelae about which psychiatrists have both expertise and a duty to

help ameliorate. Others opine that calling something a public health issue does not make it a clinical problem and takes the clinicians away from their professional role and into a political context. This debate will draw from the literature and past community mental health experiences to explore arguments for and against psychiatrists playing a role, as psychiatrists, in social justice advocacy. The debate will be organized around the following resolution: "Psychiatrists should not, in their role as clinicians or clinical experts, take on social justice advocacy."

REFERENCES

Bazelon D: The Role of the Psychiatrist in the Criminal Justice System. Bull Am Acad Psychiatry Law 6:139-46, 1978

Ewalt JR, Ewalt PL: History of the community psychiatry movement. American Journal of Psychiatry 126:41-52, 1969

QUESTIONS AND ANSWERS

The concerns raised by Alan Stone about psychiatrists leaving a clinical role behind were mainly related to work in:

a. Corrections
b. State Institutions
c. Courtroom Testimony
d. Television
ANSWER: c

Shared social determinants of mental illness and criminality include:

a. Economic instability
b. Trauma
c. Unemployment
d. Fewer social services
e. All of the above
ANSWER: e

T27 AN AUTOPSY OF MASS SHOOTINGS

James L. Knoll, IV, MD, Syracuse, NY
Phillip Candilis, MD, Alexandria, VA
Karen Rosenbaum, MD, New York, NY
Corina Freitas, MD, Oxon Hill, MD
Dennis Bechtel, Fayetteville, NC

EDUCATIONAL OBJECTIVE

To provide the historical background and evolution of mass shootings in the US; describe the evolution of forensic psychiatrists' role in assessments of perpetrators; identify three major societal, political, and legal ramifications of mass shootings; and recognize three major ethical considerations in current gun-control legislation.

SUMMARY

Mass shootings remain at the forefront of political and legislative attention. Much of the debate targets mental health and access to firearms in ways that will change forensic psychiatry. This panel from the Forensic Sciences Liaison and Law Enforcement Liaison committees will provide a comprehensive view of mass shootings and their societal, legal and psychiatric effects. We will begin with a historical background of mass shootings from the University of Texas tower shooting in Austin to date. The panel will discuss the misuse of mental illness after a shooting as well as the potential consequences of current and proposed gun laws. Speakers will address the ethical implications of current and proposed legislation as well as the ways to improve collaboration with law enforcement. Finally, the panel will analyze specific cases for their motivations and reasoning.

REFERENCES

Knoll JL 4th. The 'pseudocommando' mass murderer: part I, the psychology of revenge and obliteration. J Am Acad Psychiatry Law 38(1):87-94, 2010

Candilis P, Khurana G, Leong G, et al: Informed consent at gunpoint: when psychiatry affects gun ownership. Behavioral Sciences and the Law 33(2-3):346-355, 2015

QUESTIONS AND ANSWERS
What is the federal definition of mass killings?

a. Killing 4 or more victims over a period of time with a cooling-off period between each killing
b. Killing 4 or more victims in different locations over a discrete time period
c. Killing 4 or more victims at 1 location at 1 time
d. Killing 4 or more victims within a 24-hour period
e. Killing 3 or more in a single incident
ANSWER: e

Which of the following is true about mass shootings?

a. SSRI antidepressants have played a causative role in mass shootings
b. Most mass shooting perpetrators are psychotic
c. Lowering the threshold for civil commitment would likely deter mass shootings
d. Mass shooters are often motivated by 'payback,' 'toxic envy,' and a desire for infamy
ANSWER: d

T28 MENTAL ILLNESS AND THE RIGHT TO BEAR ARMS: ASSESSMENTS FOR RESTORATION OF RIGHTS

Joseph R. Simpson, MD, PhD, Hermosa Beach, CA
Liza H. Gold, MD, Arlington, VA
Michael A. Norko, MD, New Haven, CT

EDUCATIONAL OBJECTIVE
To gain skill in forensic service and teaching through enhanced knowledge of firearm prohibition laws and enhanced ability to perform risk assessments for petitioners seeking restoration of firearm rights.

SUMMARY
Ownership of firearms by private citizens is a highly controversial subject in the United States. The past half-century has seen the evolution of a complex patchwork of federal and state laws restricting the right to possess firearms by people with a history of mental health diagnoses or treatment. The total number of individuals in the FBI's database of persons prohibited for mental health reasons is nearly five million–roughly one-and-a-half times as many as for a criminal conviction. In some states, mental health professionals are expected to report outpatients whom they deem to be dangerous for the purpose of removing their legal access to firearms. It is important for forensic psychiatrists to have an understanding of the interface between mental health treatment and laws regulating possession of firearms. Forensic psychiatrists may also be called upon to conduct evaluations of people who are prohibited by their state or the federal government who petition for restoration of their right to possess firearms. In this workshop, participants will analyze case vignettes and write brief opinions as they learn about mental health firearms laws as well as the elements of an appropriate evaluation for restoration of firearm rights.

REFERENCES
Simpson JR. Bad risk? An overview of laws prohibiting possession of firearms by individuals with a history of mental illness treatment. Journal of the American Academy of Psychiatry and the Law 35:330-338, 2007

Gold LH, Simon RI eds: Gun Violence and Mental Illness. Arlington, VA: American Psychiatric Association Publishing, 2016

QUESTIONS AND ANSWERS
Under federal law, a person with a history of which of the following is barred for life from owning or possessing firearms:

a. Diagnosis of schizophrenia
b. Emergency involuntary psychiatric detention for observation
c. Involuntary commitment to a mental institution
d. Two or more voluntary admissions to a psychiatric hospital
ANSWER: c

When conducting an evaluation for restoration of firearms rights, an important topic to explore during the risk assessment is:

a. The petitioner's reason(s) for wanting his or her rights restored
b. The petitioner's view of the Second Amendment
c. Whether the petitioner has ever been the victim of a crime
d. The petitioner's proficiency at target shooting
ANSWER: a

T29 GUNS IN K-12: THE ROLE OF THE FORENSIC PSYCHIATRIST IN GUN VIOLENCE EDUCATION AND REDUCTION INTERVENTIONS

Drew Calhoun, MD, Seattle, WA
Ian Lamoureux, MD, Scottsdale, AZ
Jeffrey Khan, MD, Houston, TX
Charles Scott, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
In this workshop, speakers will review the data on gun violence in schools, the impact on students, and the implementation of threat assessments and other preventive measures. At the end, participants will be able to educate the public and advise policymakers on public health interventions to reduce school gun violence.

SUMMARY:
Parkland. Newtown. Columbine. Formerly unheard-of towns now widely recognized only for their infamous school shootings. In the aftermath, society looks for answers and demands action. Based on preconceived notions reinforced by the media narrative and limited evidence, conclusions about the contribution of mental illness are hastily made. The input of psychiatrists is often requested because of the popular belief that mental illness causes violence. Given our expertise in violence risk assessment, mental illness, and public safety, forensic psychiatrists are uniquely positioned to educate the public toward a more nuanced understanding of school gun violence and advise policymakers on the implementation of interventions most likely to reduce gun violence. Each presenter will review the relevant literature on: (1) school gun violence statistics including rates and potential contributory factors; (2) proposed interventions to reduce violence; (3) psychological impact on students due to gun violence exposure, school interventions, and media coverage; and (4) evidence-based threat and/or violence risk assessments of juveniles. After each subtopic is presented, specific hypothetical scenarios will be posed and participants will work together in small groups to formulate plans to address the relevant issues.

REFERENCES
Gold, L: Gun violence: psychiatry, risk assessment, and social policy. Journal of the American Academy of Psychiatry and the Law 41(3):337-343, 2013

Ferranti, J. True-threat doctrine and mental state at the time of speech. Journal of the American Academy of Psychiatry and the Law 44(2):138-144, 2016

QUESTIONS AND ANSWERS
Which of the following statements about gun-related morbidity and mortality in schools is true?

a. Mass shootings in schools are a major source of overall gun violence morbidity and mortality.
b. School gun violence occurs because people with severe mental illness have "snapped."
c. Previous violence and/or substance use are more serious risk factors for future gun violence than mental illness alone.
d. Interventions focused on students with a history of psychiatric illness are likely to have the biggest impact on reducing school shootings.
e. The majority of gun-related morbidity and mortality in schools is from homicide or attempted homicide.
ANSWER: c

Which of the following interventions to reduce school gun violence requires a higher level of scrutiny before implementation because of the heightened potential for unintended, adverse consequences?

a. Screening and mental health resources for troubled youth in grades K-12
b. Antibullying programs in grades K-12
c. Educating students to report all threats or threatening behavior to appropriate personnel
d. Funding and implementation of threat assessment teams
e. Target hardening measures (e.g. active shooter drills, arming teachers)
ANSWER: e

T30 REFUSAL OF LIFE-SAVING MEDICAL TREATMENT DUE TO SUICIDAL MOTIVATION

Ramaswamy Viswanathan, MD, Brooklyn, NY
Paul S. Appelbaum, MD, New York, NY
Paulo Marcelo Gondim Sales, MD, New York, NY

EDUCATIONAL OBJECTIVE
To enhance consulting skills by learning the importance of uncovering the motivation for treatment refusal when a patient who appears to be competent refuses life-saving treatment, know the ethical issues surrounding physician-assisted suicide for intractable depression, and know the complexities in decisional capacity assessments in depressed patients.

SUMMARY
Many decisional capacity assessment requests in general hospitals are for patients' refusal of important medical treatments. When a patient cognitively understands what is explained to him, but is depressed, there are no clear guidelines as to how to factor that emotional state into the consultant's assessment of the patient's decisional capacity. In many settings it is not possible to get judicial hearing in time, if at all. The situation becomes even more complex when a patient chooses medical treatment refusal to aid his desire to die. The consultant has to determine if this desire to die is due to the emotional burden of the physical illness alone, or is mainly due to the emotional burden of a mental illness. In some countries physician-assisted suicide for patients with intractable depression is legislatively authorized. In the United States this is against the law and against the ethical code of many major professional societies. Should one's approach to refusal of life-saving medical treatment motivated by depression be similar to one's approach to a patient requesting assistance in suicide because of suffering from a depressive disorder? This workshop will explore these issues using case examples provided by the panelists and the audience.

REFERENCES
Appelbaum PS: Physician-assisted death for patients with mental disorders: reasons for concern. JAMA Psychiatry 73:325-6, 2016

Weinberger LE, Sreenivasan S, Garrick T. End-of-life mental health assessments for older aged, medically ill persons with expressed desire to die. J Am Acad Psychiatry Law 42:350-361, 2014

QUESTIONS AND ANSWERS
Physician-assisted suicide for depressed patients is legally permissible in

a. Australia
b. Belgium
c. Indonesia
d. State of Washington
ANSWER: b

The ethical principle involved in forcing a life-saving treatment against a depressed patient's will is:

a. Nonmaleficence
b. Veracity
c. Paternalism
d. Justice
ANSWER: c

T31 CLINICAL ASSESSMENT OF MALINGERING: A CONTINUING JOURNEY FOR ADVANCING FORENSIC PRACTICE

Richard Rogers, PhD, Denton, TX

EDUCATIONAL OBJECTIVE
This presentation will improve attendee competence and/or performance in the following way(s): First, it enhances the understanding of malingering as a response style. Second, it identifies common pitfalls and controversies in malingering determinations. Third, it utilizes detection strategies to improve forensic practice for assessments of malingering.

SUMMARY
The systematic assessment of malingering began about two centuries ago as physicians searched for methods to differentiate feigned from true madness. While shunning the physical infliction of suffering, lessons may still be learned about early detection methods for evaluating malingerers. In 1917, Sir John Collie issued the first treatise on malingering, based on medical data.

In recent times, the speaker helped to refine malingering research and spent years developing the SIRS/SIRS-2. As a part of the talk, he provides personal insights involving setbacks and challenges as research on malingering matured and cherished beliefs (inkblots can't be faked!) toppled. Common pitfalls in forensic practice are explored, such as DSM-5's reliance on questionable screening indicators.

Well-validated detection strategies are illustrated with forensic examples. The goal is how astute clinical interviews can be supplemented with specialized measures of malingering.

The lecture ends with an overview of enduring challenges that face malingering. For example, some testing wrongly assumes laser-accuracy. Single-point differences are incorrectly treated as effectively distinguishing malingering from genuine disorders. Moreover, new work explores how factitious presentations may complicate malingering assessments in forensic psychiatric practice.

REFERENCES

Rogers R: Detection strategies for malingering and defensiveness, in Clinical Assessment of Malingering and Deception. Edited by Rogers R, Bender SD. New York: Guilford Press, 2018, pp 18-41

Nijdam-Jones A, Rosenfeld B: Cross-cultural feigning assessment: A systematic review of feigning instruments used with linguistically, ethnically, and culturally diverse samples. Psych Assess 29:1321-1336, 2017

QUESTIONS AND ANSWERS

Which two of the following are well validated detection strategies of malingering?

a. Rare symptoms
b. Random-like inconsistencies
c. Non-responsive answers
d. Symptom combinations
ANSWER: a and d

As a major pitfall, how does the dichotomy of malingering or mentally disordered result in misleading conclusions?

ANSWER: Pure malingering without concomitant mental disorders does not often occur. Most forensic examinees who malinger are also mentally disordered.

T32 THREATENING THE PRESIDENT: WHEN HATE TRUMPS LOVE

Charles L. Scott, MD, Sacramento, CA
Mary Gable, MD, Sacramento, CA
Scott Kikorsky, MD, Sacramento, CA
Andrea Bunker, MD, Sacramento, CA
Lauren Marasa, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

The panelists will review typologies of presidential assassins and would-be assassins, discuss the federal statute and Supreme Court case addressing such threats, highlight the forensic evaluation of potential presidential assassins, and emphasize ethical and legal issues when deciding to report vs. not report threats to the U.S. President.

SUMMARY

Threatening a U.S. President is a serious crime. Four U.S. Presidents have been killed and more than 20 attempts to kill sitting and former presidents and presidents-elect are known. In his first 12 days of office, over 12,000 tweets threatened the life of President Donald Trump. This panel provides practical and current guidance to forensic psychiatrists on assessing and managing threats against a U.S. President, President-Elect, or former President. Dr. Bunker will review three published typologies for evaluating presidential assassins or attempters. Dr. Gable will highlight components of Federal Statute 18 U.S. Code § 871 that outlines the required mens rea to prosecute presidential threats. The U. S. Supreme Court's instructions on evaluating "true threat" as articulated in Watts v. United States (1969) will be discussed. Dr. Kikorsky will outline the forensic evaluation of presidential threat-makers including a focus on written vs. verbal threats and the role of the Secret Service in the threat assessment process. Dr. Marasa will review the ethical and legal issues related to decisions to report vs. not report such threats. Dr. Scott will review findings from the malpractice action against John Hinkley's treating psychiatrist for failure to report.

REFERENCES

Coggins MH, Steadman HJ: Mental health clinicians' attitudes about reporting threats against the President. Psychiatric Services 47(8):832-6, 1996

Phillips RTM: Assessing presidential stalkers and assassins. Am Acad Psychiatry Law 34:154-64, 2006

QUESTIONS AND ANSWERS
Which of the following is CORRECT in regard to the Exceptional Case Study Project?

a. Studied only presidential attackers
b. Offered a four category typology of presidential assassins
c. Included "White House" cases, i.e. those who traveled to meet President without intent to harm
d. Focused on both attempted and successful assassinations
ANSWER: d

What percentage of Presidential threat cases have a history of contact with the mental health system?

a. 10%
b. 25%
c. 50%
d. 90%
ANSWER: c

T33 FORENSIC MENTAL HEALTH LEGISLATION: A PRIMER AND UPDATE

Tobias Wasser, MD, Middletown, CT
Debra Pinals, MD, Ann Arbor, MI
Michael Champion, MD, Honolulu, HI
Richard Krueger, MD, New York, NY
Melissa Immel, Washington, DC
Beth Lavach, Washington, DC
Christopher R. Thompson, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE
To appreciate the importance of forensic psychiatrists educating legislative and regulatory bodies about forensic mental health issues, identify mechanisms for AAPL to educate state and federal government about issues relevant to our practice, and identify current, proposed, and pending state/federal legislation relevant to forensic mental health.

SUMMARY
Forensic psychiatrists are in a unique position to use their specialized expertise to educate state and federal legislatures in the development of legislation that is evidence-based and supportive of those with mental illness in their recovery. Toward this end, the AAPL Government Affairs Committee was created to assist AAPL in liaising with and providing education and organizational expertise about forensic psychiatric/mental health issues to relevant state and federal legislatures. The committee's activities include keeping abreast of pending state and federal legislation relevant to forensic mental health issues, offering recommendations to the AAPL Council regarding input AAPL might provide to legislative offices considering such legislation (via the Consortium of Forensic Science Organizations [CFSO]), and serving as an educational resource for legislative offices and relevant federal departments and administrative bodies.

In this presentation, committee members will present an update on new or proposed state and federal legislation relevant for forensic mental health practitioners. In addition, the panel will be joined by the CFSO legislative analyst and a California state legislative analyst, who will educate participants about pending state and federal legislation and how participants can be more involved in making an impact on the development of forensic mental health legislation.

REFERENCES
Stotland NL. Psychiatry, the law, and public affairs. J Am Acad Psychiatry Law 26:281-287, 19998

Clark AB. Juvenile solitary confinement as a form of child abuse. J Am Acad Psychiatry Law 45:350-357, 2017

QUESTIONS AND ANSWERS
The acronym CFSO stands for:

a. Consortium of Forensic Science Organizations
b. Consortium of Forensic Specialists in Operation
c. Clinical Forensic Specialists of Oregon
d. Clinical Federal Specialty Organization
ANSWER: a

Pending federal legislation known as VAWA stands for:

a. Veteran Affairs Women's Association
b. Veteran Affairs Wounded Aftercare
c. Violence Against Women Act
d. Violence After Withdrawal Act
ANSWER: c

T34 SUBMITTING SUCCESSFUL RESEARCH GRANT APPLICATIONS TO AIER

Nathan Kolla, MD, PhD, Toronto, ON, Canada
Robert L. Trestman, PhD, MD, Roanoke, VA

EDUCATIONAL OBJECTIVE

Participants will learn the pragmatics of submitting a research grant proposal to the AAPL Institute for Education and Research (AIER) and how to optimize the submission to increase the likelihood of successful funding.

SUMMARY

Submitting research proposals to grant funding agencies can be daunting. The goal of the AIER research grant is to provide an opportunity for AAPL members to begin or accelerate their research experience and career through pilot funding of forensic psychiatry studies. In this workshop, jointly supported by the AAPL and AIER Research Committees, the requirements for grant submission to AIER will be detailed. Furthermore, the elements needed in the proposal to enhance the likelihood of successful funding will be explored and examined. Participants in the workshop will be posed examples of grant proposals and asked to discuss the strengths and weaknesses of each element: relevance to forensic psychiatry, scientific merit, originality, availability of other or matching funds, potential for presentation or publication of results, potential for continuing research, and the potential for having an impact on the field. Participant ideas will also be solicited and explored to enhance submission quality. Parallels and relevance to other granting sources will also be discussed and compared.

REFERENCES

Dawes, R: How do you formulate a testable exciting hypothesis?, in How to Write a Successful Research Grant Application Boston, MA: Springer, 2010, pp 147-151

Yang O: Guide to Effective Grant Writing: How to Write a Successful NIH Grant Application. Springer Science & Business Media, 2012

QUESTIONS AND ANSWERS

What are some of the key elements that must be included in an AIER research grant proposal?

a. Project aims, summary, pilot data
b. Project summary, subject protection issues, proposed budget
c. Project aims, statistical methods, history of prior funding
d. Project title, pilot data, ethical aspects
ANSWER: b

What is a common mistake that significantly reduces a proposal's chances of funding?

a. Detailed statistics
b. Multiple collaborators
c. Vague hypothesis
d. Significant likelihood of impact on the field
ANSWER: c

T35 WORKING WITH LAWYERS: THE GOOD, THE BAD AND THE UGLY

Patricia Westmoreland, MD, Denver, CO
Brian Crowley, MD, Washington, DC
Trent C. Holmberg, MD, Draper, UT
Ana Natasha Cervantes, MD, Buffalo, NY
Katayoun Tabrizi, MD, Durham, NC

EDUCATIONAL OBJECTIVE
This workshop will be conducted by private practice forensic psychiatrists. Presenters will discuss setting boundaries with regard to payment, deadlines, and work product. Audience members will be asked to respond to scenarios and share their own stories. The moderator will conclude the presentation with a synopsis of responses to audience questions.

SUMMARY
A major part of forensic practice is learning to work with attorneys, whose training and objectives differ from the medical model. The forensic psychiatrist/attorney relationship can be fraught with hazards. Problematic areas can include attorneys not educated in the area in which they seek consultation, unrealistic expectations as to the expert's role, failure to provide the expert with adequate material ("cherry picking" information), efforts on the part of the attorney to unduly influence the report, poor preparation for testimony, and contractual misunderstandings (fee structure, deadlines). Dr. Cervantes will discuss attorney expectations, educating the attorney regarding the expert's role, and obtaining the prerequisite information needed to complete an evaluation. Dr. Westmoreland will discuss her experience with attorneys attempting to influence the report and problematic experiences with testimony. Dr. Crowley will outline reimbursement issues. Audience members will be asked to share their own success (or horror) stories during each presentation. In addition, using an audience response system, attendees will be polled for their decisions at key points in each presentation. The moderator (Dr. Holmberg) will take note of audience stories, suggestions, and audience responses, and conclude the presentation with a synopsis of lessons learned.

REFERENCES
Gutheil, T: The Psychiatrist as Expert Witness, second edition. APPI Press, 2009, pp 26-29, 129-130

Gutheil S, Crowley B, personal communication 2018 (based on years of ongoing experience)

QUESTIONS AND ANSWERS
A written fee agreement with a specified amount retainer paid before starting work on a case:

a. Is usually an advisable practice
b. Simplifies billing and collection
c. Is considered good forensic practice
d. All of the above
ANSWER: d

Simple one page retainer agreements are:

a. Usually inferior to longer, more detailed ones
b. Generally accepted and provide good results
c. Not accepted in some federal jurisdictions
ANSWER: b

T36 #METOO IN COURT: PSYCHIATRIC EVALUATION IN SEXUAL HARASSMENT EMPLOYMENT LITIGATION

Liza H. Gold, MD, Arlington, VA
Patricia R. Recupero, MD, JD, Providence, RI
Philip Durst, JD, Austin, TX

EDUCATIONAL OBJECTIVE
To identify and understand relevant psychiatric issues in sexual harassment employment litigation and to improve evaluation and testimony skills in sexual harassment employment litigation.

SUMMARY
The #MeToo movement has demonstrated the widespread prevalence of sexual harassment, particularly in the workplace. Since 2010, sex-based harassment and sexual harassment have accounted for 25-30% of all EEOC discrimination charges. Psychological harm or "emotional distress" claims almost always accompany charges of sexual harassment, and attorneys generally use expert mental health professional witness testimony to prove or counter claims of causation and emotional distress damages. In addition, attorneys may request psychiatric evaluations of credibility, malingering, "welcomeness," and "hypersensitivity." Overstepping the bounds of expertise is all too easy when legal and psychiatric concepts do not neatly map together.

This course will review the legal framework of sexual harassment claims in employment litigation, the psychiatric issues that arise in such claims, and discuss competent evaluations of plaintiffs in sexual harassment litigation. Issues covered will include damages, causation of emotional harm, the role of diagnoses, the "glass jaw" or "hypersensitive" plaintiff, credibility vs. malingering, and addressing bias in sexual harassment evaluations. The course will conclude with mock depositions of a plaintiff's expert and a defense expert. The course faculty have decades of experience in sexual harassment litigation, and ample time will be provided for questions, particularly around the mock depositions.

REFERENCES

Recupero P: The notion of truth and our evolving understanding of sexual harassment. J Am Acad Psychiatry Law, in press

Gold LH: Sexual Harassment: Psychiatric Evaluation in Employment Litigation. Arlington, VA: American Psychiatric Publishing Inc., 2004

QUESTIONS AND ANSWERS

The most common type of sexual harassment in the workplace is:

a. Sexual assault
b. Gender harassment
c. Unwanted sexual harassment
d. Quid pro quo harassment
e. Hostile work environment harassment
ANSWER: b

Before filing a private civil litigation claim of workplace sexual harassment, a claimant must first file a formal complaint with:

a. Her company's human resources department
b. Her immediate supervisor
c. The Equal Employment Opportunity Commission or equivalent local government organization
d. Her company's ombudsman or union representative
e. Her immediate and second-line supervisor
ANSWER: c

T37 GINA'S GOT A GUN

Sohrab Zahedi, MD, Farmington, CT
E. J. Keisari, MD, Farmington, CT

EDUCATIONAL OBJECTIVE

To review of Genetic Information Non-Discrimination Act of 2008, to present a redacted FFD Case/Analysis of GINA & Psychiatric Evaluation Conflict Area, and to discuss GINA's Impact on Psychiatric Family History & Forensic Assessment.

SUMMARY

The Genetic Information Non-Discrimination Act (GINA) was signed into law in 2008 and its aim was prohibition against employers using genetic information in hiring or work-related decisions. Genetic information includes an employee's family history, which is the cornerstone of a comprehensive psychiatric evaluation. Subsequently, EEOC informed clinicians concerned with family-history based information included in employer-initiated assessment would not be used in work-related decisions. EEOC in 2010 specifically prohibited inquiry into family history for fitness-for-duty (FFD) evaluations. In such evaluations, "employers may need to instruct medical and mental health professionals performing such evaluations on their behalf to avoid those areas of inquiry, or at least not to report such information for the employer" (Scott). We present a redacted case report (we believe the first of its sort to be analyzed) and analyze the significance of omitting a family in determination of risk in light of EEOC's guidelines.

REFERENCES

Scott M, Appelbaum P: Family history and GINA. Psychiatric Services 6(61):634, 2010

Background Information for EEOC Final Rule on Title II of the Genetic Information Nondiscrimination Act of 2008. Available at https://www.eeoc.gov/laws/regulations/gina-background.cfm. Accessed August 2018

QUESTIONS AND ANSWERS
What was the purpose of GINA passed in 2008?

ANSWER: Using genetic information in decisions regarding hiring, promotion, terms or conditions, privileges of employment, compensation, or termination.

What are elements of the family history that pertain to the assessment of risk?

ANSWER: Parental dependence on substances of abuse

T38 RISK-BASED GUN REMOVAL LAWS: AN OVERVIEW OF FIVES STATES

William Frizzell, MD, Portland, OR
Joseph Chien, DO, Portland, OR

EDUCATIONAL OBJECTIVES
To review the similarities and differences in states' risk-based gun removal laws and discuss the role of mental health providers in advocating their usage.

SUMMARY
With the passage of Senate Bill 719, Oregon became the fifth state to adopt a legal tool for risk-based, temporary, and preemptive gun removal for individuals who are found to be at risk in the near future of harming themselves or others. The implementation of this law in Oregon is a logical step to reduce gun violence and follows policy passed in California, Connecticut, Indiana, and Washington. These policies create a process for obtaining an extreme risk protection order (ERPO), however, the laws existing in each of these states are not identical in nature. Despite the seeming practicality of these laws in reducing gun violence, greater scrutiny is desired to assess how they benefit public health. In evaluating Connecticut's risk-based gun removal law, Swanson et. al. found that from 1999 until 2013 it has been at least modestly effective in preventing suicide. We will briefly review ERPO laws in five states and the existing literature regarding their impact on public health. We will also consider whether the existence of ERPOs in Oregon may represent a de facto extension of Tarasoff duties for mental health providers given the potential liability involved with negative outcomes related to firearm possession.

REFERENCES
Swanson JW, Norko MA, Lin H, et al: Implementation and effectiveness of connecticut's risk-based gun removal law: does it prevent suicides? Law and Contemporary Problems 80:179-208, 2017

McGinty EE, Webster DW, Barry CL: Gun policy and serious mental illness: priorities for future research and policy. Psychiatr Serv 65(1):50-58, 2014

QUESTIONS AND ANSWERS
Which states have implemented risk-based gun removal laws?

ANSWER: Connecticut, Indiana, Washington, California, and Oregon

What is an Extreme Risk Protection Order (ERPO)?

ANSWER: Creates process for prohibiting a person from possessing deadly weapon when a court finds that person presents risk in the near future, including imminent risk, of suicide or causing injury to another person.

T39 USING THREAT ASSESSMENT PRACTICES FOR SCHOOL-BASED THREATS IN EMERGENCY SETTINGS

Matthew P. Lahaie, MD, JD, Boston, MA

EDUCATIONAL OBJECTIVES
To educate psychiatric and forensic psychiatric clinicians about potential application of threat assessment practices in emergency evaluations of students making threats of violence in school settings, including the potential benefit of developing practices and guidelines to facilitate community and institutional partnerships and promote risk mitigating interventions for students and schools.

SUMMARY
Increasingly, adolescent students are referred to emergency departments for psychiatric assessment due to school-based threats of violence. Traditionally, emergency department violence risk assessments determine the need for commitment or recommendation of level of care, potentially with specific referrals as intervention. Although the school's referral question is often whether a child/student is safe to return to school, emergency department clinicians typically do not address the school safety issue directly, limiting recommendations to level of care. Given circumscribed evaluation and recommendations, clinicians may continue to have concerns about potential acts of violence despite a child/student's initial presentation being inconsistent with a high risk of imminent violence due to mental illness, while schools may have continued confusion or concern about a child/student's safety in school. Opportunity exists to incorporate principles and practices of threat assessment into emergency risk assessments and treatment planning. Emergency departments have the opportunity to develop guidelines and policies to further threat assessment and to address barriers, such as privacy limiting communication with school officials. Further opportunities exist to facilitate community and institutional partnerships, providing increased opportunity for further longitudinal assessment and providing additional points of intervention, potentially decreasing risk of violent acts in schools.

REFERENCES
Copelan RI, Messer MA, Ashley DJ: Adolescent violence screening in the ED. American Journal of Emergency Medicine 24:582-594, 2006

O'Toole ME: The School Shooter: A Threat Assessment Perspective. Quantico, VA: Critical Incident Response Group, National Center for the Analysis of Violent Crime, FBI Academy, 1999

QUESTIONS AND ANSWERS
Potential members of a school threat management team include all of the following, except:

a. Law enforcement
b. Parents
c. Community liaison
d. School psychologist
e. School principal
ANSWER: b

The FBI's four-pronged school threat assessment approach includes consideration of all of the following factors, except:

a. Student personality characteristics
b. Social dynamics
c. Media coverage of acts of school violence
d. School dynamics
e. Family dynamics
ANSWER: c

T40 FROM FUN TO FELONY: CHILD PORNOGRAPHY

Nicole Sussman, MD, Cambridge, MA

EDUCATIONAL OBJECTIVE
To review the evolution of child pornography laws in the United States, describe adolescent use of pornography and sexting, highlight the current legal landscape regarding sexting, and discuss how Autism Spectrum Disorder is associated with risk factors for inappropriate online sexual behavior with relation to an evaluation of criminal responsibility.

SUMMARY
In 1977 the first federal laws prohibiting child pornography were created and since then they have evolved alongside the rise of computers and technology. Recently the sharing of digital photography and internet access on smartphones has changed the way adolescents engage with sexually explicit material. Many adolescents watch pornography and some share naked or semi-naked photos of themselves (i.e. sexting). While some jurisdictions have introduced legislation specific to sexting, in most states these acts fall within the scope of child pornography and are prosecuted as such.

Typical adolescent use of sexting and pornography has become a topic of interest for researchers, educators, and parents, though little attention has been given to adolescents with developmental disorders (e.g. Autism Spectrum Disorder [ASD]) who are at risk for inappropriate use of these technologies and subsequent legal consequences. There have been a number of legal cases where adolescents with ASD have been prosecuted for violating child pornography laws, and their criminal responsibility has been questioned. After reviewing the clinical features of ASD, the moral and legal blameworthiness of such individuals' engagement with sexual content involving minors will be discussed.

REFERENCES

Martellozzo E, Monaghan A, Adler JR, et al: "I wasn't sure it was normal to watch it" A quantitative and qualitative examination of the impact of online pornography on the values, attitudes, beliefs and behaviors of children and young people, 2016

Mahoney, M: Asperger's Syndrome and the criminal law: the special case of child pornography. Unpublished article, Harrington and Mahoney, 2009

QUESTIONS AND ANSWERS

Which of the following does not contribute to adolescents with Autism Spectrum Disorder having increased risk of facing legal consequences associated with viewing child pornography?

a. Mental and emotional age often lags behind their physical age
b. Deficits in social skills and complete disregard for societal norms
c. Aptitude and comfort with computers
d. Lack of explicit instruction to avoid digital sexual content involving minors
ANSWER: c

Which of the following is unrelated to the prosecution of those who create, distribute, or possess child pornography?

a. Goal is to avoid exploitation of children
b. Sexual interest in young children is morally wrong and should be punished
c. Efforts to control production of child pornography acknowledge the necessity of also controlling distribution
d. Those who watch child pornography are considered higher risk for exploiting a minor
e. Mandatory registration with the National Sex Offender Registry allows for ongoing monitoring
ANSWER: b

T41 PROGRAM WITHDRAWN

T42 UNDER THE INFLUENCE: DWI COURTS IN THE UNITED STATES

R. David Heekin, MD, Houston, TX
Andrea Gail Stolar, MD, Houston, TX

EDUCATIONAL OBJECTIVE

To critically appraise the evidence base for the efficacy of DWI/DUI courts and to outline future directions for program development and research.

SUMMARY

Since the 1990s, DWI courts have evolved from the preexisting drug court model as a means of reducing recidivism among repeat offenders by treating underlying addiction. While general consensus now exists that drug courts are successful in decreasing recidivism, studies examining DWI courts have returned mixed results. The existing body of research on DWI courts has been limited by methodological weaknesses of many studies, with the aggregate of evidence from more rigorous trials failing to demonstrate a clear advantage of these programs over comparison groups. Nevertheless, the expansion of DWI courts in the US continues, in many ways mirroring the earlier growth of the drug court model, which initially spread despite limited evidence of the efficacy of this approach that is now widely considered vindicated. Future efforts to improve DWI courts should include designing and conducting more robust trials examining both outcomes and process factors, identifying evidence-based best practices, and addressing certain challenges specific to DWI courts as opposed to the broader drug court model.

REFERENCES
Mitchell O, Wilson DB, Eggers A, et al: Assessing the effectiveness of drug courts on recidivism: a meta-analytic review of traditional and non-traditional drug courts. Journal of Criminal Justice 40(1):60-71, 2012

Myer AJ, Makarios MD. Understanding the impact of a DUI court through treatment integrity: a mixed-methods approach. Journal of Offender Rehabilitation 56(4):252-76, 2017

QUESTIONS AND ANSWERS
Which of the following is an example of a process evaluation of DWI/DUI courts?

a. Rate of new criminal charges among program participants
b. Correctional Program Checklist-Drug Court (CPC-DC) score
c. Rate of new DUI charges among program completers
d. Program completion rate among participants
ANSWER: b

Which of the following characterizes most DWI court outcome studies to date?

a. The use of quasi-experimental comparison groups
b. Random assignment of subjects
c. Tracking of long-term (>3 years) outcomes
d. Rigorous measurement of mediator variables
ANSWER: a

T43 INVOLUNTARY PSYCHIATRIC HOLDS DURING PREGNANCY: PROVIDERS' PERSPECTIVES

Samuel House, MD, Little Rock, AR
Jason Beaman, DO, Tulsa, OK
Tiffany Howel, PhD, Little Rock, AR
Zachary Stowe, MD, Madison, WI

EDUCATIONAL OBJECTIVE
To educate the audience on the complexity of involuntary psychiatric holds during pregnancy through the presentation of survey results. At the end of the presentation, the audience will have a better understanding of providers' perspectives of involuntary holds during pregnancy.

SUMMARY
Previous research has identified characteristics that may influence the likelihood that a patient will be committed to involuntary psychiatric treatment, including a patient's race, gender, age, diagnosis, and comorbid substance use. However, little literature is available regarding the influence of pregnancy on practitioners' placing patients on involuntary holds for psychiatric reasons. Given the vulnerability of pregnant patients, this study sought to examine psychiatrists' practice tendencies regarding psychiatric involuntary holds of pregnant and non-pregnant women, as well as the impact of substance abuse on psychiatrists' propensities to hold pregnant women. Through the use of fictional clinical vignettes sent to the membership of the American Academy of Psychiatry and the Law, this discussion will focus on the findings of the survey data in order to highlight the differences and factors involved in decision-making when handling the right to refuse psychiatric treatment in pregnant patients. Additionally, this discussion will include survey data related to the differences between psychiatric holds in pregnant patients with and without comorbid substance use. By emphasizing these data, the surveyors call attention to the difficulties of practicing forensic psychiatry at the highest level in pregnant patients due to the lack of fundamental knowledge regarding this population.

REFERENCES
Hustoft K, Larsen TK, Auestad B, et al: Predictors of involuntary hospitalizations to acute psychiatry. Int J Law Psychiatry 36(2):136-43, 2013

Opsal A, Oistein K, Larsen TK, et al: Factors associated with involuntary admissions among patients with substance use disorders and comorbidity: a cross-sectional study. BMC Health Serv Res 13(57):1-8, 2013

QUESTIONS AND ANSWERS
Which of the following are considered vulnerable patient populations? Select all that apply.

a. Pregnant women
b. Human fetuses
c. Economically disadvantaged
d. Men
ANSWER: a, b & c

According to the American Academy of Addiction Psychiatry, the American Medical Association, the American Psychiatric Association, and the American College of Obstetricians and Gynecologists, at what point during gestation should jurisdictions consider substance use during pregnancy criminal?

a. Jurisdictions should not criminalize substance use during pregnancy
b. Jurisdictions should criminalize substance use during pregnancy if it occurs prior to 15 weeks gestation
c. Jurisdictions should criminalize substance use during pregnancy if it occurs after 15 weeks gestation
d. Jurisdictions should criminalize substance use during pregnancy if it occurs at any time during gestation
ANSWER: a

T44 CITIZENSHIP AND SOCIAL JUSTICE: VOTING BY PEOPLE WITH MENTAL ILLNESS

Jennifer Okwerekwu, MD, Cambridge, MA
James B. McKenzie, DO, MBA, Cambridge, MA
Katherine A. Yates, BS, Cambridge, MA
Renée M. Sorrentino, MD, Weymouth, MA
Susan Hatters Friedman, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE
To learn about service (e.g. treatment of forensic patients, development of service delivery systems and enhancement of consulting skills); teaching, including new methods of training forensic psychiatrists and clarification of the functions of a forensic psychiatrist; and to support the voting rights of patients and educate the community about these rights.

SUMMARY
While voting laws trend towards universal suffrage, there are still some who encounter barriers in exercising the right to vote. Citizens with mental illness or cognitive and emotional impairments are especially vulnerable to exclusion from the political process, contributing to disenfranchisement. Empowering hospitalized patients to vote can be a strategy for social change by increasing their agency and amplifying their voices and concerns. Through exercising their civic responsibility, psychiatric patients can have a hand in shaping a community in which they feel welcome and safe. In this article we will review the literature about voting, our lessons learned facilitating voting by-proxy at Cambridge Hospital in the 2016 Presidential election, as well as the obstacles encountered, and propose methods for improved implementation of voting by hospitalized psychiatric patients for upcoming elections.

REFERENCES
Rowe M, L Davidson: Recovering citizenship. The Israel Journal of Psychiatry and Related Sciences 53:14-21, 2016

Raad R, Karlawish J, Appelbaum PS: The capacity to vote of persons with serious mental illness. Psych Serv 60:624-628, 2009

QUESTIONS AND ANSWERS
In the United States, which law(s) were passed to protect the suffrage of marginalized populations, including the mentally ill?

a. Voting Rights Act (VRA)
b. National Voter Registration Act (NVRA)
c. Americans with Disabilities Act (ADA)
d. Help America Vote Act (HAVA)
e. All of the above
ANSWER: e

Which assessment tool operationalizes the Doe Standard, a legal standard based on a federal district court decision in Maine, which solely requires an intact ability to understand and make a choice?

a. MMSE
b. MOCA
c. MacCAT-T
d. CAT-V
e. UBACC
ANSWER: d

T45 SERIAL KILLERS AND PSYCHIATRY: FROM PURSUIT TO TRIAL

Ryan C. Wagoner, MD, Tampa, FL
Charles L. Scott, MD, Sacramento, CA
Phillip Resnick, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

The goal of this presentation will be to describe how different aspects of forensic psychiatry may interact with serial killer cases.

SUMMARY

Serial murder is a topic that can often lead to wide media coverage and national interest in cases that go to trial. Although the lay public may perceive from movies and other fiction that psychiatrists are intimately involved in these cases, this is only true in certain circumstances.

Dr. Wagoner will discuss the history of the term co-serial killer including past and contemporary examples of individuals who took part in serial murder. Special attention will be paid to reviewing famous cases and their associated typologies, emerging trends in serial murder over time, and how psychiatrists have historically interacted with cases of serial murder. Dr. Scott will detail serial killer profiling and the FBI methodology for this. He will review the limitations of the FBI's approach and how it differs from the retrospective analysis that forensic psychiatrists typically use during evaluations. Dr. Resnick will educate the audience on the unique aspects of evaluating cases involving serial killers and mass murders, as there is often overlap in the issues raised by these high-profile cases. He will use examples of previous cases he has evaluated, including the case of Ted Kaczynski, also known as the Unabomber.

REFERENCES

Schlesinger LB, Ramirez S, Tusa B, et al: Rapid-sequence serial sexual homicides. Journal of the American Academy of Psychiatry and the Law 45(1):72-80, 2017

Morton RJ: Serial murder multi-disciplinary perspective for investigators. Federal Bureau of Investigations, 2005, Available at https://www.fbi.gov/stats-services/publications/serial-murder. Accessed September 2018.

QUESTIONS AND ANSWERS

How many murders are required for the definition of co-serial murderer according to the Federal Bureau of Investigations?

a. 1
b. 2
c. 3
d. 4
e. 10
ANSWER: b

The most common relationship between a serial killer and their victims is:

a. No prior relationship
b. Members of the killer's family
c. Coworkers
d. Previous intimate partners
e. Childhood friends
ANSWER: a

T46 FORENSIC ASPECTS OF KRATOM USE

Stephen P. Herman, MD, New York, NY

EDUCATIONAL OBJECTIVE

To teach the audience about the forensic psychiatric effects of kratom, a drug from a tree in Asia that has serious neuropsychological effects and has caused a national controversy.

SUMMARY

Kratom, a substance unknown to many psychiatrists, is a drug found in the leaves of a tree growing throughout Asia. A controversial drug, it has been touted as useful for a myriad of psychiatric problems, from ending opiate addiction to treating depression. It is not illegal in most states and is becoming a the drug of choice for youth across the world. In Arizona, for example, anyone can buy it from vending machines. The FDA has raised alarms about the substance. This paper describes the neuropsychiatric aspects of the drug and its purported uses and its dangers. It reviews present and future forensic issues related to kratom.

REFERENCES

Raffa RB, Pergolizzi JV, Taylor R, et al: Nature's first 'atypical opioids': Kratom and mitragynines. J Clin Pharm Ther. J Clin Pharm Ther. 43(3):437-441, 2018

Prozialeck WC: Update on the pharmacology and legal status of kratom. J Am Osteopath Assoc. 116(12):802-809, 2016

QUESTIONS AND ANSWERS

What are the side effects of kratom?

ANSWER: Seizures, altered consciousness, mania

What are the claims for kratom?

ANSWER: Opiate withdrawal, antidepressant

T47 THE RELATIONSHIP BETWEEN CHILD PORNOGRAPHY AND CONTACT OFFENDING

Matthew Hirschtritt, MD, MPH, San Francisco, CA
Douglas Tucker, MD, Berkeley, CA
Renée L. Binder, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

To describe the prevalence of child pornography and contact offending in the U.S., summarize federal legislation regarding child pornography, list characteristics that may differentiate child pornography from contact offenders, evaluate rates of crossover between child pornography and contact offending, and describe treatments for offenders.

SUMMARY

Over the past two decades, U.S. internet access has increased dramatically. Along with its benefits, the internet has facilitated criminal activity, including viewing and distributing child pornography. The association between child pornography use and acts of hands-on child molestation (i.e., contact offending) has been studied mainly in forensic populations and is controversial. In this review, we: (1) summarize the U.S. legal framework related to child pornography, (2) describe demographic and psychological characteristics that may distinguish child pornography from contact offenders, (3) estimate the rates of overlap between child pornography and contact offending based on limited retrospective and longitudinal studies, and (4) provide recommendations for treatment of child pornography offenders. The available data, based primarily on forensic populations, suggest there is an association between child pornography and prior contact offenses. Some studies, also based on forensic populations, have suggested that there may be a clinically distinguishable subgroup of child pornography-only offenders who are at particularly low risk of committing a contact offense. However, because many people who engage in child pornography are never arrested and are not represented in available studies, there are no reliable data about how many of them will engage in contact offenses.

REFERENCES

Henshaw M, Ogloff JRP, Clough JA. Looking beyond the screen: a critical review of the literature on the online child pornography offender. Sex Abuse. 29(5):416-445, 2017

Babchishin KM, Hanson RK, VanZuylen H. Online child pornography offenders are different: a meta-analysis of the characteristics of online and offline sex offenders against children. Arch Sex Behav 44(1):45-66, 2015

QUESTIONS AND ANSWERS

The PROTECT (Prosecutorial Remedies and Other Tools to end the Exploitation of Children Today) Act of 2003:

a. Prohibits interstate transmission of any obscene depiction of what appears to be a minor
b. Has been challenged in multiple Supreme Court cases
c. Is reflected closely in many state laws
d. Was signed into law soon after the Supreme Court case of Ashcroft v. Free Speech Coalition (535 U.S. 234, 2002)
e. a, c and d
f. All of the above

ANSWER: e

One impediment to accurate estimation of crossover rates between engagement in child pornography and contact offending is:

a. Federal law prohibits investigation of prior contact offending among adults whose index offense is child pornography
b. The available data are limited to child pornography offenders who also committed contact offenses
c. Most available data are limited to forensic populations, thereby omitting many adults who engage in child pornography undetected
d. Relevant studies have been conducted too recently to draw conclusions about rates of long-term recidivism

ANSWER: c

T48 CYBERSTALKING DIRECTED AT YOUTH

Paul M. Elizondo, III, DO, San Francisco, CA
Renée L. Binder, MD, San Francisco, CA
Dale E. McNiel, PhD, San Francisco, CA

EDUCATIONAL OBJECTIVE

This paper will review federal and state cyberstalking statutes, describe the roles a forensic psychiatrist may assume in cyberstalking cases, and elucidate the importance of a developmental formulation when examining perpetrators and victims of cyberstalking.

SUMMARY

Adolescents are increasingly exposed to Internet-facilitated crime as they spend more time online. The mental health risks and legal consequences for youth involved in cyberstalking are growing areas of concern. The nature of online stalking presents several challenges with respect to investigation, fair adjudication, fact-finding, and legislation. Laws governing online stalking behaviors inconsistently reference the age of a victim or perpetrator as a factor for consideration in case disposition. In the course of adjudication, the forensic psychiatrist may be asked to evaluate the victim or perpetrator involved in cyberstalking. This paper focuses on the current legal landscape governing cyberstalking behavior, the roles a forensic psychiatrist may assume in this context, and the opportunity to bring a developmental perspective to these cases.

REFERENCES

Dombrowski SC, LeMasney JW, Ahia CE, et al: Protecting children from online sexual predators: technological, psychoeducational, and legal considerations. Professional Psychology: Research and Practice 35(1):65, 2004

Matecki, LA: Update: COPPA is ineffective legislation–next steps for protecting youth privacy rights in the social networking era. Nw. JL & Soc. Pol'y 5:369, 2010

QUESTIONS AND ANSWERS

The number of jurisdictions in the US that have enacted cyberstalking statutes that mandate consideration of either the victim or perpetrator's age in case disposition is:

a. 6
b. 18
c. 29
d. 41

ANSWER: b

According to the Child Online Privacy Protection Act (COPPA), youth can share personal information online without parental consent starting at the following age:

a. 9
b. 11
c. 13
d. 15
e. 17
ANSWER: c

T49 WHEN DO INTERNET COMMUNICATIONS BECOME CRIMINAL?

Rami Abukamil, MD, Cincinnati, OH
Jennifer Piel, JD, MD, Seattle, WA

EDUCATIONAL OBJECTIVE

This presentation summarizes a recent legal case of violent fantasies posted online. Participants will (1) learn relevant law on freedom of speech and criminal law; (2) review the association between violent fantasies and violent crime; and (3) understand the role for forensic psychiatrists in cases involving online violent postings.

SUMMARY

The anonymity of the Internet enables people to explore and share certain thoughts they may not feel comfortable sharing through traditional means. This is true for socially unacceptable thoughts, including violent and sexually sadistic fantasies. Despite one's relative freedom to explore virtually any subject anonymously, some Internet activities can attract unwanted attention from the media and law enforcement authorities. The case of United States v. Gilberto Valle (2d. Cir. 2015) is illustrated. The Valle case addressed an interesting question at the intersection of fantasy and reality: When does one's expression of fantasies online cross into actual criminality? This presentation will summarize the Valle case and review relevant law related to free speech and conspiracy, as well as discuss online communications that have triggered further investigation from law enforcement and under what conditions, if any, thoughts may become criminal. Additionally, relevant literature will draw attention to the prevalence of violent and deviant fantasies in low risk populations and identify risk factors associated with increased likelihood of committing a violent crime.

REFERENCES

Piel J, Goldenberg E: Case of a patient's violent postings on social media. J Am Assoc Emergency Psychiatry, 2016

Larue D, Schmidt AF, Imhoff R, et al: Validation of direct and indirect measures of preference for sexualized violence. Psychological Assessment 26(4):1173-1183, 2014

QUESTIONS AND ANSWERS

In Elonis vs. US (United States v. Elonis, 2013, p 34), Mr. Elonis posted the following comments on his Facebook account after his wife left him: "There's one way to love you, but a thousand ways to kill you. I am not going to rest until your body's a mess, soaked in blood and dying from all the little cuts." Which is most applicable to this statement?

a. It is a true threat because he made a threat to kill someone and described how he would do it
b. If the intended reader felt threatened, that is sufficient to consider the statement a true threat
c. The court must consider the defendant's mens rea (his intent) before ruling this as a true threat
d. This is his Facebook account, and he can freely post whatever he wants as protected speech under the First Amendment
ANSWER: c

Which of the following statements is true:

a. Violent fantasies are infrequent among individuals in the general population
b. According to studies, less than 10% of people have paraphilias
c. At least 40% of college students have reported having one or more homicidal fantasies
d. Having a violent fantasy is predictive of future violent behavior
ANSWER: c

T50 DEVELOPING EXPERTISE IN MIRANDA CONSULTATIONS

Richard Rogers, PhD, Denton, TX

EDUCATIONAL OBJECTIVE

Learn about service (e.g. treatment of forensic patients), development of service delivery systems, and enhancement of consulting skills.

SUMMARY
Attorneys routinely overlook virtually all (99%) criminal cases with very significant Miranda issues, including psychiatric disorders and cognitive impairment. This course educates forensic psychiatrists on three critically relevant issues regarding how to (1) identify defendants with impaired Miranda comprehension and reasoning, (2) consult with counsel on Miranda issues, and (3) proceed with the Miranda assessment. Psychiatrists are provided a conceptual framework for outlining the crucial issues related to Miranda warnings and waivers. However, the primary focus involves practical methods for evaluating individual defendants and their case-specific issues. Attendees will also be informed about standardized assessment methods of Miranda abilities that can be easily implemented without specialized skills. Practice-based experiences consist of three discrete components. First, via an audio-recording of a Miranda advisement used in a recent Texas murder case, they experience the real-world challenges of Miranda comprehension. Second, they are challenged to malinger on the Miranda Quiz to learn about its detection strategies. Third, they review clinical findings in a questionable Miranda case as it relates to Miranda comprehension and reasoning.

REFERENCES
Rogers R, Drogin EY: Mirandized Statements: Successfully Navigating the Legal and Psychological Issues. Chicago: American Bar Association Publishing, 2014

Goldstein A, Goldstein NES: Evaluating Capacity to Waive Miranda Rights. New York: Oxford, 2010

QUESTIONS AND ANSWERS
What are two very common Miranda misconceptions?

a. Exerting the right to silence can be used as evidence of guilt
b. Police cannot lie to suspects about being identified by an eyewitness as the perpetrator
c. Police questioning cannot be started without the presence of legal counsel
d. Parents can waive Miranda rights for their biological or adopted child
ANSWER: a & b

Which two of the following is accurate about Miranda warnings?

a. More than 800 different Miranda warnings are currently being used in the United States
b. Following Miranda v. Arizona (1966), all federal jurisdictions use the same warning
c. Miranda warnings require less than a 10th grade reading ability
d. Miranda warnings vary in reading levels from grade 3 to more than a college education
ANSWER: a & d

T51 DAZED AND CONFUSED: HOW THE OPIOID EPIDEMIC HAS CHALLENGED PHYSICIANS, ATTORNEYS AND LAW ENFORCEMENT

Anna Lembke, MD, Stanford, CA
James A. Arnold, MA, Washington, DC
Donna Vanderpool, MBA, JD, Arlington, VA

EDUCATIONAL OBJECTIVE
To understand the factors leading to the opioid crisis in the United States as well as the continued challenges involved in stopping the misuse of opioids.

SUMMARY
In 2017, more than 72,000 people died from drug overdoses and opioids were responsible for most of these deaths. America's opioid crisis is the result of multiple complex factors. It has become clear that putting an end to the opioid crisis will require widespread engagement in initiatives that include health care providers, hospitals, the pharmaceutical industry, and federal and state government agencies. This panel brings together leaders from healthcare, the law, and law enforcement in a round table discussion to explain the genesis and evolution of the opioid crisis and the current state of this public health emergency.

REFERENCES
Rummans TA, Burton CM, Dawson NL: How good intentions contributed to bad outcomes: the opioid crisis. Mayo Clin Proc Mar 93(3):344-350, 2018

Rudd RA, Seth P, David F, et al: Increases in drug and opioid-involved overdose deaths — United States, 2010–2015. MMWR Morb Mortal Wkly Rep. 65:1445-1452, 2016

QUESTIONS AND ANSWERS

The opioid crisis involves:

a. Prescription opioid medications
b. Illegal (nonprescription) opioids
c. Orally-administered opioids
d. Both prescription and nonprescription opioids
ANSWER: d

Currently in 2018, the increasing death rate from opioid misuse is primarily due to:

a. IV Drug Use
b. Polypharmacy overdose
c. Illegal street drugs
d. Prescribed opioid medications
ANSWER: c

FRIDAY, OCTOBER 26, 2018

POSTER SESSION #2 — 7:00 AM - 8:00 AM / 9:30 AM - 10:15 AM — **LONE STAR FOYER**

F1 ***Serious Mental Illness and Solitary Confinement: The Assumptions and the Data***
Amina Ali, MD, Whitby, Ontario, Canada
Alexander Berger, DO, Ossining, NY
Matthew Grover, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY

F2 ***Expose v. Wilderson: Are Trainee Therapists Immune from Liability for Disclosures Made to Law Enforcement?***
Rana Elmaghraby, MD, Minneapolis, MN
Chinmoy Gulrajani, MD, Minneapolis, MN
Laura Sloan, MD, St. Paul, MN

F3 ***A Case of Homicidal Ideation: Differential Diagnoses and the Risk of Violence***
Tina Thomas, MD, Houston, TX
Rania Elkhatib, MD, Houston, TX
Teresa Pigott, MD, Houston, TX

F4 ***God, Government and Guns***
Rasna Patel, MD, New Haven, CT
Amit Mistry, MD, PhD, Oklahoma City, OK

F5 ***DSM-5 Changes and the Reconsideration of FPP as a Dimensional Construct***
Sarah Velsor, Denton, TX
Richard Rogers PhD, Denton, TX

F6 ***Testamentary Capacity in the Elderly***
Oliver M. Glass MD, Atlanta, GA
Peter Ash MD, Atlanta, GA

F7 ***"13 Reasons Why" and Effect on Psychiatric Presentations***
Patricia Ortiz MD, Washington, DC
Eindra Khin Khin MD, Washington, DC

F8 ***What Happened to Hearsay? The Fallout from People v. Sanchez***
Kayla Fisher, MD, JD, Riverside, CA

F9 ***Words Can Kill: Clinical and Forensic Implications of Juvenile Cyberbullying***
Neha Gupta, MD, Philadelphia, PA
Kenneth J. Weiss, MD, Philadelphia, PA

F10 ***Invoking Genetics in Death Penalty Mitigation***
Kenneth J. Weiss, MD, Philadelphia, PA
Alisa R. Gutman, MD, PhD, Philadelphia, PA
Wade H. Berrettini, MD, PhD, Philadelphia, PA

F11 ***POSTER WITHDRAWN***

F12 ***Obscene Phone Call, a Rare Paraphilia: Lesson from an American Movie***
Sebastien S. Prat, MD, Hamilton, ON, Canada
Ingrid Bertsch, MA, Touts, France
Gary Chaimowitz, MB, CHB, Ancaster, ON, Canada

F13 ***Capital Punishment and Mental Illness: Cruel and Unusual Punishment***

Paulina Riess, MD, Mamaroneck, NY
Frozan Walyzada, MD, Bronx, NY
Ahmed Albassam, MD, Bronx, NY
Charles Odom, MD, Bronx, NY
Monika Gashi, MD, Bronx, NY
Sigella Vargas, MD, Bronx, NY
Pankaj Manocha, MD, Bronx, NY
Darmant Bhullar, MD, Bronx, NY
Timur-Metin Mujdaba, MD, Bronx, NY
Ali Khadivi, PhD, Bronx, NY

F14 ***Parenting in the Twenty-First Century: What is "Dangerous"?***

Stephanie Yarnell-MacGrory, MD, PhD, New Haven, CT
Simha Ravven, MD, New Haven, CT

F15 ***Race and Standardized Risk Assessments: Are There Inherent Biases? A Look at the COMPAS***

Bridget McCoy, MD, Albuquerque, NM
Melodie Foellmi, PhD, Brooklyn, NY
Matthew Grover, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY

F16 ***Voluntary Instructional Programming (VIP) Offered to a Young Male Incarcerated Jail Population***

Erin E. Burch, PsyD, Buffalo, NY
Daniel Antonius, PhD, Buffalo, NY
Ronald Schoelerman, LMSW, Buffalo, NY

F17 ***Substance Use and Psychosis in Evaluations for Violent Crime in North Carolina***

Nichole Wolfe, MD, Butner, NC
Melisa Tyndall, MD, Raleigh, NC

F18 ***Who Said What? Mental Health Interpreting in Forensic Evaluations in Massachusetts***

Margarita Abi Zeid Daou, MD, Worcester, MA
Amam Saleh, MD, Worcester, MA
Sowmya Tewari, MD, MS, New York, NY

F19 ***Autism and Criminality: Is There A Link? A Review of the Literature***

Sowmya Tewari, MD, MS, New York, NY

F20 ***Minimizing Elopement in a Medium Security Psychiatric Hospital***

Mitchell H. Dunn, MD, Dallas, TX
Deepti Vats, MD, Rockwall, TX
Ginger Davis, LCSW, Terrell, TX

F21 ***Forensic Psychiatry in the Age of Artificial Intelligence: Implications and Applications to Risk Assessment***

Peter S. Martin, MD, MPH, Buffalo, NY

F22 ***Sibling-on-Sibling Violence***

Peter S. Martin, MD, MPH, Buffalo, NY

F23 ***Barriers to Psychiatric Advance Directive Use in an Academic Medical Center***

Elizabeth E. Sita, MD, Chicago, IL
Stephen H. Dinwiddie, MD, Chicago, IL

F24 ***POSTER WITHDRAWN***

AAPL BUSINESS MEETING (MEMBERS ONLY)	8:00 AM - 9:30 AM	**LONE STAR D**
COFFEE BREAK	**9:30 AM - 10:00 AM**	**LONE STAR FOYER**
PANEL	10:00 AM -12:00 PM	**LONE STAR D**

F25 ***The Involuntary Treatment of Opioid and Other Substance Use Disorders***

Paul S. Appelbaum, MD, New York, NY
Abhishek Jain, MD, New York, NY
Debra Pinals, MD, Ann Arbor, MI

PANEL — 10:00 AM - 12:00 PM — **LONE STAR F**

F26 ***Female Incarceration: What Is Happening in Oklahoma?***

Jason Beaman, DO, Tulsa, OK
Susan Hatters Friedman, MD, Cleveland, OH
Jennifer Piel, JD, MD, Seattle, WA
Reagan Gill, DO, Tulsa, OK

PANEL — 10:00 AM - 12:00 PM — **LONE STAR G**

F27 ***Physician Aid in Dying: The Role of the Psychiatrist***

Ariana Nesbit, MD, Sacramento, CA
William Connor Darby, MD, Los Angeles, CA
Richard Martinez, MD, Denver, CO
Anna Glezer, MD, Burlingame, CA

PANEL — 10:00 AM - 12:00 PM — **LONE STAR A**

F28 ***Consultation, Critique, and Creation: Forensic Psychiatry and Hollywood***

Vasilis K. Pozios, MD, Township, MI
Praveen Kambam, MD, Los Angeles, CA

PANEL — 10:00 AM - 12:00 PM — **LONE STAR B-C**

F29 ***Nowhere to Go: Reinstitutionalization in the US***

Barbara E. McDermott, PhD, Sacramento, CA
Katherine Warburton, DO, Sacramento, CA
Darci Delgado, PsyD, Sacramento, CA
Joel Dvoskin, PhD, Tucson, AZ

LUNCH (TICKET REQUIRED) — 12:OO PM - 2:00 PM — **LONE STAR E**

F30 ***The Opioid Epidemic: How We Got Here, Where We Are Now, and How to Get Out***

Anna Lembke, MD, Stanford, CA

PANEL — 2:15 PM - 4:00 PM — **LONE STAR D**

F31 ***Crisis Negotiation and the Waco Siege***

James L. Knoll, IV, MD, Syracuse, NY
George David Annas, MD, Syracuse, NY
Gary Noesner, Moneta, VA
Gregg McCrary, Fredericksburg, VA

PANEL — 2:15 PM - 4:00 PM — **LONE STAR A**

F32 ***Minority Report: Gender Bias in Forensic Psychiatry***

Kelly L. Coffman, MD, MPH, Atlanta, GA
Helen Farrell, MD, Boston, MA
Eric Y. Drogin, JD, PhD, Hingham, MA
Thomas G. Gutheil, MD, Boston, MA

RESEARCH IN PROGRESS #1 — 2:15 PM - 4:00 PM — **LONE STAR F**

F33 ***Pray the Gay Away: An Analysis of Laws Banning Conversion Therapy***

Andrew Halls, MD, San Francisco, CA
Vivek Datta, MD, San Francisco, CA

F34 ***Religiosity in Relation to Violence and Crime: Risk or Protective Factor?***

Elias Ghossoub, MD, Saint Louis, MO

F35 ***Adverse Childhood Experiences of Trauma and Effect on Criminal Recidivism***

Mansfield Mela, MBBS, Saskatoon, SK, Canada
Marelize Muller, BA, Saskatoon, SK, Canada
Tara Anderson, MSc, Saskatoon, SK, Canada
Gu Deqiang, PhD, Saskatoon, SK, Canada

WORKSHOP 2:15 PM - 4:00 PM **LONE STAR G**

F36 ***Working With Individuals with Neurodevelopmental Disorders in Forensic and Correctional Settings***

Debra A. Pinals, MD, Ann Arbor, MI
Bruce Gage, MD, Olympia, WA
Barry Wall, MD, Cranston, RI
Irina King, Lakewood, WA

COURSE (TICKET REQUIRED) 2:15 PM - 6:15 PM **LONE STAR B-C**

F37 ***Fundamentals of Threat Assessment***

Ronald Schouten, MD, JD, Boston, MA
John Rozel, MD, MSL, Pittsburgh, PA

COFFEE BREAK **4:00 PM – 4:15 PM** **LONE STAR FOYER**

FLASH TALK SESSION #2 4:15 PM - 6:15 PM **LONE STAR A**

F38 ***Neuroimaging in the Forensic Evaluation of Violence and Psychosis***

Nina Beizer, MD, Pittsburgh, PA
Drew Calhoun, MD, Seattle, WA
Vivek Datta, MD, MPH, San Francisco, CA

F39 ***An Appellate Case Review of Neuroimaging and the Death Penalty***

Vivek Datta, MD, MPH, San Francisco, CA

F40 ***Rappeport Fellows: Research Speed Dating***

Britta Ostermeyer, MD, MBA, Oklahoma City, OK
Susan Hatters Friedman, MD, Cleveland, OH
Gary Chaimowitz, MB, ChB, Hamilton, ON, Canada
Lisa Anacker, MD, Ann Arbor, MI
Joseph C. Cheng, MD, PhD, Charleston, SC
Matthew Hirschtritt, MD, MPH, San Francisco, CA
Brian Holoyda, MD, MPH, St. Louis, MO
David Nissan, MD, Portsmouth, VA
Jacqueline Landess, MD, JD, St. Louis, MO
Ryan Leahy, MD, Miami Beach, FL

PANEL 4:15 PM - 6:15 PM **LONE STAR D**

F41 ***Applying Differing Forensic Ethics Approaches in a Death Penalty Case***

Robert Weinstock, MD, Los Angeles, CA
Paul S. Appelbaum, MD, New York, NY
Richard Martinez, MD, Denver, CO
William Conner Darby, MD, Los Angeles, CA

PANEL — 4:15 PM - 6:15 PM — **LONE STAR F**

F42 The Face of AAPL: Diversity Matters

Katherine Michaelsen, MD, Seattle, WA
Reena Kapoor, MD, New Haven, CT
Charles Dike, MD, New Haven, CT
Carlos Salgado, MD, Miami, FL
Bipin Subedi, MD, New York, NY

WORKSHOP — 4:15 PM - 6:15 PM — **LONE STAR G**

F43 Extreme Overvalued Beliefs or Delusions?

Tahir Rahman, MD, St. Louis, MO
Willa Xiong, MD, St. Louis, MO
Phillip Resnick, MD, Cleveland, OH
Bruce Harry, MD, Columbia, MO
Jeffrey Janofsky, MD, Timonium, MD

AAPL RECEPTION — 6:30 PM - 7:30 PM — **LONE STAR E**

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

F1 SERIOUS MENTAL ILLNESS AND SOLITARY CONFINEMENT: THE ASSUMPTIONS AND THE DATA

Amina Ali, MD, Whitby, Ontario, Canada
Alexander Berger, DO, Ossining, NY
Matthew Grover, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE

To assess changes in psychiatric symptoms of inmates admitted to the SHU, and to review similarities/differences between SMI and non SMI inmates.

SUMMARY

The APA and other advocates for the mentally ill have expressed a concern that segregation over prolonged periods of time may produce harmful psychological effects, including anxiety, anger, cognitive disturbance, perceptual distortion, obsessive thoughts, paranoia, and psychosis. On January 29, 2008, New York State legislation passed the SHU exclusion law in an effort to improve conditions for seriously mentally ill inmates facing disciplinary confinement. The law mandates that people with a "serious mental illness" (SMI) who face disciplinary confinement that could exceed 30 days be diverted to a Residential Mental Health Treatment Unit (RMHTU). Along with this, it was mandated that all inmates, both SMI and non-SMI, admitted to SHU be seen by a mental health provider on a regular basis to assess for any emerging or changing symptoms and the need for services. This poster will assess how mood symptoms and psychotic symptoms change over time after inmates are admitted to the SHU. Symptoms will be tracked by analyzing assessments on the SHU mental health interview form that is filled out on admission to SHU and at least monthly thereafter. In addition, similarities and/or differences between SMI and non-SMI inmates will also be reviewed.

REFERENCES

State of New York Senate: Bill 4784-A. Available at: http://legislation.nysenate.gov/pdf/bills/2017/S4784A

Grassian S, Friedman N: Effects of sensory deprivation in psychiatric seclusion and solitary confinement. International Journal of Law and Psychiatry 8(1):49-65, 1976

QUESTIONS AND ANSWERS

Which year was the SHU exclusion law passed in New York State?

a. 2001
b. 2008
c. 2017
d. 1990
ANSWER: b

Solitary confinement has been thought to cause which psychological effects?

a. Paranoia
b. Anger
c. Psychosis
d. All of the above
ANSWER: d

F2 EXPOSE V. WILDERSON: ARE TRAINEE THERAPISTS IMMUNE FROM LIABILITY FOR DISCLOSURES MADE TO LAW ENFORCEMENT?

Rana Elmaghraby, MD, Minneapolis, MN
Chinmoy Gulrajani, MD, Minneapolis, MN
Laura Sloan, MD, St. Paul, MN

EDUCATIONAL OBJECTIVE

To demonstrate an understanding of the doctrine of Absolute Privilege and differentiate it from psychotherapist-patient privilege.

SUMMARY

This poster reports a recent opinion from the Minnesota Supreme Court that has impacted the practise of psychotherapy in the state. Mr. Jerry Expose, a patient, was convicted of making terroristic threats based on statements provided by his trainee therapist regarding his dangerousness to law enforcement and the prosecutor. While Mr. Expose appealed his conviction, he also filed a civil lawsuit against his therapist and the clinic. He

claimed that the trainee's disclosure amounted to a violation of his privacy and that the clinic was vicariously liable due to negligent supervision of the trainee. The central question presented in Expose v. Wilderson and Associates, 889 NW 2d 279 (Minn. 2016) was: is a trainee therapist who makes good faith disclosures immune from liability under the doctrine of absolute privilege? In its opinion the Supreme Court analyzed the doctrine of Absolute Privilege and laid out the limits of protections afforded to trainee therapists who make disclosures about their patients to law enforcement in the course of discharging their duty to warn.

REFERENCES

Expose v. Wilderson and Associates, 889 NW.2d 279 (Minn. 2016)

In re Zuniga, 714 F.2d 632 (1983)

QUESTIONS AND ANSWERS

What is the difference between Absolute Privilege and Privilege?

ANSWER: In absolute privilege, the person making the defamatory statement is immune from a defamation lawsuit.

When does the duty to warn stop?

ANSWER: When the first attempt to warn has been made. Any attempt after that is considered a violation of patient's privacy.

FRIDAY

F3 A CASE OF HOMICIDAL IDEATION: DIFFERENTIAL DIAGNOSES AND THE RISK OF VIOLENCE

Tina Thomas, MD, Houston, TX
Rania Elkhatib, MD, Houston, TX
Teresa Pigott, MD, Houston, TX

EDUCATIONAL OBJECTIVE

Violence linked to mental illness is a controversial subject that has received increasing publicity. The goal of this poster is to ensure clinicians are cognizant of the various causes of homicidal ideation, the factors associated with violence and the limitations to risk assessment. We aim to enhance forensic consulting skills.

SUMMARY

Background: Mental illness and violence is a subject of much public debate. There is pressure on mental health professionals to recognize "red flags" and prevent violence. We provide a case report of a patient with homicidal ideation. We discuss the differential diagnoses and importance of understanding the association of violence and mental illness.

Case: Mr A, a 25-year-old male, presented to an Emergency Department requesting help for homicidal ideation. He reported thoughts of stabbing his mother that began after watching a violent TV show at the age of 17. The thoughts had recently worsened, without any particular triggers, but he admitted to using Kush. On the night of presentation he was overcome with homicidal ideation. He reported feeling controlled to walk towards knives, but then ran out of the home to seek help. His psychiatric history was significant for Generalized Anxiety Disorder. Mr A was treated with Sertraline and Risperidone.

Discussion: We discuss how to differentiate causes for homicidal ideation including drug-induced psychosis, schizophrenia, obsessive-compulsive disorder, and factitious disorder. We examine evidence of the link between violence and mental illness and consider which conditions, factors, and limitations clinicians should be aware of in risk assessment.

REFERENCES

Oulist P, Konstantakopoulos G, Lykouras L: Differential diagnosis of obsessive-compulsive symptoms from delusions in schizophrenia: a phenomenological approach. World J Psychiatry 3(3): 50-56, 2013

Thompson CR, Beckson M: A case of factitious homicidal ideation. J Am Acad Psychiatry Law 32(3):277-81, 2004

QUESTIONS AND ANSWERS

Name a feature that can differentiate delusions from obsessive-compulsive disorder as a cause for homicidal ideation.

a. Delusions are integrated with one's belief whereas obsessions/compulsions are not
b. Delusions are felt to be excessive whereas obsessions/compulsions are recognized as justified
c. Delusions are resisted and obsessions/compulsions are not
ANSWER: a

What is the estimated attributable risk of mentally ill individuals committing violence and what does this mean?

a. 80- 95%. This means that the vast majority of violence is committed by persons with mental illness
b. 9.9%. This means that the vast majority of violence is not committed by persons with mental illness.
c. <1%. This means that the vast majority of violence is committed by persons with mental illness
ANSWER: b

F4 GOD, GOVERNMENT AND GUNS

Rasna Patel, MD, New Haven, CT
Amit Mistry, MD, PhD, Oklahoma City, OK

EDUCATIONAL OBJECTIVE

This case will demonstrate the importance of a thorough medical and psychiatric evaluation to provide appropriate treatment and mitigate the risk of recidivism in adolescent patient population.

SUMMARY

Recidivism and mental illness often occur concurrently, especially in patients with nonadherence issues. Unfortunately, these individuals are identified within the court system and are mandated by the government for treatment. LG is a 17-year-old Hispanic male who was admitted to inpatient psychiatry on a 30-day court order. He was transferred from the juvenile detention center after being detained on charges of threatening to kill his legal guardians with a gun. The court asked for etiology of his clinical presentation and recommendations on treatment and placement. LG presented with overtly psychotic symptoms including grandiose delusions (believing he was God), paranoia, auditory hallucinations with thought blocking, and labile mood. His history was significant for polysubstance use and trauma during a crucial developmental period. Full medical workup including autoimmune panel, urine drug screen, and evaluation by Pediatric Neurology were nonsignificant. Based on this, LG was diagnosed with Schizophrenia and then received appropriate treatment. This case highlights the necessity of the conjoint efforts of the courts and psychiatry to mitigate the risk of recidivism by accurately diagnosing and treating these patients.

REFERENCES

White LM, Lau KSL, Aalsma MC: Detained adolescents: mental health needs, treatment use, and recidivism. J Am Acad Psychiatry Law 44(2):200-212, 2016

McClelan J, Stock S, American Academy of Child and Adolescent Psychiatry Committee on Quality Issues: Practice parameter for the assessment and treatment of children and adolescents with schizophrenia. Journal of the American Academy of Child & Adolescent Psychiatry 52(9):976-990, 2013

QUESTIONS AND ANSWERS

What would be the most appropriate treatment recommendation for this patient?

a. Medication with follow-up in outpatient
b. Dual diagnosis program
c. Residential program
ANSWER: b

Which of the following medical conditions can present with psychotic symptoms?

a. Wilson's disease
b. Asthma
c. Diabetes
ANSWER: a

F5 DSM-5 CHANGES AND THE RECONSIDERATION OF FPP AS A DIMENSIONAL CONSTRUCT

Sarah Velsor, Denton, TX
Richard Rogers, PhD, Denton, TX

EDUCATIONAL OBJECTIVE

To understand the changes of factitious disorder for DSM-5 and the implications for forensic psychiatry practice and to consider reconceptualizing FPP as a response style that is context-specific and evaluated dimensionally.

SUMMARY
Practitioners and researchers have long been challenged with identifying deceptive response styles in forensic contexts, particularly when differentiating malingering from factitious presentations. Malingering requires feigning motivated by external goals, whereas factitious disorder (FD) is classified as a DSM-5 diagnosis with internal motivations. FDs were first recognized as a diagnostic category in DSM-III. Aligned with an effort to reduce numbers of diagnoses, DSM-5 eliminated FD subtypes. It also eliminated the specification that FD is motivated to adopt sick roles. This shift de-emphasized efforts to understand motivation for feigning in favor of more objective measures, such as identifying false symptoms. While the goal of diagnostic objectivity is laudable, turning a blind eye to the underlying motivation ignores the complexity of factitious presentations. As an alternative to formal diagnosis, practitioners may consider most factitious psychological presentations (FPPs) as dimensional constructs that parallel to malingering V code. Building on Rogers (1990), four explanatory models for FPPs are considered; three parallel malingering (pathogenic, criminological, adaptational) but differ in their central features; an additional model of nurturance was added. Relying on these models, practical guidelines are recommended for evaluating FPPs in forensic contexts.

REFERENCES
Yates GP, Mulla MM, Hamilton JC, et al: Factitious disorders in medical and psychiatric practices, in Clinical Assessment of Malingering and Deception (4th ed.). Edited by Rogers R and Bender SD. New York: Guilford Press, in press

Rogers, R: Development of a new classificatory model of malingering. Bulletin of the American Academy of Psychiatry and Law 18:323-333, 1990

QUESTIONS AND ANSWERS
The following was a major change to the diagnosis of factitious disorder in DSM-5:

a. The elimination of subtypes (physical and psychological)
b. The removal of the disorder entirely
c. The addition of a third subtype
d. The specification that to qualify for factitious disorder, it must appear in medical settings
ANSWER: a

Which of the following is the added explanatory model of FPP that does not appear in the explanatory models of malingering?

a. Compassionate model
b. Nurturance model
c. Dependency model
d. Demanding model
ANSWER: b

F6 TESTAMENTARY CAPACITY IN THE ELDERLY

Oliver M. Glass, MD, Atlanta, GA
Peter Ash, MD, Atlanta, GA

EDUCATIONAL OBJECTIVE
This poster will focus on discussing certain complex factors that may occur in late life, such as lucid intervals and cognitive fluctuations, and the impact those settings may have on the assessment of testamentary capacity.

SUMMARY
Every day 10,000 US baby boomers turn 65 years of age. It has been estimated that as many as 16 million Americans may suffer from Alzheimer's Disease (AD) by 2050, a marked increase from the 5.3 million affected in 2010. It can therefore be assumed that with the rise in dementia prevalence, there will be an increased need for forensic assessments relating to testamentary capacity. Appropriately evaluating testamentary capacity is imperative as geriatric patients are at risk for financial exploitation due to multiple factors, including cognitive impairment. This poster will focus on discussing certain complex factors that may occur in late life, such as lucid intervals and cognitive fluctuations, and the impact those settings may have on the assessment of testamentary capacity. We will delineate the two kinds of assessments relevant to this topic: those made on living people to see if they have testamentary capacity, and those made after death when a will is being contested. A case example of a geriatric individual who is still alive and whose testamentary capacity has been called into question will be included.

REFERENCES
Wick JY: Aging in place: our house is a very, very, very fine house. Consult Pharm 32(10):566-574, 2017

Vann A. Alzheimer's and baby boomers. Am J Alzheimers Dis Other Demen 25(6):477-8, 2010

QUESTIONS AND ANSWERS
Based on current estimations, how many Americans will have Alzheimer's disease by 2050?

ANSWER: 16 million

As each day passes, how many baby boomers reach the age of 65?

ANSWER: 10,000

F7 "13 REASONS WHY" AND EFFECT ON PSYCHIATRIC PRESENTATIONS

Patricia Ortiz, MD, Washington, DC
Eindra Khin Khin, MD, Washington, DC

EDUCATIONAL OBJECTIVE
To explore helpful or harmful characteristics of "13 Reasons Why" in terms of suicide contagion; identify demographics and other risk factors in the population that may increase vulnerability to media-related suicide contagion; and propose potential interventions to mitigate any increased risk associated with the "13 Reasons Why" series.

SUMMARY
In 2016, Netflix released "13 Reasons Why," a series featuring the suicide of a 15-year-old girl who left behind 13 audio recordings, each addressed to a person that she felt contributed to her decision to commit suicide. Critics of the show allege that the series romanticizes suicide, does not focus enough on mental illness, villainizes parents/school officials, depicts the suicide as a rational choice and form of revenge, and makes the victim appear to be a role model. While the series earned much attention in the media, and among schools and mental health professionals, few studies have researched any effect the series may have had on suicide contagion. This study aims to determine what quantitative impact, if any, the release of "13 Reasons Why" had on suicidal behaviors or mental health using a record review of psychiatric presentations to an urban children's hospital in the year before and after the release of the show. The goal is to identify risk factors that may amplify the effect of media-related suicide contagion, which would allow the exploration of potential interventions to mitigate any impact of this series and the impending second season, due to air later this year.

REFERENCES
Robertson L, Skegg K, Poore M, et al: An adolescent suicide cluster and the possible role of electronic communication technology. Crisis: The Journal of Crisis Intervention and Suicide Prevention 33(4):239-245, 2012

Swanson SA, Colman I: Association between exposure to suicide and suicidality outcomes in youth. CMAJ: Canadian Medical Association Journal 185(10):870, 2013

QUESTIONS AND ANSWERS
Which population is particularly vulnerable to suicide contagion?

a. Elderly
b. Minority
c. Middle-aged
d. Adolescents
e. Young adults
ANSWER: d

Electronic communication technology has affected the recognition and treatment of suicide contagion in all but which of the following ways?

a. Clusters are no longer limited by time or geographic location
b. Adolescents and young adults may be the first line in recognizing warning signs for suicide in their friends
c. Patient communication has become easier for psychiatrists with electronic technology
d. Social media sites are looking for new ways to identify at-risk individuals
e. Studies are being done on the safety and efficacy of online therapies for suicidal ideation
ANSWER: e

F8 WHAT HAPPENED TO HEARSAY? THE FALLOUT FROM PEOPLE V. SANCHEZ

Kayla Fisher, MD, JD, Riverside, CA

EDUCATIONAL OBJECTIVE

To learn the requirements for expert testimony that flow from the California Supreme Court case of People v. Sanchez, 63 4th 665 (Cal. 2016) and consider far-reaching implications and solutions.

SUMMARY

"Reliable" hearsay was allowed by common law and in California prior to the California Supreme Court case of People v. Sanchez 63 4th 665 (Cal. 2016). The "reliable" hearsay, as described in People v. Dodd 133 App. 4th 1564 (Cal. 2005) permitted an expert to rely on information that "reliable and of the type reasonably relied upon by experts on the subject" in forming their opinion. New limitations to expert opinion flowed from Sanchez. Now, experts must rely only on: (1) what they personally know; (2) what the patient tells them; (3) medical records of the patient; (4) what other witnesses testify about in court. This poster will present on overview of the Sanchez case and present possible solutions to dealing with the limitations forensic psychiatrist experts now face as a result of the Court's ruling.

REFERENCES

Volek I: Federal rule of evidence 703: the back door and the confrontation clause, ten years later. Fordham L. Rev. 80(2): 959, 2011

Wigmore JH: A Treatise on the Anglo-American System of Evidence in Trials at Common Law. Boston: Little, Brown, 1923

QUESTIONS AND ANSWERS

Before Sanchez, forensic psychiatry experts in California:

a. Could recite any hearsay
b. Court recite reasonably reliable hearsay
c. Could not recite hearsay in their testimony, but could recite hearsay in their report
ANSWER: b

The Sanchez court made clear that experts:

a. Could include any type of hearsay in their testimony
b. Could never include hearsay in testimony
c. Could include hearsay if it is otherwise admissible or has already come into evidence or will later come into evidence
ANSWER: c

F9 WORDS CAN KILL: CLINICAL AND FORENSIC IMPLICATIONS OF JUVENILE CYBERBULLYING

Neha Gupta, MD, Philadelphia, PA
Kenneth J. Weiss, MD, Philadelphia, PA

EDUCATIONAL OBJECTIVE

To identify common forms of cyberbullying in children and adolescents and its clinical and forensic implications, in addition to becoming aware of evolving legislation and caselaw related to cyberbullying.

SUMMARY

Cyberbullying is the use of electronic media to shame, threaten, or intimidate a person. Instances of cyberbullying among children and adolescents have accelerated throughout the country. Teenagers are highly vulnerable to shaming and social marginalization. It is important for forensic evaluators to be aware of the nature of these cases and their psychological impacts on the victim, including suicide, and also on the aggressor. Through the analysis of recent cyberbullying cases around the country, this poster will identify common personality traits seen in juvenile victims and aggressors, the psychological impact cyberbullying has on both parties, and the legal implications potentially faced by the juvenile aggressor. This will aid the forensic evaluator in conducting evaluations of victims and aggressors and inform interventions. Due to the evolving nature of technology, the internet, and social media, anti-bullying legislation must adapt. We address how states have met this legislative challenge.

REFERENCES

Freeman BW, Thompson C, Jaques C: Forensic aspects and assessment of school bullying. Psychiatric Clinics of North America 35:877-900, 2012

Aboujaoude E, Savage MW, Starcevic V, et al: Cyberbullying: review of an old problem gone viral. Journal of Adolescent Health 57:10-18, 2015

QUESTIONS AND ANSWERS
Which type of bullying is most strongly linked to suicidal ideations in youth?

a. Physical bullying
b. Cyberbullying
c. Verbal bullying
d. Relational bullying
ANSWER: b

When was the first state anti-bullying legislation passed?

a. 1965
b. 1976
c. 1983
d. 1999
ANSWER: d

F10 INVOKING GENETICS IN DEATH PENALTY MITIGATION

Kenneth J. Weiss, MD, Philadelphia, PA
Alisa R. Gutman, MD, PhD, Philadelphia, PA
Wade H. Berrettini, MD, PhD, Philadelphia, PA

EDUCATIONAL OBJECTIVES
Attendee will appreciate the barriers to presenting expert testimony on heritable mental disorders in death penalty mitigation.

SUMMARY
Legal arguments, in the penalty phase of capital trials or in post-conviction proceedings, may incorporate family history, environment, and other presumed nonculpable influences on the development and predispositions of the defendant. Attorneys may proffer expert testimony to enhance a defense claim that the defendant was less culpable for the behavior charged, for example, inherited traits. The terms genetic and genetics, however, have various meanings and implications when used in court. The literature shows mixed support for the efficacy of scientific testimony. This study tracks actual arguments and testimony cited in appeals. We reviewed 425 appellate decisions in which these terms appeared within mitigation arguments or claims of ineffective assistance of counsel. Of these, 268 death penalty cases reflected attempts to achieve post-conviction relief or to prove trial counsel's failure to argue facts material to juries' decisions. The results indicate general lack of specificity of the claims and poor results in achieving habeas corpus hearings or new trials. We conclude that the less-than-scientific use of genetic influences tends to be insufficient to drive a wedge between defendants' actions and their criminal culpability, thus supporting current research trends.

REFERENCES
Walker B: When the facts and the law are against you, argue the genes? a pragmatic analysis of genotyping mitigation defenses for psychopathic defendants in death penalty cases. Wash U L Rev 90:1779-1817, 2013

Farahany NA: Neuroscience and behavioral genetics in US criminal law: an empirical analysis. J Law Biosci 2(3):485-509, 2016

QUESTIONS AND ANSWERS
How have forensic experts most commonly used terms like "genetic" or "genetics" in death penalty cases?

a. For criminal responsibility
b. For mitigation
c. For mental capacity determinations
d. For arguments against the death penalty
ANSWER: b

What have the majority of outcomes been in the use of genetic arguments in death penalty appeals?

a. The trial court decision was overturned
b. The argument helped the prosecution
c. No effect (the trial court was upheld)
d. About as helpful as not
ANSWER: c

F11 POSTER WITHDRAWN

F12 OBSCENE PHONE CALL, A RARE PARAPHILIA: LESSON FROM AN AMERICAN MOVIE

Sebastien S. Prat, MD, Hamilton, ON, Canada
Ingrid Bertsch, MA, Touts, France
Gary Chaimowitz, MB, CHB, Ancaster, ON, Canada

EDUCATIONAL OBJECTIVE
To learn characteristics of obscene phone callers and their victims, the different profiles and associated behaviors, and the risk and impact of this type of hands-off offense.

SUMMARY
Introduction: For more than two decades, sexual offenses have been extensively studied and one particular type of offense is understudied: obscene phone calls. Most of these calls contain sexual words or are driven by sexual fantasies. This type of offense contains a wide range of behavior, from silent calls to the most pornographic and vulgar speeches.

Methods and Results: A literature review was conducted to analyze existing knowledge regarding the matter, particularly in terms of understanding this behavior. Unfortunately, this topic does not seem to have been something of interest as less than 20 scientific papers, over a period of more than 40 years, were collected.

Discussion: The apparent low level of interest of this offense seems to be in relation to the fact that obscene phone calls are often disregarded and not considered as psychological violence; however, these offenders truly suffer from a mental condition. This presentation will describe the offenders' and victims' profiles and the psychopathological theories underlying this behavior, through scenes from an American movie.

REFERENCES
Walby S and Allen J: Domestic violence, sexual assault and stalking: findings from the British crime survey. London, Home Office Research Study n276, 2004

Pakomou SM: Methodological aspects of telephone scatologia: a case study. Journal of Law and Psychiatry 29:178-185, 2005

QUESTIONS AND ANSWERS
Does obscene phone call behavior have to be considered as a paraphilia?

ANSWER: No

Do victims of obscene phone calls often report the behavior to the police?

ANSWER: No

F13 CAPITAL PUNISHMENT AND MENTAL ILLNESS: CRUEL AND UNUSUAL PUNISHMENT

Paulina Riess, MD, Mamaroneck, NY
Frozan Walyzada, MD, Bronx, NY
Ahmed Albassam, MD, Bronx, NY
Charles Odom, MD, Bronx, NY
Monika Gashi, MD, Bronx, NY
Sigella Vargas, MD, Bronx, NY
Pankaj Manocha, MD, Bronx, NY
Darmant Bhullar, MD, Bronx, NY
Timur-Metin Mujdaba, MD, Bronx, NY
Ali Khadivi, PhD, Bronx, NY

EDUCATIONAL OBJECTIVE
To bring to the forefront the complexity of capital punishment and its use in the mentally ill population.

SUMMARY
The United States is one of the very few western nations in which capital punishment still exists, with thirty-one of the fifty states still deeming it legal. Literature points to Ford v. Wainwright as the landmark case that deemed execution of individuals lacking competence to be a direct violation of the Eighth Amendment. However, there continue to be many individuals whose executions were carried out despite their having a history of mental illness.

Here, we examine how many death row inmates executed between the years of 2010-2017 carried diagnoses of mental illness, received treatment with psychotropic medication, or fit into both categories. We also collected other demographic information such as sex, instant offense, method of execution, and the time spent on death row from the sentencing date. We aim to bring to the forefront the complexity of capital punishment and its use in the mentally ill population.

REFERENCES

Wadsworth CS, Newman WJ, Burton PR: Ferguson v. Florida: rationally understanding competence to be executed. J Am Acad Psychiatry Law 42(2):234-241, 2014

Gogna, A: Competency to Execute: Unjustified Forcible Medication Regimes and the Insanity Defense, 2012

QUESTIONS AND ANSWERS

Which landmark case deemed capital punishment to be a direct violation of the Eighth Amendment?

a. Ford v. Wainright
b. Penry v. Lynaugh
c. Estelle v. Smith
d. Roper v. Simmons
ANSWER: a

Capital Punishment is legal in how many of the fifty states?

a. 25
b. 40
c. 31
d. 17
ANSWER: c

F14 PARENTING IN THE TWENTY-FIRST CENTURY: WHAT IS "DANGEROUS"?

Stephanie Yarnell-MacGrory, MD, PhD, New Haven, CT
Simha Ravven, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

To discuss the trends in litigation and new laws governing how one parents children in modern America and the implications.

SUMMARY

With the new amendment to the Illinois Code of Criminal Procedure taking effect in summer 2018, Illinois becomes the first state to address the legal culpability of women who commit criminal acts during episodes of postpartum mental illness, and brings legislation more in line with the longstanding Infanticide Act of 1938. The Infanticide Act of 1938 is a UK law that allows consideration of a woman's perinatal mental health in determining culpability. But is Illinois an anomaly or the first in what will become a growing trend? The cultural narrative in the United States around postpartum mental illness, a woman's risk to her children's health, and even how to parent is a complicated one with many controversial cases. Legal proceedings have stemmed from topics such as fetal harm, abortion and fetal personhood statutes; substance use and pregnancy; environmental toxins; vaccination controversies; dietary restrictions; and even whether a child should be allowed to play outside. This presentation will discuss Illinois' new legislation regarding the effects of postpartum mental illness on culpability, as well as specific, high-profile civil and criminal cases exploring what it means to be "dangerous" to a child's health.

REFERENCES

Illinois General Assembly: Public Act 100-0574. Available at: http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=100-0574&GA=100

Fentiman LC: Blaming Mothers: American Law and the Risks to Children's Health. New York University Press, 2017

QUESTIONS AND ANSWERS
Which state was the first to pass a law formalizing postpartum mental illness as a mitigating factor in criminal court?

a. Michigan
b. Massachusetts
c. Vermont
d. Illinois
e. Connecticut
ANSWER: d

Which of the following have been litigated in court?

a. Substance abuse in pregnancy
b. Fetal personhood statutes
c. Vaccinations of children
d. Dietary restrictions imposed upon children
e. All of the Above
ANSWER: e

F15 RACE AND STANDARDIZED RISK ASSESSMENTS: ARE THERE INHERENT BIASES? A LOOK AT THE COMPAS

Bridget McCoy, MD, Albuquerque, NM
Melodie Foellmi, PhD, Brooklyn, NY
Matthew Grover, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE
There has been concern that standardized risk assessment tools may be inherently biased or inaccurate. This poster analyzes data gathered from a multi-jurisdiction diversion program to examine the effect that race may have on COMPAS scores and the strength of the relationship between race, COMPAS scores, and program completion.

SUMMARY
Mental health diversion programs have been growing rapidly in the United States over the last few decades. The goals of these programs include reducing recidivism and getting people engaged in community treatment rather than incarcerated, with hopes of better long term outcomes. The incorporation of standardized recidivism risk tools has been recommended as best practice in achieving these outcomes. As these tools are increasingly incorporated, there has been concern expressed in both research and the courtroom that they may be inaccurate and inherently biased against certain groups, namely minorities and the poor. The COMPAS is one such tool, and in one study it was demonstrated that race was a factor in inaccuracies of both over-prediction and under-prediction when utilizing the COMPAS. In this study we will review data from a large, multi-jurisdiction diversion program using completion rate as the primary outcome measure. We will use a moderation analysis to examine the strength of the relationship of race on the relationship between COMPAS score and completion of the mandated program.

REFERENCES
Monahan J, Skeem JL: Risk assessment in criminal sentencing. Annual Review of Clinical Psychology 12:489-513, 2016

Bonfine N, Ritter C, Munetz MR. Exploring the relationship between criminogenic risk assessment and mental health court program completion. International Journal of Law and Psychiatry 45:9-16, 2016

QUESTIONS AND ANSWERS
Which of the following is not shown to be associated with termination of a mental health court treatment program?

a. History of substance abuse
b. Instant offense was a procedural offense
c. Instant offense was against a person
d. Instant offense was against property
ANSWER: c

Which of the following is not a factor measured by the COMPAS?

a. Criminal involvement
b. Family history of mental illness
c. Family criminality
d. History of violence
ANSWER: b

F16 VOLUNTARY INSTRUCTIONAL PROGRAMMING (VIP) OFFERED TO A YOUNG MALE INCARCERATED JAIL POPULATION

Erin E. Burch, PsyD, Buffalo, NY
Daniel Antonius, PhD, Buffalo, NY
Ronald Schoelerman, LMSW, Buffalo, NY

EDUCATIONAL OBJECTIVE

To learn how a specialized treatment program and group intervention on a Young Men's Unit (16- and 17-year-old males in an adult correctional facility) is viewed by its participants and effects disciplinary hearings/incidents.

SUMMARY

New York was the 49th state to introduce "Raise the Age" legislation and there is a current challenge that exists within correctional settings to provide young men with positive, assertive, and empathetic interventions in a safe, structured, and supportive environment. Young incarcerated men are often disengaged in treatment efforts (i.e., potential resistance, apathy, mental health stigma) and are often considered an "untreated" population, one reason being their length of time in custody would not make participation in a group intervention meaningful. Research suggests that exposure to rehabilitative environments can have impact upon this population's personality and aggression. Thus, Voluntary Instructional Programming (VIP) was developed and implemented in April 2016, centering on personal hygiene, emotion recognition, aspects of trust, and behavioral control among young males aged 16 and 17 years. The interventions are group-based and focus on cognitive behavioral and psycho-education techniques. With the expected shift in the New York criminal justice system (i.e., Raise the Age), VIP modules aim to provide open, voluntary, meaningful services and interventions to improve social skills, psychological well-being, and post-incarceration outcomes as well as establish transferable interventions from the adult setting to secure youth facilities.

REFERENCES

Reinsmith Meyer C, Tangney J, Stuewig J, et al: Why do some jail inmates not engage in treatment and services? International Journal of Offender Therapy and Comparative Criminology 58(8):914-930, 2014

Van der Helm P, Stams G, van Genabeek M, et al: Group climate, personality, and self-reported aggression in incarcerated male youth. The Journal of Forensic Psychiatry & Psychology 23(1):23-39, 2012

QUESTIONS AND ANSWERS

Young Men are often _____ in treatment efforts:

a. Hopeful
b. Disengaged
c. Forgotten
ANSWER: b

Voluntary Instructional Programming (VIP) targets _____ using group-based, cognitive-behavioral, and psycho-educational techniques:

a. Personal hygiene
b. Emotion recognition
c. Aspects of trust
d. Behavioral control
e. All of the above
ANSWER: e

F17 SUBSTANCE USE AND PSYCHOSIS IN FORENSIC EVALUATIONS FOR VIOLENT CRIME IN NORTH CAROLINA

Nichole Wolfe, MD, Butner, NC
Melisa Tyndall, MD, Raleigh, NC

EDUCATIONAL OBJECTIVE
To improve the knowledge base of NC evaluators regarding the common trends of substance use associated with psychosis in first degree murder/attempted murder crimes and the influence of substance induced psychosis on criminal competency and/or responsibility.

SUMMARY
There is much discussion and research that identifies a relationship between psychotic disorders and substance abuse. This project aims to assess whether psychosis in the context of substance abuse bears any difference in the final forensic opinion for capacity and/or criminal responsibility: is substance abuse a mere association with the disorder or does substance abuse contribute to psychosis in such a way that capacity or criminal responsibility is altered? In examining this question, the commonality of substance abuse in violent crime (first degree murder or attempted first degree murder) can be identified as well as which substances are more frequently abused in these types of crimes. This information will assist forensic evaluators in North Carolina in considering the most common relationships between substance abuse and psychotic symptoms as it pertains to violent behavior. Additionally, the results could lead to future considerations in legal standards for substance induced psychosis. The results could also be compared to state or regional trends.

REFERENCES
Bourget D: Forensic considerations of Substance-Induced Psychosis. J Am Acad Psychiatry Law 41(2), 2013

Feix D, Wolber G: Intoxication and settled insanity: a finding of not guilty by reason of insanity. J Am Acad Psychiatry Law 35(2), 2007

QUESTIONS AND ANSWERS
Does the M'Naughten standard give any consideration to whether a defendant was using drugs while committing a crime?

a. Yes
b. No
ANSWER: b

Comorbid alcohol abuse and dependence increases the likelihood of committing homicide _____ for individuals with Schizophrenia:

a. Substantially
b. Moderately
c. Modestly
ANSWER: a

F18 WHO SAID WHAT? MENTAL HEALTH INTERPRETING IN FORENSIC EVALUATIONS IN MASSACHUSETTS

Margarita Abi Zeid Daou, MD, Worcester, MA
Amam Saleh, MD, Worcester, MA
Sowmya Tewari, MD, MS, New York, NY

EDUCATIONAL OBJECTIVE
To obtain an update on forensic interpreter services in the state of Massachusetts, to highlight areas of improvement on the provision of adequate interpreter services by the Massachusetts Department of Mental Health, and to allow for the development of clear practice guidelines to which forensic evaluators could refer.

SUMMARY
Executive Order 13166 entitled “Improving Access to Services for Persons with Limited English Proficiency” requires federally-funded agencies to provide individuals with Low English Proficiency (LEP) free access to interpreters. In Federal Courts, 28 U.S. Code § 1827 provides guidance on interpreter qualification and certification requirements. In Massachusetts, the Department of Mental Health (DMH) provides interpreter services for clients with LEP hospitalized at a DMH facility. Designated Forensic Professionals (DFPs), credentialed by the Massachusetts DMH to conduct certain types of evaluations, can access these services when evaluating individuals with LEP in DMH facilities. However, DFPs also work in various settings where access to interpreters is uneven. In this study, we aimed to examine how

Massachusetts' forensic evaluators use interpreter services to overcome language barriers when evaluating individuals with LEP. Through Qualtrics, we are surveying the 123 DFPs in Massachusetts. Data collection is ongoing and final results will soon be available to examine how the experiences of different DFPs compare depending on their background (psychologists vs. psychiatrists) and their work settings. Optimizing equal access to interpreter services is crucial for forensic evaluators to provide accurate and fair opinions to the Courts when language may be a barrier.

REFERENCES

Improving Access to Services for Persons with Limited English Proficiency. Executive Order 13166. Federal Register, 65, No. 159, 2000.

Ingvarsdotter K, Johnsdotter S, Ostman M: Lost in interpretation: the use of interpreters in research on mental ill health. Int. J. social psych 58(1), 2012

QUESTIONS AND ANSWERS

What legislative code dictates requirements for certified court interpreters?

a. 24 U.S. Code § 1964
b. U.S. Code § 1983
c. 28 U.S. Code § 1827
d. Fed. U.S. Code § 1827
ANSWER: c

Which of the following are not possible types of interpreting?

a. In-person interpreting
b. Remote simultaneous interpreting
c. Telephone interpreting
d. None of the above
ANSWER: d

F19 AUTISM AND CRIMINALITY, IS THERE A LINK? A REVIEW OF THE LITERATURE

Sowmya Tewari, MD, MS, New York, NY

EDUCATIONAL OBJECTIVE

To gain a better understanding of the psychopathology associated with autism, thus leading to reduced risk of violent offending behavior.

SUMMARY

Thus far, systematic reviews have been inconclusive in identifying an association between Autism and violent offending criminality, despite trends to popularize this idea in current media and entertainment. A review of literature dating back to 1940 was conducted to determine if autism diagnosis is correlated with violent criminality. The literature suggests that people with autism are in fact overrepresented in the criminal justice system, and that co-morbidities such as ADHD, conduct disorder, and social/emotion-regulation deficits may confound this overrepresentation. At current, the criminal justice system is lacking services to identify and support possible protective factors for the autism population. By gaining a better understanding of the psychopathology associated with autism, as well as its association with commonly diagnosed co-morbidites, protective factors against violent offending behavior may be better understood, thus leading to reduced risk.

REFERENCES

Heeramun R, Magnusson C, Hellner C, et al: Autism and convictions for violent crimes: population-based cohort study in Sweden. JCAAP 56(6):491-497, 2017

Im DS: Template to perpetrate: an update on violence in autism spectrum disorder. Harvard Rev Psychiatry 24(1):14-35, 2016

QUESTIONS AND ANSWERS

Is there a link between Autism and Criminality?

ANSWER: Yes

What preventative methods can be used when assessing violent criminality in Autism?

ANSWER: Comorbid illness(es), social deficits, emotion-regulation

F20 MINIMIZING ELOPEMENT IN A MEDIUM SECURITY PSYCHIATRIC HOSPITAL

Mitchell H. Dunn, MD, Dallas, TX
Deepti Vats, MD, Rockwall, TX
Ginger Davis, LCSW, Terrell, TX

EDUCATIONAL OBJECTIVE

To educate the audience on how changing policies and increasing awareness of the risk of elopement can impact elopement risk at a state psychiatric hospital with a growing forensic population.

SUMMARY

Over the past 10 years, the forensic population at a Texas state hospital has grown from less than 10% of the total census to well over 50%. Our facility has no security fencing or guard towers. The units are locked, but the grounds are uncontrolled and the two vehicle entrances are unmonitored. As the forensic population increased, the rate of elopement seemed to be increasing as well, but elopements were not being tracked. Statewide, hospital superintendents were being threatened with dismissal if another high-profile elopement occurred. In Terrell, the Chief of Police was expressing frustration when his officers had to become involved in attempting to locate forensic patients who escaped. A review of the elopement records in the summer of 2017 revealed that successful elopements were occurring at the rate of about three per month. The presenters organized a task force to examine the issue of elopement and determine if recommendations could be made to address the problem without compromising the treatment mission of the hospital. These recommendations were then presented at Grand Rounds and policy changes were adopted. This presentation will present data on the rate and type of elopements that occurred after the policy changes.

REFERENCES

Brumbles D, Meister A: Psychiatric elopement: using evidence to examine causative factors and preventative measures. Archives of Psychiatric Nursing 27(1):3-9, 2013

Bowers L, Alexander J, Gaskell C: A trial of anti-absconding intervention in acute psychiatric wards. Journal of Psychiatric and Mental Health Nursing 10(4):410-416, 2003

QUESTIONS AND ANSWERS

After a survey of recent elopements, the hospital committee recommended which of the following changes?

a. Eliminating unsupervised grounds access for forensic patients
b. Initiating the use of a specified elopement note in the hospital EHR
c. Communication about a patient's elopement history when patients were transferred from one unit to another
d. Treatment team discussions about the risk of elopement whenever patients are granted an increase in privileges
e. All of the above
ANSWER: e

After a change in hospital policy was initiated, hospital elopements:
a. Appeared to increase, possibly due to increased documentation and reporting
b. Decreased in rate, but increased in terms of impact on the community
c. Decreased in both overall rate and community impact
ANSWER: c

F21 FORENSIC PSYCHIATRY IN THE AGE OF ARTIFICIAL INTELLIGENCE: IMPLICATIONS AND APPLICATIONS TO RISK ASSESSMENT

Peter S. Martin, MD, MPH, Buffalo, NY

EDUCATIONAL OBJECTIVE

To provide a comprehensive review of artificial intelligence in the context of forensic psychiatry, with a focus on utilization in risk assessment.

SUMMARY

The use of artificial intelligence (AI) is increasingly becoming commonplace in today's society, ranging from use in smartphones to experimentation in medical research. While research into the use of AI has begun in several branches of medicine, there have been limited applications to psychiatry. Here, we will provide a literature review of applications to date of AI in medicine, with a particular focus on forensic psychiatry. Given the nature of this information, sources of information for the review will include both traditional scholarly journals and pertinent

results from the lay press for instances with commercial products. There will be an overview of various computer-assisted tools that have been applied to traditional social sciences. Pertinent examples will be highlighted to provide perspective for how these tools can be used in psychiatry. There will be a focus on how AI could be utilized in risk assessment algorithms to provide additional insights and/or improve predictive modeling. A hypothetical example will explore how the use of these tools could improve risk assessment in those involved in probation. A discussion for other future directions and challenges, in particular access to sufficient databases to allow for exploration of these concepts, will complete this review.

REFERENCES

Constantinou AC, Freestone M, Marsh W, et al. Causal inference for violence risk management and decision support in forensic psychiatry. Decision Support Systems 80:42-55, 2015

Baumgartner K, Ferrari S, Palermo G: Constructing Bayesian networks for criminal profiling from limited data. Knowledge-Based Systems. 21(7):563-572, 2008

QUESTIONS AND ANSWERS

Which of the following is the most accurate explanation for concepts related to artificial intelligence?

a. Deep learning attempts to replicate some part of human intelligence
b. Machine learning builds upon layers of abstractions from databases to construct higher-level meaning
c. Deep learning allows computers to learn "on their own" from large datasets
d. Artificial intelligence is a narrower description than either machine learning or deep learning
e. Deep learning builds upon layers of abstractions from databases to construct higher-level meaning
ANSWER: e

Which of the following is a confirmed example of the use of artificial intelligence in risk assessment?

a. Use of facial recognition to detect increased risk of recidivism for sexual violent predators
b. Detecting suicidality from Twitter accounts
c. Risk of suspensions for violent behavior middle school students
d. Threat assessment for active shooter trainings
e. Risk of relapse of opioids in recent those released from jail
ANSWER: b

F22 SIBLING-ON-SIBLING VIOLENCE

Peter S. Martin, MD, MPH, Buffalo, NY

EDUCATIONAL OBJECTIVE

To provide a comprehensive review of sibling violence, including epidemiology, risk factors, theoretical and empirically-based frameworks, and treatment recommendations.

SUMMARY

Sibling-on-sibling violence is a unique form of harm often not fully recognized, typically due to the common acceptance of sibling rivalries, or "kids being kids." Additionally, there is no standard definition for what is considered sibling violence, either in research or legal settings. Here, we will review the literature on sibling violence to provide additional empirical support. Sibling violence is the most common form of family violence, greater than child abuse and intimate partner violence combined. Emotional abuse is more common than physical abuse, yet there are common instances of severe violence. The frequency is highest before adolescence, but severity peaks in adolescence. Theoretical frameworks to explain these behaviors include feminist theory, conflict theory, and social learning theory. Based on a review of the literature, and building off of previous evidence-based theories, there will be a description of the various factors that have been shown in empirical studies to be risk factors for the development of sibling violence, including individual and relational factors. Protective factors will be explored. The short- and long-term impact of sibling violence will be discussed. There will be a brief review of siblicide. Specific preventative and treatment options will be examined.

REFERENCES

Yeh HC, Lempers JD. Perceived sibling relationships and adolescent development. Journal of Youth and Adolescence. 32(2):133-147, 2004

Caspi, J: Building a sibling aggression treatment model: Design and development research in action. Research on Social Work Practice 18(6):575-585, 2008

QUESTIONS AND ANSWERS
Which of the following is a theoretical characteristic of parent-child relationships that can lead to sibling rivalry?

a. Positive affect and emotional closeness
b. Parents not showing favoritism towards different children
c. The use of physical punishment as a reaction to disruptive behaviors
d. Acceptance of all children
e. Parental encouragement for a child to use scapegoating of a sibling
ANSWER: c

Both perpetrators and victims of sibling violence are at risk for all of the following EXCEPT?

a. Developmental delays
b. Anxiety disorders
c. Substance use disorders
d. Suicide attempts
e. Bipolar disorder
ANSWER: e

F23 BARRIERS TO PSYCHIATRIC ADVANCE DIRECTIVE USE IN AN ACADEMIC MEDICAL CENTER

Elizabeth E. Sita, MD, Chicago, IL
Stephen H. Dinwiddie, MD, Chicago, IL

EDUCATIONAL OBJECTIVE
To identify and discuss provider-level barriers to utilization of psychiatric advance directives in the treatment of patients with serious mental illness. (Objective Area: Service)

SUMMARY
Psychiatric advance directives may facilitate procedural justice and minimize coercion among patients with serious mental illness. However, these directives are largely underutilized. To better understand provider-level barriers, a 21-item questionnaire was sent to healthcare professionals likely to discuss advance directives with mentally ill patients at our institution (psychiatrists/trainees, behavioral health nurses, therapists, social workers, and pastoral services). Respondents (N=76) were most often psychiatric residents (30.3%) or attending psychiatrists (30.3%) and either very new to practice (<4 years) or quite seasoned (>20 years). While the vast majority were acquainted with medical advance directives, less than half were familiar with Illinois' psychiatric advance directive treatment option (42.1%). Barriers most often identified included lack of awareness (40.8%), feeling inadequately trained (52.6%), and being uncertain of how to complete the directive (44.7%). Overall, respondents tended to agree that psychiatric advance directives were useful and relevant to patient care. Findings suggest that a number of practical matters impede routine utilization of psychiatric advance directives, chief among them a lack of widespread awareness that such an option exists in Illinois.

REFERENCES
La Fond JQ, Srebnik D: The impact of mental health advance directives on patient perceptions of coercion in civil commitment and treatment decisions. Int J Law Psychiatry 25:537-55, 2002

Swanson JW, Swartz MS, Elbogen EB, et al: Facilitated psychiatric advance directives: a randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. Am J Psychiatry 163:1943-51, 2006

QUESTIONS AND ANSWERS
Psychiatric advance directives (check all that apply):

a. May enhance a patient's sense of inclusion in medical decision-making
b. May diminish a patient's perception of coercion in the treatment process
c. Are not routinely utilized
d. All of the above
ANSWER: d

F24 POSTER WITHDRAWN

F25 THE INVOLUNTARY TREATMENT OF OPIOID AND OTHER SUBSTANCE USE DISORDERS

Paul S. Appelbaum, MD, New York, NY
Abhishek Jain, MD, New York, NY
Debra Pinals, MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE

To recognize the historical background and ethical underpinnings of involuntary treatment for substance use disorders; to describe addiction treatment providers' opinions and experiences regarding adult civil commitment for substance use disorders; and to summarize empirical evidence and clinical outcomes, including effectiveness and limitations, particularly as they relate to policy implications.

SUMMARY

The vast majority (about 85%) of individuals in the U.S. who need substance use disorder treatment do not think they need it. This, coupled with the rising rate of overdose deaths (now at least an average of 175 daily), helps explain the appeal of legislation that permits compulsory addiction treatment for patients before they "hit bottom." Most U.S. states have statutes allowing adult civil commitment for substance use disorders, and more states are now considering enacting similar laws or expanding their existing ones. In this panel discussion, we will explore the history of civil commitment for substance use disorders in the U.S. and discuss the ethical underpinnings of these laws – including issues such as autonomy, beneficence, capacity to make medical decisions, and fundamental questions about the degree to which substance use disorders are considered a "disease" in law and philosophy. We will summarize findings from our national survey of addiction physicians regarding their opinions and experiences with civil commitment for substance use disorders. Finally, we will review the existing scientific evidence and operational experiences, especially as they may impact policy development and help educate the public on the utility and limitations of these laws.

REFERENCES

Hall KT, Appelbaum PS: The origins of commitment for substance abuse in the United States. J Am Acad Psychiatry Law 30(1):33-45, 2002

Christopher PP, Pinals DA, Stayton T, et al: Nature and utilization of civil commitment for substance abuse in the United States. J Am Acad Psychiatry Law 43(3):313-3, 2015

QUESTIONS AND ANSWERS

According to the CDC, how many drug overdose deaths were estimated in 2016?

a. 8,000
b. 16,000
c. 32,000
d. 64,000
ANSWER: d

In which AAPL Landmark Case did the U.S. Supreme Court hold that criminalizing public intoxication did not constitute cruel and unusual punishment?

a. Robinson v. California (1962)
b. Powell v. Texas (1968)
c. North Carolina v. Alford (1970)
d. Lessard v. Schmidt (1972)
ANSWER: b

F26 FEMALE INCARCERATION: WHAT IS HAPPENING IN OKLAHOMA?

Jason Beaman, DO, Tulsa, OK
Susan Hatters Friedman, MD, Cleveland, OH
Jennifer Piel, JD, MD, Seattle, WA
Reagan Gill, DO, Tulsa, OK

EDUCATIONAL OBJECTIVE

To learn about treatment of forensic patients, development of service delivery systems, and enhancement of consulting skills.

SUMMARY
Most people are not aware that Oklahoma incarcerates more females than almost any place on the face of the earth. Oklahoma has held the highest rate of female incarceration in the United States for the past 25 years, with the rate being double the national average. This number is even more alarming when put into context of the international average, essentially placing Oklahoma at #2 in the world. There are important state and national lessons that can be examined in this alarming information. Dr. Jason Beaman will give an introduction reviewing statistics about female incarceration across the nation. Dr. Susan Hatters Friedman will examine differences in psychopathology of male and female offenders. Dr. Jennifer Piel will highlight important gender differences regarding criminal activity and recidivism with focus on Oklahoma's incarcerated female population. Dr. Reagan Gill will discuss specific interventions that have been implemented in the state of Oklahoma with hopes of mending this disturbing trend. With this knowledge, forensic psychiatrists will be better equipped to evaluate, assess, and treat female prisoners. Additionally, forensic psychiatrists can educate for improved justice for female offenders.

REFERENCES
Herrera, A: Why Oklahoma has the highest female incarceration rate in the country, 2017 Available at https://www.pri.org/stories/2017-10-03/why-oklahomas-female-incarceration-rate-so-high. Accessed March 13, 2018

MacDonald M: Women prisoners, mental health, violence and abuse. International Journal of Law and Psychiatry 36: 293-303, 2013

QUESTIONS AND ANSWERS
What are common threads for a majority of female inmates?

a. Trauma history
b. Drug charges
c. Violent crimes
d. Both A & B
ANSWER: d

How does Oklahoma rank in female incarceration?

a. #1 in the world
b. #1 in the nation
c. Both A & B
d. None of the above
ANSWER: b

F27 PHYSICIAN AID IN DYING: THE ROLE OF THE PSYCHIATRIST

Ariana Nesbit, MD, Sacramento, CA
William Connor Darby, MD, Los Angeles, CA
Richard Martinez, MD, Denver, CO
Anna Glezer, MD, Burlingame, CA

EDUCATIONAL OBJECTIVE
The objectives of this presentation are to appreciate the challenges in assessing capacity for informed decision-making in patients requesting PAD, understand guidelines and recommendations proposed by psychiatrists currently consulting on these cases, and examine the differences in capacity assessments in PAD in contrast to other situations.

SUMMARY
Physician Aid in Dying (PAD) is currently legal in six states and the District of Columbia. Because each jurisdiction provides a process and requirement under some circumstances for assessment of the requesting patient's decision-making capacity, psychiatrists are consulted in these cases. However, mental health organizations have not yet developed guidelines on how to assess capacity to consent to PAD. The panel will lead a practical and case-based discussion of several key areas for the consultant to consider. Dr. Nesbit will provide an overview of role of the psychiatrist and the unique challenges of assessing capacity to consent to PAD. Dr. Darby will lead a case-based discussion on the relevant ethical principles and several approaches to these cases. Dr. Martinez will discuss elements of capacity unique to PAD and end of life decisions, and Dr. Glezer will share her personal experience, including how her institutions are beginning to address participation in PAD, as well as the guidelines followed in assessing capacity in these cases.

REFERENCES
Ganzini L, Leong GB, Fenn DS, et al: Evaluation of competence to consent to assisted suicide: views of forensic psychiatrists. Am J Psychiatry 157(4):595-600, 2000

McCormack R, Flechais R: The role of psychiatrists and mental disorder in assisted dying practices around the world: a review of the legislation and official reports. Psychosomatics 53(4):319-26, 2012

QUESTIONS AND ANSWERS
Which of the following regarding PAD legislation is true?

a. Psychiatric consultation is required prior to PAD approval in every jurisdiction where it is legal
b. If a patient is depressed, they are not eligible for PAD in any US jurisdiction
c. Forensic psychiatrists with ethical objections to PAD advocate for higher thresholds for capacity to consent to PAD
d. All of the above
ANSWER: c

Which of the following should be considered when assessing a patient's capacity to consent to PAD?

a. The presence of non-pathological distress such as sadness or demoralization
b. The consistency of the patient's request
c. The patient's process of reasoning
d. All of the above
ANSWER: d

F28 CONSULTATION, CRITIQUE, AND CREATION: FORENSIC PSYCHIATRY AND HOLLYWOOD

Vasilis K. Pozios, MD, Township, MI
Praveen Kambam, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE
To describe the history of forensic psychiatry's interface with Hollywood, appreciate how Hollywood has shaped perceptions of the field as well as people with mental illnesses and how forensic psychiatry may have been complicit in perpetuating stigma, and understand the importance of competently and responsibly interfacing with Hollywood.

SUMMARY
Hollywood "for better or for worse" has shaped public perceptions of forensic psychiatry. Less known is how forensic psychiatrists have shaped Hollywood. Through consultation, critique, and even creation, forensic psychiatrists have played prominent roles impacting the entertainment industry. For example, Cesare Lombroso's theory of criminal atavism, first popularized in the United States by Arthur MacDonald, influenced Dracula, Jekyll & Hyde and Frankenstein. As a consultant to Hollywood's infamous Hays Office, Carleton Simon influenced classic films like Scarface. Critical of the role comic books played in juvenile delinquency, Fredric Wertham's "Seduction of the Innocent" fueled anti-comics hysteria, forever changing the comic book publishing industry. Park Dietz has consulted on some of Hollywood's most memorable films and TV series, including Se7en and Law & Order. But has forensic psychiatry been complicit in perpetuating stigma through an overemphasis on violence? Does the field have a responsibility to rectify this by proactively engaging Hollywood? The panelists share the little-known stories of some forensic psychiatrists who have interfaced with the entertainment industry while contextualizing their historical significance, arguing why it's important for AAPL members to familiarize themselves with this history and the significance of its legacy.

REFERENCES
Wertham, F: Seduction of the Innocent. New York: Rinehart & Company, 1954

Simon CP: Carleton Simon Papers (housed at SUNY Albany). 1881-1952, 1956

QUESTIONS AND ANSWERS
Pre-Motion Picture Production Code proposed "Be Careful" included:

a. The use of firearms
b. Technique of committing murder by whatever method
c. Sympathy for criminals
d. All of the above
ANSWER: d

Who coined the term "born criminal"?

a. Fredric Wertham
b. Park Dietz
c. Cesare Lombroso
d. All of the above
ANSWER: c

F29 NOWHERE TO GO: RE-INSTITUTIONALIZATION IN THE US

Barbara E. McDermott, PhD, Sacramento, CA
Katherine Warburton, DO, Sacramento, CA
Darci Delgado, PsyD, Sacramento, CA
Joel Dvoskin, PhD, Tucson, AZ

EDUCATIONAL OBJECTIVE

This panel will explore the new mental health crisis in the US: severely mentally ill receiving treatment in the criminal justice system. Attendees will identify trends in competence restoration, factors associated with these referrals, the criminal risk and criminogenic needs of these individuals, and potential solutions to this epidemic.

SUMMARY

The Supreme Court requires that all individuals facing criminal prosecution be competent to stand trial. There is evidence that the number of defendants referred for competence evaluations are rising, leading to a corresponding increase in orders for restoration. Forensic and criminal justice systems increasingly are overburdened with such individuals and lack adequate resources to manage these admissions. For example, defendants with serious psychiatric disorders frequently await admission to hospitals in county jails, often without treatment. This panel will discuss research conducted to understand and intervene with this crisis. Dr. Warburton will describe national trends, including recent case law that set unrealistic timelines for the evaluation and restoration of defendants. She will also present the results of a nationwide survey on the IST crisis. Dr. McDermott will present data on the quantity and quality of community mental health treatment received by patients committed as incompetent, as well as the linkage between mental illness, homelessness and criminality. Dr. Delgado will discuss the problems associated with the evaluation and treatment of forensic patients, specifically related to criminal risk and criminogenic needs. Dr. Dvoskin will provide insight into the national epidemic and discuss the need for more data-based decision-making.

REFERENCES

Gowensmith WN, Frost LE, Speelman DW, et al: Looking for beds in all the wrong places: outpatient competency restoration as a promising approach to modern challenges. Psychology Public Policy and Law 22:292-305, 2016

Skeem JL, Manchak S, Peterson JK: Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. Law and Human Behavior 35(2): 110-126, 2011

QUESTIONS AND ANSWERS

In national surveys, what factor is not cited as contributing to the national crisis of patients awaiting competency restoration?

a. Patients not medicated in jails
b. Unrealistic timelines for evaluation and restoration
c. Lack of community mental health treatment/resources for patients
d. Homelessness
ANSWER: b

Which factor has NOT been shown to mediate the relationship between an individual's mental illness and their criminal behavior?

a. Poverty
b. Substance abuse
c. Victimization
d. Gender
ANSWER: d

F30 THE OPIOID EPIDEMIC: HOW WE GOT HERE, WHERE WE ARE NOW, AND HOW TO GET OUT

Anna Lembke, MD, Stanford, CA

EDUCATIONAL OBJECTIVE:
Attendees will recognize ways in which opioid prescribing has changed from 1999 to 2016, learn the neurobiological, sociocultural, and psychodynamic factors driving over-prescribing and over-consumption of prescription opioids and hear about ideas for what health care providers can do to target this public health crisis.

ABSTRACT:
Dr. Lembke, an Associate Professor at the Stanford University School of Medicine, was one of the first in the medical community to sound the alarm regarding opioid overprescribing and the opioid epidemic. In 2016, she published her best-selling book, Drug Dealer, MD – How Doctors Were Duped, Patients Got Hooked, and Why It's So Hard to Stop (Johns Hopkins University Press). Her book, on which today's presentation is based, combines case studies with national data, cultural anthropology, and neuroscience, to explore the complex relationship between doctors and patients around opioid prescribing. Drug Dealer, MD has had an impact on policy makers, health care providers, and legislators across the nation. Dr. Lembke has testified before Congress, was a featured guest on Fresh Air with Terry Gross, appeared on MSNBC with Chris Hayes, the Today Show with Dr. Oz, the Megyn Kelly Show on CBS, and numerous other media broadcasts. Using her academic position and her public platform, Dr. Lembke continues to educate on the problem of overprescribing. Today you will hear about what forces inside and outside medicine are driving the opioid epidemic, and what to do about it.

QUESTIONS AND ANSWERS:
The most opioids by volume in the United States are prescribed by:

a. A small subset of ethically compromised 'pill mill doctors'
b. Pain specialists
c. Family medicine doctors
d. Dentists
ANSWER: c

CDC data on opioid related death trends between 2012 and 2016 show

a. A steep increase in deaths related to illicit opioids (heroin and illicit fentanyl), and a decline in deaths related to prescription opioids to pre-2000 levels
b. A steep increase in deaths related to illicit opioids, and a plateauing in deaths related to prescription opioids
c. An increase in deaths related to both illicit and prescription opioids
d. A decrease in deaths related to both illicit and prescription opioids
ANSWER: b

F31 CRISIS NEGOTIATION & THE WACO SIEGE

James L. Knoll, IV, MD, Syracuse, NY
George David Annas, MD, Syracuse, NY
Gary Noesner, Moneta, VA
Gregg McCrary, Fredericksburg, VA

EDUCATIONAL OBJECTIVE
To understand the crisis negotiation process and how forensic psychiatrists can best assist trained crisis negotiators.

SUMMARY
Crisis negotiation is a law enforcement technique used to communicate with those who threaten violence. It is a highly sophisticated method of managing and resolving critical events using "active listening" and other skills along a "behavioral change stairway." The process has been operationalized and refined by the FBI's Crisis Negotiation Unit (CNU). This panel will explore crisis negotiation with three experts now retired from the FBI.

During the Waco Siege of 1993, Mr. Gary Noesner served as Overall Negotiations Coordinator and his book "Stalling for Time" was made into a TV mini-series. Mr. Gregg McCrary supported crisis negotiations efforts during the Waco Siege by employing the assessment skills of the FBI's Behavioral Science Unit. These experts will explain the crisis negotiation process via their experiences during the Waco Siege. Suggestions for how forensic psychiatrists can best assist trained crisis negotiators will be discussed.

REFERENCES
Neosner G: Stalling for Time: My Life As an FBI Hostage Negotiator. Random House Publishing Group, 2018

Thibodeau D, Whiteson L: Waco: A Survivor's Story. Hachette UK, 2018

QUESTIONS AND ANSWERS
According to the Behavioral Change Stairway Model, crisis negotiators use all of the following skills, except:

a. Active Listening
b. Empathy
c. Unpredictability
d. Rapport
ANSWER: c

Most crisis negotiation incidents are:

a. Well planned by the subject
b. Resolved by tactical operations
c. Non-hostage situations
d. Likely to last at least 6 hours
ANSWER: c

F32 MINORITY REPORT: GENDER BIAS IN FORENSIC PSYCHIATRY

Kelly L. Coffman, MD, MPH, Atlanta, GA
Helen Farrell, MD, Boston, MA
Eric Y. Drogin, JD, PhD, Hingham, MA
Thomas G. Gutheil, MD, Boston, MA

EDUCATIONAL OBJECTIVE
Attendees will gain improved knowledge of perceived vs. accurate gender biases in the practice of forensic psychiatry. They will learn how gender may influence their own practice and how they are perceived by attorneys and jurors. Females will learn strategies to empower them to feel equal to their male counterparts.

SUMMARY
The fields of medicine, law, and criminal justice were historically dominated by men. However, women have an increasingly significant presence in each of these fields of work. To date, only a few authors have discussed the differences that female and male forensic psychiatrists face in their work. This panel will broadly discuss gender bias in academic medicine. It will then delve more specifically into perceived and real gender biases faced by forensic psychiatrists in their work. Situations in which gender bias or gender differences are instrumental will also be discussed. Finally, strategies for empowering women to focus on their work product rather than their gender will be discussed.

REFERENCES
Kaempf AC, Baxter P, Packer IK, et al: Gender and the experience of mental health expert witness testimony. J Am Acad Psychiatry Law 43:52-9, 2015

Price M, Recupero PR, Strong DR, et al: Gender differences in the practice patterns of forensic psychiatry experts. J Am Acad Psychiatry Law 32:250-8, 2004

QUESTIONS AND ANSWERS
The results of a 2015 study suggest which of the following:

a. More men than women are told their fees are excessive
b. Men feel more confident in their opinions compared to women
c. More men compared to women feel the case's desired outcome is due to their testimony
d. All of the above
ANSWER: d

Results of a 2001 survey of AAPL meeting attendees demonstrated that which of the following were associated with charging a professional fee greater than the median:

a. Gender
b. Years since residency
c. Having academic credentials
d. A and B
e. B and C
ANSWER: e

F33 PRAY THE GAY AWAY: AN ANALYSIS OF LAWS BANNING CONVERSION THERAPY

Andrew Halls, MD, San Francisco, CA
Vivek Datta, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

To discuss the arguments for and against legislation banning "conversion therapy" and implications for psychiatric practice, and be familiar with laws regulating the practice of sexual orientation change efforts for minors.

SUMMARY

At the time of writing, 10 states and the District of Columbia have enacted legislation that bans the practice of Sexual Orientation Change Efforts (SOCE) or "conversion therapy" for under-18s. These laws have successfully fought off a number of legal challenges to their constitutionality and while they enjoy broad support amongst LGBTQ activists, they have not received support from professional organizations such as the American Psychiatric Association or American Psychological Association. The failure to consult psychiatrists in developing such policy may lead to unintended consequences for the wider regulation of the profession. We review and analyze case law related to sexual orientation change efforts. We find that there are a number of other legal recourses to address such practices including tort law, contract law, and anti-deception statutes, and review civil litigation against practitioners of conversion therapy. Forensic Psychiatrists have a key role in educating policy makers regarding efforts to regulate psychotherapeutic practices, including those of dubious value in order to develop sensible evidence-based policies that do not overly regulate psychiatric practice.

REFERENCES

Victor JM. Regulating sexual orientation change efforts: the California approach, its limitations, and potential alternatives. Yale Law Journal 123:1532-1585, 2014

Green R. Banning therapy to change sexual orientation or gender identity in patients under 18. J Am Acad Psychiatry Law 45:7-11, 2017

QUESTIONS AND ANSWERS

In Pickup v. Brown (2013), plaintiffs challenged the constitutionality of California's ban on sexual orientation change efforts, arguing it violated which of the following constitutional amendments?

a. 1st and 5th
b. 1st and 6th
c. 1st and 8th
d. 1st and 14th
ANSWER: d

Which of the following arguments against banning sexual orientation change efforts for minors has most likely influenced organizational psychiatry's stance not to support such bans?

a. It constitutes a violation of free speech
b. It essentializes the concepts of sexual orientation and gender identity
c. It constitutes governmental intrusion into the doctor-patient relationship
d. The worst examples of such treatment are already considered ethical violations
ANSWER: c

F34 RELIGIOSITY IN RELATION TO VIOLENCE & CRIME: RISK OR PROTECTIVE FACTOR?

Elias Ghossoub, MD, St. Louis, MO

EDUCATIONAL OBJECTIVE

To understand the impact of religiosity on self-directed and other-directed violence and to explore the effect of religiosity on crime perpetration.

SUMMARY

Protective factors against self-directed and other-directed violence have been less studied than risk factors. The associations between religiosity and suicide, other-directed violence, and criminal behavior have yielded conflicting results given methodological issues. We used data of adults from the National Survey on Drug Use and Health from 2008 through 2014. We used attitudinal and behavioral indicators to measure religiosity. We then conducted bivariate analyses to compare socio-demographic and mental health profiles of non-religious and religious individuals. We then conducted regression analyses of (1) perpetration of violent behavior and (2) being arrested the past year, on religiosity. Around 18% of the sample were non-religious. The non-religious group was significantly more likely to attempt suicide, but not to commit other-directed violence. Moreover, the non-religious were more likely to commit self-directed rather than other-directed violence compared to the religious group. Religiosity did not seem to affect the likelihood of being arrested. Our individual-level data suggests that the effect of religiosity on violence and criminality is complex and our study provides some insights into these associations.

REFERENCES

Baier CJ, Wright BRE:'If you love me, keep my commandments': a meta-analysis of the effect of religion on crime. Journal of Research in Crime and Delinquency 38(1):3-21, 2001

Lawrence RE, Oquendo MA, Stanley B: Religion and suicide risk: a systematic review. Arch Suicide Res 20(1):1-21, 2016

QUESTIONS AND ANSWERS

Religiosity seems to be a protective factor to having which of the following:

a. Non-suicidal selfiInjury
b. Suicidal ideations
c. Suicide attempts
d. Completed suicide
e. Assaultive behavior
ANSWER: c

Religiosity seems to be a risk factor for which of the following:

a. Assaultive behavior among 18-25-year-olds
b. Assaultive behavior among 26-49-year-olds
c. Assaultive behavior among >49-year-olds
d. Incarceration among adults
e. Being arrested among 18-25-year-olds
ANSWER: a

F35 ADVERSE CHILDHOOD EXPERIENCES OF TRAUMA AND EFFECT ON CRIMINAL RECIDIVISM

Mansfield Mela, MBBS, Saskatoon, SK, Canada
Marelize Muller, BA, Saskatoon, SK, Canada
Tara Anderson, MSc, Saskatoon, SK, Canada
Gu Deqiang, PhD, Saskatoon, SK, Canada

EDUCATIONAL OBJECTIVE

To review the literature on adverse childhood experiences and criminality, to learn about the risks of recidivism in mentally disordered offenders (MDOs) exposed to multiple ACE, and to understand the relationship of ACE and the reintegration potential to the community of release among MDOs.

SUMMARY

The Regional Psychiatric Center is a multilevel forensic psychiatric treatment facility affiliated with the University of Saskatchewan. It admits mentally disordered offenders considered high risk high needs and in need of treatment in a highly structured and secured environment. Treatment is undertaken by an interdisciplinary team approach. The team is made up of psychiatrists, psychologists, social workers, nurses and behaviourists. In its 40 years of existence, over 7,000 different offenders have received treatment in the center. Data on psychiatric, demographic,

criminogenic, clinical, intervention and recidivism was used to rate the components of adverse childhood experiences (ACE) information, trauma history, physical, sexual and emotional. This was then correlated with clinical factors, treatment-related outcomes, and the rates of recidivism covering all patients admitted between 1996 and 2010. The results of the logistic regression and survival curve analysis showed trauma scores, especially sexual and total, may represent risk elevation. The relationship of trauma experience with other relevant outcomes, specifically recidivism, was explored. The presentation will expand on the knowledge of trauma experience to various psychiatric disorders and criminogenic factors.

REFERENCES

Cottle, Lee, Heilbrun: Criminal justice and behavior: the prediction of criminal recidivism in juveniles, a meta-analysis 28(3):367-394, 2001

Kubiak SP: The effects of PTSD on treatment adherence, drug relapse, and criminal recidivism in a sample of incarcerated men and women. Research on Social Work Practice 14(6);424-433, 2004

QUESTIONS AND ANSWERS

Which of the following are domains in the ACE ?

a. Parental support
b. Parental divorce
c. Parental employment
d. None of the above
ANSWER: d

The following are associated with increasing the rate of criminal recidivism?

a. Employment status
b. Substance use
c. Strong supportive community
d. Higher education
e. None of the above
ANSWER: b

F36 WORKING WITH INDIVIDUALS WITH NEURODEVELOPMENTAL DISORDERS IN FORENSIC AND CORRECTIONAL SETTINGS

Debra A. Pinals, MD, Ann Arbor, MI
Bruce Gage, MD, Olympia, WA
Barry Wall, MD, Cranston, RI
Irina King, Lakewood, WA

EDUCATIONAL OBJECTIVE

To develop strategies to best address the needs of persons with I/DD in correctional settings; to describe vulnerabilities of patients with I/DD as they relate to the need for enhanced programming within correctional and forensic settings.

SUMMARY

Persons with intellectual and developmental disabilities (I/DD) are over-represented in correctional and forensic settings. For largely historical and expedient reasons, within these environments, persons with I/DD are often placed side by side with persons with mental illness, and are often under-diagnosed and at times over-medicated. Programming designed for persons with mental illness, or the general inmate population leave staff feeling ill-equipped to provide uniquely suitable strategies to maximize functional autonomy and assess and support individuals with these challenges or provide means to reduce behavior that result in control measures, discipline, isolation, seclusion, and restraint. Staffing models, environmental issues, and task demands often do not align with the unique abilities of this population. Victimization risks are high. In this workshop, presenters will review unique aspects of work with persons with I/DD across justice-related settings. A review of the Slater model for competence remediation, multi-state systems issues and emerging litigation pertaining to jail wait-times for hospitalization, as well as a review of housing challenges and program needs within state correctional systems will be described. Active participation of attendees sharing experiences in developing practices for this complex population will be encouraged.

REFERENCES
Davis LA: People with intellectual disability in the criminal justice system: victims & suspects. The Arc. Available at http://www.thearc.org/page.aspx?pid=2458, accessed Mar 30, 2018

Sondennaa E, Rasmussen K, Nottestad J: Forensic issues in intellectual disability. Curr Opinion Psychiatry 21:449-453, 2008

QUESTIONS AND ANSWERS
The overall percentage of individuals in correctional settings with intellectual and developmental disabilities is:

a. 15-20%
b. 4-10%
c. 1-3%
d. 18-25%
ANSWER: b

Factors to consider about placement within forensic and correctional institutions include:

a. Exposure to potential victimization
b. Exposure to excessive stimulation
c. Exposure to coercion
d. Exposure to excessive task demands leading to frustration
e. All of the above
f. None of the above
ANSWER: e

F37 FUNDAMENTALS OF THREAT ASSESSMENT

Ronald Schouten, MD, JD, Boston, MA
John Rozel, MD, MSL, Pittsburgh, PA

EDUCATIONAL OBJECTIVE
After attending this course, attendees will be able to recognize the value of non-psychiatric approaches to violence risk management, describe the essential elements of a multidisciplinary threat management program, apply the principles of threat assessment in different settings, and evaluate ethical and legal challenges in threat assessment.

SUMMARY
Threat assessment is a professional activity related to, but distinct from, violence risk assessment. A core distinction is that violence risk assessment focuses on the likelihood that an individual poses a risk of harm to self or others, whereas threat assessment seeks to determine whether a person poses a threat of harm to another specific individual, organization, or other entity. Threat assessment is intrinsically multidisciplinary and is built on expertise from several nonclinical fields including law, law enforcement and investigation, operational security, and intelligence, with the primary focus of identifying and disrupting targeted violence. Threat assessment is typically not taught in psychiatry residency or forensic fellowship programs. Nevertheless, because of trends in workplace violence, school/campus violence, and active assailant incidents, forensic psychiatrists are increasingly likely to be asked to lend their expertise in addressing these serious societal problems. Participants will leave this course with an understanding of how to perform a threat assessment as part of a multidisciplinary team, how psychiatry contributes to the work of threat management, and what we as psychiatrists can learn from threat assessment to improve our own clinical and forensic practice. Attention will be paid to major sources of evidence, literature and ethical standards.

REFERENCES
FBI Behavioral Analysis Unit: Making Prevention a Reality: Identifying, Assessing, and Managing the Threat of Targeted Attacks. Available at https://www.fbi.gov/file-repository/making-prevention-a-reality.pdf/view. Accessed September 2018.

Fein, RA, Vossekuil B: Protective Intelligence and Threat Assessment Investigations: A Guide for State and Local Law Enforcement Officials. NCJ 170612. U.S. Department of Justice, Office of Justice Programs, 1998. Available at https://www.ncjrs.gov/pdffiles/170612.pdf. Accessed September 2018.

QUESTIONS AND ANSWERS
Which of the following statements about psychiatric illness and violence is true?

a. Most interpersonal violence is attributable to psychiatric illness and people with violence.
b. Mass shooters almost always have some type of serious mental illness.
c. Active symptoms, more than diagnosis in general, are useful risk factors for violence.
d. People with serious mental illness pose a high risk of violence in the community.
ANSWER: c

Using case management approaches to manage violence risk have the advantage of:

a. Putting the burden of responsibility on social workers so we can focus on more sophisticated issues
b. Allowing ongoing monitoring and management of dynamic risk and protective factors over time
c. Definitively correcting violence risk with a single, discrete intervention
d. Being simple and not requiring input from a multidisciplinary team
ANSWER: b

F38 THE ROLE OF NEUROIMAGING IN THE FORENSIC EVALUATION OF VIOLENCE AND PSYCHOSIS

Nina Beizer, MD, Pittsburgh, PA
Drew Calhoun, MD, Seattle, WA
Vivek Datta, MD, MPH, San Francisco, CA

EDUCATIONAL OBJECTIVE
To understand the use and limitations of structural magnetic resonance imaging in the forensic evaluation of violence and psychosis in general, and in psychosis associated with manganese toxicity in particular.

SUMMARY
Neuroimaging is increasingly a fixture in the contemporary courtroom. However, forensic psychiatrists may underuse neuroimaging when evaluating violent criminal defendants with psychosis. We present the case of a 15-year-old boy without any psychiatric or criminal history who developed psychotic symptoms, including visual hallucinations and command auditory hallucinations, and ultimately stabbed his mother in the neck several times. He faced several legal charges, including attempted murder. An extensive medical workup, including a computed tomography (CT) scan, was unremarkable. Brain magnetic resonance imaging (MRI), however, revealed bilateral globus pallidi T1 hyperintensities. This prompted further workup that revealed manganese toxicity, a rare but well-established cause of psychiatric symptoms including psychosis. This case highlights the potential for neuroimaging to reveal causes of psychosis that may aid in sentencing mitigation or even present the possibility for a defense of involuntary intoxication. The use of imaging in this case is limited to diagnosis and does not provide additional information regarding mental state at the time of the offense. Forensic psychiatrists must know when to consider neuroimaging in forensic evaluation of violent behavior and play a leading role in educating judges and policymakers in the potentials and pitfalls of neuroimaging in criminal litigation.

REFERENCES
Bouabid S, Tinakoua A, Lakhdar-Ghazal N, et al: Manganese neurotoxicity: behavioral disorders associated with dysfunctions in the basal ganglia and neurochemical transmission. J Neurochem. 136:677-691, 2016

Schug RA, Partida LS: Neuroimaging and forensic psychiatry, in Principles and Practice of Forensic Psychiatry,3rd ed., edited by Rosner R and Scott CL. Taylor and Francis Group, 2017, pp. 749-763.

QUESTIONS AND ANSWERS
A forensic psychiatrist may be called upon to opine on which of the following in criminal behavior related to manganese toxicity but not schizophrenia?

a. Competency to stand trial
b. Not guilty by reason of insanity
c. Involuntary intoxication
d. Sentencing mitigation
ANSWER: c

The use of structural brain MRI in a criminal case would most likely survive a Daubert challenge if used to:

a. Diagnose schizophrenia
b. Identify secondary causes of psychosis
c. Evaluate competence to stand trial
d. Evaluate criminal responsibility
ANSWER: b

F39 AN APPELLATE CASE REVIEW OF NEUROIMAGING AND THE DEATH PENALTY

Vivek Datta, MD, MPH, San Francisco, CA

EDUCATIONAL OBJECTIVE

To learn about murdering minds and their brains on trial: an appellate case review of neuroimaging and the death penalty.

SUMMARY

Neuroimaging has become a regular staple of capital cases, with brain imaging offered to provide mitigation evidence in the penalty phase of capital trials. Little is known, however, about how such cases are litigated. We conducted a LexisNexis search to determine how brain imaging was used in appellate cases for which there was a judicial opinion. We found 34 relevant cases from 1991 to 2017. Positron emission tomography (PET) scans were the most commonly featured, followed by magnetic resonance imaging (MRI), single positron emission computed tomography (SPECT), and computed tomography (CT). In these cases, imaging was rarely successful in vacating an initial determination of death. Imaging was used to support diagnoses as varied as traumatic brain injury, bipolar disorder, borderline personality disorder, and intellectual disability, as well as to support testimony that defendants lacked the requisite mental state for murder or extreme emotional distress. These uses extend beyond what neuroimaging is capable of answering. The implications of our findings for forensic psychiatrists, judges, and policy makers is discussed.

REFERENCES

Blume JH, EC Paavola. Life, death, and neuroimaging: The advantages and disadvantages of the defense's use of neuroimages in capital cases–lessons from the front. Mercer Law Review 62:909-931, 2011

Snead OC. Neuroimaging and the 'complexity' of capital punishment. NYU Law Review 82, 2007

QUESTIONS AND ANSWERS

The structural imaging modality most commonly presented as evidence of mitigation by the defense in criminal cases is:

a. Magnetic resonance imaging
b. Computed tomography
c. Single positron emission computed tomography
d. Positron emission tomography
ANSWER: a

Paralimbic grey matter volumes have been shown to correlate with violence recidivism risk as measured by which of the following structured risk assessment tools?

a. HCR-20
b. VRAG
c. LS/CMI
d. COVR
ANSWER: b

F40 RAPPEPORT FELLOWS: RESEARCH SPEED DATING

Britta Ostermeyer, MD, MBA, Oklahoma City, OK
Susan Hatters-Friedman, MD, Cleveland, OH
Gary Chaimowitz, MB, ChB, Hamilton, ON, Canada.
Lisa Anacker, MD, Ann Arbor, MI
Joseph C. Cheng, MD, PhD, Charleston, SC
Matthew Hirschtritt, MD, MPH, San Francisco, CA
Brian Holoyda, MD, MPH, St. Louis, MO
David Nissan, MD, Portsmouth, VA
Jacqueline Landess, MD, JD, St. Louis, MO
Ryan Leahy, MD, Miami Beach, FL

EDUCATIONAL OBJECTIVE

To utilize and experience research speed dating as a new form of AAPL presentation at the annual meeting and to advance Rappeport Fellows' research/scholarly projects.

SUMMARY

The concept of rapid-fire speed dating information exchange has been successfully applied to research and academia as well. In this presentation, the following fellows will present for 6-8 minutes with 4 minutes of audience questions: (1) Dr. Lisa Anacker on firearms, violence, and mental illness; (2) Dr. Joseph C. Cheng on occupational hazards and stressors in law enforcement placing public safety officers at risk of psychiatric disorders; (3) Dr. Matthew Hirschtritt on mental health, substance use, and sexual behavior of justice-involved, sexual minority adolescents; (4) Dr. Brian Holoyda on sexual offenders found NGRI in California Department of State Hospitals; (5) Dr. David A. Nissan on psychiatric care provided by the USNS (United States Naval Ship) Comfort humanitarian operations in Puerto Rico in the Hurricane Maria aftermath; (6) Dr. Jacqueline Landess on surveying attorneys and judges on mental illness attitudes and forensic psychiatry understanding; and (7) Dr. Ryan Leahy on a meta-analysis of the relationship between aggression and low serotonin in children and adolescents. Participants will receive notepads to write down ideas during each presentation. At the end of the workshop, audience participants will be asked to share their notes with presenters to help advance their projects.

REFERENCES

Ranwala D, Alberg AJ, Brady KT, et al: Scientific retreats with 'speed dating': networking to stimulate new interdisciplinary translational research collaborations and team science. J Investig Med 65(2):382-390, 2017

Tucker MT, Lewis DW Jr, Payne Foster P, et al: Community-based participatory research-speed dating: an innovative model for fostering collaborations between community leaders and academic researchers. Health Promot Pract 17(6):775-780, 2016

QUESTIONS AND ANSWERS

What was the original purpose of TV executive Anthony Beilinsohn's speed dating invention in 1998?

a. He wanted to help widowed Spanish women quickly find more suitable men for marriage.
b. He wanted to help the California LGBTQ community matchmaking.
c. His Rabbi asked him to conceive innovative new ways for eligible Jewish men and women to meet and marry.
d. His sister was running out of time to find a suitable man for marriage and family.
ANSWER: c

What are the advantages of "speed dating" in academic settings?

a. Networking that stimulates new interdisciplinary translational research collaborations
b. Promotion of productive scholarly relationships between researchers and community leaders
c. Matchmaking tool to connect students with suitable faculty mentors
d. All of the above
ANSWER: d

F41 APPLYING DIFFERING FORENSIC ETHICS APPROACHES IN A DEATH PENALTY CASE

Robert Weinstock, MD, Los Angeles, CA
Paul S. Appelbaum, MD, New York, NY
Richard Martinez, MD, Denver, CO
William Connor Darby, MD, Los Angeles, CA

EDUCATIONAL OBJECTIVE
To understand the various models for ethics-based decision making in forensic psychiatry; to examine the similarities and differences in implementing these approaches when attempting to resolve ethics dilemmas; and to appreciate the relevant ethics challenges regarding involvement with capital cases' specifically aggravating circumstances at the penalty phase.

SUMMARY
Several ethics models have been proposed for forensic psychiatry in relatively recent years, beginning with Paul Appelbaum's principlism. Subsequent methods included narrative, compassion, integrating ethics theories, and balancing and prioritizing duties. Ethics theory conflicts have been considered and professional role refined; however, little has been presented comparing and contrasting how these frameworks are applied. The panel, comprising of leading proponents for three ethics models, will apply separate approaches to a hypothetical involving the presentation of aggravating circumstances at the penalty phase of a capital case.

No ethics guidelines prohibit physicians from accepting a role of seeking and presenting aggravating circumstances that may increase the chance of a jury selecting the death penalty over life without parole. The AMA does not interpret this as participating in a legally authorized execution forbidden in their guidelines. Ethical questions remain, though, about whether physicians should facilitate involuntary death by accepting this role.

Dr. Appelbaum will analyze the hypothetical using his principlism model, Dr. Martinez will illustrate the robust professionalism approach, and Drs. Weinstock and Darby will showcase dialectical principlism. The panel will emphasize practical ways forensic psychiatrists may implement these models to aspire to do what is most ethical when confronted with serious dilemmas.

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

Appelbaum, PS: A theory of ethics for forensic psychiatry. J Am Acad Psychiatry Law 25(3):233-47, 1997

QUESTIONS AND ANSWERS
Which of the following is currently prohibited by the American Medical Association Ethics Guidelines?

a. Presenting aggravating circumstances at the penalty phase of capital cases
b. Testifying for the prosecution in a capital case
c. Giving an opinion regarding competence to be executed
d. Treating a defendant to make him competent to be executed
ANSWER: d

Which of the following ethics principles is least relevant when determining whether or not to present aggravating circumstances at the penalty phase of a capital case?

a. Answering the Legal Question Honestly
b. Non-maleficence
c. Distributive Justice
d. Respect for Persons
ANSWER: c

F42 THE FACE OF AAPL: DIVERSITY MATTERS

Katherine Michaelsen, MD, Seattle, WA
Reena Kapoor, MD, New Haven, CT
Charles Dike, MD, New Haven, CT
Carlos Salgado, MD, Miami, FL
Bipin Subedi, MD, New York, NY

EDUCATIONAL OBJECTIVE
To review data about diversity in AAPL and forensic psychiatry; to explore the potential impact of personal identity on professional practice; and to discuss the role of AAPL in efforts to support members of underrepresented groups in forensic psychiatry.

SUMMARY

Certain ethnic minority groups, including blacks, Latinos, and American Indians, remain underrepresented in medical schools, and women still lag behind in leadership positions despite making up more than half of all medical graduates and psychiatry residents. Little is known about how these trends apply to forensic psychiatry. However, preliminary investigations suggest that female psychiatrists may face unique challenges when performing forensic work, and senior leadership positions in AAPL "including presidents, medical directors, and JAAPL editors" have historically not reflected great diversity.

Though the experience of each individual and each underrepresented racial, sexual, and gender group is unique, this panel gathers representatives of some of these groups in an effort to begin a conversation about diversity in forensic psychiatry. We review existing data about minority representation in medicine and psychiatry, and we present findings from ongoing research on women in forensic psychiatry. In planning for AAPL's upcoming 50th anniversary, we consider diverse perspectives on (1) AAPL's history and future as a body representing an increasingly diverse group of professionals, (2) the impact of identity on professional work, and (3) AAPL's role in attracting and fostering individuals from underrepresented groups.

REFERENCES

AAMC. The State of Women in Academic Medicine: The Pipeline and Pathways to Leadership, 2015-2016. Available at https://www.aamc.org/members/gwims/statistics. Accessed Marhc 5, 2018

Kaempf AC, Baxter P, Packer IK, et al: Gender and the experience of mental health expert witness testimony J Am Acad Psychiatry Law 43(1):52-59, 2015

QUESTIONS AND ANSWERS

Male experts tended to express lower anxiety levels and greater confidence in their opinions and the impact of their testimony on case outcomes. According to Kaempf, et al's survey of forensic psychologists and psychiatrists, male and female experts approach their work differently in which of the following ways?

a. Male experts tend to express lower anxiety levels
b. Female experts tend to express lower levels of confidence in their opinions
c. Male experts tend to express greater levels of confidence regarding the impact of their testimony on case outcomes
d. All of the above
ANSWER: d

In 2016-17, what were the respective percentages of underrepresented minorities in psychiatry versus in forensics?

a. 32% psychiatry trainees and 10% forensic trainees
b. 17% and 19%
c. 11% and 5%
d. 8% and 22%
ANSWER: b

F43 EXTREME OVERVALUED BELIEFS OR DELUSIONS?

Tahir Rahman, MD, St. Louis, MO
Willa Xiong, MD, St. Louis, MO
Phillip Resnick, MD, Cleveland, OH
Bruce Harry, MD, Columbia, MO
Jeffrey Janofsky, MD, Timonium, MD

EDUCATIONAL OBJECTIVE

This interactive workshop will sharpen the forensic examiner's ability to determine the type of beliefs seen during evaluations, from delusions resulting in violence to extremist ideologies behind cults, terrorism, religious and political extremism, and online radicalization. Attendees will learn proper terminology and how to differentiate extreme overvalued beliefs from delusions.

SUMMARY

Extreme overvalued beliefs (EOB) are rigidly held, non-delusional beliefs shared by others in a person's cultural, religious, or subcultural group. EOBs serve as common motives behind mass shootings, terrorist attacks, and cults. The term extreme overvalued belief expands on Carl Wernicke's initial description of an overvalued idea, and was formally introduced in an analysis of the Anders Breivik mass murder case. In this workshop, attendees will learn about the concept of overvalued ideas and its application in explaining the motives behind well-known cases, including the 9/11 terrorist attacks, Islamic State (ISIS) militants, Oklahoma City bombing, and Breivik murders.

We will also discuss how to differentiate EOBs from delusions seen in psychosis, such as in the Andrea Yates case. The use of narrative and biographical historical facts will serve as a basis for descriptive analysis of beliefs commonly encountered during forensic evaluations. Furthermore, attendees will apply the knowledge presented to an interactive discussion of a variety of fictional cases. Data from polling the audience will aid in determining the validity, reliability, and attitudes examiners have in using these terms in the forensic setting. We plan to share the results from the data collected in the future.

REFERENCES

Rahman T, Resnick PJ, Harry B: Anders Breivik: extreme beliefs mistaken for psychosis. J Am Acad Psychiatry Law 44(1): 28-35, 2016

Weiss KJ: At a loss for words: nosological impotence in the search for justice. J Am Acad Psychiatry Law 44(1): 36-40, 2016

QUESTIONS AND ANSWERS

An individual is being evaluated by you for a possible insanity plea in an abortion clinic bombing/murder case. His defense team believes he may be psychotic because they think he is making"nonsensical statements". He belongs to a group of anti-abortionists and recently bombed an abortion clinic, killing two doctors. He believes he is "fulfilling God's commandments" and that he will receive "eternal salvation from God"since he just "saved hundreds of babies". He has no prior mental health treatments, no other symptoms and a normal speech pattern. After a thorough history and examination as well as a six month period of observation, no evidence of a psychotic mental illness is found to be present. His family believes that abortion is wrong, but they are shocked by his actions. Police find large amounts of anti-abortion material on his computer as well as his internet search history. He appears to relish his behavior and defends it throughout your interview. Which of the following best describes his odd beliefs:

a. Delusion
b. Obsession
c. Extreme Overvalued Belief
d. Paranoid thoughts
ANSWER: c

Which of the following physicians first described overvalued ideas?

a. Sigmund Freud
b. Eugene Bleuler
c. Carl Wernicke
d. Kurt Schneider
ANSWER: c

SATURDAY, OCTOBER 27, 2018

POSTER SESSION #3 — 7:00 AM - 8:00 AM / 9:30 AM - 10:15 AM — **LONE STAR FOYER**

S1 ***Intellectual Developmental Disorder and First Degree Murder***

Salman Salaria, MD, MPH, New Castle, DE
Clarence Watson, JD, MD, Philadelphia, PA
Danielle Asheinheim, Philadelphia, PA
Lisa Black, Philadelphia, PA

S2 ***Aerospace Psychiatry: Pilot's Journey for Redemption***

Amit Mistry, MD, Oklahoma City, OK
Charles Dukes, MD, Oklahoma City, OK
Britta Ostermeyer, MD, MBA, Oklahoma City, OK

S3 ***Paving the Way for Post-Conviction Mental Health Treatment***

Viviana Alvarez-Toro, MD, Baltimore, MD
Kathryn Skimming, MD, Baltimore, MD
Christopher Wilk, MD, Baltimore, MD
Ann Hackman, Baltimore, MD
Joseph Hargadon, LCSW-C, Baltimore, MD

S4 ***Evolution of the Tarasoff Duty: Revisiting the Legal Standard, 40 Years Later***

Willa Xiong, MD, Saint Louis, MO

S5 ***Imprisoned with Autism Spectrum Disorder: A Different Perception of Incarceration***

John Flo, St. Louis, MO
William Newman, MD, St. Louis, MO

S6 ***A Study of Prisoners in a Tertiary Psychiatric Institute***

V. Sabitha, MD, Kilpauk, Chennai-10, India
S. Bevin, MD, Kilpauk, Chennai-10, India
V. Ramya, MD, Kilpauk, Chennai-10, India
Periyar Rani, Kilpauk, Chennai-10, India
Jagannathan Srinivasaraghavan, MD, Carbondale, IL

S7 ***A Year in Jail: General Psychiatry Training in a Jail Based Competency Treatment Program***

Joseph Hall, MD, Sacramento, CA
Anne McBride, MD, Sacramento, CA

S8 ***Assessing Violence Risk in Bipolar I Disorder Using the HCR-20: A Case Report***

Darmant Bhullar, MD, New York, NY
Felix Matos, New York, NY
Panagiota Korenis, MD, South Bronx, NY

S9 ***Integration and Differentiation of PTSD and TBI***

Keith A. Caruso, MD, Brentwood, TN
Jeffrey Guina, MD, Dayton, OH
E. Cameron Ritchie, MD, MPH, Silver Spring, MD

S10 ***Future of the Force: Utility of Written Psychological Tests in Police Officer Pre-employment Screening***

Ann Marie Mckenzie Cassidy, MD, New York, NY
Steven Fayer, New York, NY

S11 ***Nonfatal Strangulation and Monica's Law***

Christopher Marett, MD, MPH, Cincinnati, OH
Scott Bresler, PhD, Cincinnati, Ohio

S12 ***Animal-Assisted Therapy: Role in Juvenile Detention Facilities?***

Rachael Holbreich, Washington, DC
Eindra Khin Khin, MD, Washington, DC

S13 ***Biopsychosocial Risk Factors And Charge Severity In Individuals Deemed Incompetent To Stand Trial***

Brittany Mott, MD, Rochester, NY

S14 ***State Laws on Competency to Execute Before Madison v. Alabama***

Michael S. Vaughn, PhD, Huntsville, TX

S15 ***When Your Patient's Emotional Support Animal Becomes Another's Trauma***

Gareen Hamalian, MD, MPH, New York, NY
Tara Straka, MD, New York, NY
Regina Kline, JD, Washington, DC

S16 ***POSTER WITHDRAWN***

S17 ***Martin Manley: Anatomy of a Geriatric Suicide***

Sherif Soliman, MD, Matthews, NC
Cathleen Cerny-Suelzer, MD, Seven Hills, OH
Carolyn Dessin, Akron, OH
Karen Reimers, MD, Minneapolis, MN
Michael Redinger, Kalamazoo, MI

S18 ***Do No Harm v. Do No Homo: Bans on Conversion Therapy for Minors***

Chase Hiller, Washington, DC
Patricia Ortiz, MD, Washington, DC
Eindra Khin Khin, MD, Washington, DC

S19 ***Physician Health Programs: Struggles and Suggestions***

Douna Montazeralghaem, MD, Brooklyn, NY
Christopher Marett, MD, Cincinnati, OH

S20 ***Can Jail be a Therapeutic Setting: An Architectural Review***

Mary Colavita, MD, Short Hills, NJ
Matthew Grover, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY

S21 ***The Evolution of Outpatient Commitment: A Case Study of Southern Nevada***

Jessica Arabski, DO, Las Vegas, NV
Mohammad Khan, MD, Las Vegas, NV

S22 ***Factors Influencing Restorability: Present and Future Challenges***

Cristina M. Secarea, MD, Washington, DC

S23 ***Is Kratom a Harmful Psychoactive Substance?***

Sebastien S. Prat, MD, Hamilton, ON, Canada
Gary Chaimowitz, MB, ChB, Ancaster, ON, Canada

S24 ***Alternative Interpretation Approaches to the Test of Memory Malingering***

Holly Kaufman, MS, Chapel Hill, NC
Brian Belfi, PsyD, New York, NY
Debbie Green, PhD, Teaneck, NJ

PANEL 8:00 AM - 10:00 AM **LONE STAR G**

S25 ***In the Matter of AG (NJ 2016): Anorexia Nervosa and the Capacity to Refuse Forced Feeding***

Patricia Westmoreland, MD, Denver, CO
Jeanne Kerwin, DMH, Morristown, NJ
Edward G. D'Alessandro, Jr. Esq., Florham Park, NJ

PANEL 8:00 AM - 10:00 AM **LONE STAR H**

S26 ***Forensic Telepsychiatry: Why Aren't You Doing it?***

Keelin Garvey, MD, Tiverton, RI
Elizabeth Ferguson, MD, Palm Coast, FL
Patricia Recupero, JD, MD, Providence, RI
Lisa Harding, MD, Wichita, KS

WORKSHOP 8:00 AM - 10:00 AM **LONE STAR F**

S27 The Media Interview: Keep It Interesting, and Truthful

Barry Wall, MD, Providence, RI
Ryan Wagoner, MD, Tampa, FL
Praveen Kambam, MD, Los Angeles, CA
Vasilis Pozios, MD, Ann Arbor, MI
Jennifer Okwerekwu, MD, Cambridge, MA

WORKSHOP 8:00 AM - 10:00 AM **LONE STAR A**

S28 The Forensic Psychiatrist on Trial: The Expert, Exposed

Christopher Fischer, MD, Sacramento, CA
Ariana Nesbit, MD, Sacramento, CA
Charles Scott, MD, Sacramento, CA

AUDIOVISUAL SESSION 8:00 AM – 10:00 AM **LONE STAR D**

S29 Peer Review of Sanity Assessments in High Profile Cases: The American Sniper Tragedy

David Rosmarin, MD, Newton, MA
Mitchell Dunn, MD, Dallas, TX
Robert Wettstein, MD, Pittsburgh, PA
Douglas Tucker, MD, Berkeley, CA

COURSE (TICKET REQUIRED) 8:00 AM - 12:00 PM **LONE STAR B-C**

S30 Insanity Defense Evaluations: Overcoming Jury Skepticism

Phillip J. Resnick, MD, Cleveland, OH

COFFEE BREAK 10:00 AM – 10:15 AM LONE STAR FOYER

PANEL 10:15 AM - 12:00 PM **LONE STAR H**

S31 Challenges for Inpatient Psychiatric Care of the Older Offender

Karen Reimers, MD, Minneapolis, MN
Bridget Casey-Leavell, DO, Cincinnati, OH
Rebecca Karns, DO, Cincinnati, OH
Bradleigh Dornfeld, MD, Minneapolis, MN
Sherif Soliman, MD, Charlotte, NC

PANEL 10:15 AM - 12:00 PM **LONE STAR A**

S32 Transgender Populations and the Law: Beyond the Bathroom

Brian Barnett, MD, Belmont, MA
Ariana Nesbit, MD, Sacramento, CA
Kayla Fisher, MD, Highland, CA
Renée Sorrentino, MD, Weymouth, MA

PANEL 10:15 AM - 12:00 PM **LONE STAR F**

S33 Mommy Dearest: Historical Review of Female Cult Leaders

Reagan Gill, DO, Tulsa, OK
Jason Beaman, DO, Tulsa, OK
Susan Hatters Friedman, MD, Cleveland, OH
Jennifer Piel, MD, JD, Seattle, WA

PANEL 10:15 AM - 12:00 PM **LONE STAR G**

S34 ***Vehicles for Policy Development in Public Mental Health and Correctional Systems***

Debra A. Pinals, MD, Ann Arbor, MI
Joel Dvoskin, PhD, Tucson, AZ
Jeffrey Metzner, MD, Denver, CO

PANEL — 10:15 AM - 12:00 PM — **LONE STAR D**

S35 ***PTSD Outcomes: Perilous Predictions of Prognosis***

Ryan C. Wagoner, MD, Tampa, FL
Charles Scott, MD, Sacramento, CA
William Newman, MD, St. Louis, MO
Lauren Schwarz, PhD, St. Louis, MO
Phillip Ruppert, PhD, St. Louis, MO

LUNCH (TICKET REQUIRED) — 12:00 PM – 2:00 PM — **LONE STAR E**

S36 ***Confronting an Active Shooter: Perspectives on the UT Tower Shooting 50 Years Later***

Ranger Ramiro "Ray" Martinez, Austin, TX

WORKSHOP — 2:15 PM - 4:00 PM — **LONE STAR G**

S37 ***Sex or Sin: Let the Judge Decide***

Sara West, MD, Medina, OH

PANEL — 2:15 PM - 4:00 PM — **LONE STAR H**

S38 ***Recent Cases and Why They Matter***

Ashley VanDercar, MD, JD, Cleveland, OH
Charles Scott, MD, Sacramento, CA
Stephen Noffsinger, MD, Cleveland, OH
Jennifer Piel, MD, JD, Seattle, WA
Jacqueline Landess, MD, JD, St. Louis, MO
Adrienne Saxton, MD, Cleveland, OH
Loretta Sonnier, MD, New Orleans, LA
Elie Aoun, MD, New York, NY

PANEL — 2:15 PM - 4:00 PM — **LONE STAR D**

S39 ***The Relevance of Race and the Role of Psychiatry in Correctional Settings***

Merrill Rotter, MD, White Plains, NY
Elizabeth Ford, MD, New York, NY
Bipin Subedi, MD, Brooklyn, NY
Reena Kapoor, MD, New Haven, CT
Rahn Bailey, MD, Winston-Salem, NC

PANEL — 2:15 PM - 4:00 PM — **LONE STAR A**

S40 ***School Shootings: Who Is Responsible?***

Rosa E. Negron-Munoz, MD, Lakeland, FL
Karen Mills, RN, MSEdL, Bradenton, FL
Larry Willis, Lakeland, Florida
Cheyenne Shelton, Lakeland, FL
Jakevis Brown, Bowling Green, FL
Isabella Vega, Winter Haven, FL

RESEARCH IN PROGRESS #2 — 2:15 PM – 4:00 PM — **LONE STAR F**

S41 ***The Impact of Gender on M-FAST Scores and Diagnoses in a Forensic Hospital Population***

Ariana Nesbit, MD, Sacramento, CA
Barbara McDermott, PhD, Sacramento, CA

S42 ***Outcomes of Fitness and Criminal Responsibility Assessments in Referrals from Communities without Mental Health Courts***

Michelle Mathias, MD, Ottawa, ON, Canada
Joel Watts, MD, Ottawa, ON, Canada
Lindsay Healey, MD, Brockville, ON, Canada
Susan Curry, Ottawa, ON, Canada

S43 ***Clozapine Reduces Repetitive, Treatment-Resistant Self-Injurious Behavior in a State Prison Population***

Theodore Zarzar, MD, Raleigh, NC
Joseph Williams, MD, Raleigh, NC

S44 ***Prevalence and Correlates of Criminal Behavior Among the Non-Institutionalized Elderly: Results from the National Survey on Drug Use and Health***

Elias Ghossoub, MD, Saint Louis, MO
Rita Khoury, MD, Saint Louis, MO

COURSE (TICKET REQUIRED) 2:15 PM - 6:15 PM **LONE STAR B-C**

S45 ***Contemporary Forensic Evaluation of Post-traumatic Stress Disorder***

Andrew P. Levin, MD, Hartsdale, NY
Jeffrey Guina, MD, Saline, MI
Marc A. Cohen, MD, Beverly Hills, CA
Daniel A. Martell, PhD, Newport Beach, CA

COFFEE BREAK **4:00 PM – 4:15 PM** **LONE STAR FOYER**

PANEL 4:15 PM - 6:15 PM **LONE STAR A**

S46 ***Women Who Kill***

Alan R. Felthous, MD, St. Louis, MO
Felice Carabellese, MD, Bari, Italy
Phillip Resnick, MD, Cleveland, OH
Donatella La Tegola, PsyD, PhD, Bari, Italy

PANEL 4:15 PM - 6:15 PM **LONE STAR F**

S47 ***Medication-Assisted Treatment (MAT) Implementation for Opioid Use Disorders in Correctional Systems***

Rusty Reeves, MD, Trenton, NJ
Elizabeth Ford ,MD, New York, NY
Anthony Tamburello, MD, Trenton, NJ
Radha Sadacharan, MD, MPH, Providence, RI

PANEL 4:15 PM - 6:15 PM **LONE STAR D**

S48 ***AAPL as Amicus Curiae: Retrospect and Prospect***

Jeffrey S. Janofsky, MD, Timonium, MD
Debra A. Pinals, MD, Ann Arbor, MI
Steven K. Hoge, MD, New York, NY
Marvin Swartz, MD, Durham, NC

RESEARCH IN PROGRESS #3 4:15 PM - 6:15 PM **LONE STAR G**

S49 ***Behavioral Intervention Teams (BIT) in Schools***

Robert L. Weisman, DO, Rochester, NY
Mark Concordia, Rochester, NY

S50 ***Impact of Substance Use Disorders on Self- and Other-Directed Violence: An Integrated Model Approach***

Elias Ghossoub, MD, St. Louis, MO

S51 ***The "Crazed Gunman" Myth: Examining Mental Illness and Firearm Violence***

Amanda Kingston, MD, New Haven, CT
Madelon Baranoski, PhD, New Haven, CT
Reena Kapoor, MD, New Haven, CT
Maya Prabhu, MD, New Haven, CT

WORKSHOP 4:15 PM - 6:15 PM **LONE STAR H**

S52 ***Current Policy Topics on University Campuses***

Ryan C. W. Hall, MD, Lake Mary, FL
Susan Hatters Friedman, MD, Cleveland OH
Abhishek Jain, MD, New York, NY
Renée M. Sorrentino, MD, Weymouth, MA
Jacqueline Landess, MD, JD, St. Louis, MO

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

S1 Intellectual Developmental Disorder and First Degree Murder

Salman Salaria, MD, MPH, New Castle, DE
Clarence Watson, JD, MD, Philadelphia, PA
Danielle Asheinheim, Philadelphia, PA
Lisa Black, Philadelphia, PA

EDUCATIONAL OBJECTIVE
To learn about the relationship between intellectual developmental disorder and violent crimes.

SUMMARY
This is a case report of a 47-year-old male, Mr. AA, who is currently serving two life sentences without parole for first degree murder, unlawful sexual penetration, and unlawful intercourse with a seven-year-old female when he was nineteen years old. Mr. AA is serving his life sentence in a forensic unit and has a diagnosis of intellectual developmental disorder, specific learning disorder with impairment in reading, and specific learning disorder with impairment in written expression. The objective of this case report is to educate professionals on the characteristics, prevalence, and management of individuals with intellectual developmental disorder in maximum-security forensic institutions.

REFERENCES
Hanlon RE, Brook M, Stratton J, et al: Neuropsychological and intellectual differences between types of murderers: affective/impulsive versus predatory/instrumental (premeditated) homicide. Criminal Justice and Behavior 40(8):933-948, 2013

Freeman J: The relationship between lower intelligence, crime and custodial outcomes: a brief literary review of a vulnerable group. Vulnerable Groups and Inclusion 3(1):1-15, 2012

QUESTIONS AND ANSWERS
What are 3 criteria that must be met (per DSM 5) in order to diagnose intellectual developmental disorder?

a. Deficits in problem solving, abstract thinking and age of onset before 6 years of age
b. Deficits in intellectual functioning such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning and learning from experience. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Onset of intellectual and adaptive deficits during the developmental period.
c. Deficits in intellectual functioning such as reasoning, problem solving planning, abstract thinking judgment academic learning and learning from experience. Age of onset before 2 to 6 years of age. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Lower IQ restricts results in failure in academic achievement which increases the likelihood of delinquent acts.

ANSWER: b

What test or tests (per DSM 5) are used to confirm a diagnosis of intellectual developmental disorder?

a. Clinical assessment only
b. Standardized intelligence testing only
c. Both clinical assessment and standardized testing

ANSWER: c

SATURDAY

S2 AEROSPACE PSYCHIATRY: PILOT'S JOURNEY FOR REDEMPTION

Amit Mistry, MD, Oklahoma City, OK
Charles Dukes, MD, Oklahoma City, OK
Britta Ostermeyer, MD, MBA, Oklahoma City, OK

EDUCATIONAL OBJECTIVE
This clinical case presentation will illustrate the approach to aerospace psychiatric evaluations and highlight psychiatrist's role in National Aerospace industry's ongoing efforts to mitigate risks, protect public safety, and ensure the health of flight crew.

SUMMARY

With ongoing efforts within the National Aerospace industry to mitigate risks, protect public safety, and ensure the health of flight crew, the Federal Aviation Administration requires pilots to be evaluated for medical certification. Pilots may be referred for psychiatric and psychological evaluations as part of medical certification. Mr. M was admitted to hospital due to an episode of transient forgetfulness after a night of excessive alcohol use. Electroencephalography (EEG) was performed and he was diagnosis with partial seizures. Epilepsy is medically disqualifying for a pilot. He sought a second opinion from an Aerospace Neurologist. Together with a Mayo Clinic Epileptologist, Mr. M's EEG findings were deemed a "benign normal variant" with no epileptiform activity. Mr. M was referred to psychiatry for evaluation of alcohol use. Thorough psychiatric evaluation revealed no evidence for concern of misuse. Collateral information confirmed this. He was recommended for reinstating medical certification and to be return to active flight. In this case, a single episode of substance use almost ended a successful career as a pilot. Thankfully, the Human Intervention Motivation Study (HIMS) program was established to provide a system whereby pilots with active substance use disorders are treated and successfully return to flight.

REFERENCES

Bor R, Hubbard T: Aviation Mental Health: Psychological Implications for Air Transportation. Hampshire, England: Ashgate Publishing Limited, 2006

United States Department of Transportation Federal Aviation Administration (2017, October 26). Medical Certification. Available at https://www.faa.gov/licenses_certificates/medical_certification/. Accessed September 2018.

QUESTIONS AND ANSWERS

What is the name of the program established to provide pilots with access to treatment of active substance use?

a. Title 14 of the Code of Federal Regulations
b. Federal Aviation Administration Substance Program (FAA-SP)
c. Human Intervention Motivation Study (HIMS)
ANSWER: c

In this case, what medical and psychiatric condition(s) could have precluded him from active flight?

a. Hyperlipidemia
b. Active substance use
c. Gastroesophageal reflux disease
ANSWER: b

S3 PAVING THE WAY FOR POST-CONVICTION MENTAL HEALTH TREATMENT

Viviana Alvarez-Toro, MD, Baltimore, MD
Kathryn Skimming, MD, Baltimore, MD
Christopher Wilk, MD, Baltimore, MD
Anna Hackman, Baltimore, MD
Joseph Hargadon, LCSW-C, Baltimore, MD

EDUCATIONAL OBJECTIVE

This poster aims to educate forensic psychiatrists how to teach mental health conditions and their sequelae to parole and probation officers. The goal of these interventions is to reduce mental health stigma while also decreasing revocations and re-arrests.

SUMMARY

Many barriers exist in our criminal justice system which often impede the optimal treatment of mentally ill defendants. Sometimes the needs of probationers with mental illness have not been identified, and subsequently, do not get the treatment they require. Consequently, some of these probationers may experience more frequent revocations and re-arrests. For this reason, several states have incorporated educational initiatives to appropriately instruct parole and probation officers in identifying and redirecting mentally ill probationers to the appropriate mental health community resources. Tomar et al. found that a series of educational videos shown to probation and parole officers reduced stigma toward mentally ill individuals. We developed a similar intervention for the Division of Parole and Probation in Maryland to educate their officers about how to identify people with mental health problems, the natural course of those illnesses, various treatment strategies, the limitations of treatment strategies, and the sequelae of these illnesses. The interactive intervention involved a combination of didactics, simulation of auditory hallucinations, and a panel discussion of people with mental illness. In addition to presenting data describing the costs of such an intervention, we also describe outcome measures that will be used to measure efficacy of the intervention.

REFERENCES
Tomar N, Ghezzi MA, Brinkley-Rubinstein L, et al: Statewide mental health training for probation officers: improving knowledge and decreasing stigma. Health and Justice 5(1):11, 2017

Kobau R, DiIorio C, Chapman D, et al: Attitudes about mental illness and its treatment: validation of a generic scale for public health surveillance of mental illness associated stigma. Community Ment Health J 46(2):164-76, 2010

QUESTIONS AND ANSWERS
Probationers with mental illness are:

a. Less likely to be re-arrested than probationers without mental illness
b. More likely to be re-arrested than probationers without mental illness
c. Just as likely to be re-arrested than probationers without mental illness
ANSWER: b

Forensic psychiatrists can be instrumental in the mental health education of individuals in the criminal justice system at the level of:

a. Pre-sentence
b. Post-conviction
c. Probation/Parole
d. All of the above
ANSWER: d

S4 EVOLUTION OF THE TARASOFF DUTY: REVISITING THE LEGAL STANDARD, 40 YEARS LATER

Willa Xiong, MD, St. Louis, MO

EDUCATIONAL OBJECTIVE
To educate the audience about the Tarasoff duty's evolution over the years, including recent expansion via case law in Washington state, and to present data on the state-by-state variations of the current legal standard.

SUMMARY
In the seminal 1976 case Tarasoff v. Regents of California, the California Supreme Court ruled that it is the clinician's duty to protect identifiable victims of imminent physical threats made by patients. Following this ruling, a majority of other states recognized a duty to protect the public, which includes warning potential victims, contacting law enforcement, or pursuing hospitalization of the patient. Due to the lack of a blanket federal law, significant state-by-state variation exists on the obligation to protect the public. Although the Washington Supreme Court expanded the duty in Volk v. Demeerler (2016) to a patient's 'dangerous propensities' in the absence of threats or identifiable victims, the majority of states that have adopted the Tarasoff duty notably require a specific threat. This poster will summarize the evolution and expansion efforts of the Tarasoff duty, and present data on the current breakdown of the duty's regulation in all states as follows: mandated by statute, mandated by case law, permissive, rejected Tarasoff duty, or no guidance entirely.

REFERENCES
Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976)

Volk v. DeMeerleer, 386 P.3d 254 (2016)

QUESTIONS AND ANSWERS
Which of the following best describes Washington state's Tarasoff duty regulation?

a. Mandated by case law interpretation only, no statutory guidance
b. Mandated by statute, with recent narrowing by case law
c. Mandated by statute, with recent expansion by case law
d. No duty, but state permits breach of confidentiality if a threat is present
ANSWER: c

Which of the following is NOT true regarding states' application of the Tarasoff duty?

a. The duty applies to clinicians, but not to nurses, case workers, or social workers.
b. The duty often applies to psychiatrists and psychologists.
c. The duty may apply to physicians not accredited in psychiatry.
d. Some states do not specify which health professionals the duty applies to.
ANSWER: a

S5 IMPRISONED WITH AUTISM SPECTRUM DISORDER: A DIFFERENT PERCEPTION OF INCARCERATION

John Flo, St. Louis, MO
William Newman, MD, St. Louis, MO

EDUCATIONAL OBJECTIVE
To educate participants about the unique challenges of incarcerated people with Autism Spectrum Disorder.

SUMMARY
While the prevalence of Autism Spectrum Disorder (ASD) has grown in recent decades, awareness of how to properly manage these individuals in the correctional justice system (CJS) has not reflected this change. The available research does not indicate that individuals with ASD are overrepresented in the CJS, but there is evidence that these individuals may have more difficulty coping within this environment where routines and rules may fluctuate or be unclear. It is intuitive that the communication deficits with which individuals with ASD struggle would make it difficult for them to navigate the complex social ecosystem of the CJS. Indeed, ASD traits may make these individuals more susceptible to bullying, confrontations, exploitation, anxiety, and social isolation. There is a need for more research investigating the experience of inmates with ASD in order to evaluate how to properly manage and rehabilitate these individuals.

REFERENCES
Michna I, Trestman R:. Correctional management and treatment of autism spectrum disorder. J Am Acad Psychiatry Law 44(2):253-258, 2016

King C, Murphy GH: A systematic review of people with autism spectrum disorder and the criminal justice system. Journal of Autism and Developmental Disorders 44(11):2717-33, 2014

QUESTIONS AND ANSWERS
What properly reflects the experience of challenges of individuals with ASD in the criminal justice system?

a. Individuals with ASD report less anxiety and depression while incarcerated.
b. Individuals with ASD are more likely to participate in prison gangs.
c. Individuals with ASD are more susceptible to bullying and confrontations in prison.
d. The experience of incarceration for individuals with and without ASD is equivalent.
ANSWER: c

The prevalence of incarcerated individuals with ASD represented in the literature can be described as:

a. Highly variable, ranging from less than 3-27%
b. Highly variable, ranging from 1-42%
c. Minimally variable, ranging from 2-3%
d. Minimally variable, ranging from 6-8%
ANSWER: a

S6 A STUDY OF PRISONERS IN A TERTIARY PSYCHIATRIC INSTITUTE

V. Sabitha, MD, Kilpauk, Chennai, India
S. Bevin, MD, Kilpauk, Chennai, India
V. Ramya, MD Kilpauk, Chennai, India
Periyar Rani, MD, Kilpauk, Chennai, India
Jagannathan Srinivasaraghavan, MD, Carbondale, IL

EDUCATIONAL OBJECTIVE
To evaluate the crime pattern and psychiatric morbidity in prisoners.

SUMMARY
Background: Even though psychiatric patients are more often victims of violence, a small number of them are perpetrators of crime. Psychiatric disorders seen among prisoners are less studied. Indian studies are very limited and mostly from prison settings. Hence, this is an attempt to study the psychiatric morbidity among prisoners in a psychiatric hospital.

Aim: To assess the crime pattern and psychiatric morbidity among prisoners in a tertiary psychiatric hospital.

Materials and methods: Institute of Mental Health, Chennai is providing psychiatric care to about 1000 inpatients, out of which 50 to 70 inpatients are in the prisoner ward. The data of 354 consecutive prisoners referred to the Institute of Mental Health, Chennai from 2001 to 2016 is being assessed. Socio-demographic profile, criminal history, clinical history and psychiatric diagnosis made as per ICD-10 are obtained. The methodology used is retrospective chart review.

Results: The mean age of prisoners is found to be 34.7. Males constitute 85% and the rest are females except one transgender. Most of them are married. Murder is found to be the most common crime. The predominant diagnosis is schizophrenia. Further details are being collected and statistical analysis is under progress.

REFERENCES

Goyal SL, Singh P, Gargi PD, et al: Psychiatric morbidity in prisoners, Indian Journal of Psychiatry 53(3), 2011

Kumar V, Daria U: Psychiatric morbidity in prisoners, Indian Journal of Psychiatry 55(4), 2013

QUESTIONS AND ANSWERS

The most common crime among the prisoners admitted to a psychiatric hospital is:

a. Rape
b. Robbery
c. Murder
d. Possession of illegal drugs
e. None of the above
ANSWER: c

The most common diagnosis among the prisoners admitted to a psychiatric hospital is:

a. Bipolar disorder
b. Schizophrenia
c. Posttraumatic Stress disorder
d. Substance Use disorder
e. None of the above
ANSWER: b

S7 A YEAR IN JAIL: GENERAL PSYCHIATRY TRAINING IN A JAIL-BASED COMPETENCY TREATMENT PROGRAM

Joseph Hall, MD, Sacramento, CA
Anne McBride, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

The poster presents a novel method of integrating forensics training in general psychiatry residency through a longitudinal rotation in a jail based competency treatment program

SUMMARY

Within the core rotations of general psychiatry training, the Accreditation Council for Graduate Medical Education requires an experience in forensic psychiatry. Experiences in forensic psychiatry during general residency vary widely across training programs. Within medical education and training, longitudinal experiences are increasingly being implemented to provide continuity of care, continuity of supervision, and greater level of competence working within a specific healthcare environment. Within the University of California, Davis general psychiatry program, a novel opportunity was created to complete a longitudinal forensics rotation through the Sacramento County jail system. The resident rotation is at a jail-based competency treatment program at the Rio Cosumnes Correctional Center, providing psychiatric care throughout a year to patients being restored to competency. The unique experience provides an opportunity to learn about the unique challenges of correctional psychiatry and the statutes and processes surrounding jail-based competency restoration. The rotation also allowed experience treating patients with severe mental illness over an extended amount of time, especially with severe psychosis and the use of long-acting injectables. The unique rotation provides an opportunity for great growth in confidence and ability to independently treat patients leading to a greater sense of satisfaction and engagement in training.

REFERENCES
Accreditation Council for Graduate Medical Education. ACGME program requirements for graduate medical education in psychiatry. Available at http://www.acgme.org/acgmeweb/Portals/0/PFAssets/2013-PR-FAQ-PIF/140_internal_medicine_07012013.pdf. Accessed March 26, 2018.

Ellaway R, Graves L, Berry S, et al: Twelve tips for designing and running longitudinal integrated clerkships. Med Teach. 35(12):989-995, 2013

QUESTIONS AND ANSWERS
Is a forensics experience a requirement in general psychiatry training?

ANSWER: Yes

What are some benefits of longitudinal training experiences?

ANSWER: Continuity of care, continuity of supervision, and a greater level of competence working within a specific healthcare environment

---

S8 ASSESSING VIOLENCE RISK IN BIPOLAR I DISORDER USING THE HCR-20: A CASE REPORT

Darmant Bhullar, MD, New York, NY
Felix Matos, Bronx, NY
Panagiota Korenis, MD, Bronx, NY

EDUCATIONAL OBJECTIVE
Teaching, including new methods of training forensic psychiatrists and clarification of the functions of a forensic psychiatrist.

SUMMARY
Bipolar I disorder has been strongly linked to traumatic childhood experiences and the potential for violence. Research suggests that the combination of impulsivity, grandiosity and active substance use increase the likelihood that these individuals will engage in violent acts, in both the inpatient setting and community. Additionally, Bipolar I disorder is associated with an increased rate of interpersonal violence compared with other psychiatric disorders, and this risk significantly increases with factors such as low-income families and immigration. 37-year-old male has a history of Bipolar I Disorder, Amphetamine use disorder, Human Immunodeficiency Virus, and incarceration due to assault charges. He was admitted due to decompensation in the context of medication non-compliance and active amphetamine use. Per the HCR-20, he had significant findings on the historical, clinical and risk management scale. The aim of this abstract is to stratify the violence risk on the inpatient unit using HCR-20 and develop an effective treatment plan that will mitigate those factors in order to ensure safety of peers and unit staff. Currently, there is a lack of a scored screening instrument that helps objectively classify violence risk and no treatment guidelines to consider the above.

REFERENCES
Lee A, Galynker I, Kopeykina I, et al: Violence in bipolar disorder. Psychiatric Times 31(12), 2014

Nielssen O, Malhi G, Large M: Mania, homicide and severe violence. Australian & New Zealand Journal of Psychiatry, 46(4):357-363, 2012

QUESTIONS AND ANSWERS
Which test was used to stratify for violence in this case?

a. MMPI-2-RF
b. HCR-20
c. PHQ9
d. SVR-20
ANSWER: b

Which illicit substance was the patient actively abusing prior to admission?

a. Crystal meth
b. LSD
c. MDMA
d. Marijuana
ANSWER: a

S9 INTEGRATION AND DIFFERENTIATION OF PTSD AND TBI

Keith A. Caruso, MD, Brentwood, TN
Jeffrey Guina, MD, Dayton, OH
E. Cameron Ritchie, MD, MPH, Silver Spring, MD

EDUCATIONAL OBJECTIVE

This poster aims to allow readers to recognize deficits common to and differentiating PTSD and TBI; to devise an integrative model of treatment for PTSD and TBI; and to evaluate disability related to co-morbid PTSD and TBI in service members, veterans and in private disability cases.

SUMMARY

Improvised explosive devices detonated in Iraq and Afghanistan resulted in numerous PTSD and TBI casualties among American military service members, challenging providers with these comorbid presentations. Evaluation and treatment of these conditions involves neuropsychological testing, pharmacotherapy, psychotherapy, cognitive rehabilitation and other treatments outside of the mainstream of psychiatric treatment. While the evaluation of these conditions in military and civil settings may initially follow a common pathway, the 24-month mental and nervous condition limitation commonly written into most disability policies leads to a different analysis and outcome. In those policies, disability payments for PTSD may terminate after 24 months under limitations for psychiatric conditions, whereas disability payments for TBI are not temporally limited because these are considered neurological conditions. The authors, all former military psychiatrists, write on their experience with the VA system and private disability insurance industry.

REFERENCES

Golden CJ, Lashley L, Driskell LD. The Intercorrelation of Traumatic Brain Injury and PTSD in Neuropsychological Evaluations. Cham, Switzerland: Springer International Publishing AG, 2016

Ritchie EC Ed. Forensic and Ethical Issues in Military Behavioral Health: Textbook of Military Medicine. Washington, DC: Borden Institute, 2014

QUESTIONS AND ANSWERS:

Findings that may occur in both PTSD and TBI include:

a. Irritability
b. fMRI findings in the frontal lobes, especially the dorsolateral prefrontal, orbitofrontal, medial frontal and anterior cingulated cortex
c. Sleep disturbance
d. Increased risk of developing dementia
e. All of the above
ANSWER: e

Findings that may differentiate between PTSD and TBI include:

a. Positive response to psychotherapy in PTSD
b. Positive neuroimaging findings in TBI
c. IQ decrement in TBI
d. Lesser degree of memory impairment in PTSD
e. All of the above
ANSWER: e

S10 FUTURE OF THE FORCE: UTILITY OF WRITTEN PSYCHOLOGICAL TESTS IN POLICE OFFICER PRE-EMPLOYMENT SCREENING

Ann Marie Mckenzie Cassidy, MD, New York, NY
Steven Fayer, New York, NY

EDUCATIONAL OBJECTIVE

To improve the development of a uniform, well validated, psychological screening procedure for police applicants.

SUMMARY

Police work is evolving to become a more psychologically demanding occupation, community-police tensions continue to rise, and there has never been a greater need to identify emotionally stable candidates suited for contemporary police work. Written self-reported measurements have been part of police officer pre-employment

screening evaluations since the 1960s. The incremental value of using written tests to predict officer performance, in addition to an interview with a qualified mental health professional, is complicated. This is partly because of inherent limitations in existing research regarding the validity of personality assessments in predicting performance, but also because the concept of what constitutes police officer performance is changing. Contemporary police work requires a more complex social understanding and improved collaborative decision making skills. Additional stressors, such as escalating counter-terrorism responsibilities and greater public scrutiny, contribute to the complexity of modern police work. This paper reviews how standards for police officer pre-employment psychological evaluations evolved, focusing on the incremental utility of written personality assessments, as well as questions what part these instruments will play in recruiting officers suitable for the contemporary stressors of police work.

REFERENCES

Behind the Badge, Pew Research Center, 2017. Available at http://assets.pewresearch.org/wpcontent/uploads/sites/3/2017/01/06171402/Police-Report_FINAL_web.pdf

Weiss PA: Personality assessment in police psychology: a 21st century perspective. Springfield, IL: Charles C. Thomas Publishers, 2010.

QUESTIONS AND ANSWERS

The changing scope of modern day police work would prioritize the following in a candidate:

a. History of military experience
b. Having no record of any mental illness
c. Ability to interact with the community
d. Being an adept marksman
e. Having politic beliefs in line with the community's leadership
ANSWER: c

What is the current concept of the utility of written personality assessments?

a. The MMPI is the definitive tool for screening out candidates with psychopathology
b. There is no use for psychological testing to make any determination about duties to perform
c. The in-person psychological evaluation has greater utility than written personality assessments
d. The same battery of tests should be used for all applicants
ANSWER: c

S11 NONFATAL STRANGULATION AND MONICA'S LAW

Christopher Marett, MD, MPH, Cincinnati, OH
Scott Bresler, PhD, Cincinnati, OH

EDUCATIONAL OBJECTIVE

This poster reviews the epidemiology of nonfatal strangulation, the association of nonfatal strangulation with other types of violence, and legislative efforts to reduce the risk of further violence to victims of nonfatal strangulation.

SUMMARY

While it had been underreported and understudied for years, there is now a growing research literature on nonfatal strangulation. Strangulation usually occurs late in a progression of violence in a relationship. Up to 10% of women have been strangled by an intimate partner, and it is more common among those who are socially vulnerable. Those who have been strangled are at elevated risk of sexual assault, traumatic brain injury, and homicide.

In addition to reviewing pertinent epidemiology of nonfatal strangulation, this poster will also detail a proposed law in Ohio, Monica's Law, that would make nonfatal strangulation a felony. At least 39 states already allow for the prosecution of strangulation as a felony. The authors review variations in such laws among states and describe tools for the identification and assessment of those at risk for strangulation and other types of violence by intimate partners.

REFERENCES

Laughon K, Glass N, Worrell C: Review and analysis of laws related to strangulation in 50 states. Evaluation Review 33(4):358-369, 2009

Pritchard AJ, Reckdenwald A, Nordham C: Nonfatal strangulation as part of domestic violence: a review of research. Trauma, Violence, and Abuse 18(4):407-424, 2015

QUESTIONS AND ANSWERS
Approximately what percentage of victims of intimate partner femicide had experienced at least one prior attempted strangulation?

a. 10%
b. 20%
c. 40%
d. 70%
ANSWER: c

Among women who have been strangled, approximately what percentage reported having been threatened to be killed?

a. 30%
b. 50%
c. 75%
d. 90%
ANSWER: d

S12 ANIMAL-ASSISTED THERAPY: ROLE IN JUVENILE DETENTION FACILITIES?

Rachael Holbreich, Washington, DC
Eindra Khin Khin, MD, Washington, DC

EDUCATIONAL OBJECTIVE
To explore the potential short-term and long-term benefits of animal-assisted therapy for psychiatric patients in juvenile detention and to investigate the feasibility of implementing animal-assisted therapy in juvenile detention facilities.

SUMMARY
The purpose of this study is to evaluate the feasibility and utility of implementing animal-assisted therapy (AAT) in juvenile detention centers as part of the treatment of acute psychiatric illnesses. AAT is well recognized as having the potential to positively influence psychological, behavior and physiological well-being. In pediatric patients hospitalized for acute mental disorders, AAT has been shown to improve global functioning and have an overall positive impact on therapeutic progress. There are currently no studies that evaluate the influence of AAT on the treatment of psychiatric populations in juvenile detention facilities. Juveniles involved with the criminal justice system have disproportionately higher rates of psychiatric disorders than the general population. Providing mental health treatment for these individuals within juvenile detention facilities allows opportunity for improved treatment adherence. This study seeks to (1) determine the feasibility of instituting AAT in a juvenile detention center; (2) examine studied benefits of AAT for pediatric psychiatric patients; (3) examine potential contributors to outcome of effect including gender, age, diagnosis, psychosocial economic background, race, exposure to violence, reason for admission to the facility; and (4) examine how these benefits may be applied to individuals with psychiatric illnesses in juvenile detention.

REFERENCES
Stefanini M, Martino A, Allori P, et al: The use of animal-assisted therapy in adolescents with acute mental disorders: a randomized controlled study. Complementary Therapies in Clinical Practice 21(1):42-46, 2015

Desai RA, Goulet JL, Robbins J, et al: Mental health care in juvenile detention facilities: a review. J Am Acad Psychiatry Law 34(2), 2006

QUESTIONS ANSWER ANSWERS
Animal-assisted therapy has been associated with which of the following?

a. Improved socialization
b. Stress reduction
c. Improved regulation of anger
d. Enhanced treatment adherence
e. All of the Above
ANSWER: e

Which of the following is the strongest risk factor for juvenile recidivism?

a. Length of stay
b. Substance abuse
c. Caucasian
d. Parent criminality
ANSWER: b

SATURDAY

S13 BIOPSYCHOSOCIAL RISK FACTORS AND CHARGE SEVERITY IN INDIVIDUALS DEEMED INCOMPETENT TO STAND TRIAL

Brittany Mott, MD, Rochester, NY

EDUCATIONAL OBJECTIVE
To learn about new research data for criminal competency.

SUMMARY
In New York State, individuals deemed incompetent to stand trial with felony arrest charges are committed to a forensics hospital to receive treatment to restore them to fitness to stand trial. Individuals deemed incompetent to stand trial with misdemeanor charges are transferred to a state civil psychiatric hospital and their charges are dropped. This study will compare the biopsychosocial profiles of individuals deemed incompetent to stand trial who were admitted to the Rochester Psychiatric Center Forensic Unit with those individuals admitted to the Rochester Psychiatric Center Civil Unit. A number of parameters will be studied. The biological factors include substance use and medical co-morbidities. Psychological factors include psychiatric diagnoses and previous mental health treatment. Social factors include socioeconomic status, family structure, and education. This study will be a retrospective chart review data collection study for five years, from January 1, 2013 to December 31, 2017. The research objective is to determine if certain factors are more likely to predict charge severity in individuals who are deemed incompetent to stand trial.

REFERENCES
Colwell LH, Gianesini J: Demographic, criminogenic, and psychiatric factors that predict competency restoration. J Am Acad Psychiatry Law 39:297-306, 2011

Gillis A, Holoyda B, Newman WJ, et al: Characteristics of misdemeanants treated for competency restoration. J Am Acad Psychiatry Law 44:442-50, 2016

QUESTIONS AND ANSWERS
Briefly explain the restoration process for individuals in New York State who are deemed incompetent to stand trial.

ANSWER: It depends on the charge severity. Misdemeanors are dropped and the patient goes to the state hospital civil unit for treatment, and felonies are not dropped and the patient is sent for restoration at a state forensic hospital. There is also the option for outpatient competency restoration.

In previous research regarding competency restoration, which of the following has been shown?

a. Single marital status was associated with a significant increase in the odds of non-restorability
b. Individuals not restorable had more previous incarcerations
c. Individuals restored to competency had more serious charges than those not restored
d. All of the above
ANSWER: d

S14 STATE LAWS ON COMPETENCY TO EXECUTE BEFORE MADISON V. ALABAMA

Michael S. Vaughn, PhD, Huntsville, TX

EDUCATIONAL OBJECTIVE
To review U.S. Supreme Court case law on competency to execute; to examine state laws on competency to execute; and to present recommendations for states to alter their laws after the U.S. Supreme Court decides Madison v. Alabama to ensure constitutional compliance.

SUMMARY
In Ford v. Wainwright (1986), the U.S. Supreme Court categorically exempted the mentally insane from execution on the basis that the protected class was less morally culpable, and therefore less deserving of society's most serious punishment. Twenty-one years later, the Court revisited the issue in Panetti v. Quarterman (2007) to criticize states for ignoring the spirit of its Ford decision and for continuing to execute mentally incompetent inmates. On February 26, 2018, the U.S. Supreme Court granted certiorari to hear Madison v. Alabama, presenting the questions whether evolving standards of decency permit "the state [to] execute a prisoner whose mental disability leaves him without memory of his commission of the capital offense or understanding the circumstances of his scheduled execution." This poster reviews state laws on competency to execute after Madison v. Alabama and makes suggestions to bring them in line with constitutional standards.

REFERENCES
Ford v. Wainwright, 477 U.S. 399 (1986)

Panetti v. Quarterman, 551 U.S. 930 (2007)

QUESTIONS AND ANSWERS
Ford v. Wainwright (1986) stands for the following?

a. Insane individuals on death row are entitled to have a competency to execute hearing.
b. Insane individuals on death row are not entitled to have a competency to execute hearing.
c. Death row inmates may not be executed if they are unaware of the punishment they are about to suffer and why they are to suffer it.
d. a and c
e. b and c
ANSWER: d

Panetti v. Quarterman (2007) held that:

a. Death row inmates who suffer from serious delusions may be incompetent to be executed.
b. Whether a death row inmate is suffering from delusions is not relevant to the competency to execute question.
c. A death row inmate who suffers from a serious mental illness may not be executed.
d. a and c
e. None of the above
ANSWER: a

S15 WHEN YOUR PATIENT'S EMOTIONAL SUPPORT ANIMAL BECOMES ANOTHER'S TRAUMA

Gareen Hamalian, MD, MPH, New York, NY
Tara Straka, MD, New York, NY
Regina Kline, JD, Washington, DC

EDUCATIONAL OBJECTIVE
To explore the role conflicts that treatment providers may face in their practice related to requests for emotional support animal letters; examine press coverage related to unruly such animals and related concerns about liability; and review ethical standards, legal regulations and any practice guidelines.

SUMMARY
Federal regulations governing the status of emotional support animals are not as clear as those for service animals. Emotional support animals do not need to be a particular species nor do they need to be trained; you simply have to be under treatment for a mental disorder and obtain a letter from a licensed mental health professional certifying the animal is necessary for your well-being or treatment for your condition. Writing emotional support animal letters for your own patients is not without risk. The increasing number of patient requests for accommodations for emotional support animals in a variety of settings, most commonly air travel or no-pet housing, raises a variety of questions and issues related to risk, liability and therapeutic alliance. Given the complexity of this area of regulation, this type of recommendation would ideally be made by a third-party evaluator who can objectively review the facts. This poster will explore the role conflicts that treatment providers may face in their practice related to letter requests. It will look at the rising recent press coverage related to unruly ESAs and related concerns about liability. It will review ethical standards, legal regulations and make suggestions for practice guidelines.

REFERENCES
Schoenfeld-TacherRM , Kogan LR: Professional veterinary programs' perceptions and experiences pertaining to emotional support animals and service animals, and recommendations for policy development. J Vet Med Educ 44(1):166-178, 2017

Younggren JN, Boisvert JA, Boness CL: Examining emotional support animals and role conflicts in professional psychology. Prof Psychol Res Pr. 47(4):255-260, 2016

QUESTIONS AND ANSWERS

Do requests for emotional support animal letters pose a conflict of interest between psychiatrist and patient?

ANSWER: Special accommodation recommendations for animals are usually administrative in nature and therefore best that they be performed by a neutral third party who is not involved in the patient's treatment. Separating the treatment issues from those that are administrative helps avoids potential role conflict and is in the best interests of the therapy and the patient.

What's the difference between a psychiatric service animal and an emotional support animal?

ANSWER: A psychiatric service animal (PSA) is a special type of SA that has been trained to perform tasks that assist individuals with disabilities to detect the onset of psychiatric episodes and lessen their effects. Emotional Support Animals do not require the training that is necessary to certify an animal as an ADA-compliant SA and are not directly covered by Title II (Nondiscrimination on the basis of disability in state and local government services; 42 U.S.C.) or Title III (Nondiscrimination on the basis of disability by public accommodations and in public commercial facilities; 42 U.S.C.) of the ADA.

S16 POSTER WITHDRAWN

S17 MARTIN MANLEY: ANATOMY OF A GERIATRIC SUICIDE

Sherif Soliman, MD, Matthews, NC
Cathleen Cerny-Suelzer, MD, Seven Hills, OH
Carolyn Dessin, Akron, OH
Karen Reimers, MD, Minneapolis, MN
Michael Redinger, Kalamazoo, MI

EDUCATIONAL OBJECTIVE

The audience will be able to discuss some of the unique psychological underpinnings of and risk factors for geriatric suicide through the lens of Martin Manley's suicide. They will learn about clinical and legal issues in this at-risk population.

SUMMARY

On his 60th birthday, sports writer Martin Manley called police to report a suicide: his own. He left behind a website detailing his life and his reasons for killing himself. Among the reasons he listed were beliefs that he would lose control of both his body and mind as he aged. These fears are common among the growing elder population. The CDC estimates the suicide rate among Americans 65 years of age and older at 14.9 per 100,000, higher than the overall rate (12). This is particularly concerning considering the rapid growth of this population. This poster will explore the Manley case from clinical and legal perspectives. Authors will discuss the Manley case, the lessons it offers, and the questions it raises; clinical aspects of risk management; the forensic aspects of suicide including liability and standard of care; how the law views suicide including institutional and professional liability as well as the concept of mental capacity at the time of suicide; and evolving standards for physician assisted suicide and capacity assessment.

REFERENCES

Martin Manley: My Life and Death. Available at http://martin-manley.eprci.com. Accessed March 25, 2018.

Edelstein BA, Heisel MJ, McKee DR, et al: Development and psychometric evaluation of the reasons for living–older adults scale: a suicide risk assessment inventory. Gerontologist 49(6):736-45, 2009

QUESTIONS AND ANSWERS

In the absence of other risk factors, which patient has the highest suicide risk?

a. A 76-year-old white woman
b. An 80-year old-African-American man
c. A 56-year-old white man
d. An 87-year-old white man
e. A 26-year-old African-American woman
ANSWER: d

Which of the following is the most common method used in completed suicide?

a. Jumping from high building or bridge
b. Car accident
c. Hanging
d. Overdose
e. Firearm
ANSWER: e

S18 "DO NO HARM" V. "DO NO HOMO": BANS ON CONVERSION THERAPY FOR MINORS BY LICENSED MENTAL HEALTH PROFESSIONALS

Chase Hiller, Washington, DC
Patricia Ortiz, MD, Washington, DC
Eindra Khin Khin, MD, Washington, DC

EDUCATIONAL OBJECTIVE

To review the history of homosexuality in the field of psychiatry; examine the evidence-based data on conversion therapy regarding efficacy and harms; highlight the current status of bans on conversion therapy for minors and pertinent legal issues; and explore opportunities for our profession to address this practice.

SUMMARY

Despite rapidly growing acceptance and understanding of sexual orientation and lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) people in the United States, the highly questionable practice of so-called conversion therapy, also referred to in the literature as "reparative therapy" or sexual orientation change efforts (SOCE), still persists. In response, and in the interest of the welfare of children, states have begun to enact or consider bans on conversion therapy for minors. We present a brief history of homosexuality in psychiatry in addition to a scientific overview of conversion therapy, examining purported efficacy and potential harms. We then review the current status of bans on conversion therapy for minors and discuss the relevant case law and pertinent legal issues, such as professional conduct versus free speech, parental rights, informed consent and the right to choose treatment, as well as deceptiveness. Finally, we highlight further opportunities on the advocacy and legal platforms to address this practice that has been repudiated by our professional organizations.

REFERENCES

American Psychological Association. Report of the American Psychological Association task force on appropriate therapeutic responses to sexual orientation. 2009. Available at https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf. Accessed September 2018.

Substance Abuse and Mental Health Services Administration. Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. Substance Abuse and Mental Health Services Administration, 2015. Available at: https://store.samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf. Acessed September 2018.

QUESTIONS AND ANSWERS

The first state-wide ban on conversion therapy enacted in California applied to:

a. State-licensed mental health providers attempting to change a minor's sexual orientation
b. Either party in the professional-client relationship regardless of the professional's degree or the client's age
c. SOCE therapists only; professionals with medical degrees were exempted under a conscience clause
d. Any licensed mental health professional who discusses the topic of sexual orientation with his/her client
ANSWER: a

A promising legal means to ban the practice of conversation therapy is based on the deception-related policies as outlined by the:

a. Better Business Bureau
b. Federal Communications Commission
c. Federal Trade Commission
d. Department of Commerce
e. Department of Labor
ANSWER: c

S19 PHYSICIAN HEALTH PROGRAMS: STRUGGLES AND SUGGESTIONS

Douna Montazeralghaem, MD, Brooklyn, NY
Christopher Marett, MD, Cincinnati, OH

EDUCATIONAL OBJECTIVE

This poster identifies common areas of concern raised by physicians as the patient participants in physician health programs and the challenges faced by these organizations. It also highlights gaps in research findings and plausible suggestions for future research and development.

SUMMARY

Physician Health Programs (PHPs) serve the dual function of providing a buffer to the disciplinary actions that are taken against impaired physicians by their medical boards, while simultaneously assuring public safety. Limitations in funding, oversight, research, and information dissemination have subjected these programs to recurring challenges, lawsuits, and objections from some participants. Although some studies have demonstrated higher success rates for PHP participants with substance use disorders (SUD) than the general population, others have highlighted concerns regarding overutilization of inpatient long-term addiction treatment and underutilization (as low as 6%) of indicated medication treatment for physicians with SUD. In addition to presenting data regarding the advantages of PHPs interventions, this poster also examines the mismatch between expectations and available infrastructure. PHPs' struggles with funding and staffing require further acknowledgement by policy makers. Lastly, we offer suggestions for future development.

REFERENCES

Carr GD, Hall PB, Finlayson R, DuPont RL: Physician Health Programs: The US Model. Physician Mental Health and Well-Being. Springer, 2017: pp. 265-294

Merlo LJ, Campbell MD, Skipper GE, et al: Outcomes for physicians with opioid dependence treated without agonist pharmacotherapy in physician health programs. J Subst Abus Treat 64:47-54, 2016

QUESTIONS AND ANSWERS

Which of the following is true regarding treatment of physicians with substance use disorders while enrolled in Physician Health Programs?

a. They do not receive sufficient length of inpatient treatment.
b. They have higher relapse rates than non-physician patients with substance use disorders.
c. Very few receive medication treatment, even when indicated.
d. They are provided with access to more treatment options and resources than non-physician patients with substance use disorders.

ANSWER: c

Which of the following has been raised as a common concern of physicians who enroll as patients in Physician Health Programs?

a. High cost of recommended evaluation and treatment options
b. Limited clarity of their due process rights
c. Lack of income while their licenses are suspended
d. Feeling humiliated during their treatment course and when returning to work
e. All of the above

ANSWER: e

S20 CAN JAIL BE A THERAPEUTIC SETTING: AN ARCHITECTURAL REVIEW

Mary Colavita, MD, Short Hills, NJ
Matthew Grover, MD, Bronx, NY
Merrill Rotter, MD, Bronx, NY

EDUCATIONAL OBJECTIVE

To review the opportunities for and limitations on incorporating therapeutic architectural elements in mental health units of a large urban jail.

SUMMARY
The built environment has been shown to both directly and indirectly affect mental health outcomes. Literature on secure facility design from the early 21st century has emphasized the importance of safety, privacy, and operational efficiency, with a focus on declining trends of inmate violence and recidivism rates. Building design features that influence perception of staff-prisoner relationships (e.g. less double bunking and smaller living units might mean more individual attention from staff) and sense of security are noted to foster positive mental health outcomes. Research from civil psychiatric facilities indicate that elements such as building age, residential density, access to natural light, windows, nature scenes, corridor length, perceptual consistency of media, noise levels, color variability, clearly defined spaces for therapeutic activities, residential features (e.g. gallery kitchens, laundry), and physical barriers between staff and patients are associated with shifts in intensity of psychiatric symptoms and willingness to participate in treatment. In this review, we compare mental health units and regular pods at a large urban jail, some of which have been recently renovated, and discuss the possible ways in which they comport with a more or less therapeutic environment.

REFERENCES
Connellan KA, Gaardboe M, Riggs D, et al: Stressed spaces: mental health and architecture. Health Environments Research & Design Journal 6(4): 127-168, 2013

Dvoskin J, Radomski S, Bennett C, et al: Architectural design of a secure forensic state psychiatric hospital. Behavioral Sciences and Law 20:481-493, 2002

QUESTIONS AND ANSWERS
Although all of the following architectural elements are associated with positive perception of officer-prisoner interactions, which two have proven to be statistically significant in multivariate controlled studies?

a. Smaller units
b. Newer units
c. Lower percentage of double cells
d. Improved lines of sight
ANSWER: b and c

Which of the following models posits that prison architecture contributes to an inmate's perception of safety, his need to compete for limited resources, and the likelihood that there are consequences for his actions?

a. Rational Choice Theory
b. Situational Theory
c. Importation Theory
d. Deprivation Theory
ANSWER: b

SATURDAY

S21 THE EVOLUTION OF OUTPATIENT COMMITMENT: A CASE STUDY OF SOUTHERN NEVADA

Jessica Arabski, DO, Las Vegas, NV
Mohammad Khan, MD, Las Vegas, NV

EDUCATIONAL OBJECTIVE
To review the history of involuntary outpatient commitment, court-ordered treatment for the severely mentally ill that is also commonly known as assisted outpatient treatment, or AOT. To examine the process of implementing an AOT program using southern Nevada as a case study.

SUMMARY
The efficacy of Court-mandated outpatient psychiatric treatment has been a source of controversy dating back to at least the 1980s. Arguments for AOT include delivery of treatment in a less restrictive setting, facilitation of patient independence, and broader delivery of rehabilitative services. The model also encourages proactive "as opposed to reactive" interventions. However, arguments against AOT include concern the program is intrusive and coercive, particularly when the target population is often already considered vulnerable. In addition, AOT is often said to lack "teeth" meaning in many jurisdictions, the outcome of treatment non-adherence is minimal. In 2013, Nevada became the 45th state to adopt an AOT law. The program was developed by the Southern Nevada Adult Mental

Health Services and Clark County Specialty Court Program and implemented in the greater Las Vegas area. This study examines the evolution of AOT since the program was first established five years ago. This poster explores the challenges associated with the program, including patient selection, barriers to care in the community, and the consequences of shifting public perception of AOT over time. We also discuss cost-effectiveness of the program, as well as the impact of AOT on psychiatry in southern Nevada.

REFERENCES

Geller JL: The evolution of outpatient commitment in the USA: From conundrum to quagmire. International Journal of Law and Psychiatry 29:234-48, 2006.

Morrissey JP, Desmarais SL, Domino ME: Involuntary Outpatient Commitment: Current Evidence and Options. Prepared for the Continuity of Care Panel, Maryland Department of Health and Mental Hygiene, October 2013. Available at dhmh.maryland.gov/bhd/Documents

QUESTIONS AND ANSWERS

Arguments against AOT have historically included:

a. Concerns over intrusive treatment
b. Concerns about coercion of a vulnerable population
c. Sentiment the program lacks "teeth"
d. All of the above
ANSWER: d

Nevada was the 45th state to adopt an AOT law. What year did this occur?

a. 1983
b. 1993
c. 2003
d. 2013
ANSWER: d

S22 FACTORS INFLUENCING RESTORABILITY: PRESENT AND FUTURE CHALLENGES

Cristina M. Secarea, MD, Washington, DC

EDUCATIONAL OBJECTIVE

To recognize the significance of competence to stand trial (CST); identify factors influencing restorability; and provide guidance to improve treatment and shorten the time to restoration.

SUMMARY

The forensic literature is unclear on the most consistent influences on length of time needed to restore (LOR) inpatients' competence to stand trial. Some studies find that a younger age at admission and a more severe charge are associated with an increased likelihood of restorability, while others emphasize the relationship between LOR and IQ or diagnosis. Generally speaking, cognitive disorders and psychotic disorders have a strong influence, although differences in sample size and population affect the generalizability of data.

The two largest restorability studies in the literature agree on some factors that positively influence adjudicative competence, like younger age, female sex, and presence of mood disorder, but disagree on the influence of psychosis. Other studies do not comment on LOR and only one study focuses on "treatment-specific variables" like medication adherence. Uncertainty affecting adjudicatory competence continues to surround the role of psychosis, personality and substance use–the most prevalent disorders in forensic populations. In the context of long periods of time in the hospital and high costs, a greater empirical base is needed to inform the judicial and mental health systems on the factors that affect restoration.

REFERENCES

Warren JI, Chauhan P, Kois L, et al: Factors influencing 2260 opinions of defendants' restorability to adjudicative competency. Psychology, Public Policy and Law 19(4):498-508, 2013

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

QUESTIONS AND ANSWERS
Which disorder has the highest association with unrestorability?

a. Psychotic Disorder
b. Borderline Personality Disorder
c. Cognitive Disorder
d. Substance Use Disorder
ANSWER: c

Based on recent studies, what is the percentage of defendants restored to competence?

a. 0-25%
b. 25-50%
c. 50-75%
d. 75% and up
ANSWER: d

S23 IS KRATOM A HARMFUL PSYCHOACTIVE SUBSTANCE?

Sebastien S. Prat, MD, Hamilton, ON, Canada
Gary Chaimowitz, MB, ChB, Ancaster, ON, Canada

EDUCATIONAL OBJECTIVE
To learn about the pharmacological properties of Kratom; and defining if Kratom is to be considered as a dangerous substance.

SUMMARY
For more than a decade, new psychoactive substances have invaded the market. These substances are legal until deemed otherwise by the authorities. Kratom (Mytragina speciose), a South Asian tea, is one of them. It is considered an opioid-like drug. It is used to increase the energy level or to treat opioid withdrawal symptoms. In our clinical case, a young adult, suffering from Schizophrenia, has developed acute psychotic symptoms within a few hours of using Kratom. Although several articles report psychosis and hallucinations as a possible effect of Kratom, the scientific evidence is quite limited. It remains unclear is Kratom is a dangerous substance from a psychiatric standpoint. This presentation will also address the concept of legal high which is of a major concern, in psychiatry and especially in forensic psychiatry, due to the limited regulation of some harmful substances.

REFERENCES
Suwanlert S: A study of kratom eaters in Thailand. Bull Narc. 27(3):21-7, 1975

Chang-Chien GC, Odonkor CA, Amorapanth P: Is kratom the new 'legal high' on the block?: the case of an emerging opioid receptor agonist with substance abuse potential. Pain Physician 20(1):E195-E198, 2017

QUESTIONS AND ANSWERS
How is Kratom defined from a pharmacological perspective?

ANSWER: An opioid-like substance

What is a legal high?

ANSWER: A substance that is used to get high but still legal

S24 ALTERNATIVE INTERPRETATION APPROACHES TO THE TEST OF MEMORY MALINGERING

Holly Kaufman, MS, Chapel Hill, NC
Brian Belfi, PsyD, New York, NY
Debbie Green, PhD, Teaneck, NJ

EDUCATIONAL OBJECTIVE
The purpose of the current study is to examine patterns of responding among individuals classified as genuine and feigning in an effort to identify alternative decision rules for the TOMM that may increase efficiency and potentially address some of the concerns that defendants are becoming aware of the administration methods.

SUMMARY
The Test of Memory Malingering is a commonly used and widely researched tool designed to identify individuals who may be exerting poor cognitive effort or feigning cognitive impairment. Previous studies examining alternative decision rules have focused on Trial One. Many of these studies demonstrate that administration of Trial Two and even sometimes all of Trial One may not be necessary. In addition to increasing administration efficiency, there is a need to update and refine measures of malingering as defendants become more aware of these methods, challenging the capacity to accurately identify those who exaggerate impairments. This study examines potential alternative decision rules by analyzing 550 TOMMs from pre-trial defendants admitted to a northeast forensic psychiatric facility for the purposes of competency restoration. Implications for administration and interpretation of the TOMM will be discussed.

REFERENCES
Hilsabeck RC, Gordon SN, Hietpas-Wilson T, et al: Use of trial 1 of the Test of Memory Malingering (TOMM) as a screening measure of effort: suggested discontinuation rules. The Clinical Neuropsychologist 25:1228-1238, 2011

Tombaugh TN: Test of Memory Malingering (TOMM). New York: Multi-Health Systems, Inc, 1996

QUESTIONS AND ANSWERS
Alternative decision rules for the TOMM may be important because:

a. It is the only available measure of malingered cognitive impairment
b. Defendants may become familiar with the measure
c. It is a rarely used measure
d. The measure is difficult to administer
ANSWER: b

Which of the following is the estimated base rate of malingering and symptom exaggeration in criminal cases?

a. 5%
b. 10%
c. 20%
d. 50%
ANSWER: c

S25 IN THE MATTER OF AG (NJ 2016): ANOREXIA NERVOSA AND THE CAPACITY TO REFUSE FORCED FEEDING

Patricia Westmoreland, MD, Denver, CO
Jeanne Kerwin, DMH, Morristown NJ
Edward G. D'Alessandro, Jr. Esq., Florham Park, NJ

EDUCATIONAL OBJECTIVE
This panel will discuss the court decision in the matter of A.G. The panel will be conducted by a forensic psychiatrist who treats patients with life threatening anorexia nervosa, as well as the ethicist who evaluated A.G. and the judge who decided the case.

SUMMARY
In 2016, a New Jersey court ruled that A.G., a 29-year-old woman with severe anorexia nervosa, had the right to refuse forced feeding, a matter that culminated in her death several months later. After years of unsuccessful treatment attempts and recent severe complications of artificial feeding, A.G. refused further treatment and requested palliative care. The State of New Jersey argued A.G. was not capable of making informed decisions about her treatment and should be forced to receive further treatment. In this panel discussion, Dr. Westmoreland will outline forensic decision-making when an individual such as A.G. requests palliative care and the treatment team are considering whether to abide by her wishes or treat her against her will. Bioethicist Dr. Kerwin will explain why she testified in this case and the ethical analysis and opinion that was rendered supporting the patient's request to forgo forced treatments and to receive palliative care.

REFERENCES
Eddy KT, Tabri N, Thomas JJ, et al: Recovery from anorexia nervosa and bulimia nervosa at 22-year follow-up. J Clin Psychiatry, 78(2):184-189, 2017

Westmoreland P, Mehler PS: Caring for patients with severe and enduring eating disorders (SEED): certification, harm reduction, palliative care, and the question of futility. J Psychiatr Pract. 22(4):313-320, 2016

QUESTIONS AND ANSWERS
Recent research has demonstrated that patients with anorexia nervosa:

a. Are more likely than those with bulimia nervosa to recover earlier in the course of their illness
b. Are unlikely to recover after being ill for five years
c. May still recover after 20 years of illness
d. Should always be offered palliative care after being ill for 10 years
ANSWER: c

Regarding futility in severe anorexia nervosa:

a. Capacity should be the only determination when a patient requests to stop treatment
b. Psychiatric advance directives are always respected by the courts
c. Anorexia can be compared to cancer in its terminal course
d. Every situation should be considered individually taking into account patients' suffering even if they lack capacity
ANSWER: d

S26 FORENSIC TELEPSYCHIATRY: WHY AREN'T YOU DOING IT?

Keelin Garvey, MD, Tiverton, RI
Elizabeth Ferguson, MD, Palm Coast, Fl
Patricia Recupero, JD, MD, Providence, RI
Lisa Harding, MD, Wichita, KS

EDUCATIONAL OBJECTIVE
We will review current evidence on the use of telepsychiatry in community and correctional settings. We will discuss relevant case law and constitutional challenges raised in the application of telepsychiatry to the courts, highlighting setbacks and triumphs in the advancement of the practice of forensic telepsychiatry.

SUMMARY
Telepsychiatry breaks down geographical barriers to care, allowing individuals living in underserved and correctional settings or needing specialized treatment to access the same quality of care others receive. It is supported in the literature, endorsed by the APA, and embraced nationwide for direct patient treatment and collaborative care. The psychiatry shortage is not unique to treatment, however. Many court systems have difficulty meeting the increasing need for skilled forensic evaluators, resulting in unnecessary jail time for mentally ill offenders and in litigation against the courts. We believe the judicial system would benefit from increased access to specially trained forensic psychiatrists that goes beyond the clinical correctional applications to include forensic evaluations. Telepsychiatry appears to be the perfect solution, so why isn't it being used routinely?

Our panel will review the history of telepsychiatry, discuss its use in clinical forensic settings, and examine limitations to its growth within the legal system. We will discuss the present state of remote testimony in civil and criminal litigation, highlighting influential cases. Finally, we will propose a model for advancing into the next frontier of forensic telepsychiatry, focusing on adherence to the strictest standards of quality and ethics in the application of technology to the courtroom.

REFERENCES
Antonacci DJ, Bloch RM, Saeed SA, et al: Empirical evidence on the use and effectiveness of telepsychiatry via videoconferencing: implications for forensic and correctional psychiatry. Behav Sci Law 26(3):253-69, 2008

Garofano A: Avoiding Virtual Justice: Video-Teleconference Testimony in Federal Criminal Trials, 56 Cath. U. L. Rev. 683 (2007). Available at: http://scholarship.law.edu/lawreview/vol56/iss2/10. Accessed September 2018.

QUESTIONS AND ANSWERS
Which amendment has been cited most frequently in cases and articles challenging the constitutionality of remote video testimony in criminal courts?

a. 1st Amendment–Freedom of speech
b. 5th Amendment–Self-incrimination
c. 5th Amendment–Due process
d. 6th Amendment–Confrontation clause
ANSWER: d

In the absence of legislative guidance, lower courts have used all but which of the following cases to guide decision-making regarding the allowance of remote witness testimony?

a. Estelle v. Gamble
b. Maryland v. Craig
c. Crawford v. Washington
d. Coy v. Iowa
ANSWER: a

S27 THE MEDIA INTERVIEW: KEEP IT INTERESTING, AND TRUTHFUL

Barry Wall, MD, Providence, RI
Ryan Wagoner, MD, Tampa, FL
Praveen Kambam, MD, Los Angeles, CA
Vasilis Pozios, MD, Ann Arbor, MI
Jennifer Okwerekwu, MD, Cambridge, MA

EDUCATIONAL OBJECTIVE

To improve media interview skills for television, print, and voice-only and video online interviews.

SUMMARY

Educating policymakers and the public on forensic psychiatric matters consists of fast-paced, fleeting media interviews, as well as posting on electronic news, which can remain available over time. This interactive workshop provides an overview of the ethical and professional issues to consider when participating in media interviews, and summarizes the mechanics of interacting with media interviewers. It provides information on how to balance facts with sound bites for television interviews, print media (online and paper), and voice-only and video online interviews. The workshop concludes with an interactive mock television interview with workshop participants.

REFERENCES

Cooke BK, Goddard ER, Werner TL, et al: The risks and responsible roles for psychiatrists who interact with the media. J Am Acad Psychiatry Law 42(4):459-468, 2014

Levine MA: Journalism ethics and the goldwater rule in a "post-truth" media world. J Am Acad Psychiatry Law 45(2):241-248, 2017

QUESTIONS AND ANSWERS

The "Goldwater Rule" is an ethical principle for which of the following professional organizations?

a. American Psychiatric Association
b. American Psychological Association
c. American Medical Association
d. a and b
e. All of the above
ANSWER: e

A forensic psychiatrist participating in media interviews must consider which of the following risks?

a. Violation of professional ethical principles
b. Breach of confidentiality
c. Libel
d. Slander
e. All of the above
ANSWER: e

S28 THE FORENSIC PSYCHIATRIST ON TRIAL: THE EXPERT, EXPOSED

Christopher Fischer, MD, Sacramento, CA
Ariana Nesbit, MD, Sacramento, CA
Charles Scott, MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

To identify the factors that establish someone as a forensic expert; to discuss potential standards and guidelines for forensic assessment; to discuss common types of lawsuits against forensic psychiatrists; and to review strategies to reduce liability and avoid pitfalls.

SUMMARY
Although forensic psychiatrists often evaluate the negligence of others, there are significant situations where forensic psychiatrists themselves may be scrutinized under the law. Dr. Nesbit will review the admissibility criteria of forensic testimony including emerging and controversial areas such as "affluenza," child sexual abuse accommodation syndrome, the relationship between SSRIs and violence, and the use of genetic and neuroimaging evidence to assess violence risk. Dr. Nesbit will also discuss the use of standards and guidelines, including the role that APA, AAPL, and NHCC guidelines play in establishing standards of care within the field of forensic psychiatry. Dr. Fischer will review the most common types of malpractice claims and allegations of ethical misconduct against the forensic psychiatrist. Dr. Fischer will also use case examples and video clips to illustrate concerning and problematic expert testimony. Specific issues to be highlighted include testimony regarding malingering and defamation of character, child custody, and forensic testimony in death penalty cases including the US Supreme Court case, Buck v. Davis. Dr. Scott will review general guidelines to minimize one's liability and discuss proactive steps one can take to protect against malpractice claims when conducting forensic evaluations, writing forensic reports, and taking the stand.

REFERENCES
Gold LH, Davidson JE: Do you understand your risk? liability and third-party evaluations in civil litigation. J Am Acad Psychiatry Law 35(2):200-210, 2007

Binder RL: Liability for the psychiatrist expert witness. The American Journal of Psychiatry 159(11): 1819-1825, 2002

QUESTIONS AND ANSWERS
What is the most common claim filed against forensic psychiatrists?

a. Defamation of character
b. Negligence
c. Breach of confidentiality
d. None of the above
ANSWER: b

Which of the following risk-management techniques should forensic psychiatrists use to protect themselves from malpractice liability?

a. Maintain strict records, including audiotaping or videotaping interviews when appropriate
b. Preserving the attorney's and client's confidences as specified in the legal proceedings in which you are involved
c. Not taking cases beyond your ability and expertise
d. All of the above
ANSWER: d

SATURDAY

S29 PEER REVIEW OF SANITY ASSESSMENTS IN HIGH PROFILE CASES: THE AMERICAN SNIPER TRAGEDY

David Rosmarin, MD, Newton, MA
Mitchell Dunn, MD, Dallas, TX
Robert Wettstein, MD, Pittsburgh, PA
Douglas Tucker, MD, Berkeley, CA

EDUCATIONAL OBJECTIVE
The case will focus on parsing out PTSD and substance abuse in cases involving delusional self-defense.

SUMMARY
The 2013 murders of American war hero and author Chris Kyle and Chad Littlefield generated headlines and a film by Clint Eastwood. Peer Review will present video testimony and examine stressors involved in testifying in high profile cases. In this case, the judge referenced Ruffin v. Texas (2008), which stated, "in Bigby v. State, we explained, several expert witnesses testified appellant knew his conduct was illegal, however, these experts contended that appellant did not know the act was 'morally' wrong." In other words, appellant believed that regardless of society's views about this illegal act and his understanding it was illegal, under his "moral" code it was permissible. This focus upon appellant's morality is misplaced. The question of insanity should focus on whether a defendant understood the nature and quality of his action and whether it was an act he ought to do. By accepting and acknowledging his action was "illegal" by societal standards, he understood that others believed his conduct was "wrong." The judge dismissed one expert who defined wrongfulness incorrectly on voir dire. It was argued the defendant killed in psychotic self-defense, however. M'Naghton originally allowed legal-only wrongfulness knowledge, since broadened in Britain and some states.

REFERENCES

Ruffin v. State, 270 S.W.3d 586 (Tex. Crim. App. 2008)

James Eugene Bigby, Appellant v. The State of Texas, Appellee, 892 S.W.2d 864 (1994)

QUESTIONS AND ANSWERS

Which of the following is the statutory legal standard for insanity in Texas:

a. It is an affirmative defense to prosecution that, at the time of the conduct changed, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong
b. Whether the defendant lacked substantial capacity to appreciate the legal or moral wrongfulness of his act
c. Whether the defendant lacked substantial capacity to conform his behavior to the law

ANSWER: a

Which of the following require forensic assessment in insanity cases?

a. Whether the defendant thought he was was doing something legal
b. Whether the defendant thought he was morally justified
c. Whether the defendant thought society considered his actions morally justified
d. All of the above

ANSWER: D

S30 INSANITY DEFENSE EVALUATIONS: OVERCOMING JURY SKEPTICISM

Phillip J. Resnick, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

To systematically evaluate criminal defendants, formulate well reasoned opinions about criminal responsibility, and overcome jury skepticism.

SUMMARY

The distinctions between the defenses of not guilty by reason of insanity, guilty but mentally ill, and diminished capacity will be explained. Tests for criminal responsibility will be placed in their historical perspective, including the wild beast test, M'Naghten standard, irresistible impulse, Durham rule, Model Penal Code, and the 1984 Federal rule. Participants will receive practical suggestions on conducting sanity interviews. Clues to knowledge of wrongfulness (legal and moral) and ability to refrain will be delineated. The limitations of the 'policeman at the elbow' test will be examined. The faculty will discuss which diseases may qualify for an insanity defense. Intoxication and battered woman syndrome will also be covered. Common errors in writing insanity reports will be identified. Emphasis will be given on how to educate jurors about insanity to overcome common myths and jury skepticism.

Participants will practice writing insanity opinions after watching a videotaped case interview. Handouts will include 55 suggestions for cross-examiners of psychiatrists, 12 clues to malingered psychoses, principles of writing insanity reports, and two sample reports.

REFERENCES

Resnick, PJ: Malingered Psychosis, Clinical Assessment of Malingering and Deception. Edited by Rogers R. New York: Guilford Press, 2018.

Janofsky JS, Hanson A, Candilis PJ, et al: AAPL practice guideline for forensic psychiatric evaluation of defendants raising the insanity defense. J Am Acad Psychiatry Law 42(4):S3-S76, 2014

QUESTIONS AND ANSWERS

Components of the M'Naghten test do not include:

a. Mental disease or defect
b. Lack of understanding of the nature and quality of the act
c. Lack of knowledge of the wrongfulness of the act
d. Inability to refrain
e. A causal nexus between the disease and other arms of the test

ANSWER: d

Which of the following does not qualify for an insanity defense:

a. Schizophrenia
b. Multiple Personality Disorder
c. PTSD
d. Voluntary intoxication
e. Mental retardation
ANSWER: d

S31 CHALLENGES FOR INPATIENT PSYCHIATRIC CARE OF THE OLDER OFFENDER

Karen Reimers, MD, Minneapolis, MN
Bridget Casey-Leavell, DO, Cincinnati, OH
Rebecca Karns, DO, Cincinnati, OH
Bradleigh Dornfeld, MD, Minneapolis, MN
Sherif Soliman, MD, Charlotte, NC

EDUCATIONAL OBJECTIVE

To identify challenges and future service needs for care of older offenders on forensic and general psychiatric inpatient units.

SUMMARY

Given changing demographics in the forensic population with rapidly growing numbers of older offenders, clinicians working in inpatient forensic psychiatric settings increasingly face challenges caring for elderly patients referred to their service. Facilities are seldom set up with older people in mind, leading to difficulties in clinical management of geriatric patients.

This session will explore challenges in the care of older offenders in inpatient forensic psychiatry services. Two forensic psychiatrists in active clinical practice in forensic inpatient psychiatry, Dr. Bridget Casey-Leavell and Dr. Rebecca Karns, will present composite clinical cases highlighting the difficulty of caring for geriatric patients on inpatient units designed for younger patients. Dr. Sherif Soliman will discuss medicolegal and forensic aspects of caring for older adults in forensic settings. Dr. Bradleigh Dornfeld will review challenges of discharge and disposition planning for older inpatients with a criminal history from general psychiatric inpatient units. Dr. Karen Reimers will present demographic and statistical information about older offenders being cared for on forensic inpatient services. The session will conclude with group discussion of current clinical challenges and identify areas of future service need.

REFERENCES

Yarnell SC, Kirwin PD, Zonana HV: Geriatrics and the legal system. J Am Acad Psychiatry Law 45(2):208, 2017

Tomar R, Treasaden IH, Shah AK: Is there a case for a specialist forensic psychiatry service for the elderly? Int J Geriatr Psychiatry, 20(1):51-56, 2005

QUESTIONS AND ANSWERS

Accelerated aging in incarcerated men and women can be due to

a. Inadequate access to medical care prior to incarceration
b. Substance abuse
c. Stress of incarceration
d. Lack of appropriate health care during incarceration
e. All of the above
ANSWER: e

Factors limiting research on offending by the elderly, especially the mentally disordered elderly, include

a. Differences in age range criteria for research
b. Classification based on service needs rather than age-related behavioral changes
c. Varying patterns of crimes involving elderly people across different areas
d. Varying judicial process across different jurisdictions
e. All of the above
ANSWER: e

S32 TRANSGENDER POPULATIONS AND THE LAW: BEYOND THE BATHROOM

Brian Barnett, MD, Cleveland, OH
Ariana Nesbit, MD, San Diego, CA
Kayla Fisher, MD, Highland, CA
Renée M. Sorrentino, MD, Weymouth, MA

EDUCATIONAL OBJECTIVE

The objectives of this panel are to inform participants about common forensic referral questions and evaluations in the transgender population and to describe key policies and laws and their implications for forensic psychiatrists working with transgender populations.

SUMMARY

Like the general public, the field of psychiatry has struggled to conceptualize transgender identity. Although the DSM-5 depathologized individuals with non-conforming gender identities by replacing the diagnosis of "gender identity disorder" with "gender dysphoria," this significant alteration was implemented only five years ago. Many governmental and healthcare policies affecting transgender individuals have struggled to catch up with psychiatry's current understanding of transgender identity and remain predicated on old notions.

Transgender individuals are at high risk of interaction with the criminal justice system, and this panel will explore common forensic and legal issues which arise when working with this population. Incarceration poses a number of difficulties for transgender prisoners and correctional facility administrators. Housing and right to treatment issues for transgender inmates will be discussed. In the community, the question of access to gender-specific bathrooms has resulted in legal debates about so-called "bathroom bills." The legal, ethical, forensic, and clinical implications of these bills, which mandate that individuals use the bathroom that corresponds to their biological sex, will be reviewed. The panel will also review the implications of the term "sex" as it relates to Title VII of the Civil Rights Act.

REFERENCES

Barnett BS, Nesbit AE, Sorrentino RM: The transgender bathroom debate at the intersection of politics, law, rthics and dcience. J Am Acad Psychiatry Law, in press

Broadus K: The criminal justice system and trans people. Temple Political and Civil Rights Law Review 18:561-472, 2009

QUESTIONS AND ANSWERS

Which of the following statements is true?

a. There are no national nondiscrimination laws for transgender individuals
b. 18 states and the District of Columbia have legislation that prohibits discrimination against transgender individuals
c. The United States Equal Employment Opportunity Commission has stated that discrimination against an individual because of gender identity is sex discrimination in violation of Title VII
d. All of the above
ANSWER: d

Which of the following statistics regarding transgender individuals' public restroom experience over the past year is incorrect?

a. 59% report avoiding public restrooms due to fear of confrontations or other problems they might experience
b. 32% limited the amount they ate and drank to avoid using the restroom
c. 5% report being verbally harassed
d. None of the above
ANSWER: c

S33 MOMMY DEAREST: HISTORICAL REVIEW OF FEMALE CULT LEADERS

Reagan Gill, DO, Tulsa, OK
Jason Beaman, DO, Tulsa, OK
Susan Hatters Friedman, MD, Cleveland, OH
Jennifer Piel, MD, JD, Seattle, WA

EDUCATIONAL OBJECTIVE

To gain access to new scientific data as well as improved data in areas that form the basis for practice of the discipline.

ABSTRACT
The word "cult" harbors many infamous names: Jim Jones and the Peoples Temple, David Koresh and Branch Davidians, Marshall Applewhite and Heaven's Gate. However, little attention is paid to female cult leaders of our time. This includes Anne Hamilton-Byrne, Clementine Barnabet, and Valentina De Andrade. They may not be household names, but they left a legacy of manipulation and destruction that rivals their male counterparts. This panel will educate the audience on the topic of female cult leaders and better enrich the comprehensive knowledge-base of forensic psychiatrists in this unconventional area. Dr. Reagan Gill will give an introduction defining what makes a cult and discuss psychopathology of cult leaders as we understand them today. Dr. Jason Beaman will review the case of Anne Hamilton-Byrne and her collection of children known as The Family. Dr. Jennifer Piel will discuss Clementine Barnabet's voodoo-based cult activity with The Church of Sacrifice. Finally, Dr. Susan Hatters Freidman will highlight the activity of Valentina De Andrade and her still active group of followers, the Superior Universal Alignment. At the end of the presentation, audience members will have a better understanding of cults and female cult leaders.

REFERENCES
Johnston JE: Female Cult Leaders Who Kill: Murder, Money, and Religion. Available at: https://www.psychologytoday.com/blog/the-human-equation/201205/female-cult-leaders-who-kill. Accessed March 13, 2018

Van Sant P: The Family: A Cult Revealed, 2017. Available at: https://www.cbsnews.com/news/48-hours-inside-the-family-cult-australia-anne-hamilton-byrne/. Accessed March 13, 2018

QUESTIONS AND ANSWERS:
Which female cult leader collected children and modeled them after the Von Trapp family?

ANSWER: Anne Hamilton-Byrne

What is the current status of Valentina De Andrade?

ANSWER: Not incarcerated, continuing to lead her following

S34 VEHICLES FOR POLICY DEVELOPMENT IN PUBLIC MENTAL HEALTH AND CORRECTIONAL SYSTEMS

Debra A. Pinals, MD, Ann Arbor, MI
Joel Dvoskin, PhD, Tucson, AZ
Jeffrey Metzner, MD, Denver, CO

EDUCATIONAL OBJECTIVE
At the end of this presentation, participants will be able to (1) describe how litigation has shaped research and policy in public systems, (2) discuss correctional and public mental health system practice evolution, and (3) provide information for further system development.

SUMMARY
Over many decades, advocacy and landmark litigation have shaped research, policy and practice in mental health and correctional settings. In this presentation, panelists will present pivotal historic and recent cases exemplifying their far-reaching aftermath driving policy implementation and research. Baxstrom v. Herold (1966), a U.S. Supreme Court landmark decision, will be highlighted as an early example, with a firsthand video-recorded interview of Hank Steadman, Ph.D., the architect of "Operation Baxstrom" research. This effort was undertaken after the decision and yielded foundational data regarding violence, mental illness and systems of care for the "criminally insane." Additional impactful cases that will be presented include Estelle v. Gamble (1976) and the more recent Brown v. Plata (2011), which continue to significantly shape correctional mental health services and system reform. Finally, panelists will review Jackson v. Indiana (1972), the Supreme Court case focused on purpose of confinement and duration of restoration treatment for incompetent to stand trial defendants, and how today's focus on that population has shifted more toward access to evaluative, diversion, and restoration services. Through the lens of the presenters, participants will learn about the importance of direct care, research, and expert testimony in influencing policy and law.

REFERENCES
Steadman HJ, Keveles G: The community adjustment and criminal activity of the Baxstrom patients: 1966-1970. Am J Psychiatry 129:304-10, 1972

Horne C, Newman WJ: Updates since Brown v. Plata: alternative solutions for prison overcrowding in California. J Am Psychiatry Law 43:87-92, 2015

QUESTIONS AND ANSWERS

In Baxstrom v. Herold (1966), the U.S. Supreme Court ruled that there must be due process and a civil commitment hearing for individuals with mental illness thought to need psychiatric hospitalization at the following point:

a. Upon expiration of a prison sentence
b. During a period of incarceration
c. At the time of being adjudicated incompetent to stand trial
d. At the time restoration was determined to be unlikely
e. The case did not involve civil commitment, it involved standards of dangerousness

ANSWER: a

In Brown v. Plata, the U.S. Supreme Court found:

a. Courts could not fix the systemic overcrowding in California through judicial action
b. Overcrowding has no constitutional remedy
c. Overcrowding alone is an eighth Amendment violation in the absence of any other factor
d. The California overcrowding and resultant impact on medical and mental health care reflected a constitutional violation
e. This was a California case and not a U.S. Supreme Court case related to prison overcrowding

ANSWER: d

S35 PTSD OUTCOMES: PERILOUS PREDICTIONS OF PROGNOSIS

Ryan C. Wagoner, MD, Tampa, FL
Charles Scott, MD, Sacramento, CA
William Newman, MD, St. Louis, MO
Lauren Schwarz, PhD, St. Louis, MO
Phillip Ruppert, PhD, St. Louis, MO

EDUCATIONAL OBJECTIVE

The goal of this panel is to review four common types of injuries resulting in PTSD and provide structured guidelines on how to provide an evidence-based approach to formulating prognosis.

SUMMARY

PTSD is associated with high levels of social, occupational, and physical disability, as well as considerable economic costs and medical utilization. Forensic psychiatrists are often asked not only to opine on the diagnosis and causation of PTSD, but also the individual's prognosis, recommended treatment, and estimated cost of treatment. Dr. Scott will discuss psychiatric outcomes for paralysis/amputee victims and burn victims with specific case examples illustrating assessment of long term prognosis. Specifically, he will detail the relationship, if any, between the degree of physical injury and the related psychiatric injury. Dr. Newman will detail the potential overlap and diagnostic confusion between mild TBI and PTSD. Dr. Wagoner will discuss if PTSD itself can be considered a "physical injury," as this question arises in some states that require this aspect of the diagnosis to make a disability or personal injury claim. Particular focus will be spent in discussing if the physical symptoms that arise from PTSD meet this legislative criterion. Drs. Ruppert and Schwartz will educate the audience on the common neurocognitive sequelae of PTSD and provide updates on the diagnosis of chronic traumatic encephalopathy (CTE).

REFERENCES

Friedman MJ: Finalizing PTSD in DSM-5: getting here from there and where to go next. J Trauma Stress 26:548-556, 2013

Rasco SS, North CS: An empirical study of employment and disability over three years among survivors of major disasters. J Am Acad Psychiatry Law 38(1):80-86, 2010

QUESTIONS AND ANSWERS

According to the DSM-5, which of the following is NOT a trauma which meets criteria for PTSD?

a. Directly experiencing a traumatic event
b. Witnessing, in person, a traumatic event as it occurred to others
c. Exposure to aversive details of a traumatic event through television
d. Learning that a traumatic event occurred to a close family member

ANSWER: c

The available literature indicates that which of the following is the most likely employment outcome after an individual is exposed to a disaster?

a. Most individuals switch to part-time employment
b. Most individuals stop working altogether
c. Most individuals go on long-term disability
d. Most individuals continue working as usual
ANSWER: d

S36 CONFRONTING AN ACTIVE SHOOTER: PERSPECTIVES ON THE UT TOWER SHOOTING

Ranger Ramiro "Ray" Martinez, Austin, TX

EDUCATIONAL OBJECTIVE

This presentation will improve attendee competence and/or performance by providing information about mass shooting incidents from a law enforcement perspective.

ABSTRACT

On August 1, 1966, the first documented mass shooting on a school campus occurred when Charles Whitman ascended to the top of the University of Texas Tower with an arsenal of weapons and rained down gunfire on unsuspecting students and citizens.

The mass shooting incident caught the Austin Police Department unprepared to cope with such an event and the response was disorganized due to a breakdown in leadership compounded with the available communication that existed at the time. The incident was brought to a successful conclusion when two officers, including Ranger Ramirez, assisted by a civilian, confronted the sniper and neutralized him. By that point, Mr. Whitman had killed sixteen and wounded thirty-one innocent victims.

Mr. Whitman had confided to a school psychiatrist that he had thoughts of going to the top of the tower and shooting people. On the day of the shooting, he had an appointment with the psychiatrist.

Fifty-plus years later, school shootings remain a problem all over the country. Despite improved training for law enforcement agencies to respond quickly, these incidents remain potentially deadly. Weapons capable of causing mass casualties are readily available. Screening for individuals at risk of perpetrating mass shootings remains a developing practice.

REFERENCES

1. Knoll J, Newman WJ, Holoyda BJ. "Mass Murder." In: Rosner R, Scott C (eds.). Principles and Practice of Forensic Psychiatry, Third Edition. Boca Raton: CRC Press, December 2016.

2. Dietz P: Mass, serial and sensational homicides. Bull N Y Acad Med 62(5):477–491, 1986.

QUESTIONS & ANSWERS

Which of the following is not a typical contributing factor associated with mass shooters?

a. History of aggression
b. Frequently blames others for problems
c. Troubled family relationships
d. Feeling accepted by peers
ANSWER: d

The UT Tower shooting would best be classified as which class of mass murder?

a. Familial-Depressed type
b. Workplace-Resentful type
c. School-Resentful type
d. Pseudocommunity-Psychotic type
ANSWER: c

S37 SEX OR SIN: LET THE JUDGE DECIDE

Sara West, MD, Medina, OH

EDUCATIONAL OBJECTIVE

To understand sexually deviant behavior as described by the DSM-5; to review legal decisions related to these paraphilias; and to investigate the intersection of mental illness and criminal sexual behavior.

SUMMARY

Uncommon sexual practices have gained increasing public awareness and mainstream acceptance in recent years. The shifting of public perception and professional definition of these behaviors can complicate forensic evaluations. Come delve into necrophilia and define and discuss other more obscure examples of sexual deviance, including frotteurism, auto-erotic asphyxiation, coprophilia, urophilia and teratophilia. Then let's examine how these practices may arise in forensic cases, including a sanity evaluation illustrating a number of these disorders. As one could argue that feelings of power or sexual gratification could always serve as a rational motive for sexual crimes, let's discuss if the NGRI plea ever even has a role in these circumstances. Finally, we will highlight the ways in which pop culture satiates society's salacious interest in these macabre topics.

REFERENCES

West S, Resnick PJ: Necrophilia, in Unusual and Rare Psychological Disorders. Edited by Sharpless B. New York: Oxford University Press, 2017, pp. 124-135.

Abel GG, Osborn C. The paraphilias: the extent and nature of sexually deviant and criminal behavior. Psychiatr Clin North Am. 15(3):675-87, 1992

QUESTIONS AND ANSWERS

What term applies to a sexual attraction to amputees?

a. Teratophilia
b. Acrotomophilia
c. Klismaphilia
d. Coprophilia
ANSWER: b

Which of the following is not described in the DSM-5?

a. Frotteurism
b. Telephone Scatologia
c. Dacryphilia
d. Exhibitionism
ANSWER: c

S38 RECENT CASES AND WHY THEY MATTER

Ashley VanDercar, MD, JD, Cleveland, OH
Charles Scott, MD, Sacramento, CA
Stephen Noffsinger, MD, Cleveland, OH
Jennifer Piel, MD, JD, Seattle, WA
Jacqueline Landess, MD, JD, St. Louis, MO
Adrienne Saxton, MD, Cleveland, OH
Loretta Sonnier, MD, New Orleans, LA
Ellie Aoun, MD, New York, NY

EDUCATIONAL OBJECTIVE

To inform AAPL members about the newly created Judicial Action Committee, and educate them on some of the recent and current/pending appellate court cases relevant to the practice of forensic psychiatry.

SUMMARY

A legal reporter recently noted, after the McWilliams v. Dunn decision, that "the Supreme Court doesn't know how the justice system should deal with mental illness." This comment, while hyperbole, highlights a frequent disconnect between the judiciary and organized psychiatry.

There are a variety of efforts, especially by the American Psychiatric Association, to provide judicial education on mental illness. The APA has several outreach programs, and files amicus briefs on cases of interest. However, there is a need for further resources to educate judges, legislators, and policy makers specifically, pertaining to forensic psychiatry.

AAPL's Judicial Action Committee was created to assist in this role, both by helping AAPL to liaise with the judiciary and providing education. To this end, the committee will also provide education to AAPL members on relevant appellate cases, both recent and ongoing. This presentation provides brief summaries of eight such cases, detailing pertinent legal issues and associated gaps in judicial knowledge about forensic psychiatry.

REFERENCES

McWilliams v. Dunn, 582 U.S. _____ (2017)

The Council of State Governments, Justice Center: Judges' Guide to Mental Illness in the Courtroom. Available at https://csgjusticecenter.org/wp-content/uploads/ 2016/09/ judges-guide-to-mental-illnesses-in-the-courtroom.pdf.

QUESTIONS AND ANSWERS

Which U.S. Supreme Court case recently reiterated the holding from Ake, emphasizing that Ake "requires more than just an examination," in that a defendant is also entitled to psychiatric assistance in the evaluation, preparation, and presentation of their defense?

a. Davis v. Ayala
b. Crane v. Kentucky
c. McWilliams v. Dunn
d. Gill v. Whitford
ANSWER: c

Which state Supreme Court case recently evaluated the limits of the Crawford rule as it pertains to expert witness testimony on case-specific hearsay?

a. People v. Sanchez
b. Dee Ward v. State of Indiana
c. Ohio v. Clark
d. Greene v. Fisher
ANSWER: a

S39 THE RELEVANCE OF RACE AND THE ROLE OF PSYCHIATRY IN CORRECTIONAL SETTINGS

Merrill Rotter, MD, White Plains, NY
Elizabeth Ford, MD, New York, NY
Bipin Subedi, MD, Brooklyn, NY
Reena Kapoor, MD, New Haven, CT
Rahn Bailey, MD, Winston-Salem, NC

EDUCATIONAL OBJECTIVE

To review the relevance of race on clinical and administrative practice for individuals with justice-involvement and serious mental illness, with suggestions for addressing and ameliorating its impact.

SUMMARY

As clear as the data is regarding the overrepresentation of individuals with mental illness in the criminal justice system, so too is the overrepresentation of people of color. In fact, as the literature increasingly points to non-clinical, social determinants as critical drivers of justice-involvement for people with mental illness, the relevance of race is increasingly evident. While much of the work in addressing the challenging social and political issues associated with race and criminal justice may seem outside the scope of traditional clinical practice, opportunities still exist for individual clinicians to bring evidence-based practices to the provision of care in ways that can ameliorate at least some of the inherent injustice. In this panel, we will review how assessment, diagnosis and treatment may be impacted by race, but can provide the platform for ensuring that race is appropriately accommodated and potential stigma not perpetuated. Specifically, panelists will review the relevance of race and their experiences assessing risk for recidivism, addressing the diagnosis of antisocial personality and schizophrenia, the use solitary confinement and incorporation of cultural competence.

REFERENCES

Scurish N, Monahan J: Evidence-based sentencing: public openness and opposition to using gender, age, and race as risk factors for recidivism. Law and Human Behavior 40(1): 36-41, 2015

Metzl JM, Roberts DE: Structural competency meets structural racism: race, politics, and the structure of medical knowledge. Virtual Mentor 16(9):674, 2014

QUESTIONS AND ANSWERS

The most common confounding reason for differences in risk scores associated with race is

a. Age
b. Criminal history
c. Gender
d. Jurisdiction
ANSWER: b

Race has been known to influence:

a. Diagnosis
b. Prescribing practices
c. Treatment utilization
d. All of the above
ANSWER: d

S40 SCHOOL SHOOTINGS: WHO IS RESPONSIBLE?

Rosa E. Negron-Munoz, MD, Lakeland, FL
Karen Mills, RN, MSEdL, Bradenton, FL
Larry Willis, Lakeland, FL
Cheyenne Shelton, Lakeland, FL
Jakevis Brown, Bowling Green, FL
Isabella Vega, Winter Haven, FL

EDUCATIONAL OBJECTIVE

To identify and discuss the multiple levels of responsibility involved in school shootings; including but not limited to aspects of education, legal, mental health, children in the custody of the state and the view of students who are in the schools every day and who have become activist.

SUMMARY

The recent shooting in Parkland, Florida has once again brought to the forefront the topic of school shootings. Given the rise in school shootings over the past two decades and not having been able to identify effective ways to prevent them, a lot of attention has been given to gun control. There are many contributors that affect the make-up of a school shooter. Everyone seeks answers as to whom is ultimately responsible for school shootings and safety, but no evidence-based effective answers have been found. We have gathered a diverse panel to address different aspects of this question. From an educational perspective we will have the Principal of SABLE, a school in Bradenton, Florida that identifies children with behavioral and educational problems as early as elementary school. These children are seen by an onsite psychiatrist, who will provide their mental health perspective on the topic. A Law Enforcement Officer who has provided defensive tactic training will provide their legal view and three young adults join the panel to give their views as a warden of the state, a member of the #neveragain movement and being a "regular" student in today's schools. Together we will determine who is responsible.

REFERENCES

Jonson CL: Preventing school shootings: the effectiveness of safety measures. Victims & Offenders 12(6):956-973, 2017

Leary MR, Kowalski RM, Smith L, et al: Teasing, rejection, and violence: case studies of the school shootings. Aggressive Behavior 29(3):202-214, 2003

QUESTIONS AND ANSWERS

What percentages of schools during the 2005-2006 school year reported one violent incident other than a school shooting (i.e. theft, gang violence, fighting, etc.)?

a. 35%
b. 55%
c. 75%
d. 86%
ANSWER: d

Which of the following are risk factors identified in school shooters?

a. Social rejection
b. Interest in firearms
c. Psychological problems (depression, poor impulse control, etc.)
d. Fascination with death
e. All of the above
f. None of the above
ANSWER: e

S41 THE IMPACT OF GENDER ON M-FAST SCORES AND DIAGNOSES IN A FORENSIC HOSPITAL POPULATION

Ariana Nesbit, MD, San Diego, CA
Barbara McDermott, PhD, Sacramento, CA

EDUCATIONAL OBJECTIVE

To appreciate the differences in M-FAST scores, diagnoses, and length of stay between male and female forensic patients and to understand the implications of these findings with regards to the assessment of malingering in female forensic patients.

SUMMARY

The interaction of gender and malingering has received little attention in the literature. The Miller Forensic Assessment of Symptoms Test (M-FAST), a screening instrument widely used to detect feigned psychiatric symptoms, was developed and validated with only male forensic inpatients. Although several follow-up studies have included female forensic inpatients, the samples were small and differences in M-FAST scores between male and female patients were not reported. Our study examined data from 3134 patients committed as incompetent to stand trial to a forensic state hospital between 2008 and 2017, of whom 716 (22.8%) were female. M-FAST scores for men were only slightly higher than for women (mean scores of 4.6 and 4.1 respectively, p=.065). However, clinicians believed that over 19% of men but less than 11% of women were malingering (p <.001). Length of stay (LOS) for restoration to competence differed between men and women if feigning was suspected. If women were suspected of feigning, their LOS was longer. If men were suspected of malingering, their LOS was shorter. The implications of these findings for the assessment of malingering in female forensic patients will be discussed.

REFERENCES

Kois L, Pearson J, Chauhan P, et al: Competency to stand trial among female inpatients. Law and Human Behavior 37(4):231-240, 2013

Rogers R, Payne J, Correa A, et al.: A study of the SIRS with severely traumatized patients. Journal of Personality Assessments 91(5):429-438, 2009

QUESTIONS AND ANSWERS

Which of the following has been associated with false positives on malingering assessments?

a. Post-traumatic stress disorder
b. Dissociative identity disorder
c. Severe disorganization
d. All of the above
ANSWER: d

Which of the following is true about female forensic patients found incompetent to stand trial?

a. Active psychotic symptoms predict incompetency findings for females more so than males
b. Most studies have found no relationship between length of stay and gender
c. All of the above
d. None of the above
ANSWER: c

S42 OUTCOMES OF FITNESS AND CRIMINAL RESPONSIBILITY ASSESSMENTS IN REFERRALS FROM COMMUNITIES WITHOUT MENTAL HEALTH COURTS

Michelle Mathias, MD, Ottawa, ON, Canada
Joel Watts, MD, Ottawa, ON, Canada
Lindsay Healey, MD, Brockville, ON, Canada
Susan Curry, Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE
To demonstrate a serious gap in the legal system in communities where there are no mental health courts or psychiatric consultation for accused experiencing a mental illness and in conflict with the law.

SUMMARY
Mental Health Courts (MHC) divert accused with a mental illness from the traditional criminal justice system, but can also be a route for fitness to stand trial (FST) and criminal responsibility (CR) screening assessments. In Ottawa's MHC, legal parties (e.g. defense lawyers, crown attorneys) recommend accused for these forensic assessments, but prior to formal and complete assessment, forensic psychiatrists briefly screen these individuals at the MHC. Of these referrals, 55% of cases are screened out from undergoing lengthy and costly FST/CR assessments. Not all FST and CR assessments, however, originate from Ottawa's MHC. Many smaller, neighboring communities also send accused directly to hospital for assessments, without a psychiatric screening process beforehand. Anecdotal evidence strongly supports that many of these referrals do not meet the required threshold for the assessments, and that these individuals are found fit to stand trial and criminally responsible at higher proportions than the sample originating from Ottawa's MHC. This presentation explores the differences between these two samples on demographic, psychiatric, and legal characteristics and, most importantly, compares assessment conclusions. This research has immediate, tangible clinical and forensic implications for small communities without MHCs, for accused, and on cost and efficiency in forensic hospitals.

REFERENCES
Schneider R, Bloom H, Heerema M: Mental Health Courts: Decriminalizing the Mentally Ill. Toronto, Ontario: Irwin Law, 2007

Pirelli G, Gottdiener WH, Zapf PA: A meta-analytic review of competency to stand trial research. Psychology, Public Policy, and Law 17(1):1, 2011

QUESTIONS AND ANSWERS
What proportion of the referrals from the legal partners proceed beyond a psychiatric screening assessment to a complete, fulsome assessment of fitness or criminal responsibility?

a. 10%
b. 45%
c. 90%
d. 60%
ANSWER: b

Of the potential negative implications resulting from unnecessary forensic assessments below, which one is false?

a. Slows the accused's progression through the legal system
b. It is costly for the forensic psychiatric and legal systems to be providing unnecessary forensic assessments
c. Permits the accused to avoid a criminal responsibility assessment for a subsequent crime
d. Takes up beds in forensic psychiatric hospitals that may be required for other assessments or admissions
ANSWER: c

S43 CLOZAPINE REDUCES REPETITIVE, TREATMENT-RESISTANT SELF-INJURIOUS BEHAVIOR IN A STATE PRISON POPULATION

Theodore Zarzar, MD, Raleigh, NC
Joseph Williams, MD, Raleigh, NC

EDUCATIONAL OBJECTIVE
This presentation will review the evidence of clozapine's effectiveness in treating self-injurious behavior and violence, and will present preliminary data on the use of clozapine at N.C. Central Prison for inmates with severe, treatment-refractory self-injurious behaviors.

SUMMARY
Self-injurious behavior (SIB) is a common, disruptive, and costly occurrence in U.S. prisons. In this presentation, we describe the use of clozapine to treat ten offenders with chronic, repetitive self-injury refractory to other medications and behavioral therapies. The primary diagnosis for all ten offenders was a personality disorder. Eight of the ten inmates allowed weekly blood draws and took medication regularly (approximately a 95% compliance rate) while two discontinued treatment within the first 2 weeks. For these eight patients, we compared the number of in-house urgent care visits and outside emergency room visits related to SIB for the six-month periods pre- and post-clozapine treatment. After clozapine initiation there was a 70% reduction in both urgent care and emergency room visits. As a secondary outcome we assessed disciplinary infractions. There was a 67% reduction in infractions after clozapine was started. The median dose of clozapine used was 125 mg/day, substantially lower than doses typically used to treat schizophrenia. Clozapine appears to be a feasible and effective treatment for some patients with chronic, repetitive SIB who have failed other treatments.

REFERENCES
Appelbaum KL, Savageau JA, Trestman RL, et al: A national survey of self-injurious behavior in American prisons. Psychiatr Serv 62(3):285-290, 2011

Chengappa KNR, Ebeling T, Kang JS, et al: Clozapine reduces severe self-mutilation and aggression in psychotic patients with borderline personality disorder. J Clin Psychiatry 60(7):477-484, 1999

QUESTIONS AND ANSWERS
When controlling for psychiatric symptoms and socioeconomic status, the risk of violent crime among individuals with a history of self-injurious behavior compared to the general population is approximately:

a. 25% higher
b. 2x higher
c. 3x higher
d. 5x higher
ANSWER: b

Appropriate candidates for clozapine treatment of chronic self-injurious behavior have:

a. Multiple episodes of self-injury or suicide attempts
b. Tried and failed other pharmacologic and behavioral therapies
c. Ability to provide informed consent
d. No medical contraindications
e. All of the above
ANSWER: e

SATURDAY

S44 PREVALENCE AND CORRELATES OF CRIMINAL BEHAVIOR AMONG THE NON-INSTITUTIONALIZED ELDERLY: RESULTS FROM THE NATIONAL SURVEY ON DRUG USE AND HEALTH

Elias Ghossoub, MD, St. Louis, MO
Rita Khoury, MD, St. Louis. MO

EDUCATIONAL OBJECTIVE
To explore the prevalence of criminal behavior committed by the non-institutionalized geriatric American population and to compare the socio-demographic and mental health profiles of (1) arrestees to non-arrestees and (2) lawbreakers and non-lawbreakers to determine correlates of criminal behavior among this population.

SUMMARY
Little is known about the epidemiology of criminal behavior among the non-institutionalized geriatric population. We used data of adults aged ≥65 years from the National Survey on Drug Use and Health from 2008 through 2014. We conducted bivariate analyses to compare the socio-demographic and mental health profiles of arrestees to non-arrestees and lawbreakers to non-lawbreakers. We then determined the correlates of being arrested and breaking the law by conducting regression analyses. Around 0.4% of the population reported being arrested and 5% reported breaking the law in the past year. The most prevalent charge and offense was driving while intoxicated. Arrestees were significantly more likely to be male and to have had an alcohol or a drug(s) use disorder in the past year. Lawbreakers had a significant likelihood of being male, having a high educational level and having an alcohol or a drug(s) use disorder in the past year. Elderly lawbreakers seem to have distinct characteristics that not just separate them from non-offenders, but also probably from younger lawbreakers. Future studies should focus on longitudinal predictors of criminal behavior among the elderly, as well as preventive and rehabilitation strategies for this population.

REFERENCES
Lewis CF, Fields C, Rainey E: A study of geriatric forensic evaluees: who are the violent elderly? J Am Acad Psychiatry Law 34(3):324-332, 2006

Fazel, S: Psychiatric aspects of crime and the elderly, in Oxford Textbook of Old Age Psychiatry (First Edition). Edited by Jacoby R, Oppenheimer C, Dening T, et al. Oxford University Press, 2008, pp. 747-751

QUESTIONS AND ANSWERS
What is the most common offense reported by the elderly?

a. Robbery
b. Assault
c. Driving while intoxicated
d. Trespassing
ANSWER: c

Elderly Lawbreakers are more likely to (choose false answer):

a. be male
b. Have a low educational level
c. Have an alcohol use disorder
d. Have a drug use disorder
ANSWER: b

S45 CONTEMPORARY FORENSIC EVALUATION OF POST-TRAUMATIC STRESS DISORDER

Andrew P. Levin, MD, Hartsdale, NY
Jeff Guina, MD, Saline, MI
Marc. A. Cohen, MD, Beverly Hills, CA
Daniel A. Martell, PhD, Newport Beach, CA

EDUCATIONAL OBJECTIVES
To provide attendees with the tools and knowledge to perform an expert evaluation of adults exposed to trauma facing actions in criminal, civil, and military settings. The course will review diagnosis, biology, treatment methodologies, and legal frameworks as they bear on issues of causation, psychological injury, criminal responsibility, and disability.

SUMMARY
This course will prepare attendees to perform a comprehensive evaluation of adults exposed to trauma to determine issues of causation, psychological injury, criminal responsibility, and disability. After an initial presentation focused on diagnostic considerations, course, biological underpinnings, and current standards of care in the treatment of PTSD, subsequent segments will address the role of psychological testing as well as specific considerations for evaluation in military, civil, and criminal settings. In addition to didactic presentations, attendees will be invited to review and discuss cases with a focus on malingering, prognosis, and disability.

REFERENCES
Guina J, Welton RS, Broderick PJ, et al. DSM-5 criteria and its implications for diagnosing PTSD in military service members and veterans. Current Psychiatry Reports: 18(5):1-9, 2016

Berger O, McNeil DE, Binder R: PTSD as a criminal defense: a review of case law. J Am Acad Psychiatry Law 40:509-21, 2012

QUESTIONS AND ANSWERS
Which of the following is false?

a. Rates of exaggerating PTSD in military settings range from 37-75%
b. Reverse malingering is a common issue in military disability and fitness for duty evaluations
c. PTSD is automatically disqualifying from military service
d. PTSD is the third most common disability for which veterans receive compensation, behind tinnitus and hearing loss
e. Fewer than 10% of veterans with PTSD have completed evidence-based trauma-focused psychotherapy
ANSWER: c

Which of the following treatments for PTSD has the greatest effect size?

a. Selective serotonin inhibitors
b. Prazosin
c. EMDR
d. CBT with exposure
e. Mindfulness
ANSWER: d

S46 WOMEN WHO KILL

Alan R. Felthous, MD, St. Louis, MO
Felice Carabellese, MD, Bari, Italy
Phillip Resnick, MD, Cleveland, OH
Donatella La Tegola, PsyD, PhD, Bari, Italy

EDUCATIONAL OBJECTIVE

To examine the significance of psychopathy in women who kil; to explain how different typologies of mothers who kill their children fare with an insanity defense; and to identify correlations between homicide and various psychopathologies among females who have been found NGRI or of diminished responsibility for murder.

SUMMARY

Women who kill others constitute a much understudied minority of homicide offenders. This panel will address findings concerning four aspects of homicide among women. Dr. Resnick will describe how each of five categories of women who killed their children fared with their insanity defense (altruistic, acutely psychotic, unwanted child, fatal maltreatment, and spouse revenge). Dr. La Tegola will describe the psychopathology among 40 females who were found NGRI or of diminished responsibility for murder. Most of the NGRI offenders had killed a child and were diagnosed with a psychotic disorder. Combined-homicide suicide committed by females, as discussed by Dr. Felthous, fall into two groups, domestic killings such as filicide and, today increasingly, suicide terroristic bombing. Finally, Dr. Carabellese will present findings on the significance of psychopathy in female murderers. This study compared and found significant differences between female killers with respect to psychopathy.

REFERENCES

Caretti V, Manzi GS, Schimmenti A, et al (Eds.): PCL-R. Hare Psychopathy Checklist-Revised di Hare, R.D. Florence: Giunti O.S., 2011

Giordano PC, Cernkovich SA:. Gender and antisocial behavio, in Handbook of Antisocial Behavior. Edited by Stoff DM, Breiling J, Maser JD. New York: Wiley, 1997, pp. 496-510

QUESTIONS AND ANSWERS

What is the most frequent diagnosis in NGRI female murderers?

a. Borderline personality disorder
b. Schizophrenic disorder
c. Schizotypal personality disorder
d. Bipolar I disorder
ANSWER: b

Compared with 25 years ago, the percentage of suicide bombers who are female has been:

a. Increasing
b. Decreasing
c. Fluctuating
d. Staying about the same
ANSWER: a

S47 MEDICATION-ASSISTED TREATMENT (MAT) IMPLEMENTATION FOR OPIOID USE DISORDERS IN CORRECTIONAL SYSTEMS

Rusty Reeves, MD, Trenton, NJ
Elizabeth Ford, MD, New York, NY
Anthony Tamburello, MD, Trenton, NJ
Radha Sadacharan, MD, MPH, Providence, RI

EDUCATIONAL OBJECTIVE

The purpose of this discussion is to teach leaders in correctional systems how two state prison systems and a major jail system implemented MAT for opioid use disorder. Participants will leave the session informed of strategies, challenges, and choices so that they may successfully implement MAT in their own systems.

SUMMARY

Opioid use disorder is an epidemic in the United States. From 1999 to 2016, the number of overdose deaths involving opioids quintupled. There were over 42,000 deaths in the U.S. involving opioids in 2016. Opioid use disorders persist during incarceration despite forced abstinence. Most detainees and inmates with opioid use disorders rapidly return to pre-incarceration levels of opioid use upon release and subsequently experience much higher rates of overdose deaths than the national average. Jails and prisons have an opportunity to offer treatment to persons with opioid use disorders in a tightly controlled setting. However, few state prison systems and jails offer medication-assisted treatment (MAT), especially opioid agonist medications, which are widely regarded as effective treatments for opioid use disorders. The discussants represent two state prison systems (Rhode Island and New Jersey) and one major jail system (New York City), which are leaders in the provision of opioid agonist MAT to their inmate and detainee patients. These systems have faced challenges and opportunities–some similar, some different–that can inform leaders attempting to introduce MAT into their correctional systems.

REFERENCES

Lopez, G: How America's prisons are fueling the opioid epidemic. Vox. Available at https://www.vox.com/policy-and-politics/2018/3/13/17020002/prison-opioid-epidemic-medications-addiction. Accessed September 2018.

Lee JD, Nunes EV Jr, Novo P, et al: Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomized controlled trial. Lancet 391:309-318, 2018

QUESTIONS AND ANSWERS

_____ percent of released inmates return to heroin use within three months.

a. 25%
b. 50%
c. 75%
d. 95%
ANSWER: c

_____ of all heroin-addicted individuals in the United States pass through the criminal justice system annually.

a. 10-12%
b. 15-18%
c. 18-22%
d. 24-36%
ANSWER: d

S48 AAPL AS AMICUS CURIAE: RETROSPECT AND PROSPECT

Jeffrey S. Janofsky, MD, Timonium, MD
Debra A. Pinals, MD, Ann Arbor, MI
Steven K. Hoge, MD, New York, NY
Marvin Swartz, MD, Durham, NC

EDUCATIONAL OBJECTIVE

Discussants will review the history of past APA and AAPL amicus briefs. Selected briefs and resulting appellate court outcomes will be presented in detail.

SUMMARY
Amicus Curiae briefs are typically written in appellate court cases by non-parties in order to educate the Court about specific issues. AAPL has never been the primary writer of an amicus brief. Instead, AAPL has joined other interested groups, usually the American Psychiatric Association.

Panelists, who have participated in both the APA and AAPL process for reviewing amicus briefs, will explain the process and review several briefs, discussing how those briefs affected subsequent court decisions. Cases to be discussed will include: City and County of San Francisco, California v. Teresa Sheehan (a USSC case questioning whether Title II of the Americans with Disabilities Act applied to arrests, where APA wrote an amicus brief and AAPL Council decided not to participate); Charles v. Orange County (a Second Circuit Court of Appeals case where persons with severe mental illness were held in Immigration Detention, with APA and AAPL taking the position that appropriate discharge planning was a critical part of the minimally adequate mental health care that the Constitution requires); and Jaffee v. Redmond (a USSC case that established therapist-patient privilege in the federal courts with AAPL and APA educating the Court about the need for such a privilege).

REFERENCES
Janofsky JS: AAPL as Amicus Curiae. AAPL Newsletter April: 5, 2014

American Psychiatric Association. Amicus Briefs. Available at https://www.psychiatry.org/psychiatrists/search-directories-databases/library-and-archive/amicus-briefs. Accessed September 2018.

QUESTIONS AND ANSWERS
Amicus Briefs are written by:

a. Non-parties
b. Party respondents
c. Party petitioners
ANSWER: a

Jaffee v. Redmond established:

a. Therapist-patient privilege
b. Physician-patient privilege
c. Therapist-patient confidentiality
d. Physician-patient confidentiality
ANSWER: a

S49 BEHAVIORAL INTERVENTION TEAMS (BIT) IN SCHOOLS

Robert L. Weisman, DO, Rochester, NY
Mark Concordia, Rochester, NY

EDUCATIONAL OBJECTIVE
Audience members will be able to appreciate the essential elements of a behavioral intervention team (BIT) within K-12 school environments and appreciate the risk factors leading to mental hygiene transports to emergency services by law enforcement from one study of that specific age group.

SUMMARY
The rise and severity of school violence has captured the attention of the media, law enforcement, school staff members, families and students, alike. In 1999, Janet Reno, then Attorney General of the United States wrote, "youth violence has been one of the greatest single crime problems we face in this country–if communities, schools, government pull together to address the roots of violence, we can make America safer for our children." Since then, little progress has addressed this mounting concern. The authors will describe development of Behavioral Intervention Teams (BITs) in upstate New York communities and report on research investigating potential variables for those individuals at risk for school violence. The volume of police calls servicing community members 13-19 years of age experiencing various mental health crises has also escalated. This research in progress will review demographic and threatened-target data for school aged (n-1681) individuals over a two-year period requiring mental health transport (police pick-up orders). This study also looks to identify patterns to assist both local New York police departments and school BITs towards more informed strategies to identify and manage young individuals undergoing mental health emergencies while mitigating downstream violence risk.

REFERENCES
O'Toole ME: The School Shooter: A Threat Assessment Perspective (FBI Academy). Critical Incident Response Group (CIRG), National Center for the Analysis of Violent Crime (NCAVC) FBI Academy Quantico, Virginia, December 12, 2013

Langman P: School Shooters: Understanding High School, College, and Adult Perpetrators. Rowan & Littlefield, 2015

QUESTIONS AND ANSWERS
Which of the following is not correct regarding school behavioral intervention team (BIT) development?

a. The biopsychosocial model is critical to understanding violent student risk.
b. The role of a forensic psychiatrist is limited as a part of a school BIT.
c. Individuals at risk for school violence are not always obvious concerns to staff.
d. Copycat mass school shootings have increased since the Columbine massacre.
e. An example of prescription for behavior includes an armed attack as a model for problem solving.
ANSWER: b

Which of the following are considered justifications for developing a school behavioral intervention (BIT) team?

a. Concerns regarding violence and school safety
b. Response to State and regional policies requiring process and procedure
c. Zero-Tolerance and reactive public policy measures
d. Psychological safety of school children
e. All the above
ANSWER: e

S50 IMPACT OF SUBSTANCE USE DISORDERS ON SELF- AND OTHER-DIRECTED VIOLENCE: AN INTEGRATED MODEL APPROACH

Elias Ghossoub, MD, St. Louis, MO

EDUCATIONAL OBJECTIVE
To discuss the differential associations between substance use disorders and different forms of violence using an integrated model approach and explore the modulating effect of age on the association between substance use disorders and violence.

SUMMARY
Extensive research has shown that self- and other-directed violence share similarities in predispositions and stressors, including substance use. However, one important question stands out: what are the determinants of directionality? To answer this question, an integrated conceptualization of violence is required. Using data from the National Survey on Drug Use and Health pooled across survey years 2008-2014 (270,227 respondents), we aimed to determine whether alcohol and/or drug use disorders acted as "forces of direction" (i.e. increased the likelihood of assaults as opposed to suicide attempts). We found that individuals with drug use disorder(s) alone or combined alcohol and drug use disorders were up to two times more likely to commit assaults than suicide attempts, whereas individuals with alcohol use disorder alone were not likely to commit one over the other. We also found that among 18-25 year-olds, individuals with any substance use disorder category were more likely to commit other- rather than self-directed violence. The integrated model of violence offers great value in understanding the nature and magnitude of violence risk factors. Further research is needed to identify longitudinal predictors of directionality of violence and to design better preventive and therapeutic strategies.

REFERENCES
Prabha Unnithan N, Huff-Corzine L, Corzine J, et al: The Currents of Lethal Violence: An Integrated Model of Suicide and Homicide. Albany, New York: State University of New York Press, 1994

Lubell KM, Vetter JB: Suicide and youth violence prevention: the promise of an integrated approach. Aggression and Violent Behavior 11(2):167-175, 2006

QUESTIONS AND ANSWERS
Which of these statements is false?

a. The integrated model of violence conceptualizes self-directed and other-directed violence as "two sides of one coin."
b. The integrated model of violence identifies "forces of production" and "forces of direction" as two sets of causal factors for violence within a population.
c. Drug use disorders seem to act as "forces of production" of violence but not "forces of direction."
d. Serotonergic dysfunction is implicated in manifestation of aggressive behavior towards self and others.
ANSWER: c

Assaultive behavior is more likely than attempted suicide among which of the following:

a. Elderly with alcohol use disorder
b. Youth with alcohol use disorder
c. Middle-aged with alcohol use disorder
d. Youth with a psychiatric disorder
ANSWER: b

S51 THE "CRAZED GUNMAN" MYTH: EXAMINING MENTAL ILLNESS AND FIREARM VIOLENCE

Amanda Kingston, MD, New Haven, CT
Madelon Baranoski, PhD, New Haven, CT
Reena Kapoor, MD, New Haven, CT
Maya Prabhu, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

To review recent legislation that limits firearm access for individuals with mental illness in the United States; examine existing evidence about the relationship between mental illness, gun violence, and suicide; and learn about new data from the presenters' research on insanity acquittees and gun violence in Connecticut.

SUMMARY

In response to high-profile mass shootings, many states have enacted legislation that limits access to firearms for people with mental illness. These measures are often framed as a "common sense" approach to stopping gun violence, but the evidence supporting them is less robust than one might imagine. We seek to move past politics and ideology, instead focusing on a scholarly exploration of data that can guide policy and legislation in this controversial area. We begin by reviewing recent state laws that arose in response to Sandy Hook and other mass shootings, as well as long-standing, national prohibitions on gun access for individuals with mental illness. We then examine data about the outcome of these laws and their impact on preventing gun violence. Next, we turn to novel research by the presenters. We present new findings about the relationship between mental illness, violence, and suicide that uses data from the MacArthur Violence Risk Assessment Study. We also examine the frequency and context of firearm use in crimes that resulted in an insanity acquittal in Connecticut, seeking to explore whether individuals with mental illness are more likely than others to misuse firearms.

REFERENCES

Monahan J, Steadman H, Silver E, et al: Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence. New York: Oxford University Press, 2001

National Conference of State Legislatures. Possession of Firearms by People with Mental Illness. 5 Jan. 2018. Available at www.ncsl.org/research/civil-and-criminal-justice/possession-of-a-firearm-by-the-mentally-ill.asp

QUESTIONS AND ANSWERS

What is the primary instrument used in violent acts by those acquitted as NGRI in Connecticut?

ANSWER: Fire/Arson

True or False? All 50 states have enacted laws prohibiting persons with mental illness from purchasing and/or possessing a firearm.

ANSWER: False

S52 CURRENT POLICY TOPICS ON UNIVERSITY CAMPUSES

Ryan C.W. Hall, MD, Lake Mary, FL
Susan Hatters Friedman, MD, Cleveland, OH
Abhishek Jain, MD, New York, NY
Renée M. Sorrentino, MD, Weymouth, MA
Jacqueline Landess, MD, JD, St. Louis, MO

EDUCATIONAL OBJECTIVE

To appreciate the conflicting laws and regulations, affecting universities' "Medical Marijuana" policies; to discuss policy regarding firearms on college campuses; how to assess violence risk while avoiding discrimination against those with a mental illness; and to discuss confidentiality issues and Family Educational Rights and Privacy Act (FERPA).

SUMMARY

In the last 5-10 years, a wide range of societal concerns have rapidly emerged on college campuses. Universities, along with courts, are now facing the challenge of how to handle issues such as increased state-based legalization of marijuana, gun safety concerns with changes in concealed weapon laws, identification of potentially dangerous students, and release of personal information of students by faculty often after a news event. This workshop will discuss these issues, provide examples of pertinent legal considerations that could affect forensic mental health issues, and review recent court rulings on these issues. For example, the 2017 Arizona court ruling of State v. Maestas, 394 P. 3d 21 - Ariz: Court of Appeals, 1st Div. 2017, and its implication for marijuana on college campus will be discussed as we as Texas Senate Bill 11, known as the Campus Carry Law. We will discuss where campuses are in terms of identifying risk of mass harm. We will also look at notions of confidentiality issues and statements made by educators after large news events and whether such actions violate the Family Educational Rights and Privacy Act (FERPA).

REFERENCES

Regehr C, Glancy G, Carter A, et al: A comprehensive approach to managing threats of violence on a university or college campus. Int J Law Psychiatry 54:140-147, 2017

National Center for Public Safety. The Effects of Marijuana Legalization and Decriminalization on Campus Safety at Institutions of Higher Education: Findings of a Critical Issues in Campus Public Safety Forum with Campus Safety Leaders, 2016. Available at https://www.campusdrugprevention.gov/sites/default/files/Effects%20of%20Marijuana%20Legalization%20on%20Campus%20Safety%20%28NCCPS%29%20%28September%202016%29.pdf. Accessed September 2018.

QUESTIONS AND ANSWERS

Which of the following is not part of the Virginia Threat Assessment Model for addressing threats on a college campus?

a. Universal screening of all students, especially those with mental illness, to identify potentially dangerous or unstable individuals
b. Identifying threats, including communications that emerge from interactions with any members of the community
c. Evaluating the seriousness of the threat on a continuum (e.g. figure of speech or jokes vs. specific warning of impending violence)
d. Intervention, including warning potential victims and taking protective action
e. Follow-up monitoring of the safety plan

ANSWER: a

The Case of State v. Maestas, 394 P. 3d 21 - Ariz: Court of Appeals, 1st Div. 2017 based its legal opinion on the following:

a. Marijuana has been shown to be a safe and effect medical treatment
b. The national growing prevalence of acceptance of marijuana
c. The state legislator cannot re-criminalizes an action approved by statewide referendum action
d. State universities can not legally set restrictive marijuana policies

ANSWER: c

SUNDAY, OCTOBER 29, 2017

PANEL 8:00 AM – 10:00 AM **LONE STAR A**

Z1 Outpatient Competency Programming: Policy Contender for Forensic Service

Nicole R. Johnson, MD, Ashton, MD
Philip Candilis, MD, Alexandria, VA
Neil Gowensmith, PhD, Denver, CO
Jessica Morel, MD, Fayetteville, NC

PANEL 8:00 AM – 10:00 AM **LONE STAR B-C**

Z2 Roles for Forensic Psychiatrists in National Security Cases

Maya Prabhu, MD, New Haven, CT
Emily Keram, MD, Santa Rosa, CA
Ronald Schouten, MD, Boston, MA
Stephen N. Xenakis, MD, Arlington, VA
Jacob Holzer, MD, Belmont, MA
Chinmoy Gulrajani, MD, Minneapolis, MN

PAPER SESSION #2 8:00 AM – 10:00 AM **LONE STAR F**

Z3 Predicting Competence Restorability and Length of Time to Restoration

Cristina M. Secarea, MD, Washington, DC
Sean D. Cleary, PhD, Washington, DC
Philip J. Candilis, MD, Washington, DC

Z4 Cultural Competency in Competence to Stand Trial Evaluations

Jennifer Piel, MD, JD, Seattle, WA
Katharine McIntyre, PhD, Lakewood, WA

Z5 The Effectiveness of Police Crisis Intervention Programs

Michael Rogers, MD, San Francisco, CA
Dale McNeil, PhD, San Francisco, CA
Renée L. Binder, MD, San Francisco, CA

Z6 Pacific Island Patients Admitted to Regional Forensic Psychiatry Services in New Zealand

Lisi Petaia, MBBS, FRANZCP, Auckland, New Zealand
Tom Stoner, BSc, Auckland, New Zealand
Gannin Bell, MBChB, Auckland, New Zealand
Himadri Seth, MBChB, MRCPsych, FRANZCP, Auckland, New Zealand
Susan Hatters Friedman, MD, Cleveland, OH

WORKSHOP 8:00 AM – 10:00 AM **LONE STAR G**

Z7 Forensic Considerations of Treatment When You Haven't Seen the Patient

Michael Greenspan, MD, Glen Oaks, NY
Brian Cooke, MD, Gainesville, FL
Andrew Levin, MD, Hartsdale, NY
Ryan Hall, MD, Lake Mary, FL
Bruce Gage, MD, Lakewood, WA

COFFEE BREAK 10:00 AM – 10:15 AM LONE STAR FOYER

PANEL 10:15 AM – 12:15 PM **LONE STAR H**

Z8 Victims and Perpetrators of Sexual Assault and Interpersonal Violence

Aimee Kaempf, MD, Tucson, AZ
Kelly Coffman, MD, MPH, Atlanta, GA
Susan Hatters Friedman, MD, Cleveland, OH
Renée M. Sorrentino, MD, Weymouth, MA
Susan Ditter, MD, San Jose, CA

PANEL 10:15 AM – 12:15 PM **LONE STAR B-C**

Z9 Suicide by Text: The Legal and Forensic Implications of Facilitated Suicide

Elias Ghossoub, MD, St. Louis, MO
Jacqueline Landess, MD, St. Louis, MO
Brian Holoyda, MD, St. Louis, MO
William Newman, MD, St. Louis, MO

PANEL 10:15 AM – 12:15 PM **LONE STAR A**

Z10 New Innovations in Forensic Psychiatry Education

Chinmoy Gulrajani, MBBS, Minneapolis, MN
Mikel Matto, MD, San Francisco, CA
Reena Kapoor, MD, New Haven, CT
Richard Martinez, MD, Denver, CO
James L. Knoll, IV, MD, Syracuse, NY

WORKSHOP 10:15 AM – 12:15 PM **LONE STAR F**

Z11 Physician Impairment and Self-Disclosure: Hazards & Hardships

Patricia Westmoreland, MD, Denver, CO
Maryrose Bauschka, MD, Salt Lake City, UT
Anne Marie Melia, MD, Denver, CO
Doris C. Gundersen, MD, Denver, CO
Elizabeth Collis, JD, Columbus, OH

WORKSHOP 10:15 AM – 12:15 PM **LONE STAR G**

Z12 Casey's Law Cases: Using Civil Commitment for Substance Use Disorders

Abhishek Jain, MD, New York, NY
Elizabeth Ford, MD, New York, NY
Corina Freitas, MD, Oxon Hill, MD
Cristina Secarea, MD, Arlington, VA
Ryan Wagoner, MD, Lutz, FL

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

Z1 OUTPATIENT COMPETENCY PROGRAMMING: A POLICY CONTENDER FOR FORENSIC SERVICE

Nicole R. Johnson, MD, Ashton, MD
Philip Candilis, MD, Alexandria, VA
Neil Gowensmith, PhD, Denver, CO
Jessica Morel, MD, Fayetteville, NC

EDUCATIONAL OBJECTIVE

To review policy and practice of outpatient competency restoration and provide a viable alternative to inpatient restoration. Cost savings and efficacy will be examined.

SUMMARY

With the growing cost of inpatient psychiatric treatment, decreasing numbers of available inpatient beds and increased need for forensic evaluations, a functioning Outpatient Competency Restoration program is one answer. This panel will focus on a multi-state outpatient competency restoration program project. An outpatient competency restoration program can provide a service for forensic patients that would otherwise be delayed. An outpatient program allows forensic patients to receive education in the least restrictive environment and allows the state to provide service in a cost effective manner.

The panelists will discuss data collection from the project and the program in DC and educate the attendees about the benefits of an outpatient competency restoration program. The panelists will discuss how the program is set up and the materials which are used to facilitate groups. A question and answer session regarding outpatient competency programming and management will be included.

REFERENCES

Johnson NR, Candilis PJ: Outpatient competence restoration: a model and outcomes. World Journal of Psychiatry 5(2), 2015

Gowensmith WN, Frost LE, Speelman DW, et al: Looking for beds in all the wrong places: outpatient competency restoration as a promising approach to modern challenges. Psychology, Public Policy, and Law 22(3):293-305, 2016

QUESTIONS AND ANSWERS

Which of the following is a competency assessment instrument?

a. Stanford-Binet IQ test
b. Inventory of Legal Knowledge (ILK)
c. Rorschach Inkblot test
d. MMPI
ANSWER: b

How many states operate an outpatient competency restoration program?

a. 25
b. 10
c. 16
d. 42
ANSWER: c

Z2 ROLES FOR FORENSIC PSYCHIATRISTS IN NATIONAL SECURITY CASES

Maya Prabhu, MD, New Haven, CT
Emily Keram, MD, Santa Rosa, CA
Ronald Schouten, MD, Boston, MA
Stephen N. Xenakis, MD, Arlington, VA
Jacob Holzer, MD, Belmont, MA
Chinmoy Gulrajani, MD, Minneapolis, MN

EDUCATIONAL OBJECTIVE

Audience members will have a better understanding of the variety of roles forensic psychiatrists may play in cases with a national security dimension; consideration will also be given to ethical challenges and role conflict.

SUMMARY

Increasingly, forensic psychiatrists are being called upon to partake in a variety of roles with "national security" implications. Dr. Maya Prabhu will provide an overview of existing research on mental illness and terrorism. Dr. Ron Schouten will describe his involvement with the Expert Behavioral Analysis Panel convened to review the FBI investigative file in the 2001 anthrax mailings; he will discuss the formation and functioning of the Panel, the report it produced, and the experience of involvement in a project that was the subject of much attention from bloggers, conspiracy theorists, and various other critics and supporters. Dr. Steven Xenakis will address self-radicalization of Muslim-American teenagers who have sought to join jihadist movements abroad. Dr. Chinmoy Gulrajani will speak to his understanding of the socio-cultural underpinnings which make some young Somali immigrants to the United States vulnerable to ISIS recruitment. Dr. Jacob Holzer will discuss the challenges involved in people with a history of combat-related PTSD and TBI applying for sensitive security positions in law enforcement, intelligence, and other areas involving a security clearance. Dr. Keram will discuss ethical issues concerning forensic psychiatrists that arise at the intersection of Human Rights and National Security.

REFERENCES

Corner E, Gill P, Mason O: Mental health disorders and the terrorist: a research note probing selection effects and disorder prevalence. Studies in Conflict and Terrorism 3(6):560-568, 2016

Dom G, Schouler-Ocak M, Bhui K, et al: Mass violence, radicalization and terrorism: a role for psychiatric profession? European Psychiatry 49:78-80, 2018

QUESTIONS AND ANSWERS

Research has shown that mental disorders are less prevalent among:

a. Mass causality lone offenders
b. Lone actor terrorist
c. Solo actor under influence of a group
d. Group actor in an official terrorist group
ANSWER: d

Potential roles for psychiatrists in addressing mass violent event policy may include:

a. Understanding the public mental health research
b. Explicating the link between violence and mental illness
c. Understanding individual perpetrator motivations
d. Shaping early screening and intervention programs
e. All of the above
ANSWER: e

Z3 PREDICTING COMPETENCE RESTORABILITY AND LENGTH OF TIME TO RESTORATION

Cristina M. Secarea, MD, Washington, DC
Sean D. Cleary, PhD, Washington, DC
Philip J. Candilis, MD, Washington, DC

EDUCATIONAL OBJECTIVE

To identify competence to stand trial (CST) as a critical focus of public sector hospitalization; identify remediable variables influencing restorability; recognize factors influencing length of time to restoration (LOR); and provide guidance that supports interventions to improve treatment and shorten the time to restoration.

SUMMARY

Few studies on adjudicative competence explore the relationship between diagnosis, treatment and restorability. Most focus on demographics and major psychiatric diagnosis with very few exploring variables specific to the forensic population, like personality disorders, substance abuse and medication non-adherence.

Our study of 365 incompetent to stand trial (IST) defendants at a state psychiatric facility indicates that non-restored defendants have a greater likelihood of cognitive disorders, misdemeanor charges, and history of prior hospitalizations, and less likelihood of personality disorders. In addition, the odds of having a substance use disorder and being medication non-adherent were greater among restored defendants.

A significant difference was observed in the mean length of time to restoration (LOR): LOR for the entire study sample was 61 days, with an average of 88 days for the non-restored group and 56 days for those restored. In the restored group, defendants charged with a misdemeanor had significantly fewer days to restoration, while psychotic defendants had more. Among the non-restored group, LOR was significantly greater among those with no prior hospitalization and other race compared to whites.

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

Gillis A, Holoyda B, Newman WJ, et al: Characteristics of misdemeanants treated for competency restoration. J Am Acad Psychiatry Law 44:442-50, 2016

QUESTIONS AND ANSWERS
Which combination of the two disorders is associated with restorability?

a. Psychotic disorder and cognitive disorder
b. Substance use disorder and cognitive disorder
c. Mood disorder and borderline personality disorder
d. Personality disorder and substance use disorder
ANSWER: d

What is the maximum number of days allowed in the District of Columbia for inpatient competence restoration for a felony charge?

a. 60 days
b. 90 days
c. 180 days
d. 360 days
ANSWER: c

Z4 CULTURAL COMPETENCY IN COMPETENCE TO STAND TRIAL EVALUATIONS

Jennifer Piel, MD, JD, Seattle, WA
Katharine McIntyre, PhD, Lakewood, WA

EDUCATIONAL OBJECTIVE
This presentation will review recent case law addressing cultural competency in competence to stand trial evaluations and discuss relevant literature on cultural factors in forensic evaluations. From these, practical suggestions for culturally-informed competency evaluations will be discussed.

SUMMARY
A case from Washington, State v. Sisouvanh (2012), considered the significance of cultural factors in competency evaluations. It was argued in Sisouvanh that evaluators' cultural incompetence violates the due process rights of criminal defendants. Although the court did not find that the defendant's due process rights were violated in the Sisouvanh case, the court made clear that culture should not be ignored in adjudicative competency evaluations. Requirements for cultural competent practice is specifically addressed in the AAPL Practice Guidelines for the Forensic Psychiatric Evaluation of Competence to Stand Trial. The Guidelines highlight seven areas where cultural competence most closely intertwines with the process of conducting competency evaluations. The Guidelines encompass much of the spirit of what the judiciary in the Sisouvanh case was attempting to convey–that culture needs to be considered in a multifaceted manner and adjustments to how forensic evaluations may typically be conducted may need to occur in order to complete a culturally fair assessment. This presentation will review the Sisouvanh case and subsequent legal cases on cultural competence in forensic evaluations. The presentation will also provide a framework for providing culturally-informed competency evaluations.

REFERENCES
State v. Sisouvanh, 175 Wn. 2d 607, 290 P.3d 942 (2012)

Mossman D, Noffsinger SG, Ash P, et al: AAPL practice guideline for the forensic psychiatric evaluation of competence to stand trial. J Am Acad Psych Law 35:S3-72, 2007

QUESTIONS AND ANSWERS
The AAPL Practice Guidelines for the Forensic Psychiatric Evaluation of Competence to Stand Trial (2007) discuss the following areas to where cultural competence my present in adjudicative competence evaluations:

a. Interviewing
b. Communication
c. Transference/Countertransference
d. All of the above
ANSWER: d

What constitutional right could be violated in cases where cultural competence is not reasonably accounted for in competence to stand trial evaluations?

a. Due process
b. Free speech
c. Right against double jeopardy
d. Speedy trial
ANSWER: a

Z5 THE EFFECTIVENESS OF POLICE CRISIS INTERVENTION PROGRAMS

Michael Rogers, MD, San Francisco, CA
Dale McNeil, PhD, San Francisco, CA
Renée L. Binder, MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

To understand the core elements of Crisis Intervention Training (CIT) for law enforcement and learn about the evidence for its effectiveness and where it lacks evidence for effectiveness.

SUMMARY

Approximately 1,000 people in the United States were shot by police officers during 2017 and people with mental illness were involved in approximately 25% of those fatalities. Crisis Intervention Team (CIT) training is a specialized police curriculum that aims to reduce the risk of serious injury or death during an emergency interaction with police officers. CIT has been widely implemented nationally and internationally. This article describes the CIT model and its implementation and reviews research on outcomes of CIT. Studies generally support that CIT has beneficial officer-level outcomes, such as officer satisfaction and self-perception of a reduction in use of force. CIT also likely leads to pre-booking diversion from jails to psychiatric facilities. However, there is little evidence in the peer-reviewed literature that shows CIT's benefits on objective measures of arrests, officer injury, citizen injury, or use of force.

REFERENCES

Taheri SA: Do crisis intervention teams reduce arrests and improve officer safety? A systematic review and meta-analysis. Crim Justice Policy Rev. 27(1):76-96, 2016

Watson AC, Ottati VC, Morabito M, et al: Outcomes of police contacts with persons with mental illness: the impact of CIT. Adm Policy Ment Health Ment Health Serv Res 37(4):302-317, 2010.

QUESTIONS AND ANSWERS

Of the approximately 1,000 people shot annually by police officers in the United States, roughly what percentage involves people with mental illness?

a. 10%
b. 25%
c. 33%
d. 50%
ANSWER: b

When evaluating CIT programs, the highest benefit is seen in which of the following:

a. Decreased citizen injury rates
b. Decreased officer injury rates
c. Decreased use of force rates
d. Increased officer satisfaction
ANSWER: d

Z6 PACIFIC ISLAND PATIENTS ADMITTED TO REGIONAL FORENSIC PSYCHIATRY SERVICES IN NEW ZEALAND

Lisi Petaia, MBBS, FRANZCP, Auckland, New Zealand
Tom Stoner, BSc, Auckland, New Zealand
Gannin Bell, MBChB, Auckland, New Zealand
Himadri Seth, MBChB, MRCPsych, FRANZCP, Auckland, New Zealand
Susan Hatters Friedman, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

Emerging themes from this study may help establish how to provide interdisciplinary care including appropriate cultural interventions for this group of patients and may identify areas in which training can be augmented to better provide care for this culturally diverse group of patients.

SUMMARY

To describe the characteristics of Pacific Island patients admitted to the largest forensic hospital in New Zealand and to identify barriers in accessing mental health care prior to their admission to Mason clinic. The health outcomes for Pacific people are worse compared to the general New Zealand population. Cultural misunderstanding and unconscious bias by doctors can contribute to a poor state of Pacific health. Integrating cultural with clinical competence should lead to better outcomes by improving communication and adherence to treatment plans. Pacific people make up 6% of the New Zealand population but it has been estimated that approximately 8% of prisoners are Pacific Islanders, an overrepresentation compared with community ethnicity. Treatment for mental illness is less for Pacific prisoners, both while incarcerated and in the community. Since 2009, approximately 25% of patients admitted to Mason Clinic identified as Pacific Islander. There is no published literature on forensic psychiatric patients specifically of Pacific Island background. This study aims to aid our understanding of the characteristics of Pacific Island patients in forensic hospitals as this is critical in the designing and delivery of high-quality health care that is responsive to the needs of this group of patients.

REFERENCES

Mauri Ora Associates: Best Health Outcomes for Pacific People. Medical Council of New Zealand, 2010. Available at https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Best-health-outcomes-for-Pacific-Peoples.pdf. Accessed September 2018

Simpson AI, Brinded PM, Fairley N, et al: Does ethnicity affect need for mental health service among New Zealand prisoners? Australian and New Zealand Journal of Psychiatr, 37(6):728-734, 2003

QUESTIONS AND ANSWERS

Decision-making on mental health treatment in Pacific cultures:

a. Involves only the individual
b. Does not exist because only the doctor can make medical decisions
c. Involves the individual, immediate and/or extended family, and significant others only
d. Involves the individual, his/her partner, and immediate family only
ANSWER: c

Pacific cultural views of mental illness and their value of Western medical treatment:

a. Do not matter as people will seek and access help with mental health services when they need it
b. Have no influence on how people seek help with their mental health in Western countries
c. Has a huge influence on their compliance with treatment and engagement with mental health services
d. Has no influence as Pacific people are more aware and accepting of better Western models of mental health care.
ANSWER: c

Z7 FORENSIC CONSIDERATIONS OF TREATMENT WHEN YOU HAVEN'T SEEN THE PATIENT

Michael Greenspan, MD, Glen Oaks, NY
Brian Cooke, MD, Gainesville, FL
Andrew Levin, MD, Hartsdale, NY
Ryan Hall, MD, Lake Mary, FL
Bruce Gage, MD, Lakewood, WA

EDUCATIONAL OBJECTIVE

Participants will be able to better understand the forensic ramifications of treatment in collaborative care settings, as well as manage their own liability when delivering such care.

SUMMARY

National efforts at expanding psychiatric coverage are consistent with our profession's goals and ethics, and have been shown in multiple trials to improve outcomes over treatment as usual. In response to this increasingly large patient footprint and clinical need, behavioral health care providers and systems have begun to develop and implement schemes of "extending" psychiatric expertise. These include, amongst others, collaborative care models (including integration), psychiatric supervision of non-physician team members (usually nurse practitioners or physician associates, though this list is growing), and tele-psychiatric treatment. While delivering on aforementioned desired outcomes (increased access and improved outcomes), these treatment schemes potentially challenge traditional medical-legal notions of the doctor patient relationship and have downstream forensic ramifications. This workshop will explore the case law and legal theory underlying these challenges, and provide recommendations for clinicians to reduce their risk exposure when practicing in such environments.

REFERENCES

Katon W, Von Korff M, Lin E, et al: Collaborative management to achieve treatment guidelines. Impact on depression in primary care. JAMA 273(13):1026-31, 1995

Bland D, Lambert K, Raney L: Resource document on risk management and liability issues in integrated care models. American Journal of Psychiatry 171(5):592-592, 2014

QUESTIONS AND ANSWERS

An in-person direct examination is required to establish a doctor patient relationship for the purposes of collaborative care treatment.

a. True
b. False
c. Neither of the above
d. True only in cases of intentional tort claims
e. True only in cases of negligence claims
ANSWER: b

Of the roles described by the APA resource document on liability issues in collaborative care models, which of the following roles assumes the most liability risk?

a. Management role
b. Collaborative role
c. Supervisory role
d. Consultant role
e. Observer role
ANSWER: c

Z8 VICTIMS AND PERPETRATORS OF SEXUAL ASSAULT AND INTERPERSONAL VIOLENCE

Aimee Kaempf, MD, Tucson AZ
Kelly Coffman MD, MPH, Atlanta GA
Susan Hatters Friedman, MD, Cleveland, OH
Renée M. Sorrentino, MD, Weymouth, MA
Susan Ditter, MD, San Jose, CA

EDUCATIONAL OBJECTIVE

This panel is intended to update forensic mental health professionals on issues related to cases of sexual assault and intimate partner violence to inform and improve assessment, treatment, and consultation in these areas.

SUMMARY
From Harvey Weinstein to Rob Porter, numerous high-profile cases of alleged sexual assault and domestic violence have made headlines, leading to increased public discourse on the topic of violence against women. The #MeToo movement, started on social media to help demonstrate the widespread prevalence of sexual assault and harassment, spread virally in the fall of 2017. Despite heightened awareness, many misconceptions remain about sexual assault and intimate partner violence. Domestic violence is most often portrayed as physical in nature and as perpetrated by men. More subtle forms of abuse (such as possessive and intimidating behaviors) and abuse perpetrated by women may be overlooked. Expectations about how "real" victims would behave may raise doubts about the credibility of a victim and her allegations. Forensic mental health professionals, in their roles as treatment providers or as expert witnesses, may encounter victims and perpetrators of sexual assault and domestic violence, and thus should be familiar with some of these complexities. This panel aims to explore topics relevant to sexual assault and domestic violence cases including bidirectional intimate partner violence, coercive control, and counterintuitive victim behaviors.

REFERENCES
Langhinrichsen-Rohling J, Misra TA, Selwyn C, et al: Rates of bidirectional versus unidirectional intimate partner violence across samples, sexual orientations, and race/ethnicities: a comprehensive review. Partner Abuse 3(2):199-230, 2012

Schneider N: The mask of unhappiness: unmasking coercive control in intimate relationships. Journal of Psychiatric Practice 24(1):48-50, 2018

QUESTIONS AND ANSWERS
Which of the following statements is true regarding coercive control?

a. It is a form of intimate partner violence.
b. It often involves strategies such as isolation, intimidation, and bullying to dominate and control the other partner.
c. Victims often deny or minimize abuse to health care providers.
d. Coercive control is not a criminal offense in the U.S.
e. All the above.
ANSWER: e

Which of the following statements is most accurate regarding victims of sexual assault?

a. Victims usually scream and forcefully resist attackers.
b. Victims usually report assaults immediately.
c. Victims have individual responses to trauma that are often counterintuitive to public expectations.
d. Victims rarely blame themselves for an assault.
ANSWER: c

Z9 SUICIDE BY TEXT: THE LEGAL AND FORENSIC IMPLICATIONS OF FACILITATED SUICIDE

Elias Ghossoub, MD, St. Louis, MO
Jacqueline Landess, MD, St. Louis, MO
Brian Holoyda, MD, St. Louis, MO
William Newman, MD, St. Louis MO

EDUCATIONAL OBJECTIVE
To discuss recent and pending legal cases involving facilitated suicide; describe the legal basis for criminalizing certain forms of facilitated suicide; and outline the role of forensic psychiatry in cases of facilitated suicide.

SUMMARY
In June 2017, a media frenzy ensued after Michelle Carter was convicted of assisting in the suicide of Conrad Roy in the state of Massachusetts. Both were adolescents at the time of the suicide. The verdict stirred controversy regarding the protections and limitations of the First Amendment and the potential for digital speech to facilitate suicide. While facilitated suicide has been the subject of heated discussion in both the legal and medical fields, Commonwealth v. Carter has broadened the debate and emphasized the current social relevance of digital forms of communication, especially among youths. This panel explores facilitated suicide from both the legal and psychiatric points of view. We will conduct a review of the US legal tradition and all fifty states' legislation regarding assisted suicide. We will discuss relevant legal cases involving facilitated suicide. Lastly, we will detail the role of forensic psychiatry in investigating facilitated suicide, with a focus on adolescents and youths.

REFERENCES
Luxton DD, June JD, Fairall JM: Social media and suicide: a public health perspective. Am J Public Health 102(Suppl 2):S195-200, 2012

Scott CL, Swartz E, Warburton K: The psychological autopsy: solving the mysteries of death. Psychiatr Clin North Am 29(3):805-822, 2006

QUESTIONS AND ANSWERS
Which landmark case deemed states' bans on assisted suicide to be constitutional?

a. Cruzan v. Director, Missouri Department of Mental Health
b. Washington v. Glucksberg
c. Atkins v. Virginia
d. Washington v. Harper
ANSWER: b

Which state supreme court ruled that verbal assistance to suicide is NOT protected speech?

a. Georgia
b. Minnesota
c. Ohio
d. Washington
ANSWER: b

Z10 NEW INNOVATIONS IN FORENSIC PSYCHIATRY EDUCATION

Chinmoy Gulrajani, MBBS, Minneapolis, MN
Mikel Matto, MD, San Francisco, CA
Reena Kapoor, MD, New Haven, CT
Richard Martinez, MD, Denver, CO
James L. Knoll IV, MD, Syracuse, NY

EDUCATIONAL OBJECTIVE
Attendees will learn new methods of training forensic psychiatrists that they can incorporate into their own program.

SUMMARY
The Accreditation Council for Graduate Medical Education (ACGME) sets and monitors the professional educational standards for all residencies and fellowships in the United States. It provides minimum program requirements that set standards with respect to program duration, eligibility, resources, faculty and training sites. For fellowship training in Forensic Psychiatry, the ACGME also provides a list of topics in which trainees must gain proficiency. With regards to experiential training, the ACGME provides broad strokes guidance to programs but does not offer or mandate any specific types of training modules. However, almost all training programs in the country have incorporated innovative rotations/modules in their curricula that incorporate unique facets of training in forensic psychiatry. There is no common platform where programs can get together and share ideas about the innovations they have incorporated in their program. In this panel, program faculty from five fellowship programs across the country will present novel training modules that are unique to their programs. Presenters will discuss the goals of each training module, the competencies attained by trainees and provide guidance to other programs that wish to incorporate similar training into their curriculum.

REFERENCES
ACGME: Program Requirements and FAQs for Forensic Psychiatry (Effective July 1, 2017). Available at: http://www.acgme.org/Specialties/Program-Requirements-and-FAQs-and-Applications/pfcatid/21/Psychiatry. Accessed March 18, 2018.

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

QUESTIONS AND ANSWERS

Which of the following statements regarding the ACGME minimum program requirements for a fellowship in Forensic Psychiatry is TRUE?

a. A fellowship training program must have a minimum of 2 participating training sites in addition to the Sponsoring Institution to gain accreditation.
b. A Program Letter of Agreement (PLA) with participating training sites must be renewed annually.
c. Within at least one of the participating sites there should be an ACGME accredited program in at least one of the following non-psychiatric specialties: family medicine, internal medicine, neurology, or physical medicine and rehabilitation.
d. The Program Director may not serve as the faculty who will assume educational and supervisory responsibilities at a participating training site.

ANSWER: c

Which of the following statements regarding the ACGME minimum program requirements for a fellowship in Forensic Psychiatry is TRUE?

a. The Program Director must devote at least 15 hours per week to a program with 1 -2 fellows.
b. The Program Director must be a full time employee of the Sponsoring Institute.
c. The Program Director must devote at least 15 hours per week to a program with 3 or more fellows.
d. The Program Director must devote at least 20 hours a week to clinical activities related to forensic psychiatry.

ANSWER: c

Z11 PHYSICIAN IMPAIRMENT AND SELF-DISCLOSURE: HAZARDS & HARDSHIPS

Patricia Westmoreland, MD, Denver, CO
Maryrose Bauschka, MD, Salt Lake City, UT
Anne Marie Melia, MD, Denver, CO
Doris Gundersen, MD, Denver, CO
Elizabeth Collis, JD, Columbus, OH

EDUCATIONAL OBJECTIVE

This workshop will be conducted by two forensic psychiatrists, an eating disorder specialist, a psychiatrist formerly impaired by anorexia nervosa (AN), and an attorney. Participants will learn about how a physician with AN underwent treatment and returned to practice. Implications regarding physician impairment and medical board oversight will be discussed.

SUMMARY

Physicians who suffer from mental illness may be faced with far-reaching consequences of their illnesses. Do physicians' patients know when they are impaired? What happens if a license is suspended voluntarily? Dr. Westmoreland will moderate this workshop and outline cognitive effects of eating disorders, patients' insight into their illness and implications for their professional practice. Dr. O'Melia, an expert in treating eating disorders, will discuss treating a physician with anorexia nervosa. Dr. Bauschka will describe the conflict between being a patient with anorexia nervosa and wanting to practice as a psychiatrist. Dr. Gundersen, Medical Director of the Colorado Physician Health Program and Immediate Past President of the Federation of State Physician Health Programs, will discuss negative licensure and practice implications for physicians who disclose their illnesses directly to regulatory bodies. She will discuss an alternative model of intervention affording physician confidentiality while also ensuring the public's safety. Elizabeth Collis, Esq, will discuss medical board disciplinary processes and how physicians diagnosed with mental conditions are subjected to discipline. Using an audience response system, attendees will be polled for their opinions at key points in this case, and their responses with be incorporated into a summary by Dr. Westmoreland.

REFERENCES

Brooks E, Gendel MH, Early SR, et al: Physician boundary violations in a physician's health care program: a 19-year review. J Am Acad Psychiatry Law 40(1):59-66, 2012

Brooks E, Gendel MH, Gundersen DC, et al: Physician health programs and malpractice claims: reducing risk through monitoring. Occup Med (Lond) 63(4):274-280, 2013

QUESTIONS AND ANSWERS
Research has demonstrated that physicians who have participated in a physician health program:

a. Have recovery rates from addiction that exceed that of the general population by a wide margin
b. Have lower risk for malpractice relative to their peers in the general physician population
c. Have low recidivism rates for professional boundary violations
d. All of the above
ANSWER: d

Diminished mental capacity occurs in a third of patients with severe anorexia nervosa and is associated with:

a. A low BMI
b. First treatment for anorexia nervosa
c. Low appreciation of illness and treatment
d. Good social functioning
e. a and c
ANSWER: e

Z12 CASEY'S LAW CASES: USING CIVIL COMMITMENT FOR SUBSTANCE USE DISORDERS

Abhishek Jain, MD, New York, NY
Elizabeth Ford, MD, New York, NY
Corina Freitas, MD, Oxon Hill, MD
Cristina Secarea, MD, Arlington, VA
Ryan Wagoner, MD, Lutz, FL

EDUCATIONAL OBJECTIVE
To summarize the variability of U.S. laws authorizing civil commitment for substance use disorders; appraise the utility and impact of civil commitment for substance use disorders in diverse settings and special patient populations; and apply civil commitment for substance use disorder laws in practical, case-based scenarios.

ABSTRACT:
In 2004, two years after Matthew "Casey" Wethington died of a heroin overdose at age 23, Casey's Act for Substance Abuse Intervention became effective in Kentucky. Other states have passed similar, often-eponymous laws, such as Indiana's Jennifer Act and Florida's Marchman Act, that authorize the civil commitment of individuals with substance use disorders. As of 2015, at least 32 states and the District of Columbia had statutes permitting adult civil commitment for addiction treatment–and more are now considering these laws with the rising rate of opioid overdose deaths. However, these laws are complex, vary considerably across states, and outcomes data is limited. The first half of our workshop will provide an overview of these laws, contrasting them from other compulsory interventions (e.g., drug courts) and appraising their utility in diverse settings (e.g., assisted outpatient treatment) and among special patient populations (e.g., pregnant women). The second half will involve interactive cases with audience participation and practical application of these laws. Throughout our session, we will use the audience response system. We ultimately aim for the audience to consider: "If your patient or evaluee refuses addiction treatment, can civil commitment be a reasonable option?"

REFERENCES
Jain A, Christopher PP, Appelbaum PS: Civil commitment for opioid and other substance use disorders: does it work? Psychiatric Services, 2018. Available at https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201800066. Accessed September 2018.

Williams AR, Cohen S, Ford EB: Statutory definitions of mental illness for involuntary hospitalization as related to substance use disorders. Psychiatric Services 65(5):634-640, 2014

QUESTIONS AND ANSWERS
According to a 2015 review, how many U.S. states (including the District of Columbia) authorize the use of adult civil commitment for substance use disorders?

a. 0
b. 11
c. 33
d. 51
ANSWER: c

According to SAMHSA's 2016 national survey, roughly what percentage of individuals who need substance use treatment do not think they need it?

a. 15%
b. 33%
c. 50%
d. 85%
ANSWER: d

EARNING CME CREDIT AT THE ANNUAL MEETING

The American Academy of Psychiatry and The Law is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AMA Category 1 CME Credit is awarded for attendance at presentations according to the time listed on the two-part CME credit form found in your registration envelope.

To obtain CME credit, fill in your name, check off the programs you attended and total the hours of credit you earned. Return the CME credit form and your completed evaluation form to the Registration Desk.

The CME credit form will be initialed and one copy will be given back to you. NO Certificates will be mailed.

Non-MDs may receive a Certificate of Attendance that can be initialed at the Registration Desk but no copies will be kept by AAPL.

INDEX OF AUTHORS

INDEX OF AUTHORS

INDEX OF AUTHORS