American Academy of Psychiatry and the Law

48th Annual Meeting

October 26-29, 2017
Denver, Colorado

The American Academy of Psychiatry and the Law is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The American Academy of Psychiatry and the Law designates this live activity for a maximum of *31.75 AMA PRA Category 1 Credits™.* Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Forty-eigth Annual Meeting
American Academy of Psychiatry and the Law
October 26-29, 2017
Denver, Colorado

OFFICERS OF THE ACADEMY

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Councilor

Richard Martinez, MD
Councilor

Hal S. Wortzel, MD
Councilor

PAST PRESIDENTS

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

2016 ANNUAL MEETING CHAIR

Reena Kapoor, 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 2018

The 49th Annual Meeting of the
American Academy of Psychiatry and the Law will be held in
Austin, TX – October 26-29, 2018

Inquiries may be directed to Drs. Jessica Ferrante and William Newman

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, 2018

FUTURE ANNUAL MEETING DATES and LOCATIONS

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

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

GENERAL INFORMATION

Table of Contents

REGISTRATION DESK
(Centennial Ballroom 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
Centennial Ballroom Foyer

NOETIC FILMS
Centennial Ballroom Foyer

PRESENTATION CODES

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

DESIGNATIONS USED IN THIS PROGRAM

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

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

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

MERCHANDISE FOR SALE

All proceeds used to fund AIER grants.

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

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

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

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

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

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

A MESSAGE TO PHYSICIAN ATTENDEES
CONTINUING MEDICAL EDUCATION CHANGES

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

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

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

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

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

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

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

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

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

Thank you in advance.

Richard Frierson, MD, and Christopher Thompson, MD
Co-chairs, Education Committee

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

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

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

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

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

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

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

Adopted: September 5, 2008

FINANCIAL DISCLOSURE/CONFLICT OF INTEREST

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

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

All speakers have been advised of the following:

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

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

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

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

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

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

FINANCIAL DISCLOSURES

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

SPEAKERS/PRESENTERS

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

Abi Zeid, M.; Acosta-Armas, A.; Adkins S.; Ahmed, A.; Albassam. A.; Ali, A.; Alonzo-Katzowitz, J.; Altice, F.; Anacker L.; Anand, S.; Andrade J.; Anfang, S.; Annas, G.; Antonius, D.; Armontrout, J.; Arrowsmith, M.; Ash, P.; Ashai, A.; Azores-Gococo, N.; Baranoski M.; Barros A.; Bazzi, L.; Beaman, J.; Bell, K.; Berger, A.; Berry, M.; Bhargava, M.; Billick, S.; Binder R.; Biswas, J.; Bradford, J.; Brook, M.; Brown, R.; Bryant, P.; Bryson, W.; Bundrick J.; Burkholder, K.; Candilis, P.; Cardasis, W.; Casey, J.; Casey-Leavell, B.; Cerny C.; Cervantes, A.; Champion, M.; Chapman, M.; Chen, M.; Cheng, J.; Cherner, P.; Chesanow, C.; Chien, J.; Choi, O.; Cohen, M.; Colavita, M.; Colley, J.; Collins, T.; Danziger, J.; Datta, V.; Dauria, E.; Dessin, C.; DiCiro, M.; Dike, C.; Dinwiddie, S.; Dixon, L.; Domon, S.; Drogin, E.; Dumas, C.; Dunlop, J.; Dwyer, R.; Easton, S.; Ee, J.; Egan, G.; Eizirik, C.; Evans, S.; Faerstein, S.; Falls, B.; Fedoroff, J.; Ferguson, E.; Ferranti, C.; Ferranti, J.; Fink, S.; Fischer, C.; Fishbein, S.; Fisher, K.; Ford, E.; Forman, P.; Fox, A.; Fried, A.; Frierson, R.; Frischer, K.; Gage, B.; Gandhi, T.; Garvey, K.; Gaudiani, J.; Georgakas, J.; Gilbo, N.; Glancy, G.; Glezer, A.; Goldberg, B.; Goldenberg, E.; Gopalakrishnan, G.; Goradia, V.; Gosein, V.; Granacher, R.; Graves, A.; Gray, B.; Gray, J.; Griffith, E.; Griswold, K.; Groth, L.; Guina, J.; Gulrajani, C.; Gutheil, T.; Hackman, D.; Hall, J.; Halverson, D.; Hanlon, R.; Hanna, M.; Hanson, A.; Hartman, J.; Hatters Friedman, S.; Hauck, S.; Hayes, L.; Heffler, M.; Heintzman, M.; Hidrovo, C.; Hirachan, S.; Hirschtritt, M.; Hoge, S.; Holmberg, T.; Holoshitz, Y.; Holoyda, H.; Holzer, J.; House, S.; Howdeshell, J.; Howell, S.; Howell, T.; Jahdi, M.; Janofsky, J.; Jones, T.; Jones-Jacques, M.; Joseph, A.; Joshi, K.; Joy, M.; Junewicz, A.; Kaempf, A.; Kahn, B.; Kane, J.; Kaplan, J.; Kastner, J.; Kenner, W.; Keram, E.; Kerner, J.; Khadivi, A.; Khan, J.; Khin Khin, E.; Knoll, J.; Kolla, E.; Korenis, P.; Krueger, R.; Kruse, M.; Kurlyandchik, D.; Kushner, D.; Lamoureux, I.; Landess, J.; Lape, M.; Laskoski, P.; Leahy, R.; Lee, E.; Lee, L.; Leetch, C.; Leidenfrost, C.; Levin, A.; Levitt, W.; Lilly, S.; Lisch, D.; Liu, Y.; Lluberes, L.; Manguso, R.; Marett, C.; Marett, E.; Marino, L.; Marshall, B.; Martin, P.; Martinez, R.; Matarazzo, B.; McAnallen, J.; McBride, A.; McCoy, J.; McDermott, B.; McNiel, D.; McNiel, M.; Menkel-Meadow, C.; Metzner, J.; Meyer, D.; Miceli, J.; Misquitta, D.; Moravecek, M.; Mossman, D.; Murphy, L.; Myers, W.; Nanton, A.; Naqvi, H.; Nazem, S.; Negron Munoz, R.; Nesbit, A.; Nesbit, D.; Newkirk, C.; Newman, A.; Newman, W.; Nissan, D.; Njoku, I.; Noffsinger, S., Norko, M.; Noroian, P., Nossel, I.; Olufade, R.; Opara, R.; Orman, R.; Ortiz, P.; Oryema, N.; Otopalik, B.; Oyer, J.; Padoan, C.; Parke, S.; Parker, G.; Parmegiani, J.; Penn, J.; Peters, J.; Piel, J.; Pinals, D.; Pinals, J.; Pinsky, H.; Pollard, J.; Prabhu, M.; Pustilnik, A.; Rafla-Yuan, E.; Ramachandran, G.; Ranger, R.; Ravven, S.; Reid, W.; Reimers, K.; Reisman, J.; Remmert, B.; Resnick, P.; Reynolds, B.; Reynolds, G.; Rice, K.; Riess, P.; Rolin, I.; Rolin, S.; Rosenbaum, M.; Rosenbaum, W.; Rosenfeld, B.; Rosmarin, D.; Roth, B.; Rotter, H.; Rotter, M.; Ryan, E.; Sabatello, M.; Sahadevan, D.; Saleh, A.; Sayed, A.; Scott, A.; Scott, C.; Scott, L.; Scott, W.; Scurich, N.; Secarea, V.; Shand, J.; Shchupak, K.; Shivale, S.; Sidhu, N.; Simpson, A.; Simpson, S.; Simpson, T.; Simring, S.; Singh, M.; Siu, B.; Skidmore, J.; Smith, D.; Smith, L.; Sokolov, G.; Solanki, K.; Soliman, K.; Soliman, S.; Solimo, A.; Solis, O.; Sorrentino, R.; Spanggaard, B.; Spanggaard, D.; Sparr, J.; Spohn, R.; Srinivasaraghavan, J.; Stankowski, J.; Stevens, J.; Stowe, Z.; Subedi, B.; Swartz, M.; Tamburello, A.; Tayeb, N.; Teche, P.; Teralandur, R.; Testa, M.; Thompson, J.; Tolou-Shams, B.; Torous, J.; Trestman, R.; Tucker, D.; Vaibhav, V.; Vargas, S.; Vella, N.; Venable, M.; Virani, J.; Virdi, S.; Wager, A.; Wagoner, R.; Waldron, G.; Wallen, O.; Wang, W.; Washburn, J.; Wasser, T.; Watts, M.; Way, B.; Weisman, R.; Westmoreland, P.; Westphal, A.; Westphal, T.; Wheeler, A.; Whittle, M.; Williams, J.; Williamson, J.; Wills, C.; Winston, H.; Wollert, D.; Wortzel, H.; Zhong, R.; Zonana, H.

PROGRAM AND EDUCATION COMMITTEE MEMBERS DISCLOSURE

The following meeting planners in control of content for this meeting have indicated that they have no relevant financial relationships with any commercial interests.

Ash, P.; Billick, S.; Champion, M.; Dike, C.; Federoff, J.; Ferguson, E.; Ferranti, J.; Frierson, R.; Gold, L.; Gulrajani, C.; Hanson, A.; Henry, S.; Holzer, J.; Holoyda, B.; Holzer, J.; Johnson, N.; Kaempf, A.; Kapoor, R.; Kaye, N.; Keram, E.; Klein, C.; Knoll, J.; Krueger, R.; Lee, L.; Lewis, C.; Lewis, R.; Michaelsen, K.; Newman, A.; Newman, W.; Noffsinger, S.; 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.; Sokolov, G.; Srinivasaraghavan, J.; Stolar, A.; Subedi, B.; Thompson, C.; Wills, C.

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

Gary Chaimowitz: Received speaker honoraria from Otsuka, Janssen and Pfizer Pharmaceuticals.

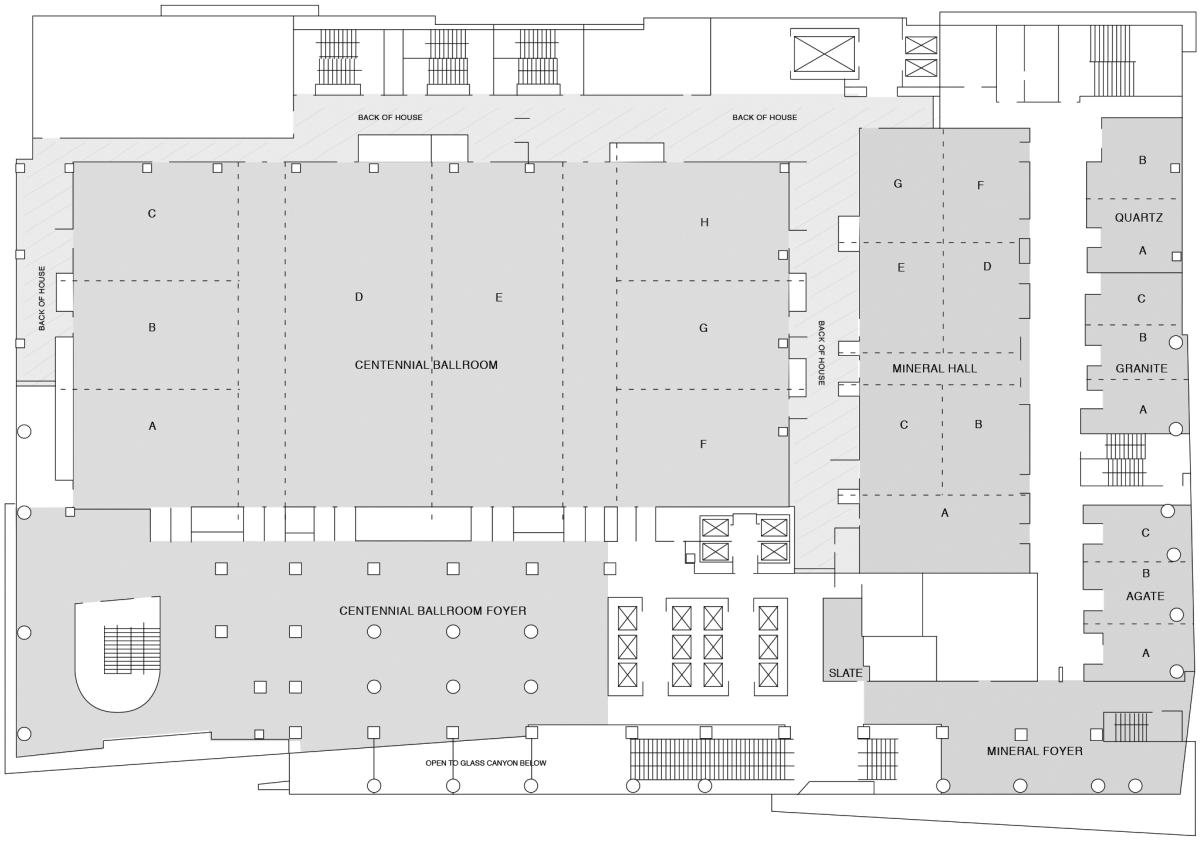
SPECIAL EVENTS

WEDNESDAY, OCTOBER 25		
AIER Board Meeting	7:00 a.m. – 8:30 a.m.	Mineral B-C
Council Meeting	8:45 a.m. – 2:00 p.m.	Mineral B-C
Council with Committee Chairs	6:00 p.m. – 7:00 p.m.	Quartz A-B
Committee Reception and Dinner (ticket required)	7:00 p.m. – 9:00 p.m.	Centennial Ballroom A-C
THURSDAY, OCTOBER 26		
Past President's Breakfast	7:00 a.m. – 8:00 a.m.	Granite A
Opening Ceremony – President's Address (open to all attendees)	8:00 a.m. – 10:00 a.m.	Centennial Ballroom D
Association of Directors of Forensic Psychiatry Fellowships Reception (for fellowship program faculty, fellows and potential applicants)	6:00 p.m. – 7:00 p.m.	Centennial Ballroom A
Mock Trial	7:00 p.m. – 9:00 p.m.	Centennial Ballroom D
Women of AAPL Reception	9:00 p.m. – 10:00 p.m.	Granite B-C
FRIDAY, OCTOBER 27		
Rappeport Fellows Breakfast (Rappeport Fellows and Committee)	7:00 a.m. – 8:00 a.m.	Granite A
Research Committee	7:00 a.m. – 8:00 a.m.	Granite B
AAPL Business Meeting (members only)	8:00 a.m. – 9:30 a.m.	Centennial Ballroom D
AAPL Reception	6:00 p.m. – 7:30 p.m.	Centennial Ballroom A-C
SATURDAY, OCTOBER 28		
Early Career Development and Fellows Breakfast (for those in the first seven years after training and current fellows)	7:00 a.m. – 8:00 a.m.	Quartz
Midwest AAPL Chapter Meeting (chapter meetings by request only; contact AAPL staff)	6:00 p.m. – 7:00 p.m.	Quartz A

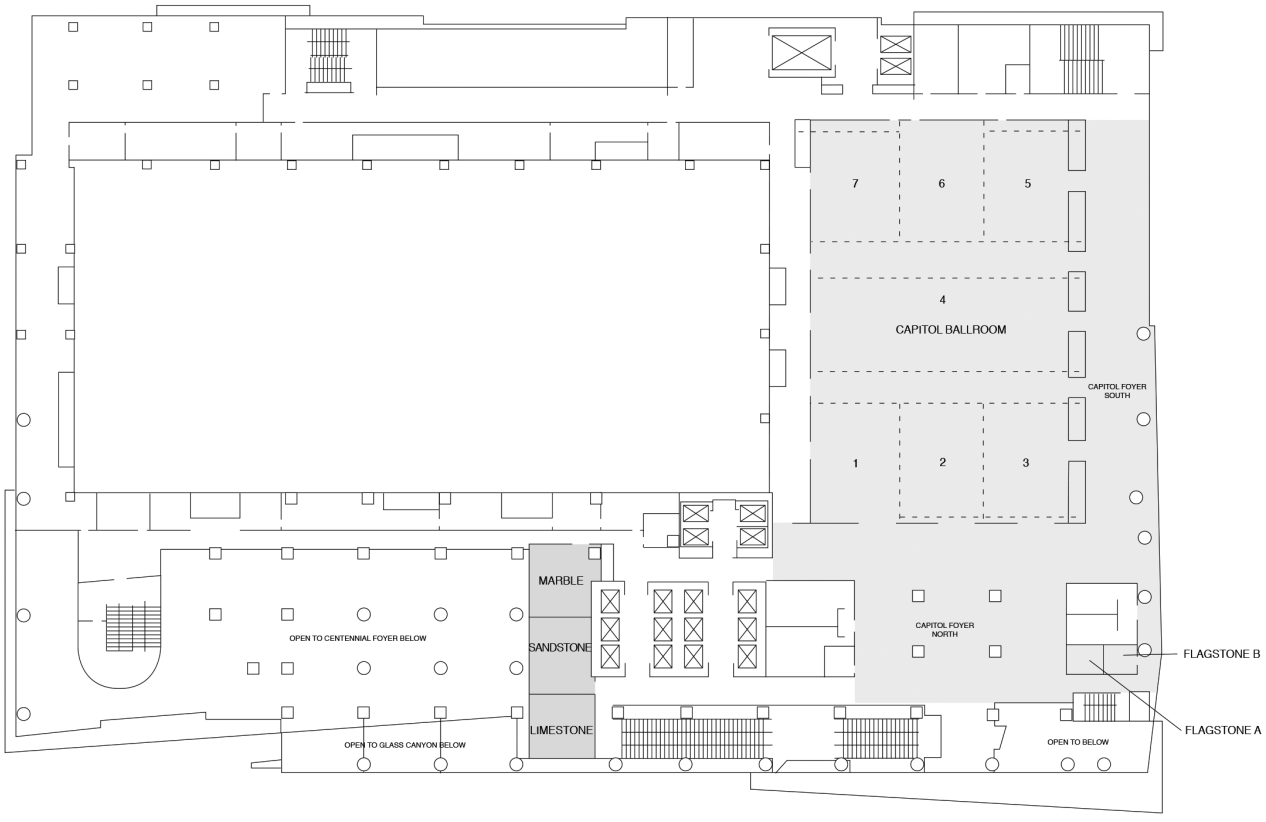
COFFEE BREAKS WILL BE HELD IN THE CENTENNIAL BALLROOM FOYER

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

THIRD LEVEL



FOURTH LEVEL



PLEASE

BE COURTEOUS TO YOUR FELLOW ATTENDEES.

TURN CELL PHONES OFF OR SET THEM TO VIBRATE.

HOLD YOUR PHONE CONVERSATIONS OUTSIDE THE MEETING ROOM.

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

(SESSION MODERATORS HAVE BEEN ASKED TO ENFORCE THESE POLICIES)

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

OPENING CEREMONY

Thursday, October 26, 2017
8:00 a.m. - 10:00 a.m.

WELCOME, INTRODUCTIONS
Michael A. Norko, MD
President

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

Lisa Anacker, MD
University of Michigan

Jonathan Dunlop, MD, JD
University of Michigan

Sarah Baker, MD
University of Texas, Southwestern

Matthew Hirschtritt, MD, MPH
University of California, San Francisco

Joseph Cheng, MD, PhD
Medical University of South Carolina

R. Ryan Leahy, MD
University of Miami/Jackson Memorial Hospital

AWARD PRESENTATIONS

Golden Apple Award
Douglas Mossman, MD

Seymour Pollack Award
Alan Felthous, MD

Red Apple Awards
Thomas Gutheil, MD
Susan Hatters Friedman, MD

Young Investigator Award
James A. Armontrout, MD

Nathan J. Kolla, MD
Chair, Research Committee

2016 Poster Awards
Samuel J House, MD

INTRODUCTION OF GRANTEES
AAPL INSTITUTE FOR EDUCATION AND RESEARCH
Larry Faulkner, MD
President, AAPL AIER

OVERVIEW OF THE PROGRAM
Reena Kapoor, MD
Chair, Program Committee

INTRODUCTION OF THE PRESIDENT
Charles C. Dike, MD, FRCPsy

PRESIDENT'S ADDRESS
Michael A. Norko, MD

ADJOURNMENT
Reena Kapoor, MD
Chair, Program Committee

AWARD RECIPIENTS

RED AAPL OUTSTANDING SERVICE AWARDS

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

THOMAS GUTHEIL, MD

As chairman of the AAPL Research Committee (1989-1994), Thomas Gutheil, MD, designed and edited the very first research manual for AAPL, aimed at moving AAPL from think pieces and case reports into a true empirical field. As president of AAPL from 1999-2000, his presidential speech featured a number of empirical studies of the attorney-expert relationship, some done for the first time.

Dr. Gutheil had several roles in connection with the original AAPL-based American Board of Forensic Psychiatry (1984-1992) as an examiner and member of the Board of Directors, as Chair of the Board's own Ethics committee, and as a member of the Oral Examination committee.

For twenty-two years (1992-2014)) Dr. Gutheil was faculty member for the very successful Forensic Board Review course, speaking on a variety of topics over the years.

Other notable contribution to AAPL include being the chair of the Rappeport Fellowship committee (1987-1990), chair of the Ethics committee (1988-1992), AAPL program chair (1998), and member of the Board of Directors of the AAPL foundation. Dr. Gutheil's extensive writings have included many published in JAAPL and the AAPL newsletter.

SUSAN HATTERS FRIEDMAN, M.D.

The outstanding service award (Red AAPL) is awarded in recognition of service to AAPL. Susan Hatters Friedman, MD, has served on the editorial board of JAAPL since 2012 and has been the editor of AAPL's newsletter since 2016. She has served on the Newsletter's editorial board since 2011. Not surprisingly, she has published extensively in JAAPL and in the Newsletter.

Her participation in AAPL committees have included being an active member of the subcommittee producing the self-assessment examination questions for AAPL since 2010
and being on the Rappeport Fellowship committee since 2009 (co-chair since 2011). She has also been an active member of the Gender Issues committee since 2003, and has previously served as its chairperson. Dr. Hatters Friedman has also been an active member of the Ethics committee and has given multiple presentations with other committees including the Research committee, the Psychopharmacology committee, and the Early Career committee.

Dr. Hatters Friedman was a Rappeport fellow in 2003. She has also served AAPL as councilor, secretary, and vice-president of AAPL. On a regional level, she has been program co-chair for two Midwest AAPL meetings. She is a past councilor and president of the Midwest AAPL.

GOLDEN AAPL AWARD

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

DOUGLAS MOSSMAN, MD

The Golden APPL is awarded in recognition of AAPL members (60 years or older), who have made significant contributions to the field of forensic psychiatry.

This year's awardee, Douglas Mossman, MD, is Professor of Clinical Psychiatry and Program Director of the Forensic Psychiatry Fellowship at the University of Cincinnati College of Medicine. In addition to having made hundreds of presentations to mental health professionals and attorneys at local, regional, national, and international meetings, Dr. Mossman has authored more than 185 publications. Among these are three books, eleven law review articles and seven papers that describe original statistical procedures, and scores of other relevant articles. Dr. Mossman's article "Critique of Pure Risk Assessment or, Kant Meets Tarasoff" received the 2008 Manfred S. Guttmacher Award from the American Psychiatric Association (APA) for outstanding contributions to the literature on forensic psychiatry.

Dr. Mossman's current faculty duties include training psychiatry residents and teaching physicians and attorneys about mental disabilities and the law. His clinical practice focuses on outpatient treatment and evaluations of individuals involved in legal proceedings. His current scholarly projects investigate forensic assessment techniques, new statistical procedures, and mathematical models for describing diagnostic accuracy and agreement.

SEYMOUR POLLACK AWARD

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

ALAN R. FELTHOUS, MD

he Seymour Pollack Award recognizes distinguished contributions to the field of forensic psychiatry. This year's awardee is Alan R. Felthous, MD, who is a Professor and Director of Forensic Psychiatry at the Saint Louis University School of Medicine.

Dr. Felthous has written numerous journal articles and book chapters and has lectured internationally on topics in legal and forensic psychiatry. His correctional research interests include impulsive and premeditated aggression, pharmacotherapy of aggression, self-destructive behaviors and completed suicides. He is author of the book The Psychotherapist's Duty to Warn or Protect, senior editor of Behavioral Sciences and the Law, and co-editor of The International Handbook of Psychopathic Disorders and the Law which won the 2009 Guttmacher Award. He is the section editor of the criminal forensic psychiatry section in the Principles and Practice of Forensic Psychiatry, Third Edition (2017).

Dr. Felthous is the Past President of the Association of Directors of Forensic Psychiatry Fellowship Programs, Past Vice President of the American Academy of Forensic Sciences, Past President of the American Board of Forensic Psychiatry and Past President of the American Academy of Psychiatry and the Law. Dr. Felthous chaired the Learning Resources Committee, which first made landmark cases in forensic psychiatry available to AAPL members.

DISTINGUISHED LECTURERS

Thursday, October 26, 2017

THE HONORABLE JOHN L. KANE, JR.

Reflections on Judging and the Mentally Ill

John L. Kane, Jr. has served as a Senior United States District Judge of the United States District Court for the District of Colorado since his nomination by President Carter in 1977. As one of Colorado's most experienced and outspoken judges, he has served as a passionate advocate for legal reform for over 40 years, including for defendants with mental illness. Born in Tucumcari, New Mexico, Judge Kane received a B.A. from the University of Colorado in 1958 and a J.D. from the University of Denver College of Law in 1960. Prior to becoming a judge, he had an eclectic career, including work as a prosecutor, in private practice, as a public defender, and as a director of Peace Corps programs in India and Turkey. He was an Adjunct professor at the University of Denver College of Law from 1978 to 1988 and a Visiting Lecturer in Law at Trinity College in Dublin, Ireland in 1989. He was a Miller distinguished visiting professor of law at the University of Denver College of Law from 1990 to 1996. Since 1996, he has served as Adjunct Professor at the Colorado School of Law.

Friday, October 27, 2017

PROFESSOR CARRIE MENKEL-MEADOW

The Dangers of Adversarialism in the Legal System and Elsewhere

Carrie Menkel-Meadow is Professor Emerita at Georgetown Law and director of the Georgetown Hewlett Fellowship Program in Conflict Resolution and Problem-Solving. A national expert in alternative dispute resolution, legal ethics, clinical legal education, feminist legal theory, and women in the legal profession, Professor Menkel-Meadow has written and lectured extensively in these fields. She is the author of Dispute Resolution: Beyond the Adversarial Model (2005); Negotiation: Processes for Problem Solving (2006); Mediation: Theory, Policy & Practice (2006); Dispute Processing & Conflict Resolution (2003); and over 100 articles. Prior to joining the faculty at Georgetown Law, she served as a professor of law at UCLA from 1979 to 1996, where she was co-director of UCLA's Center on Conflict Resolution. She has won numerous awards for her work, including the Center for Public Resources' First Prize for Scholarship in Alternative Dispute Resolution three times (in 1983, 1990, and 1998), the Rutter Award for Excellence in Teaching at UCLA, and the Frank Flegal Teaching Award at Georgetown (2006). In addition to her scholarship, research, and teaching, Professor Menkel-Meadow often serves as a mediator and arbitrator in public and private settings and has trained lawyers and mediators in the United States and abroad.

Saturday, October 28, 2017

MR. ANTHONY GRAVES

Graves Injustice

Anthony Graves is the 138th death row exoneree in the United States. Mr. Graves spent eighteen and a half years in prison, sixteen of those in solitary confinement, twelve on Texas Death Row, with two execution dates, for a crime he did not commit. With his steadfast focus on his innocence and the tireless work of The Innocence Network, he was vindicated and released in 2010. Since then, he has spoken at universities and organizations all over the world, including the American Bar Association Death Penalty Representation Project's 25th Anniversary celebration with retired Supreme Court Justice John Paul Stevens and the U.S. Senate Judiciary Hearing on Solitary Confinement. Mr. Graves' story has been featured on two covers of Texas Monthly magazine, the Katie Couric Show, and the 48-hours documentary "Grave Injustice," which won the 2012 Emmy Award. Mr. Graves founded the Anthony Graves Foundation to promote fairness and effect reform in the criminal justice system, and he also started a scholarship at the University of Texas Law School in the name of his attorney and champion, Nicole Casarez. Since 2015, he has served on the Board of Directors for the Houston Forensic Science Center, helping the city to prevent wrongful convictions.

THURSDAY, OCTOBER 26, 2017

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

T1 ***Impact of Pharmacotherapy on Crisis Bed Usage in NYS Prisons***
Jonathan S. Kaplan MD, Poughkeepsie, NY
Stephanie Lilly MA, Marcy, NY (I)
Megan Lape PhD, Marcy, NY (I)
Vaibhav, BA, Marcy, NY (I)
Nicholas Vella, BA, Marcy, NY (I)

T2 ***Gunning for Safety in Schools: Is Campus Carry the Answer?***
Sarina Adkins MS IV, Washington, DC (I)
Eindra Khin Khin MD, Washington, DC

T3 ***Interdisciplinary Course in Forensic Mental Health Research***
Jennifer L. Piel MD JD, Seattle, WA
Edward Goldenberg PhD, Seattle, WA (I)

T4 ***Clinicians' Attitudes Toward Experimental Drugs***
Jennifer L. Piel MD JD, Seattle, WA

T5 ***CA's New End of Life Option Act in an Academic Institution***
Anna Glezer MD, San Francisco, CA

T6 ***Violence Risk and the School Shooter Phenomenon***
R. Ryan Leahy MD, Miami Beach, FL

T7 ***The Forensic Experience in Psychiatry Residency Training***
Viral Goradia MD, Liverpool, NY
Bruce Way MD, Ottawa, ON, Canada (I)
James L. Knoll IV MD, Syracuse, NY

T8 ***Outcomes of 20-Day Inpatient Competency to Stand Trial Evaluation***
David Sahadevan MD, Westerville, OH
Maryam Jahdi MD MPH, Columbus, OH (I)
Matthew P. Arrowsmith MD, Columbus, OH
Douglas A. Misquitta MD, Hilliard, OH
Delaney Smith MD, Columbus, OH

T9 ***POSTER WITHDRAWN***

T10 ***Update on Gun Control and Mental Illness: Impact on Practice***
Lisa Anacker MD, Ann Arbor, MI
Debra A. Pinals MD, Ann Arbor, MI
O. Lizette Solis MD, San Antonio, TX (I)

T11 ***Assisted Suicide Debate Comes to Minnesota***
Benjamin Otopalik MD MPH, Minneapolis, MN
Chinmoy Gulrajani MD, Minneapolis, MN

T12 ***Juvenile Sex Offender Treatment: Substance Use & Personality***
Martin R. Watts MD, Little Rock, AR
Samuel J. House MD, Sherwood, AR
John Casey MD, Little Rock, AR
Tiffany Howell PhD, Little Rock, AR (I)
Stacy M. Simpson MD, Little Rock, AR
Steven Domon MD, Little Rock, AR (I)
Zachary Stowe MD, Little Rock, AR (I)

T13 ***Child Abandonment in the Psychiatric Emergency Department***
Jessica Ee MD, Rochester, NY (I)
Maura Hanna DO, Rochester, NY (I)
Robert Weisman DO, Rochester, NY

T14 ***Effects of Legalized Recreational Cannabis on Youth***
Jeramy Peters DO, Portland, OR (I)
Joseph Chien DO, Marylhurst, OR

T15 ***Mental Health and Law in India***
Ganesan Gopalakrishnan MD, Hoskote, India (I)
Jagannathan Srinivasaraghavan MD, Carbondale, IL

T16 ***Violence Factors, Ambush Killers and Mental Illness***

Amina Z. Ali MD, New York, NY (I)
Panagiota Korenis MD, Eastchester, NY (I)
Ali Khadivi PhD, Providence, RI (I)

T17 ***Burn Baby Burn: Inpatient Evaluations of Firesetters***

Sigella Vargas MD, Bronx, NY (I)
Katya Frischer MD JD, New York, NY

T18 ***Violence Risk Assessment in Delusional Disorder Somatic Type***

Sanya Virani MD, Brooklyn, NY (I)
Meghaa Bhargava MD, Brooklyn, NY (I)
Jenna Hartman DO, Brooklyn, NY (I)
Lama Bazzi MD, Brooklyn, NY

T19 ***Comparison of Suicide Rate and Gun Laws in Developed Nations***
International Relations Committee

Aaima Sayed, Addison, IL (I)
Hassan A. Naqvi MD, Atlanta, GA (I)

T20 ***Suicide Contagion: Best Practices for Media Reporting***

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

OPENING CEREMONY — 8:00 AM – 10:00 AM — **CENTENNIAL BALLROOM D**

T21 ***What is Truth?***

Michael A. Norko MD, New Haven, CT

COFFEE BREAK — **10:00 AM – 10:15 AM**

WORKSHOP — 10:15 AM – 12:00 PM — **CENTENNIAL BALLROOM D**

T22 ***Truth to Power: Committee Chairs and the Presidential Theme***
Ethics Committee

Philip Candilis MD, Alexandria, VA
Aimee Kaempf MD, Tucson, AZ
Emily Keram MD, Santa Rosa, CA
Nathan Kolla MD, Toronto, ON, Canada
Richard Krueger MD, New York, NY

WORKSHOP — 10:15 AM – 12:00 PM — **MINERAL F-G**

T23 ***On Target? Legislating Gun Violence and the Mentally Ill***

Jeffrey Khan MD, Houston, TX
Ian Lamoureux MD, Rochester, MN
Megan Testa MD, Shaker Heights, OH

WORKSHOP — 10:15 AM – 12:00 PM — **MINERAL D-E**

T24 ***Tax Dollars at Work: Treating Inmates with Gender Dysphoria***

Keelin A. Garvey MD, Westborough, MA
Joel Andrade PhD LICSW, Westborough, MA (I)

PANEL — 10:15 AM – 12:00 PM — **AGATE**

T25 ***Pregnancy Denial and Neonaticide: Murderess or Victim?***

Margarita Abi Zeid Daou MD, Worcester, MA
Phillip Resnick MD, Cleveland, OH
William Kenner MD, Nashville, TN (I)

WORKSHOP — 10:15 AM – 12:00 PM — **MINERAL A-C**

T26 ***Will I Be Harmed at Work Today?***
Private Practice Committee

Trent C. Holmberg MD, Draper, UT
Sumit Anand MD, Charlottesville, VA (I)
Robert Granacher MD MBA, Lexington, KY
Navneet Sidhu MD, Alexandria, VA

LUNCH (TICKET REQUIRED) 12:00 PM – 2:00 PM **CENTENNIAL BALLROOM A-C**

T27 Reflections on Judging and the Mentally Ill

The Honorable John L. Kane (I)

PANEL 2:15 PM – 4:00 PM **CENTENNIAL BALLROOM D**

T28 Navigating the Stormy Seas of Competency Restoration
Forensic Hospital Services Committee

Kayla Fisher MD JD, Sacramento, CA
Ariana Nesbit MD, Sacramento, MA
Michael Champion MD, Honolulu, HI
Daniel Hackman MD, Louisville KY
Debra Pinals MD, Ann Arbor, MI

WORKSHOP 2:15 PM – 4:00 PM **MINERAL F-G**

T29 Prison Psychiatry in the UK: Pathways to the Health Service

Mary C. Whittle MB MRC Psy, London, United Kingdom
Alex Acosta-Armas MRCPsych, London, United Kingdom
John McAnallen MBBS MRCPsych, London, United Kingdom (I)
Gerard Waldron MRCPsych, London, United Kingdom (I)

DEBATE 2:15 PM – 4:00 PM **MINERAL D-E**

T30 Should Psychiatrists Ever Opine on the "Ultimate Question"?
Geriatric Psychiatry and the Law Committee

Karen Reimers MD, Minneapolis, MN
Sherif Soliman MD, Cleveland, OH
Carolyn L. Dessin JD, Akron, OH (I)
Adam M. Fried JD, Cleveland, OH (I)

RESEARCH-IN-PROGRESS #1 2:15 PM – 4:00 PM **AGATE**

T31 A Review of 53 Child Custody Evaluations

Barbara Kahn JD, Chicago, IL (I)
Jason Washburn PhD, Chicago, IL (I)
Stephen H. Dinwiddie MD, Chicago, IL

T32 Certification for Patients With AN: a 5-Year Review

Patricia Westmoreland MD, Denver, CO
Jane Miceli MD, Denver, CO (I)
Helena Winston MD, Aurora, CO (I)

T33 Update on the Assessment of Battered Woman's Syndrome Defense

Graham Glancy MD, Toronto, ON, Canada
Marissa Heintzman, Toronto, ON, Canada (I)
Adam Wheeler, Toronto, ON, Canada (I)

COURSE (TICKET REQUIRED) 2:15 PM – 6:15 PM **MINERAL A-C**

T34 The Clinical Detection of Malingered Mental Illness

Phillip Resnick MD, Cleveland, OH

COFFEE BREAK **4:00 PM – 4:15 PM**

PANEL 4:15 PM – 6:15 PM **CENTENNIAL BALLROOM D**

T35 The Suicide Prescription: Practical and Policy Problems

Jeffrey S. Janofsky, Timonium, MD
Michael Champion MD, Honolulu, HI
Annette Hanson MD, Baltimore, MD
Alexander Simpson FRANZCP, Toronto, ON, Canada

PANEL — 4:15 PM – 6:15 PM — **MINERAL F-G**

T36 ***Mental Illness and Crime: Are they Social Diseases?***

Merrill R. Rotter MD, White Plains, NY
Patrick Fox MD, Denver, CO
Debra Pinals MD, Ann Arbor, MI
Karen Rice MD, Longmont, CO (I)

WORKSHOP — 4:15 PM – 6:15 PM — **MINERAL D-E**

T37 ***The APA in the Courts***

Marvin S. Swartz MD, Durham, NC
Howard Zonana MD, New Haven, CT
Renée L. Binder MD, San Francisco, CA

PAPER SESSION #1 — 4:15 PM – 6:15 PM — **AGATE**

T38 ***Legislative Advocacy and Forensic Psychiatry Training***

Jennifer Piel MD JD, Seattle, WA
Rejoice Opara MD, Seattle, WA (I)

T39 ***Examination Disclosure as a Test of Adjudicative Competence***

Rebecca Brown DO, Cincinnati, OH
Bridget Casey-Leavell DO, Cincinnati, OH
Elliot Lee MD PhD, Fitchburg, WI
Christopher Marett MD, Cincinnati, OH
Douglas Mossman MD, Cincinnati, OH

T40 ***Nature, Nurture, and Attachment***

Stephen Billick, M.D., New York, NY
Alexandra Junewicz, New York, NY (I)

T41 ***The Challenge and Impact of Truth in Forensic Psychiatry***

Madelon Baranoski PhD, New Haven, CT (I)

MOCK TRIAL — 7:00 PM – 9:00 PM — **CENTENNIAL BALLROOM D**

T42 ***An Inquisitorial, Expert Consensus Panel Model***

Michael A. Norko MD, Durham, CT
John L. Kane JD, Denver, CO (I)
Jeffrey L. Metzner MD, Denver, CO
Phil Cherner JD, Denver, CO (I)
Rich Orman JD, Denver, CO (I)
Phillip J. Resnick MD, Cleveland, OH
William H. Reid MD, Horseshoe Bay, TX

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

T1 IMPACT OF PHARMACOTHERAPY ON CRISIS BED USAGE IN NYS PRISONS

Jonathan S. Kaplan MD, Poughkeepsie, NY
Stephanie Lilly MA, Marcy, NY
Megan Lape PhD, Marcy, N
Vaibhav, BA, Marcy, NY
Nicholas Vella, BA, Marcy, NY

EDUCATIONAL OBJECTIVE

The study will assess the impact of pharmacotherapy on crisis bed utilization in the New York State Prison system.

SUMMARY

The risk for dangerous behavior resulting in crisis increases when delusions, command hallucinations, threats of violence and a history of violence are present. Hence, optimal psychopharmacological treatment is essential. The objective of this study is to compare the benefits of long acting injectables, STAT medications and clozapine to inform crisis psychiatric service delivery in prison. Under the auspices of New York State Office of Mental Health, Central NY Psychiatric Center's Residential Crisis Treatment Program (RCTP) operates as a prison based comprehensive psychiatric emergency program with 7000 plus admissions per year. Participants will have had at least one admission to RCT. Demographic, mental health and criminogenic determinants of crisis bed usage will be examined; as well as the impact of pharmacotherapy on stabilization and reduction of subsequent RCTP utilization. Outcomes will include length of stay in RCTP, readmissions (crisis and inpatient) and duration of time between admissions. We anticipate that the type of specific pharmacotherapy will uniquely predict length of stay in a crisis bed unit as well as frequency of RCTP admissions and duration of stability. Patient demographics, mental health and criminogenic variables may be affected to a lesser extent.

REFERENCES

Bissos S, Veguilla MR, et al: The role of long-acting injectable antipsychotics in schizophrenia: a critical appraisal. Therapeutic advances in Psychopharmacology 4(5): 198-219, 2014
Likwack TR, Schlesinger LB: Applying Psychology to Criminal Proceedings, Dangerous Risk Assessments: Research, Legal and Clinical Considerations. The Handbook of Forensic Psychology-2nd ed. 171-217, 1999

QUESTIONS AND ANSWERS

Approximately, how many crisis bed admissions occur annually in New York State prisons?
a. 70
b. 700
c. 7000
d. 70000
ANSWER: c

How many crisis beds are found in New York State prisons?
a. 30
b. 60
c. 90
d. 110
ANSWER: d

T2 GUNNING FOR SAFETY IN SCHOOLS: IS CAMPUS CARRY THE ANSWER?

Sarina Adkins MS IV, Washington, DC
Eindra Khin Khin MD, Washington, DC

EDUCATIONAL OBJECTIVE

To review the history of concealed handgun laws in Texas leading to the legalization of campus carry. To examine the status of campus carry in colleges nationwide. To present evidence-based data evaluating common assertions regarding the necessity, safety and effectiveness of campus carry.

SUMMARY

On August 1, 2016, Texas became the eighth state to legalize the carrying of concealed handguns onto college campuses, only eight months after Texas legalized the open carrying of firearms statewide. Both events have rekindled

a nation-wide debate regarding the rights of citizens to bear arms amidst a seemingly increasing number of mass shootings in the U.S. Indeed, several states have expanded firearm rights throughout the years and are currently considering campus carry legislation. In the wake of shootings such as Sandy Hook and Virginia Tech, firearm rights advocates assert that allowing legally concealed weapons into classrooms and dormitories can potentially reduce the number of casualties should another active shooter event occur. Alternatively, firearm control advocates argue that allowing weapons on campus will not promote safety on campus, but instead endanger it. But what does the research say? Using Texas as an example, this study examines the history of firearm laws in Texas that led to the state's passage of campus carry. It also reviews the nationwide stance on campus carry. Finally, it presents data that evaluates common assertions regarding the necessity, safety and effectiveness of campus carry and provides recommendations for future research.

REFERENCES

Blair JP, Schweit KW: A Study of Active Shooter Incidents. Texas State University and Federal Bureau of Investigation, U.S. Department of Justice: Washington DC, 2014

Krouse W, Richardson D: Mass Murder with Firearms: Incidents and Victims 1999-2013. Congressional Research Service, 2015. Available at https://fas.org/sgp/crs/misc/R44126.pdf. Accessed August 31, 2017

QUESTIONS AND ANSWERS

The University of Texas has established implementation policies for campus carry that prohibit the presence of firearms at:

a. Research laboratories
b. Designated sole-occupant offices
c. Sporting events
d. Patient-care areas
e. All of the above

ANSWER: e

How many states currently allow licensed students to carry concealed weapons on campus?

a. 1
b. 8
c. 25
d. 50

ANSWER: b

T3 INTERDISCIPLINARY COURSE IN FORENSIC MENTAL HEALTH RESEARCH

Jennifer Piel, MD, JD, Seattle, WA
Edward Goldenberg, PhD, Seattle, WA

EDUCATIONAL OBJECTIVE

The authors describe an educational training approach aimed at increasing involvement in forensic psychiatry research. The program provides a model for collaborative research as well as peer mentorship for those wanting to continue in academic programs after graduation.

SUMMARY

Opportunities for mentored and collaborative research in psychiatry residency – and other healthcare training programs – are often limited. Here, we describe an interdisciplinary course aimed at collaborative research in the area of psychiatry and the law. Students and clinical trainees in multiple disciples (medicine, social work, nursing, law, psychology, and psychiatry) may participate in an elective course in psychiatry and the law. The course includes didactics on key concepts in forensic psychiatry and research. Participants are grouped into small mentorship teams with a faculty advisor and students from multiple disciplines. Assisted by their mentorship team, each student completes an individual research project. Based on survey, the course has received high ratings from participants. Trainees had improved knowledge and comfort with key topics in forensic psychiatry; research design and development; and interdisciplinary collaboration. Open-ended comments promoted values in professional development, specifically teamwork and creating an academic network. The interdisciplinary approach promotes teamwork and enhances learning from differing perspectives. Although this program is focused on forensic psychiatry research, similar programs could focus on other areas of psychiatry or medicine. The program provides a model for collaborative research and peer mentorship for those wanting to continue in academic programs after graduation.

REFERENCES
Ferguson KJ, Wolter EM, Yarbough DB, et al: Defining and describing medical learning communities: results of a national survey. Academic Medicine 84(11): 1549-56, 2009
Lord JA, Moutzanos E, McLaren K, et al: A peer mentoring group for junior clinician educators: four years' experience. Academic Medicine 87(3): 387-383, 2012

QUESTIONS AND ANSWERS
Key attributes of mentorship teams include
a. Promote teamwork
b. Develop an academic support network
c. Leadership development
d. All of the above
ANSWER: d

The following is true of mentorship teams in promoting academic work:
a. Provide aspects of accountability
b. Provide collaboration and information sharing
c. Provide mutual learning
d. All of the above
ANSWER: d

T4 CLINICIANS ' ATTITUDES TOWARD EXPERIMENTAL DRUGS

Jennifer Piel, MD, JD, Seattle, WA

EDUCATIONAL OBJECTIVE
Fueled by media portrayals of use of experimental drugs for Ebola and other conditions, there has been a renewed interest in access to experimental drugs. This poster reviews clinicians' views on access to experimental agents and implications for clinicians performing assessments for capacity and informed consent to such treatments.

SUMMARY
There has been renewed interest in patient access to experimental treatments in recent years. More than 20 states have passed right-to-try bills aimed at increasing access to experimental treatments by bypassing some FDA requirements. Although right-to-try laws have yet to be upheld by the courts, there are other avenues by which patients obtain experimental treatments, such as formal research protocols or the FDA's expanded access and compassionate use measures. These channels prompt discussion of attitudes toward experimental treatments and informed consent to experimental agents. This pilot study examines the attitudes of mental health clinicians toward access to experimental treatments. I surveyed clinicians about their experiences with terminal illness, desire for autonomy in medical treatment, and opinions about access to experimental treatments, both for their patients and personally. There was a split in responses between psychiatrists and non-physician clinicians with respect to several study questions. Non-physician clinicians viewed favorably allowing easier access to experimental treatments and rated higher the likelihood of therapeutic benefit from an experimental drug. Physicians demonstrated a negative bias toward experimental agents that have not gone through the FDA process. The results have implications for possible bias in assessing patients' abilities to give informed consent to experimental treatments.

REFERENCES
Piel JL: Informed consent in right-to-try cases, J Am Acad Psychiatry Law 44(3): 290-296, 2016
Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach, 495 F.3d 695 (D.C. Cir. 2007) (en banc)

QUESTIONS AND ANSWERS
Risks with experimental agents include:
a. Uncertainty as to possible side effects of the agent
b. Patients medical insurance may not cover management of side effects from the experimental agent
c. Drug manufactures can charge for the drug
d. All of the above
ANSWER: d

Right-to-try laws permit patients to request experimental treatments once the treatments have passed which phase of the FDA's clinical regulatory testing?
a. No FDA clinical testing required
b. Phase I
c. Phase II
d. Phase III
ANSWER: b

T5 CA 'S NEW END OF LIFE OPTION ACT IN AN ACADEMIC INSTITUTION

Anna Glezer MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

Participants will become familiar with California 's End of Life Option Act and its provisions and learn about the challenges and questions raised in implementing this at UCSF, learning about issues of capacity, voluntariness, and ethics.

SUMMARY

End of Life Option Act is a new California law that went into effect on June 9, 2016. It allows patients who have a terminal disease, (with a life expectancy of less than six months) to request a life-ending drug prescription from their doctor. At UCSF, for a patient to request a life-ending drug prescription from their doctor, they must be under the care and treatment of that provider for their terminal disease and meet the several other criteria. This poster will discuss the differences between states and institutions, teach about capacity assessments for patients making this difficult decision, and touch on the ethics of participation by physicians.

REFERENCES

UCSF's Policy on the End of Life Option Act. Available at https://www.ucsfhealth.org/education/end_of_life_option_act/. Accessed August 31, 2017
California Medical Association's Document #3459: The California End of Life Option Act. Available at http://www.cmanet.org/resource-library/detail/?item=the-california-end-of-life-option-act. Accessed August 31, 2017

QUESTIONS AND ANSWERS

Which of the following is a requirement a patient must meet to be able to use the Act?
a. Must be 18+ years old
b. Must be a resident of California
c. Must have a terminal disease with probable end of life within 6 months
d. Must make two verbal requests 15 days apart and one written request
e. Must be able to take the life-ending drug without assistance
f. All of the above
ANSWER: f

Is physician participation (such as a consultation psychiatrist evaluating the patient who is interested in using the Act) mandatory if a hospital has chosen to participate?
a. Yes
b. No
c. It depends on the institution/hospital's written code
ANSWER: b

T6 VIOLENCE RISK AND THE SCHOOL SHOOTER PHENOMENON

R. Ryan Leahy, Miami Beach, FL

EDUCATIONAL OBJECTIVE

To discuss a case report of an adolescent who presents with involuntary commitment after threatening to shoot students at his school, to discuss the school shooter phenomenon, violence risk and prevention.

SUMMARY

This poster will describe a case report involving a 13 year old male who presented to an urban inpatient child and adolescent psychiatry unit involuntarily with verbal threats of violence including “shooting up his school” and concerns for violence risk that became even greater following psychological testing. The poster will include results from the CDI and SCARED rating scales , the Rorschach, Projective Drawings and the Youth Psychopathology Index. The poster will go on to define mass murder with special emphasis on school shooters. It will describe recent trends

in school shooting incidents as well as common motivations, personality traits, and typology of warning behaviors seen with school shooters and how they differ from adults. The poster will discuss the notions of "leakage" and "contagion, and the influence of media on school shooting incidents. The poster will discuss threat assessment and common violence risk assessments for adolescents, advocate for better screening measures in non-forensic settings and features that would warrant more intensive follow up before one has offended. It will conclude with suggestions for decreasing risk including prevention strategies, and the role mental health professionals, in particular, child and adolescent psychiatrists can play in decreasing risk.

REFERENCES

O'Toole ME: The school shooter: A threat perspective. Quantico: FBI Academy National Center for the Analysis of Violent Crime, 2000
Vossekuil B, Fein RA, Reddy M, et al: The final report and findings of the safe school initiative: Implications for the prevention of school attacks in the United States. Washington, DC: United States Secret Service, 2004

QUESTIONS AND ANSWERS

A common personality trait or behavior seen in school shooters includes which of the following
a. Poor coping skills
b. Low tolerance for frustration
c. Narcissism
d. Alienation
e. All of the above
ANSWER: e

In a study of 37 incidents of targeted school violence in the United States, the percentage where one person had information that a person was thinking of or planning a school attack was:
a. 20%
b. 40%
c. 60%
d. 80%
ANSWER: d

T7 THE FORENSIC EXPERIENCE IN PSYCHIATRY RESIDENCY TRAINING

Viral Goradia, MD, Liverpool, NY
Bruce Way MD, Ottawa, ON, Canada
James Knoll IV MD, Syracuse, NY

EDUCATIONAL OBJECTIVE

The purpose of this study is to investigate the forensic training exposure in general psychiatry residency training programs. The ultimate goal of this study will be to use collected data to make recommendations towards developing a minimum core curriculum for forensic training to general residents.

SUMMARY

Most psychiatry residency programs provide little to no exposure in forensic psychiatry, both, in terms of the length of the rotation as well as the depth and breadth of the forensic curriculum. Training programs end up creating a pool of psychiatry graduates who have 3-5 days of forensic psychiatry exposure over a 4-year period. Medico-legal issues and risk assessments in psychiatry are pivotal to a resident's training from Day One and yet many residency programs do not have their residents fulfill their forensic psychiatry requirements until their fourth year of residency. Forensic psychiatry is the only major subspecialty to not have a FTE requirement as per ACGME and the core requirements are vague. A voluntary and anonymous survey will be sent out to members of the forensic psychiatry community (AAPL) to develop minimum expectations for what a graduating resident's exposure to forensic psychiatry should be. They will be asked to rate possible forensic experiences on a scale from 1 (not at all important) to 5 (critically important.) Based on the data collected, a second survey will be sent out nationwide to PGY- 3&4 psychiatry residents to gather data on what their forensic experience consists of.

REFERENCES

Schouten R: Law and psychiatry:what should our residents learn? Harvard Rev Psychiatry 9(3):136-139, 2009
Lewis C: Teaching forensic psychiatry to general psychiatry residents. Academic Psychiatry 28(1):40-46, 2004

QUESTIONS AND ANSWERS

Which of these subspecialties within psychiatry does not have a FTE (Full Time Equivalent) requirement as per ACGME (American Council of Graduate Medical Education) guidelines?

a. Addiction Psychiatry
b. Forensic Psychiatry
c. Child and Adolescent Psychiatry
d. Psychosomatic Medicine

ANSWER: b

Which of these is a core forensic psychiatry requirement as per the ACGME requirements for general psychiatry residency training?

a. Appropriateness for commitment
b. Psychiatric Malpractice
c. Correctional psychiatry
d. Sex offender evaluation & treatment

ANSWER: a

T8 **OUTCOMES OF 20-DAY INPATIENT COMPETENCE TO STAND TRIAL EVALUATIONS**

David Sahadevan MD, Westerville, OH
Maryam Jahdi MD MPH, Columbus, OH
Matthew P. Arrowsmith MD, Columbus, OH
Douglas A. Misquitta MD, Hilliard, OH
Delaney Smith MD, Columbus, OH

EDUCATIONAL OBJECTIVE

To study diagnostic impressions and eventual findings regarding competence to stand trial of defendants whose evaluation was unsuccessful in outpatient or corrections settings, resulting in inpatient evaluation. We attempt to describe the underlying causes for these admissions, with the hope of minimizing the use of scarce inpatient resources.

SUMMARY

The Ohio Revised Code section 2945.371 provides, in cases where concerns regarding competence to stand trial arise, for evaluation of the defendant's present mental condition. Most of these evaluations occur in the outpatient setting if the defendant is released on bail, or at their place of detention. However, if the forensic examiner is unable to complete the evaluation and opine regarding competence, at the examiner's request the court may order an evaluation at a "center, program, or facility operated or certified by the department of mental health and addiction services or the department of developmental disabilities where the defendant may be held for evaluation for a reasonable period of time not to exceed twenty days." Potential reasons for inpatient evaluation include refusal to cooperate or submit to evaluation due to paranoid delusions or psychosis, malingering, or an unclear presentation precluding the examiner opining with confidence. Given the number of these inpatient evaluations requested, and the considerable use of limited inpatient beds to accommodate them, examination of the outcomes of these evaluations is undertaken, by retrospective review of discharge summaries, the resulting court report, and/or review of public records regarding the eventual finding by the court regarding competence.

REFERENCES

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Geller JL, Fisher WH, Kaye NS: Effect of evaluations of competency to stand trial on the state hospital in an era of increased community services. Hosp Community Psychiatry 42:818-823, 1991

QUESTIONS AND ANSWERS

Where can competence to stand trial evaluations be conducted in Ohio?

a. In outpatient settings if released on bail
b. In the place of detention
c. In inpatient settings
d. All of the above

ANSWER: d

What are some possible reasons outpatient competency evaluations may result in no opinion being rendered?
a. Psychotic disorders
b. Malingering or antisocial behavior
c. Mood disorders
d. All of the above
ANSWER: d

T9 **POSTER WITHDRAWN**

T10 **UPDATE ON GUN CONTROL AND MENTAL ILLNESS: IMPACT ON PRACTICE**

Lisa Anacker MD, Ann Arbor, MI
Debra A. Pinals MD, Ann Arbor, MI
O. Lizette Solis MD, San Antonio, TX

EDUCATIONAL OBJECTIVE
By reviewing this poster, participants will be able to 1) describe recent case law related to gun ownership and mental illness; 2) delineate background legislation and its evolution; 3) discuss clinical practice implications of this shifting landscape

SUMMARY
Gun control legislation continues to garner a significant amount of public attention in the United States, especially as tragic mass shootings have become more common and highly publicized, and gun ownership becomes increasingly politicized. Issues of gun violence remain controversial, especially when there are specific concerns about how these issues relate to mental illness. Because the general public often looks to mental health professionals to predict or stop acts of gun violence, it is important to understand the legal foundation, clinical implications, and the currently known data related to firearms and mental illness. To increase awareness of the mental health professional on this important topic, this poster will review recent legal cases related to gun ownership in the United States, especially as they concern mental illness. Updated review of gun control laws on both the state and national level, including a review of the recent ruling striking down the Florida "gun-gag" law that prohibited physician inquiry into firearm safety and other cases will be described. Understanding the background and current developments of these important issues will aid the forensic professional on matters pertaining to firearm related risk assessment, relief from disabilities and other assessments.

REFERENCES
Pinals D, Anacker L: Mental Illness and Firearms: Legal Context and Clinical Approaches, in Psychiatric Clinics of North America. Edited by Knoll J. Pennsylvania: Elsevier 39(4):611 – 621, 2016
Parmet WE, Smith JA, Miller MJ: Wollschlaeger v. Governor of Florida — The first amendment, physician speech, and firearm safety. N Engl J Med. 374:2304-7, 2016

QUESTIONS AND ANSWERS
Federal law mandates disqualification of individuals from owning certain firearms in which of the following situations:
a. Voluntary psychiatric hospitalization
b. A diagnosis of mental illness by a physician
c. Court ordered commitment to psychiatric treatment
d. Voluntary outpatient treatment
ANSWER: c

Legal themes that have been incorporated into legislation related to firearm access include all of the following except:
a. "Gun-gag" laws prohibiting physician inquiry into firearm safety
b. Restrictions on adolescent access to guns
c. Relief from disabilities
d. Gun violence restraining orders
ANSWER: b

T11 ASSISTED SUICIDE DEBATE COMES TO MINNESOTA

Benjamin Otopalik, MD, MPH, Minneapolis, MN
Chinmoy Gulrajani, MD, Minneapolis, MN

EDUCATIONAL OBJECTIVE

This poster provides education on the recent legal debate in Minnesota regarding assisted suicide.

SUMMARY

Last year, the debate on assisted suicide (AS) concluded another chapter in the Minnesota state courts. In State v. Final Exit Network, Inc. the Minnesota Court of Appeals upheld the constitutionality of a state statute barring AS. This poster outlines and explores the consequences of this ruling for Minnesota physicians. In Final Exit, the defendant argued that the statute, which criminalizes "intentionally assisting another in taking (their) own life," violates the First Amendment. The Court's opinion relied on a Minnesota Supreme Court case State v. Melchert-Dinkel in which the Court (a) narrowed the statute's language by remanding the overly broad terms "encouraging" and "advising" suicide from the statute and (b) upheld the constitutionality of barring "assisted" suicide because such a restriction serves a compelling state interest to preserve and protect human life. State v. Final Exit highlights the ethical and legal arguments surrounding AS. The case represents a new avenue for countering AS bans by addressing whether such restrictions unconstitutionally restrict free speech. The ruling does not specifically target physicians but rather is broader to include healthcare and non-healthcare providers alike. These opinions provide clear legal guidance for Minnesota physicians who may find themselves involved in AS cases.

REFERENCES

State v. Final Exit Network, Inc., Minn. Court of Appeals (2016)
State v. Melchert-Dinkel, 844 N.W.2d 13 (Minn. 2014)

QUESTIONS AND ANSWERS

In State v. Final Exit Network, Inc., the Minnesota state court of appeals upheld the constitutionality of a Minnesota state statute barring assisted suicide. The defendant argued that the statute unfairly restricted free speech. The court disagreed, primarily because:

a. Assisted suicide is inconsistent with the historical values of American society.
b. Final Exit is not a Minnesota-based company, and therefore does not have equal protection under the law.
c. The statute serves a compelling state interest and is neither overly broad nor narrow.
d. Assisted-suicide is a political issue that should be voted on by the public.
ANSWER: c

Despite national efforts to legalize the practice, Minnesota is joined by the majority of other states in banning assisted-suicide. The United States Supreme court cases Washington v. Glucksberg and Vacco v. Quill are considered the seminal cases in protecting such bans. Both cases involved legal challenges based on which of the following amendments to the United States Constitution?

a. First Amendment (Freedom of speech)
b. Ninth Amendment (Protects rights not specifically outlined in the Constitution)
c. Tenth Amendment (Powers not delegated to the United States are reserved for individual states)
d. Fourteenth Amendment (Due process and equal protection)
ANSWER: d

T12 JUVENILE SEX OFFENDER TREATMENT: SUBSTANCE USE & PERSONALITY

Martin R. Watts MD, Little Rock, AR
Samuel J. House MD, Sherwood, AR
John Casey MD, Little Rock, AR
Tiffany Howell PhD, Little Rock, AR
Stacy M. Simpson MD, Little Rock, AR
Steven Domon MD, Little Rock, AR
Zachary Stowe MD, Little Rock, AR

EDUCATIONAL OBJECTIVE

As little systematic research has examined factors associated with juvenile sex offender treatment completion, the objective is to provide preliminary scientific findings regarding the possible association of substance use history, personality factors, and treatment completion vs. dropout.

SUMMARY
Of the sexual offenders who offend against minors, likely >1/3 are juveniles, and in 2014 juveniles accounted for nearly 1/5 of the 1,501 arrests for rape (Uniform Crime Reports 2015.) While the magnitude of juvenile sexual offending is considerable, as is its impact on victims, families, offenders, and society at large, factors that may attenuate or amplify the risk of offending are not yet fully elucidated. Evidence suggests that treatment of juvenile sex offenders is effective for improving function and reducing recidivism of both sexual and non-sexual offenses (Worling and Curwen 2000); however, little systematic research has been conducted to investigate factors associated with treatment completion vs. dropout. This study, a preliminary retrospective chart review of 144 male juvenile inpatients in a sex offender treatment program, examines the potential impact of factors including personality pathology and substance use history on treatment completion rates. Treatment completion among patients with substance use histories, specific substance use disorders, and exposure to substance use were compared to completion rates among patients without the respective exposure. Associations of MMPI scale elevations with treatment completion were also examined. Ultimately, these data may provide insight to improve treatment completion rates for juvenile sex offenders.

REFERENCES
Seto M, Lalumiere M: What is so special about male adolescent sexual offending? A review and test of explanations through meta-analysis. Psychol Bull 136(4): 526-75, 2010
Worling, J, Curwen, T: Adoloscent sexual offender recidivism: success of specialized treatment and implications for risk prediction. Child Abuse and Neglect 24(7): 965-982, 2000

QUESTIONS AND ANSWERS
Juvenile sex offenders who receive specialized treatment exhibit _____ recidivism rates for sexual offenses and _____ recidivism rates for non-sexual offenses compared to peers who did not receive treatment.
a. similar, similar
b. decreased, similar
c. decreased, decreased
ANSWER: c

Juvenile sex offenders are _____ likely to use drugs and alcohol compared to peers who offend non-sexually.
a. more
b. less
c. just as
ANSWER: b

T13 CHILD ABANDONMENT IN THE PSYCHIATIC EMERGENCY DEPARTMENT

Jessica Ee, MD, Rochester, NY
Maura Hanna, DO, Rochester, NY
Robert Weisman, DO, Rochester, NY

EDUCATIONAL OBJECTIVE
To discuss the legal, community, and healthcare systems based issues that are confronting families, patients, and emergency department services in cases of children being abandoned in the psychiatric emergency department.

SUMMARY
New York State law classifies a child as abandoned if the guardian "forego[es] his or her parental rights and obligations as manifested by his or her failure to visit the child and communicate with the child… although able to do so." Resident physicians within a university psychiatric emergency department have noticed a significant increase in child abandonment cases involving children with developmental disabilities or autism spectrum disorders. Although several children were connected to multiple community services, their complex needs failed to be met prompting presentations for chronic behavioral issues. Behaviors not improved, and typically worsened, during inpatient admissions. Though cleared for discharge, these individuals are left for days in an acute setting without a legal status to retain them, yet lack the capacity to leave. These children require intensive staff support at an expense greater than the average $1300/emergency department visit covered by insurance. The cases are reported to Child Protective Services, but this leverages little support or incentive for families to bring their children home. This case report describes one patient abandoned in the psychiatric emergency department repeatedly and illustrates several of the legal, community and systems based issues confronting families, patients and emergency department services.

REFERENCES
New York State Legislature Law Database. Available at http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: Social Services Law 384-b. Accessed August 31, 2017
Easterseals. Available at http://www.easterseals.com/. Accessed August 31, 2017

QUESTIONS AND ANSWERS
What is the legal definition of child abandonment according to New York State Law
a. A child left alone
b. A child whose parents live in another house
c. A child whose physical health, mental health, safety and welfare are ignored
d. A child whose parents do not visit or communicate with the child though are able to do so
ANSWER: d

Under what legal status are children held while abandoned by their guardians in the psychiatric emergency department.
a. 9.39
b. 9.13
c. No status
d. 9.27
ANSWER: c

T14 EFFECTS OF LEGALIZED RECREATIONAL CANNABIS ON YOUTH

Jeramy Peters, DO, Portland, OR
Joseph Chien, DO, Marylhurst, OR

EDUCATIONAL OBJECTIVE
To learn about the growing trend towards legalizing recreational cannabis, and explore the effects that acceptance of cannabis use and the burgeoning cannabis industry has on the vulnerable population of children and adolescents.

SUMMARY
Currently, recreational cannabis for adults is legal in eight states and the District of Columbia, and the list is growing. This poster explores current trends in legalization of recreational cannabis, the growing cannabis industry, and changes in THC potency and means of consuming cannabis as a result of these changes. Specifically, we examine how some of the marketing efforts of the cannabis industry for new forms of cannabis, such as edibles, are being made to look almost indistinguishable from candy products, and may target children or be mistakenly consumed by children. The potential effects of the higher visibility of cannabis products, as well as higher potency products, is also explored in the context of research that suggests that younger populations may be more vulnerable to cognitive impairment and more susceptible to developing psychosis with cannabis use.

REFERENCES
Wilkinson ST, Yarnell S, Radhakrishnan R, et al: Marijuana legalization: Impact on physicians and public health. Annu Rev Med. 67:453-466, 2016
Pierre JM: Risks of increasingly potent cannabis: The joint effects of potency and frequency. Current Psychiatry 16(2): 15-20, 2017

QUESTIONS AND ANSWERS
How did the popular opinion about cannabis change in States after the legalization of recreation and/or medicinal cannabis?
a. People felt cannabis was less dangerous
b. People felt cannabis was more dangerous
c. The opinion did not change
d. People felt cannabis was more dangerous for adults and less dangerous for children
ANSWER: a

Leading members of the cannabis industry have remarked that the industry is basing their marketing and development concepts after what current market?
a. Fast Food
b. Tobacco
c. Children's Toys
d. Point of Sale
ANSWER: b

T15 MENTAL HEALTH AND LAW IN INDIA

Ganesan Gopalakrishnan MD, Hoskote, India
Jagannathan Srinivasaraghavan MD, Carbondale, IL

EDUCATIONAL OBJECTIVE

This presentation provides an overview of the need to develop the current laws relating to mental health delivery systems in India. The relevant new amendments to the existing laws are to be discussed in detail and their implications for forensic psychiatry in India.

SUMMARY

The laws governing Mental Health Care in India are aimed at safeguarding public from dangerous patients by isolating them from public. However, in the contemporary world, there has been a paradigm shift from custodial care to community care and from charity based to rights based approach. The epidemiological studies of psychiatric disorders in India estimate the prevalence of Mental Disorders vary from 9.5-370/1000. The provision of mental health care in India is unsatisfactory because of stigma, inadequate budget and acute shortage of trained professionals. The tragedy in Erwadi (2001), where 28 inmates of a faith-based mental asylum were burnt alive, triggered the National Human Rights Commission India to make recommendations and suitable legislation for the care of the mentally ill. The laws relating to mental health care in India to be addressed include Mental Health Act, 1987, The Protection of Children from Sexual Offenses Act, 2012 Narcotic Drugs & Psychotropic Substances Act, 1985, National trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation & Multiple Disabilities Act, 1999, Persons with Disabilities Act, 2012, Protection of Human Right Act, 1993, Protection of Women from Domestic Violence Act, 2005, and Rehabilitation Council of India Act, 1992.

REFERENCES

Gopalakrishnan G: Forensic psychiatry update. Indian Journal of Psychiatry 58(2): 2016
Asokan TV: Forensic psychiatry in India: the road ahead. Indian Journal of Psychiatry 56(2): 121-7, 2014

QUESTIONS AND ANSWERS

Which of the following governs mentally ill in India?
a. Indian Lunacy Act of 1912.
b. Mental Health Act 1987
c. National Mental Health Care Act 2010
ANSWER: b

Which of the following was enacted most recently?
a. Persons with Disabilities Act
b. National Mental Health Care Bill
c. Protection of Children from Sexual Offenses Act
ANSWER: b

T16 VIOLENCE FACTORS, AMBUSH KILLERS AND MENTAL ILLNESS

Amina Z. Ali MD, New York, NY
Panagiota Korenis MD, Eastchester, NY
Ali Khadivi PhD, Providence, RI

EDUCATIONAL OBJECTIVE

To educate the forensic community about violent risk factors in those that commit ambush killings and alert them of the increased incidence of ambush killings in the United States.

SUMMARY

On average, 47 felonious police deaths occur annually in the United States. Of these, 10 occur annually in the context of police ambush shootings. Police ambush shootings are defined as predatory and sudden attacks on police officers with the intent to kill or injure. Data shows that alleged offenders in the felonious killings of officers share certain characteristics, including predominately male offenders, having prior arrests, and being under the influence of controlled substances or alcohol at the time of the incident. This poster will review the police ambush killings from 2015 to present, using publicly available sources such as FBI websites and media. It will identify commonalities between the perpetrators and risk factors for violence and compare these assailants to 2 control populations. The first population will consist of violent offenders with no mental illness and no history of targeting police while the second group will consist of mentally ill violent offenders who have no history of targeting police. Using these populations the risk factors for violence in mental illness will be reviewed. In comparing these 3 groups we aim to assess the relationship between mental illness and violence and educate the forensics community.

REFERENCES
U.S Department of Justice. Available at https://ucr.fbi.gov/leoka/leoka-2010/officers-feloniously-killed. Accessed February 1, 2017
CNN. Fallen Officers: Separated by thousands of miles, united by similar dangers. Available at http://www.cnn.com/2015/08/03/us/police-officers-killed-nationwide/. Accessed February 1, 2017

QUESTIONS AND ANSWERS
What factor is not considered a risk factor for violence?
a. alcohol use
b. past history of violence
c. having children
d. male gender
ANSWER: c

What trend has been seen in ambush killings in recent years?
a. decrease in killings
b. increase in killings
c. no change
d. 50% decrease in killings
ANSWER: b

T17 BURN BABY BURN: INPATIENT EVALUATIONS OF FIRESETTERS

Sigella Vargas MD, Bronx, NY
Katya Frischer MD JD, New York, NY

EDUCATIONAL OBJECTIVE
The presentation will educate forensic science community about the relationship between fire setters and mental illness.

SUMMARY
As documented by the National Fire Protection Association, an estimate of 282,600 intentional fires was reported to U.S. fire departments each year during 2007-2011. In 2013 U.S. fire departments responded to an estimated 29,200 home structure fires that were set intentionally Fire-setting behaviors are described in the DSM but also have legal implications. The literature has shown that common motives for fire setting revolve around psychosis (88%), revenge/anger (34%) and suicide (20%). Psychiatric patients admitted with firesetting behaviors present a diagnostic and treatment challenge for the treatment team. This poster will present the cases of three patients who were admitted to a community hospital inpatient psychiatric unit in the context a fire setting incident. We will discuss risk assessments, factors considered in discharge planning, diagnostic questions and questions of recidivism that are commonly raised in these types of cases.

REFERENCES
Burton PRS, McNiel DE, Binder RL: Firesetting, arson, pyromania, and the forensic mental health expert. Am Acad Psychiatry Law 40(3):355-65, 2012
Repo E, Virkkunen M: Criminal recidivism and family histories of schizophrenic and non schizophrenic fire setters: comorbid alcohol dependence in schizophrenic fire setters. J Am Acad Psychiatry Law 25(2):2017-215, 1997

QUESTIONS AND ANSWERS
What is the most is the most likely diagnosis associated with fire setting?
a. Schizophrenia
b. Bipolar Disorder
c. Psychopathy
d. Borderline Personality Disorder
ANSWER: a

What is the likelihood a firesetting incident is associated with a diagnosis of schizophrenia?
a. 20 times greater than the general population
b. 10 times greater than the general population
c. 5 times greater than the general population
d. 8 times greater than the general population
ANSWER: a.

T18 VIOLENCE RISK ASSESSMENT IN DELUSIONAL DISORDER SOMATIC TYPE

Sanya Virani MD, Brooklyn, NY
Meghaa Bhargava MD, Brooklyn, NY
Jenna Hartman DO, Brooklyn, NY
Lama Bazzi MD, Brooklyn, NY

EDUCATIONAL OBJECTIVE
To describe Delusional Disorder, Somatic Type cases presenting for admission due to imminent dangerousness and premeditated violence. To explore the events leading to violent threats and subsequent planned attacks on physicians. To describe the importance of violence risk assessments in Delusional Disorders, including Somatic Type, not traditionally associated with violence.

SUMMARY
The DSM-5 characterizes Delusional Disorder (DD) by the presence of delusions for longer than 1 month, without bizarre behavior or functional impairment. Somatic Subtype (SS) delusions center on bodily functioning/sensations. The lifetime prevalence of DD, all subtypes is about 0.2%. Delusional Disorder, Persecutory Subtype (DD-PS) is most common, making SS exceedingly rare. Unlike PS, SS is not traditionally described as increasing dangerousness or violence risk. Our extensive literature review revealed only one case where Delusional Disorder, Somatic Subtype (DD-SS) was implicated in elevating a mass shooter's violence risk. We describe two cases of DD-SS, both presenting as imminently dangerous and threatening. Both patients were psychiatrically involuntarily hospitalized after their doctors called 911 to report that the patient was threatening them with a weapon. Both patients, who had no established psychiatric diagnoses, were evaluated thoroughly and diagnosed with DD-SS. Both cited frustration with their physician, who they perceived as indifferent to their needs, as triggers for planning the attacks on the doctors. Thorough violence risk assessments are not usually performed in DD-SS. Our cases demonstrate that DD-SS can be associated with premeditated violence and formal psychiatric violence risk assessments remain a useful tool to methodically stratify and effectively address violence risk.

REFERENCES
Meloy, JR, Hoffmann J, Guldimann A, et al: The role of warning behaviors in threat assessment: an exploration and suggested typology.
Behav Sci Law 30(3):256-279, 2012
Sarteschi C: Severe mental illness, somatic delusions, and attempted mass murder. Psych Behav Sci 61(1):284-287, 2016

QUESTIONS AND ANSWERS
What is the most common symptom reported by patients with delusional disorder?
a. Irritability
b. Depressive mood
c. Self-reference
d. Aggressiveness
e. Suspiciousness
ANSWER: c

Which of these is not a core component of dangerousness?
a. Magnitude
b. Likelihood
c. Imminence
d. Premeditation
e. Frequency
ANSWER: d

T19 COMPARISON OF SUICIDE RATE AND GUN LAWS IN DEVELOPED NATIONS

Aaima Sayed, Addison, IL
Hassan A. Naqvi MD, Atlanta, GA

EDUCATIONAL OBJECTIVE
Inform the audience of various gun laws in the world's most developed nations - Discuss the relationship between gun laws and suicide rates - Discuss the impact of Australia's gun restrictions on suicide rates

SUMMARY
The CDC reports 42,733 Americans died by suicide in 2014, making it the tenth leading cause of all deaths in the country. Half of these deaths involved the use of firearms. Despite epidemiologists' and politicians' label of gun violence in the United States as an ongoing "epidemic," few major legislative changes have occurred in the past decade to address such an alarming death toll. This poster compares the total incidence of suicide, incidence of suicide by firearms, and national gun laws of the ten nations with the highest United Nations Human Development Index of 2015 (Norway, Australia, Switzerland, Denmark, Netherlands, Germany, Ireland, United States, Canada, New Zealand). Special attention is paid to Australia, whose National Firearms Act of 1996 has sparked intense debate regarding its effect on Australian suicide rates.

REFERENCES
Chapman S, Alpers P, Jones M: Association between gun law reforms and intentional firearm deaths in Australia, 1979-2013. JAMA 316(3):291-299, 2016
Suicide and Self-Inflicted Injury. Available at https://www.cdc.gov/nchs/fastats/suicide.htm. Accessed August 31, 2017

QUESTIONS AND ANSWERS
Between 1979 and 2013, firearm suicide accounted for what component of total intentional firearm deaths?
a. 24%
b. 44%
c. 64%
d. 84%
ANSWER: d

In 2013, which of the countries with the top ten Human Development Index had the highest suicide rate?
a. Australia
b. Canada
c. Norway
d. United States
e. Ireland
ANSWER: d

T20 SUICIDE CONTAGION: BEST PRACTICES FOR MEDIA REPORTING

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

EDUCATIONAL OBJECTIVE
To review the existing literature on the effect of media on suicide contagion. To identify interventions/guidelines aimed to help reduce this effect. To examine novel risks of suicide contagion, including the role of social media. To highlight the psychiatrist's role in helping to mitigate the effect of suicide contagion.

SUMMARY
The role of the media (non-fictional and fictional) in suicide contagion has been well established, ostensibly beginning with the publication of Goethe's "The Sorrows of Young Werther." Some countries have implemented guidelines for the media to use in an attempt to mitigate the risk they may play in suicide contagion. Since the end of the 20th century, however, several new forms of media (eg: websites, blogs, social media, mobile applications) have emerged and have quickly been adopted as a primary form of social interaction for many people, especially adolescents and young adults. This study will briefly review the current suicide statistics and analyze the existing literature regarding suicide contagion and the media. We will discuss special populations who are susceptible (eg: adolescents) as well as contribute (eg: celebrities) to suicide contagion. We will review guidelines and other interventions that have been implemented, examine their content and effectiveness, and consider what, if any, modifications should be made. We will also explore the role of the new forms of media in suicide contagion. Finally, we will examine the psychiatrist's role in helping to mitigate the established, and novel, risks of suicide contagion.

REFERENCES
Pirkis J, Blood RW: Suicide and the media. Part I: Reportage in nonfictional media. Crisis 22(4):146-54, 2001
Maloney J, Pfuhlmann B, Arensman E, et al: How to adjust media recommendations on reporting suicidal behavior to new media developments. Arch Suicide Res 18(2):156-169, 2014

QUESTIONS AND ANSWERS

All of the following are recommended guidelines for media reporting on suicide EXCEPT for:
a. Take the opportunity to educate the public about suicide.
b. Use language that normalizes suicide or presents it as a solution to problems.
c. Avoid prominent placement and undue repetition of stories about suicide.
d. Avoid explicit description of the method used in a completed or attempted suicide.
ANSWER: b

Suicide contagion is best described as:
a. A higher number of observed cases occurring in space and/or time than would typically be expected.
b. The process by which one suicide becomes a compelling model for successive suicides.
c. The spread of a virus that leads to suicide.
d. None of the above.
ANSWER: b

T21 **WHAT IS TRUTH?**

Michael A. Norko MD, New Haven, CT

EDUCATIONAL OBJECTIVE

At the conclusion of this program, participants will be able to: discuss various spiritual dimensions of forensic psychiatric practice; assess their own sense of calling to healthcare; and imagine the potential for larger truths and healing in a courtroom in which lawyers and mental health experts together viewed their work as healing vocation.

SUMMARY

My title is the query put to Jesus by Pilate in John's account of the trial of Jesus (Jn 18: 38). It is a profound question, with obvious importance to the field of forensic psychiatry. I wish to use this question as a probe, a tool with which to unearth the terrain of a spirituality of forensic psychiatry. Spiritual exploration is a personal matter; it is about relatedness. I choose to approach it from within, as an individual privileged by membership in a group of devoted colleagues, to whom this effort is addressed. This search begins with a definition of spirituality, such that we might recognize it when we see it. I will then examine the nature of vocation, the first stirrings of our attraction to truth. This proceeds to a deep evaluation of the postures and processes that I will argue occupy the foundation of forensic work – presence, empathy, compassion, and centering – and some of the forces that weigh against their expression. I conclude with thoughts on the search for truth – in our work and in ourselves. My hope is that this endeavor will invite further inquiry and explication.

REFERENCES

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Puchalski CM, Guenther M: Restoration and re-creation: spirituality in the lives of healthcare professionals. Curr Opin Support Palliat Care 6(2):254-258, 2012

QUESTIONS AND ANSWERS

Which of the following activities is LEAST representative of the spiritual dimensions of forensic psychiatric practice:
a. Being present to a fellow human being in an evaluation
b. Bearing witness to suffering in a forensic report
c. Empathic insight into an evaluee's experience
d. Efficiency in conducting forensic interviews
e. Humility in assessing one's areas of competence
ANSWER: d

Which of the following models has not been proposed in the search for truth in forensic mental health testimony:
a. Professionals should avoid courtroom testimony
b. Experts should participate fully in adversarial advocacy
c. Psychiatric experts should cling to medical values of compassion
d. Courts should consider utilizing a consensus panel in important cases
e. Courts should impose upon contestants a primary duty to pursue truth
ANSWER: b

T22 TRUTH TO POWER: COMMITTEE CHAIRS AND THE PRESIDENTIAL THEME

Philip Candilis MD, Alexandria, VA
Aimee Kaempf MD, Tucson, AZ
Emily Keram MD, Santa Rosa, CA
Nathan Kolla MD, Toronto, ON, Canada
Richard Krueger MD, New York, NY

EDUCATIONAL OBJECTIVE
At the conclusion of this workshop, participants will be able to apply a series of approaches to reports and testimony that optimize persuasive communication.

SUMMARY
Expert reports and testimony are influenced by procedural, empirical, and practical standards that may conflict during the course of a trial. Presenting truthful information in a way that is credible and persuasive is consequently the cardinal goal of forensic practice. This workshop by AAPL committee chairs looks at the Presidential Theme, "The Search for Truth," as an opportunity to present approaches to the great controversies of the field in ways that optimize persuasive communication. Emily Keram, chair of Security and Human Rights will review the forensic challenges of balancing security and civil freedoms, while Richard Krueger of the Sex Offenders Committee explores the uncertainties of diagnosis and treatment of persons with sexual behavior disorders facing civil commitment, incarceration, and community supervision. Aimee Kaempf of the Gender Issues Committee will offer updates on how gender affects the experiences of mental health experts and how they are perceived, and Nathan Kolla of the Research Committee will describe the differences between the truth of research and testimony. Philip Candilis of the Ethics Committee will lead exercises using classic models of objective and subjective truth as well as newer models of persuasive communication.

REFERENCES
Griffith E, Stankovic A, Baranoski M: Conceptualizing the forensic report as performance narrative. J Amer Acad Psych Law 38(1):32-42, 2010
Diamond BL: Reasonable medical certainty, diagnostic thresholds, and definitions of mental illness in the legal context. J Amer Acad Psych Law 13(2): 121-128, 1985

QUESTIONS AND ANSWERS
The use of narrative detail, vocabulary, appeals to the audience, and positioning are elements of which approach to forensic practice?
a. The search for subjective truth
b. Striving for objectivity
c. The habits and skills of the ethical practitioner
d. Performance narrative
e. Advocacy for one's opinion
ANSWER: d

The standard of "Reasonable medical certainty" was recognized by the US Supreme Court in which landmark case?
a. Daubert v. Merrell Dow.
b. Frye v. US
c. Addington v. Texas
d. GE v. Joiner
e. Kumho Tire Co. v. Carmichael
ANSWER: c

T23 ON TARGET? LEGISLATING GUN VIOLENCE AND THE MENTALLY ILL

Jeffrey Khan MD, Houston, TX
Ian Lamoureux MD, Rochester, MN
Megan Testa MD, Shaker Heights, OH

EDUCATIONAL OBJECTIVE
This workshop will improve forensic psychiatrists' understanding of relevant policy, case law, and statistics regarding mental illness and gun violence. Further, this workshop will enhance the skills of forensic psychiatrists' evaluation of safety and gun ownership in the mentally ill by proposing various approaches to this evaluation.

SUMMARY
Despite relative scarcity, mass shootings are high-profile crimes that captivate public attention and spur nationwide debate regarding mental illness and the prevention of gun violence. Recently, the Social Security Administration finalized rule 20 CFR Part 421 detailing how some beneficiaries with payees would be reported to the National Instant Criminal Background Check System, barring them from purchasing a firearm. While recently repealed, it raises an interesting question: what role does mental illness play in gun violence? Much of the current legislation is focused on persons "adjudicated mentally defective" or who have been involuntarily committed. Does this type of legislation capture those at risk for future violence? Should these people be permanently barred from owning a firearm or only during crisis periods? Forensic psychiatrists may be increasingly asked to weigh in on removal and restoration of an individual's gun rights but can also play a critical role in navigating the advocacy for the rights of mentally ill persons while working to increase public safety and reduce gun violence.

REFERENCES
Swanson JW, McGinty EE, Fazel S, et al: Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. Annals of Epidemiology 25(5):366-376, 2015
McGinty EE, Webster DW, Barry CL: Gun policy and serious mental illness: priorities for future research and policy. Psychiatric Services 65(1):50-58, 2014

QUESTIONS AND ANSWERS
Which of the following was the first federal law to explicitly prohibit the "mentally defective" from possessing a firearm?
a. National Firearms Act (1934)
b. Gun Control Act (1968)
c. Firearm Owners Protection Act (1986)
d. Brady Handgun Violence Prevention Act (1993)
e. Hughes Amendment (1986)
ANSWER: b

Some studies estimate violence attributable to mental illness constitutes what percentage of violent behavior in the general population?
a. 73%
b. 41%
c. 17%
d. 4%
e. 0.9%
ANSWER: d

T24 TAX DOLLARS AT WORK TREATING INMATES WITH GENDER DYSPHORIA

Keelin A. Garvey MD, Tiverton, RI
Joel Andrade, PhD LICSW, Westborough, MA

EDUCATIONAL OBJECTIVE
To discuss the evaluation of gender dysphoria in an incarcerated individual, describe treatment options and review relevant legal decisions and present fictional cases to illustrate the complexity of diagnostic and treatment decisions, calling upon audience members to determine the medical necessity of different interventions for unique cases.

SUMMARY
Societal awareness and high-profile litigation have prompted correctional systems to develop strategies for the identification and treatment of gender dysphoric inmates. These changes have led to significant improvements in access to care. For the correctional mental health professional who treats gender dysphoria, however, this means navigating a minefield of advocates on one side and disapproving tax-payers on the other, while maintaining focus on the psychosocial complexity and unique needs of the individual inmate. Careful exploration of trauma and ambivalence, and consideration of the irreversibility of highly desired forms of treatment, are often represented by plaintiffs' experts as negligence and discrimination. Advocacy groups call for gender dysphoric inmates to receive treatment that mirrors the community. These advocates emphasize inmate patients' rights and deemphasize important distinctions between community-dwelling gender dysphoric individuals and those serving life sentences for violent crimes. Minimizing the unique context of the correctional setting, they fail to provide correctional clinicians with strategies to determine whether certain irreversible forms of treatment are likely to lead to more benefit or harm. In this workshop, we will use fictional cases to engage the audience in the challenge of defining medical necessity and selecting appropriate treatment strategies without the benefit of outcome data.

REFERENCES
Levine S: Reflections on the legal battles over prisoners with gender dysphoria. J Am Acad Psychiatry Law 44(2): 236-45, 2016
Osborne CS, Lawrence AA: Male prison inmates with gender dysphoria: when is sex reassignment surgery appropriate? Arch Sex Behav 45(7): 1649-63, 2016

QUESTIONS AND ANSWERS
Though controversial, the decision to keep Gender Dysphoria as a diagnosis in the DSM-5 was driven primarily by:
a. Recognition that Gender Dysphoria is a major mental illness
b. Concerns regarding access to treatment
c. The influence of advocacy groups
d. The relatively high incidence of co-morbid mental disorders
ANSWER: b

All of the following represent constitutional violations except:
a. Denying a transgendered inmate's request for a special diet to accommodate food preferences
b. Limiting the treatment of Gender Dysphoria to supportive therapy only
c. "Freeze frame" policies
d. Policies that prohibit specific Gender Dysphoria treatment interventions
ANSWER: a

T25 PREGNANCY DENIAL AND NEONATICIDE: MURDERESS OR VICTIM?

Margarita Abi Zeid Daou MD, Worcester, MA
Phillip Resnick MD, Cleveland, OH
William Kenner MD, Nashville, TN

EDUCATIONAL OBJECTIVE
To present pregnancy denial as a well defined medical condition which outcomes can be intertwined with neonaticide and examine relevant evidence that can shape the practice of forensic psychiatrists conducting evaluations of defendants with pregnancy denial or charged with neonaticide.

SUMMARY
From antiquity, uncertainty about women's gravida status has driven men to legislative extremes. In early modern England, if a single woman with pregnancy denial delivered a stillborn or the baby died immediately postpartum, the mother was presumed guilty of murder and hung. A pregnancy denial/neonaticide stereotype was unquestioned until the late 20th Century, when further studies began to undercut support for the neonaticide profile in unassisted deliveries. The strengths and weaknesses of that stereotype will be debated. We will also propose new diagnostic criteria for pregnancy denial based on: pregnancy's missing clinical signs and symptoms; the woman's lack of functional knowledge of her pregnancy, and absence of an effort to hide her pregnancy. The pros and cons of these criteria will be discussed with the audience. Then, an actual case will be discussed in an interactive session with audience members assigned to either the defense or the prosecution's side: A 25-year-old woman with pregnancy denial was charged with neonaticide of her newborn twins. The unassisted deliveries left her unconscious, yet a later police interrogation substituted the detective's neonaticide narrative for hers. Finally, the participants will discuss the strengths and weaknesses of each side.

REFERENCES
Kenner WD, Nicholson SE: Psychosomatic Disorders of Gravida Status: False and Denied Pregnancies. Pscychosomatics 56(2):119-28, 2015
Friedman SH, Horwitz SM, Resnick PJ: Child murder by mothers: a critical analysis of the current state of knowledge and a research agenda. Am J Psychiatry 162(9):1578-87, 2005

QUESTIONS AND ANSWERS
Which of the following statements about pregnancy denial is true:
a. 1/2455 pregnancies are denied to 20 weeks, and 1/475 may go undiagnosed to delivery
b. When a woman accepts her pregnancy when it's revealed to her, physiologic changes reveal her gravid status
c. Delirium is never an issue with unassisted deliveries
d. 5% of doctors fail to diagnose pregnancy in women with pregnancy denial
ANSWER: b

Which of the following statements about 'neonaticide' is wrong?
a. Neonaticide is the murder of a neonate in the first week of life
b. The term "neonaticide" was coined by Resnick in 1970
c. Neonaticide is the murder of a neonate in the 24 hours of life
d. In the United States, murder of an adult or a neonate are not treated distinctly.
ANSWER: a

T26 **WILL I BE HARMED AT WORK TODAY?**

Trent C. Holmberg MD, Draper, UT
Sumit Anand MD, Charlottesville, VA
Robert Granacher MD MBA, Lexington, KY
Navneet Sidhu MD, Alexandria, VA

EDUCATIONAL OBJECTIVE
By attending this workshop, participants will gain a better understanding of the safety risks we face in our work as psychiatrists. Attendees will also participate in a case-based discussion of what we can do to mitigate those risks.

SUMMARY
June 30, 2016. Texas. "Physician Dies After Patient Attack in Dallas Hospital." October 14, 2015. Delaware. "Revenge Killing: Mental Patient Stabs To Death Psychiatrist Who Had Him Committed." These recent headlines underscore the dangers associated with practicing psychiatry. In this workshop, a number of psychiatrists who have been assaulted at work will share their stories and discuss what lessons they learned through their experience. Common threads running through these experiences will be explored. The prevalence of, and risk factors for, patient/evaluee on psychiatrist violence will be discussed. Security issues relating to the personal safety of psychiatrists (and other mental health professionals) at work that we should be aware of will be discussed. Attendees will be encouraged to share their own stories (either of times they have been assaulted or of "near misses"), and to discuss what lessons they have learned from those events. Practical ideas relating to how to maximize our safety at work will be generated and discussed.

REFERENCES
Faulkner LR, Grimm NR, McFarland BH, et al: Threats and assaults against psychiatrists. J Am Acad Psych Law 18(1):37-46, 1990
Anderson A, West SG: Violence Against Mental Health Professionals: When the Treater Becomes the Victim. Innov Clin Neurosci. 8(3): 34-39, Mar 2011.

QUESTIONS AND ANSWERS
Which kind of patient poses the most danger to the treatment provider?
a. A young male with Schizophrenia
b. A woman with Borderline Personality Disorder
c. Both are equal risk
ANSWER: a

Do a majority of psychiatrists report threats made against them to the police?
a. No, because the patient was already confined
b. No, because they believe nothing would be done about it
c. Yes, because being threatened contributes to burnout
ANSWER: a

T27 **REFLECTIONS ON JUDGING AND THE MENTALLY ILL**

The Honorable John L. Kane

EDUCATIONAL OBJECTIVE
By attending this workshop, participants will …

SUMMARY
With the increasingly infrequent use of Not Guilty by Reason Of Insanity pleas, the fields of forensic psychiatry and psychology are now most pertinent in evaluations for sentencing and, to a lesser extent, on competency to stand trial issues. Evaluations by contract professionals are consistently limited in time and profundity, due to insufficient budgets, and resort to pro forma work products. I have witnessed the grave consequences of such superficiality in several criminal cases. In this presentation, I discuss four illustrative ones. Each case is different, but shares a common nexus in a paradigm of disillusion, which is the making of diagnoses and the imposition of sentences to fit the available and unsatisfactory remedy. Although we have developed systems and procedures to streamline and improve our work, they often have the unintended consequence of making it less than satisfactory. Given routine reliance on the DSM in all of its editions and the fiscal limitations produced by competitive bidding for service contracts and specialized training programs, the administration of justice and the contribution to it of forensic psychiatry and psychology have, over time, lost a deeper understanding of human behavior and development. Allowing systems or manuals to become ends in themselves, rather than starting points, creates illusions of credibility. Such systems are organized lists of instructions that, when executed, produce predictable results. But they are predictable only because they exclude factors not contained in their guiding programs. Yet, it is often those very factors that make the difference between a just result and an arbitrary one.

REFERENCES

QUESTIONS AND ANSWERS

T28 **NAVIGATING THE STORMY SEAS OF COMPETENCY RESTORATION**

Kayla Fisher MD JD, Sacramento, CA
Ariana Nesbit MD, Sacramento, MA
Michael Champion MD, Honolulu, HI
Daniel Hackman MD, Louisville KY
Debra Pinals MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE
By attending this presentation, participants will be able to 1) discuss the practice of competency restoration in various settings and review landmark cases that provide the foundation for the current restoration landscape, and 2) describe recent trends, case law, and resultant developments to address system challenges surrounding restoration services.

SUMMARY
As the demand for competency restoration services increases, and the interplay between jails and hospitals is spotlighted, states must find new ways to provide efficient and effective evaluations and treatments as well as broader solutions to the conundrum of increased forensic demands. Patient advocacy groups and state leaders have raised concerns about the increase in wait lists for competency restoration services and several states have faced related legal challenges. Mental health systems have responded to growing demands by examining practices along a variety of dimensions to expedite access to evaluations and restoration services, and to develop criminal justice diversion strategies. To effectively address these issues, it is important for forensic psychiatrists to maintain their compass bearing and provide leadership and direction consistent with legal precedents, clinical guidelines, and ethical considerations. This panel will 1) outline the legal cases that provide the framework for competency evaluation and restoration, 2) review current practices, 3) explore recent court cases impacting future practice, 4) present solutions

that involve considerations related to jail-based, outpatient, and forensic hospital restoration programs, and 5) discuss policy and ethical considerations as well as broader implications for systems and for the persons and challenges these programs are aimed to address.

REFERENCES

A.B. by and through Trueblood et al v. Washington State Department of Social and Health Services (DSHS). 101 F.Supp.3d 1010 (W.D. Wash. 2015)
Mossman D, Noffsinger S, Ash P, et al: AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial. J Am Acad Psych Law 35(4), 2007

QUESTIONS AND ANSWERS

Jackson v. Indiana can be interpreted to require which of the following?
a. Forensic hospitals should develop efficient and effective treatment programs
b. Due to their punitive setting, competency restoration programs in jails should be avoided
c. Outpatient competency restoration for all patients without psychosis
d. Forensic hospitals should only admit patients who have first failed a jail-based competency restoration program.
ANSWER: a

At issue in A.B. by and through Trueblood et. al. v. Washington State Department of Social and Health Services (DSHS) is which of the following?
a. Whether a person deemed incompetent to stand trial can give valid consent for certain psychotropic medications.
b. Whether the state can legally detain a person in the state psychiatric hospital for up to 5 years to restore competency.
c. Whether the Due Process Clause compels the state to perform a competency evaluation of pretrial detainees within seven days of a court order requiring the evaluation.
d. Whether a competency evaluation completed utilizing telepsychiatry technologies violates the Due Process Clause.
ANSWER: c

T29 PRISON PSYCHIATRY IN THE UK: PATHWAYS TO THE HEALTH SERVICE

Mary C. Whittle MB MRC Psy, London, United Kingdom
Alex Acosta-Armas MRCPsych, London, United Kingdom
John McAnallen MBBS MRCPsych, London, United Kingdom
Gerard Waldron MRCPsych, London, United Kingdom

EDUCATIONAL OBJECTIVE

To learn about pathways for mentally ill, personality disordered, learning disabled and autistic prisoners between correctional institutions and the National Health Service in the UK. Attendees will acquire knowledge of effective care pathways, transfer options, and the problems encountered in new developments.

SUMMARY

While models of health care provision for prisoners have often focused on in-prison services and transfer of prisoners to the NHS, recent emphasis on care pathways to and from correctional institutions has offered opportunities for new ideas and developments around how the two systems work together to provide responsive, flexible, safe and effective healthcare for prisoners. In this workshop pathway models will be explored using problem based learning principles. Speakers will introduce actual practice models for the different patient/prisoner groups - a prison liaison model with data from two London prisons; PIPE - an assessment and therapy service in prison for personality disordered offenders; new provision for autistic and learning disabled prisoners and new developments in pathways for mentally ill prisoners into forensic psychiatry hospitals from prison. A series of examples of increasing complexity, simulated from actual practice, will provide a basis for delegates to compare and contrast new and old systems, ideas and services; evaluate what works (and does not); anticipate where the pitfalls lie and to formulate ideas on new ways of working with complex problems in complex institutions which have differing needs and aims.

REFERENCES

Oliver D: Prison riots should set off alarms in hospitals. BMJ Available at www.bmj.com/bmj/section-pdf/938609?path=/bmj/356/8092/Comment.full.pdf. Accessed September 1, 2017
Till A, Exworthy T, Forrester A: Integration and offender mental health. J Foren Psych and Psych 26(1):11-21, 2015

QUESTIONS AND ANSWERS

In the past six years the number of suicides in prisons has gone up by:
a. 20%
b. 50%
c. 100%
d. 150%
ANSWER: c

What has been the percentage population increase in UK prisons in the past 25 years?
a. 50%
b. 75%
c. 90%
d. 200%
ANSWER: c

T30 **SHOULD PSYCHIATRISTS EVER OPINE ON THE "ULTIMATE QUESTION"?**

Karen Reimers MD, Minneapolis, MN
Sherif Soliman MD, Cleveland, OH
Carolyn L. Dessin JD, Akron, OH
Adam M. Fried JD, Cleveland, OH

EDUCATIONAL OBJECTIVE

To understand arguments for and against experts opining on the ultimate question in undue influence cases, review literature and case law in this area
And participate in debate and discussion of the role of experts in undue influence cases.

SUMMARY

Psychiatric experts have an important place in undue influence cases, however their role is limited. Just how limited should the expert's role be? Should experts ever opine on the "ultimate question"? Some scholars in the field argue that in cases of undue influence, psychiatrists and other mental health professionals should never opine on the "ultimate question." They recommend that experts in these cases restrict themselves to areas where they have true psychiatric expertise. Opining on the ultimate question is seen to be outside the psychiatric expert's scope. Others suggest a more comprehensive role for expert psychiatrists in undue influence cases. They note that psychiatrists can integrate various sources of complex information, providing crucial context for the trier of fact. For example, the expert may conduct a comprehensive review of financial and legal documents alongside medical and nursing home records. This debate will explore arguments for and against psychiatric experts opining on the "ultimate question" of undue influence, citing literature and case law in this area. The debate will be organized around the following resolution: "Psychiatrists should not be permitted to testify regarding the ultimate issue in undue influence cases."

REFERENCES

Peisah C, Finkel S, Melding P, et al: The wills of older people: risk factors for undue influence. Int Psychogeriatr 21(1):7–15, 2009
Plotkin D, Sparr J, Horwitz H: Assessing undue influence. J Am Acad Psych Law 44(3):344-351, 2016

QUESTIONS AND ANSWERS

A person subject to undue influence is assumed by the court to have testamentary capacity. Elements of testamentary capacity include the following EXCEPT:
a. Sufficient cognitive capacity to understand the concept of a will
b. Knowledge of their assets
c. Absence of dementia, mood, psychotic and substance use disorders
d. Awareness of who might have acclaim on their assets
e. Able to communicate disposition of their estate
ANSWER: c

When would a claim if undue influence apply?
a. The victim does not understand the nature of a will
b. The victim is unaware of the nature and extent of his or her assets
c. The victim has no mental disorder or mental "defect"
d. The victim is unable to understand the impact of the distribution of the assets of his or her estate
e. The influencer had no inclination or disposition to influence
ANSWER: c

T31 **A REVIEW OF 53 CHILD CUSTODY EVALUATIONS**

Barbara Kahn JD, Chicago, IL
Jason Washburn PhD, Chicago, IL
Stephen H. Dinwiddie MD, Chicago, IL

EDUCATIONAL OBJECTIVE
To review current clinical and legal standards in child custody evaluations and discuss how well current practice, as indicated by review of 53 evaluations, addresses those standards.

SUMMARY
Child custody evaluations (CCEs) frequently are relied on by judges in child custody cases [1] but long-standing concerns remain that evaluators may not consistently address relevant legal standards or adhere to professional guidelines.[2] This study analyzed 53 de-identified CCE reports prepared by experts with a variety of clinical backgrounds (psychiatrists, psychologists and social workers). The reports were coded for content by two doctoral students using a standardized protocol and supervised by an experienced forensic psychiatrist, a clinical psychologist, and an attorney with experience in family law. Raters cross-coded 20% of reports to establish and maintain reliability. Significant findings from the reports included: over one-third (35.8%) failed to address issues of confidentiality; only 13.2% indicated any specific reason(s) for the evaluation; when evaluating factors used in determining the child's best interests, 94.3% reported the parents' preference for custody yet only 56.3% reported the child's preference. Some form of psychological testing was completed for 59.6% of the evaluations but only 18.4% articulated a reason or rationale for use. Finally, evaluators frequently provided no basis for their recommendations: over one-third (35.4%) of findings were unsupported by any explicit rationale or reference to information obtained from the evaluation process.

REFERENCES
Ackerman MJ, Pritzl TB: Child custody evaluation practices: a 20 year follow up. Family Court Review 49(3):618-28, 2011
Bow JN, Quinnell FA: Psychologists' current practices and procedures in child custody evaluations: five years after American Psychological Association guidelines. Professional Psychology: Research and Practice 32(3):261, 2001

QUESTIONS AND ANSWERS
Empirical reviews of child custody evaluations have concluded that:
a. Routine use of standardized psychological assessment instruments (e.g., MMPI-A, IQ testing) should be considered standard of care in assessing children in disputed custody cases
b. Structured observation of parent-child interaction is the most valid and commonly-used means of assessing which parent should be awarded custody in disputed custody cases
c. Disclosure of purpose of evaluation and limitations on confidentiality is not consistently documented in reports
d. Use of multiple sources of information to supplement clinical evaluation of parents has been found to be unnecessary in most cases of disputed custody.
ANSWER: a

Clinical factors that should be considered in rendering an opinion regarding child custody should include all except:
a. Best interest of the child
b. History of physical or sexual abuse of child by one parent
c. Child's mental health needs
d. Nature and symptoms of mental illness in parent(s)
ANSWER: c.

T32 CERTIFICATION FOR PATIENTS WITH AN: A 5 YEAR REVIEW

Patricia Westmoreland, MD, Denver, CO
Jane Miceli, MD, PC, Denver, CO
Helena Winston, MD, PC, Aurora, CO

EDUCATIONAL OBJECTIVE
Attendees will learn about certifying patients with severe Anorexia nervosa who were admitted to an inpatient treatment unit. We will present data obtained over 5 years of treating patients on an involuntary basis and will discuss predictors of treatment success vs. situations in which involuntary treatment is unlikely to be successful.

SUMMARY
Anorexia nervosa (AN) is the psychiatric illness with the highest mortality rate. However, patients who are treated early in the course of their illness and undergo full weight restoration greatly improve their chance of recovery. Unfortunately, patients with AN often refuse treatment. Certification may thus be critical to recovery. In this presentation we plan to present data regarding patients who were certified for treatment at ERC in Denver between April 2012 (when ERC was first became a designated involuntary treatment facility) and April 2017, adding additional information to data already obtained: between April 2012 and March 2016, 5.2% of patients admitted to Eating Recovery Center (ERC) were certified. 39% were transferred from ACUTE. 31% of certified patients successfully completed treatment. 42% returned for further care. 24% of certifications were terminated as involuntary treatment was not helpful. While many severely ill patients with AN successfully complete treatment, certification is not helpful almost 1/4th of the time. We will present examples in which certification was (or was not) helpful, and outline reasons as to when certification is likely to be successful, and when attempts at involuntary treatment should be abandoned for other management models such as harm reduction or palliative care.

REFERENCES
Westmoreland P, Johnson C, Stafford M, et al: Involuntary treatment of patients with life-threatening anorexia nervosa. J Am Acad Psych Law, in press
Westmoreland P, Mehler PS: Caring for patients with severe and enduring eating disorders (SEED): certification, harm reduction, palliative care, and the question of futility. Journal of Psychiatric Practice 22(4):313-320, 2016

QUESTIONS AND ANSWERS
Feeding can never be forced on a patient, unless
a. The patient will likely die in the next few minutes if they are not fed.
b. The patient will likely die in the next few months if they are not fed.
c. The patient's doctors believe s/he is so cognitively impaired that s/he is not able to make the decision to eat or not to eat.
d. A court has granted this authority to an institution regarding this particular patient.
ANSWER: a

Certification allows which of the following?
a. The psychiatric hospitalization of a patient against his or her will due to reasons of grave disability, danger to self, or danger to others.
b. The involuntary administration of medications.
c. The involuntary feeding of a patient.
d. Admission of a patient to a medical unit
ANSWER: d

T33 UPDATE ON THE ASSESSMENT OF BATTERED WOMAN'S SYNDROME DEFENSE

Graham Glancy MD, Toronto, ON, Canada
Marissa Heintzman, Toronto, ON, Canada
Adam Wheeler, Toronto, ON, Canada

EDUCATIONAL OBJECTIVE
Participants will learn to assess defendants claiming a battered women defense using checklists and rating scales in an evidenced based manner.

SUMMARY
Most jurisdictions allowed the use of force in self-defense in certain circumstances, which generally include self-defense against an unprovoked assault. This is generally qualified to include the condition if there is a reasonable apprehension of death or grievous bodily harm from the violence with which the assault was originally made, and the person believes on reasonable grounds that he cannot otherwise preserve himself from death or grievous bodily

harm. Approximately 25 years ago, the courts began to recognize that expert evidence was necessary to modify these assumptions as applied in the context of a battered woman's attempts to repel an assault. The issues included whether an abused woman would remain in an abusive relationship, the nature and extent of the violence that exists in the relationship and the accused's ability to perceive danger from her abuser. Expert evidence was often admitted by the courts and considered in these cases. Changes to the Criminal Code of Canada have included, in the general section on self-defense, many of the issues that were the subject matter of the expert evidence. We will discuss the changes to the Canadian Code and review a framework for assessing women who may be considering using this defence.

REFERENCES

Walker L: The Battered Woman Syndrome. New York, NY: Springer Publishing, 2001
Regehr C, Glancy G: Battered woman syndrome defence in the Canadian courts. Canadian Journal of Psychiatry 40(2) 130-135, 1995

QUESTIONS AND ANSWERS

In assessing a woman charged with the murder of her husband what is paramount?
a. A connection between the BWS and the murder
b. Presence of financial gain from the murder
c. The woman is sexually jealous
d. The woman has a military background
e. All of the above
ANSWER: a

When assessing a woman charged with the murder of her husband which of the following tools should be used?
a. Clinical interview
b. Self-report scales for PTSD
c. Collateral information
d. All of the above
ANSWER: d

T34 THE CLINICAL DETECTION OF MALINGERED MENTAL ILLNESS

Phillip Resnick, MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

To be more skillful in detecting deception and malingering, especially in defendants pleading not guilty by reason of insanity.

SUMMARY

This course is designed to give psychiatrists practical advice about the detection of malingering and lying. The latest research on malingered hallucinations will be covered. Psychotic hallucinations will be distinguished from non-psychotic hallucinations. Suspect auditory hallucinations are less likely to be associated with delusions. Persons faking auditory hallucinations may say they have no strategies to diminish malevolent voices and claim that all command hallucinations must be obeyed. Malingerers are more likely to report extreme severity and intensity of their hallucinations. Suspect visual hallucinations are more likely to be reported in black and white rather than in color, be dramatic and are more likely to include miniature or giant figures. Resolution of genuine hallucinations and delusions with anti-psychotic treatment will be delineated. Participants will learn 12 clues to detect malingered psychosis and four clues to detect malingered insanity defenses. Videotapes of several defendants describing hallucinations will enable participants to assess their skills in distinguishing between true and feigned hallucinations.

REFERENCES

McCarthy-Jones S, Resnick PJ: Listening to voices: the use of phenomenology to differentiate mallingered from genuine auditory verbal hallucinations. Int J Law Psych 37(2):183-189, 2014
Knoll JL, Resnick PJ: Malingering and factitious disorder, in Forensic Psychiatry: Fundamentals and Clinical Practice. New York, NY: Taylor & Francis, 2016, pp 195-204

QUESTIONS AND ANSWERS

The following are true except:
a. When people lie they usually have less eye contact.
b. When people lie they make more slips of the tongue.
c. When people lie they speak in a higher pitched tone.
d. When people lie they are more likely to give hesitant answers.
ANSWER: a

The following characteristics of auditory hallucinations are suspect except:
a. Voices refer to me as Mr. or Mrs.
b. I hear only female voices.
c. I hear only children's voices.
d. Voices chastise me for delaying my homework.
e. I don't feel any control over my voices.
ANSWER: d

T35 THE SUICIDE PRESCRIPTION: PRACTICAL AND POLICY PROBLEMS

Jeffrey S. Janofsky, MD, Timonium, MD
Michael Champion, MD, Honolulu, HI
Annette Hanson, MD, Baltimore, MD
Alexander Simpson, FRANZCP, Toronto, ON, Canada

EDUCATIONAL OBJECTIVE

Participants will understand public policy problems implementing existing physician suicide laws. They will also understand practical problems assessing capacity and susceptibility to coercion in patients requesting physician assistance in dying. Participants will further understand potential problems if physician assisted suicide is extended to persons suffering only from a psychiatric illness.

SUMMARY

Physician Assisted Suicide has been legalized in seven U.S. jurisdictions. All of these jurisdictions allow physicians to prescribe lethal doses of medications for persons determined to be terminally ill. All require some assessment of the patient 's capacity to make treatment decisions. No state has explicitly recognized having a mental disorder as a reason to allow physician assisted suicide. Forty-four states consider assisted suicide illegal. States including Hawaii, Maryland and New Mexico are actively considering legislation in 2017 to legalize physician assisted suicide. In Carter v. Canada the Canadian Supreme Court ruled that Canada 's prior law banning "physician assisted death" violated the Canadian Charter of Rights and Freedoms. The Court stayed its decision until enabling legislation could be written. The Canadian Parliament passed legislation in June 2016 limiting physician assisted death to patients suffering from illness that are "reasonably foreseeable" with "suffering" that is intolerable.

REFERENCES

State-by-State Guide to Physician-Assisted Suicide. Available at http://euthanasia.procon.org/view.resource.php?resourceID=000132. Accessed September 1, 2017
Carter v. Canada, 1 SRC 331 (2015)

QUESTIONS AND ANSWERS

Which of the following issues have been identified as a barrier to accurate data collection regarding the efficacy of statutory safeguards in assisted suicide legislation?
a. Information about patient qualification is reported only by the prescribing physician.
b. Inaccurate information on the death certificate bars investigation from law enforcement.
c. Deaths that are not attended by an impartial witness.
d. All of the above
ANSWER: d

Canadian Legislation passed in reaction to Carter v. Canada allowed physician assisted death when a patient:
a. suffers from a terminal condition
b. when death is reasonably foreseeable
c. when a patient has intolerable suffering
d. B and C
e. A and C
ANSWER: d

T36 MENTAL ILLNESS AND CRIME: ARE THEY SOCIAL DISEASES?

Merrill R. Rotter MD, White Plains, NY
Patrick Fox MD, Denver, CO
Debra Pinals MD, Ann Arbor, MI
Karen Rice MD, Longmont, CO

EDUCATIONAL OBJECTIVE
To review the social determinants and community-based issues that are associated with mental health, criminal recividism, and general health as well.

SUMMARY
Fifty years before the recent Risk/Needs/Responsivity-based focus highlighting the importance of criminogenic needs and responsivity factors in addressing recidivism in justice-involved individuals with mental illness, Broadway lyricist Stephen Sondheim identified the "social" nature of the problem. Increasingly, we are recognizing that forensic clinicians who want to support both recovery and recidivism reduction can do so by focusing additionally, though not exclusively, on the social determinants associated with health, mental health, substance use and crime. Trauma, poverty, lack of services, and housing are among the many vexing treatment planning challenges faced by forensic psychiatrists and other community mental health providers. In this presentation, we review the concepts of responsivity and recidivism, including the evolving concept of Systemic Responsivity, that focuses on the preparedness of communities to address these complex populations. Through descriptions of policy initiatives and programmatic interventions, we will explore the broader social determinants that are associated with the more specific clinical problems with which we are primarily tasked. In considering our task as forensic psychiatrists working in community corrections and other justice-related treatment contexts, we will discuss the appropriate limits, if any, on our role in addressing these broader social goals.

REFERENCES
Taxman F: The importance of systemic responsivity in expanding core principles of responsivity. Federal Probation 78(2):32-40, 2014
Compton MT: The Social Determinants of Mental Health. Arlington, VA: American Psychiatric Association Publishing, 2015

QUESTIONS AND ANSWERS
Which of the following factors has not been shown to be associated with both mental illness and criminal recividism:
a. Trauma
b. Poverty
c. Parental substance abuse
d. Gender
ANSWER: d

In West Side Story, the treatment plan for Riff's "social disease" is
a. Take him to a head shrinker
b. Take him to a social worker
c. A year in the pen
d. A good honest job
ANSWER: b

T37 THE APA IN THE COURTS

Marvin S. Swartz MD, Durham, NC
Howard Zonana MD, New Haven, CT
Renée L. Binder MD, San Francisco, CA

EDUCATIONAL OBJECTIVE
Understand how the APA decides to become involved as a friend of the court in major cases Discuss the issues involved in the rights of transgender students Recognize the ongoing legal challenges related to the right to an independent psychiatric expert. Appreciate the issues involved in expanding the Tarasoff-type duties

SUMMARY
The Committee on Judicial Action reviews on-going court cases of importance to psychiatrists and our patients, and makes recommendations regarding APA participation as amicus curiae (friend of the court). This workshop offers AAPL members the opportunity to hear about several major issues that the Committee has discussed over the past year, and to provide their input concerning APA's role in these cases. Several cases will be summarized and the issues

they raise will be addressed. Since new cases are likely to arise before the annual meeting, the Committee will select current cases on its agenda for discussion. Feedback from the participants in the workshop will be encouraged.

REFERENCES

Ake v. Oklahoma 470 U.S. 68 (1985)
Volk v. Demeerleer Washington Supreme Court. Available at http://caselaw.findlaw.com/wa-court-of-appeals/1683873.html. Accessed September 1, 2017

QUESTIONS AND ANSWERS

Ake v. Oklahoma
a. involved the competency of a defendant to be executed:
b. involved the plaintiff right to treatment of his condition in prison
c. the right of the plaintiff to an independent psychiatrist to assist his defense
d. none of the above
ANSWER: c

Potential expansion of Tarasoff-type duties are under litigation in which two states?
a. Washington
b. California
c. Both states
d. Neither state
ANSWER: c

T38 LEGISLATIVE ADVOCACY AND FORENSIC PSYCHIATRY TRAINING

Jennifer Piel, MD, JD, Seattle, WA
Rejoice Opara, MD, Seattle, WA

EDUCATIONAL OBJECTIVE

Described here is a model program in legislative advocacy. The presentation will focus on ways that legislative advocacy can support training in forensic psychiatry and contribute to a more balanced understanding of the legal system, how laws are made, and relevant skills for forensic psychiatrists.

SUMMARY

Although advocacy is recognized as an important topic for medical education, educational programs and experiences in advocacy are varied. Discussed here is one type of advocacy – legislative advocacy. Exposure to this type of advocacy may be of interest to general psychiatry residents, but it may be particularly useful for trainees with intention to specialize in forensic psychiatry. The American Academy of Psychiatry and the Law's Ethics Guidelines defines the field as: "a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment." Although, historically, regulatory or legislative matters have not been a primary focus of training in forensic psychiatry, described here is a model curriculum in legislative advocacy. This presentation will focus on the ways that legislative advocacy can support training in forensic psychiatry, including understanding the legal system, statutory interpretation, learning to think like a lawyer, serving in a consulting/teaching role, testifying, and ethics in advocacy for forensic psychiatrists. Challenges in creating the model training program will also be discussed.

REFERENCES

Bloom JD: Forensic psychiatry, statutory law, and administrative rules. J Am Acad Psych Law 39:418-21, 2011
American Medical Association: Declaration of professional responsibility: medicine's social contract with humanity. Available at https://cms.org/uploads/Declaration-of-Professional-Responsibility.pdf. Accessed November 18, 2016

QUESTIONS AND ANSWERS

Legislative advocacy may include which of the following activities?
a. Drafting legislation
b. Lobbying
c. Testifying in opposition to proposed legislation
d. All of the above
ANSWER:

What skills relevant to legislative advocacy support training in forensic psychiatry?
a. Understanding the legal system
b. Understand statutory interpretation
c. Testifying
d. All of the above
ANSWER: d

T39 **EXAMINATION DISCLOSURE AS A TEST OF ADJUDICATIVE COMPETENCE**

Rebecca Brown, DO, Cincinnati, OH
Bridget Casey-Leavell, DO, Cincinnati, OH
Elliot Lee, MD, PhD, Fitchburg, WI
Christopher Marett, MD, Cincinnati, OH
Douglas Mossman, M.D., Cincinnati, OH

EDUCATIONAL OBJECTIVE
At the conclusion of this presentation, participants will: (1) briefly describe two parts of consent during forensic evaluations; (2) explain why the disclosure process that begins a competence examination might be a test of competence itself; (3) describe what disclosure responses reveal about a defendant's competence.

SUMMARY
The ethics guidelines for forensic mental health professionals direct practitioners to begin their in-person assessments by explaining the nature and purpose of the examination. To learn if evaluees have understood and can give consent, forensic practitioners may ask evaluees to paraphrase the explanation. Yet whether an evaluee can do this is itself a clue to the evaluee's mental functioning, because accurate paraphrasing requires that the evaluee assimilate the disclosure information, appreciate its bearing on the situation, and explain it rationally. This study tested whether an evaluee's disclosure response (DR) prior to an examination of competence to stand trial (CST) was itself a diagnostic test of CST. Using archival data from 255 CST reports previously submitted to courts, we classified the examiner's description of the DR at three levels: "yes" (accurate paraphrasing), "no" (inability to paraphrase or provide a relevant response), and "other" (an intermediate level implying less-than-accurate responding). As a diagnostic test of CST, DR had a ROC area of 0.74. None of the 28 DR = "no" evaluees were CST, and only 7 (17%) of the 48 DR = "other" evaluees were CST. These findings illustrate the diagnostic and moral significance of informed consent processes in forensic evaluations.

REFERENCES
Mossman D, Noffsinger S, Ash P, et al: AAPL Practice guideline for the forensic psychiatric evaluation of competence to stand trial. J Am Acad Psychiatry Law 2007; 35(S):3-72, 2007
Mossman D, Wygant DB, Gervais RO: Estimating the accuracy of neurocognitive effort measures in the absence of a "gold standard." Psychol Assess 24:815–82, 2012

QUESTIONS AND ANSWERS
Findings from this and previous studies show which of the following relationships between mental disorders and adjudicative competence?
a. Bipolar disorder is an uncommon cause of incompetence to stand trial
b. Few individuals found incompetent to stand trial have substance use disorders
c. Among those defendants who do have substance use disorders, those disorders predict poor response to restoration efforts
d. Defendants whose schizophrenia is the cause of their incompetence have a lower change of successful restoration that defendants rendered incompetent by bipolar disorder
ANSWER: d

According to this study, which statement correctly describes the relationship between ability to paraphrase disclosure information and competence to stand trial?
a. Giving little or no response is strongly indicative of incompetence
b. Accurate paraphrasing almost certainly implies competence
c. Both of the above
d. None of the above
ANSWER: a

T40 NATURE, NURTURE, AND ATTACHMENT

Stephen Billick, M.D., New York, NY
Alexandra Junewicz, New York, NY

EDUCATIONAL OBJECTIVE

To explore and discuss the extent to which the presence of a genetic parent-child relationship affects attachment, and thereby enhance the consulting skills of child forensic psychiatrists

SUMMARY

Recent expansion of the legal definition of parenthood raises the question of whether the presence of a genetic relationship between a parent and child trumps environmental and interpersonal factors in the formation of a strong, secure attachment bond. This paper attempts to shed light on the extent to which the presence of a genetic parent-child relationship affects attachment. It begins with an overview of attachment and its biological basis, then explores the impact of environmental and interpersonal influences, which have the power to alter brain biology. While attachment certainly involves biological processes, there is no clear evidence that a genetic relationship confers a significant advantage. Indeed, the real biological parent of a child is the parent with whom the child shares a strong attachment bond.

REFERENCES

Moriceau S, Sullivan RM: Neurobiology of infant attachment. Dev Psychobiol 47:230-42, 2005
Newman L, Sivaratnam C, Komiti A: Attachment and early brain development - neuroprotective interventions in infant-caregiver therapy. Transl Dev Psychiatry Available at http://www.translationaldevelopmentalpsychiatry.net/index.php/tdp/article/vi. Accessed September 1, 2017

QUESTIONS AND ANSWERS

What is the significance of the recent New York State Court of Appeals decision, Brooke S.B. v. Elizabeth A.C.C?
a. It allowed a "non-biological," non-genetic parent to seek custody and visitation rights
b. It limited custody rights to genetic or adoptive parents
c. It limited visitation rights to genetic parents only
d. None of the above
ANSWER: a

Which of the following statements is true?
a. There is clear evidence that a genetic parent-child relationship confers a significant advantage in the formation of a strong, secure attachment bond
b. Though attachment involves biological processes, it is powerfully influenced by environmental and interpersonal factors
c. Environmental and interpersonal influences do not alter brain biology
d. None of the above
ANSWER: b

T41 THE CHALLENGE AND IMPACT OF TRUTH IN FORENSIC PSYCHIATRY

Madelon Baranoski, PhD, New Haven, CT

EDUCATIONAL OBJECTIVE

Participants will be prepared to examine and explain factors that make psychiatry unique within medical specialties, to examine their own biases through a process of self-cross-examination, and to appreciate the impact and limitations of diagnoses-bound formulations. Participants will consider and discuss the impact of forensic psychiatric opinions within cultural-social frameworks.

SUMMARY

Forensic psychiatry is a recognized but still evolving subspecialty in medicine. The discipline has established truth in rich theory, critical discourse, and ethics. In concert with the created truth of Law, forensic psychiatry, in particular, and psychiatry, in general, stand apart from other medical specialties founded on basic sciences with replicable methodologies and biological indicators. The differences between psychiatry and medical disciplines (like oncology, immunology, and infectious disease among others) correspond to the target of their work: psychiatry diagnoses, treats, and monitors personhood; other specialties focus on organ systems and disease. The differences also affect how work is done and the risks that threaten truth. This paper will focus on three challenges of establishing psychiatric truth: the dependence on function rather than biological markers to determine health and disorders, the limitations of diagnoses, and the overt and subtle impact of countertransference. The paper will describe approaches

including self-cross examination, hypotheses analysis, and peer review to approach truth in formulation and testimony. The concluding portion of the paper will present the ethics challenge for forensic psychiatry – recognition of the impact of its influence and acceptance of social obligations that derive from international status as arbitrator of behavior, culpability, and worth.

REFERENCES

Dobson S, Voyer S, Regehr G: Agency and activism: rethinking health advocacy in the medical profession. Acad Med 87(9):1161–1164, 2012

Mikton C, Grounds A: Cross-cultural clinical judgment bias in personality disorder diagnosis by forensic psychiatrists in the UK: a case-vignette study. J of Personality Disorders 21(4): 400-417, 2007

QUESTIONS AND ANSWERS

The absence of biomarkers of disorders in psychiatry

a. Limits the relevance of psychiatry in medicine.
b. Increases reliance on critical analysis, examination of countertransference, and cultural sensitivity.
c. Eliminates the need for replication of diagnostic results.
d. Prevents the risk of over-diagnosis.

ANSWER: Answer b.

The role for forensic psychiatry in addressing issues of racism, social inequality, poverty, and violence

a. Is limited by the need to preserve objectivity and professional integrity.
b. Is no different from the role of any physician from any medical specialty.
c. Is undergirded by behavioral, social, and neuroscience research.
d. Is easily conflated with political activism and social advocacy.

ANSWER: C.

T42 AN INQUISITORIAL, EXPERT CONSENSUS PANEL MODEL

Michael A. Norko MD, Durham, CT
John L. Kane JD, Denver, CO
Jeffrey L. Metzner MD, Denver, CO
Phil Cherner JD, Denver, CO
Rich Orman JD, Denver, CO
Phillip J. Resnick MD, Cleveland, OH

EDUCATIONAL OBJECTIVE

Participants will be able to demonstrate the use of an expert consensus panel in a criminal trial; to illustrate an inquisitorial method in presentation of mental health testimony; to stimulate discussion of the pros and cons of this methodology versus the traditional, adversarial presentation of expert witnesses in authentically representing psychiatric evidence.

SUMMARY

This session will demonstrate an alternative approach to the traditional, adversarial model of presenting psychiatric expert testimony in criminal cases. The death penalty trial of James Holmes (the Aurora, Colorado cinema shooter) will be revisited with experts from the real case: Drs. Jeffrey Metzner, William Reid and Phillip Resnick. Rather than the defense and prosecution attorneys putting on their respective expert witnesses, the mock trial will presume that all three experts were appointed by the court and tasked with attempting to form a consensus opinion on the medicolegal questions posed. The judge will elicit testimony from the experts about their consensus opinion and any areas of disagreement, focusing on three main topics: Mr. Holmes' diagnosis; his ability to distinguish right from wrong or to form a culpable mental state; and the presence of psychiatric mitigating factors. Prosecution and defense attorneys will examine the panel members after they have presented their consensus opinions. After the conclusion of the mock trial exercise, audience members will be invited to engage in a discussion about the pros and cons of their alternative, consensus-based method of presenting psychiatric opinions to the court.

REFERENCES

Frankel ME: The search for truth: an umpireal review. Univ PA Law Rev 123:1031-1059, 1975

Menkel-Meadow C: The trouble with the adversary system in a post-modern, multi-cultural world. Wm & Mary L Rev 38: 5-44, 1996

QUESTIONS AND ANSWERS

The inquisitorial trial model is distinguished from the adversarial model by:
a. Requiring witnesses to stand during testimony
b. Removing attorneys from the trial process
c. Establishing truth as the proximate goal of the process
d. Creating a sense of fairness in the outcome
ANSWER: c

The consensus panel approach to expert mental health testimony has the advantage of:
a. Decreasing the work of individual forensic experts
b. Diminishing the impression of a battle of the experts
c. Immunizing experts against rigorous cross-examination
d. Forcing experts to agree upon legally-relevant questions
ANSWER: b

FRIDAY, OCTOBER 27, 2017

POSTER SESSION B — 7:00 AM – 8:00 AM, 9:30 AM – 10:15 AM — **CENTENNIAL BALLROOM FOYER**

F1 ***The Case for Landmark Cases: Support for Sequential Seminar***
Merrill R. Rotter MD, Bronx, NY
Jeremy H. Colley MD, New York, NY
Elizabeth B. Ford MD, New York, NY
Howard L. Forman MD, New York, NY (I)

F2 ***Communication Disorders and Juvenile Sex Offender Treatment***
Samuel J. House MD, Sherwood, AR
John M. Casey MD, Little Rock, AR
Martin R. Watts MD, Little Rock, AR
Stacy M. Simpson MD, Little Rock, AR
Steven Domon MD, Little Rock, AR (I)
Tiffany A. Howell PhD, Little Rock, AR (I)
Zachary N. Stowe MD, Little Rock, AR (I)

F3 ***Conditional Release of NGRI Acquittees: Outcomes and Trends***
Samuel J. House MD, Sherwood, AR (I)
Tiffany A. Howell PhD, Little Rock, AR (I)
Jessica F. Howdeshell LCSW, Little Rock, AR (I)
Carrie E. Jones LCSW, Little Rock, AR (I)
Rebecca B. Spohn PhD, Little Rock, AR (I)

F4 ***Survey of Treatment Refusal by Defendants Found IST***
Amam Z. Saleh MD, Falmouth, ME

F5 ***Why Incompetent and Unrestorable?***
Cristina M. Secarea MD, Arlington, VA
Philip J. Candilis MD, Alexandria, VA

F6 ***When Legal Rights and Clinical Need Collide: Involuntary ECT***
Jacob Oyer MD, Springfield, MA (I)
Rebecca Olufade MD, Springfield, MA (I)
Stuart Anfang MD, Springfield, MA

F7 ***Expanding Tarasoff: The Implications of Volk v. DeMeerleer***
Kayla Fisher MD JD, Sacramento, CA

F8 ***"Bad" Patients or Bad Diagnosis: What Does ASPD Predict?***
Kanishk S. Solanki MD, New York, NY
Merrill Rotter MD, Bronx, NY
Ali Khadivi PhD, Bronx, NY (I)
Katya Frischer MD, Bronx, NY

F9 ***Fecal Fallacy – Managing the Disorder and the Doer***
Adnan Ahmed MBBS, Prior Lake, MN
Soniya Hirachan MD, Saint Peter, MN

F10 ***Can Naltrexone Cure Antisocial Personality Disorder?***
William Levitt MD, Hackensack, NJ
Steven Fishbein MS IV, Paramus, NJ (I)

F11 ***Neuropsychological Profiles of Murderers of Children***
Nicole M. Azores-Gococo MS, Durham, NC (I)
Michael Brook PhD, Chicago, IL (I)
Robert E. Hanlon PhD, Chicago, IL (I)
Saritha Teralandur MS, Chicago, IL (I)

F12 ***Abuse Histories and Treatment of Juvenile Sex Offenders***
John M. Casey MD, Little Rock, AR
Samuel J. House MD, Sherwood, AR
Martin R. Watts MD, Little Rock, AR
Tiffany Howell PhD, Little Rock, AR (I)
Stacy M. Simpson MD, Little Rock, AR
Steven Domon MD, Little Rock, AR (I)
Zachary N. Stowe MD, Little Rock, AR (I)

F13 ***Violence Risk Assessment in the Treatment of Early Psychosis***
Stephanie A. Rolin MD MPH, New York, NY (I)
Leslie Marino MD MPH, New York, NY (I)
Nannan Liu EdD, New York, NY (I)
Yael Holoshitz MD, New York, NY (I)
Ilana Nossel MD, New York, NY (I)
Jean-Marie Bradford MD, New York, NY (I)
Barry Rosenfeld PhD, Bronx, NY (I)
Merrill Rotter MD, Bronx, NY
Lisa Dixon MD MPH, New York, NY (I)

F14 ***Clinical and Legal Needs Accompanying Unaccompanied Children***
Makeda Jones-Jacques MD, Brooklyn, NY (I)
Merrill R. Rotter MD, Bronx, NY

F15 ***Beyond the Sliding Scale: Context and Decisional Capacity***
Rocksheng Zhong MD, New Haven, CT

F16 ***A History of Racially Segregated American State Hospitals***
Paul E. Noroian MD, Westborough, MA

F17 ***Asylum Evaluations in a Forensic Psychiatry Fellowship***
Peter S. Martin MD MPH, Buffalo, NY
Melissa D. Heffler MD, Buffalo, NY
Kim Griswold MD, Buffalo, NY (I)

F18 ***Mental Health Outcomes of the Post-Critical Incident Seminar***
Joseph C. Cheng MD PhD, Charleston SC
J. Eric Skidmore DMin, Columbia, SC (I)
R. Gregg Dwyer MD EdD, Charleston, SC

F19 ***False Pregnancies, False Narratives: Pseudocyesis and Crime***
Michelle T. Joy MD, Philadelphia, PA
Ijeoma Jennifer Njoku MD, Philadelphia, PA
Sundeep Virdi MD JD, New York, NY

F20 ***Positive Countertransference for the Psychopathic Patient***
Paulina Riess MD, Mamaroneck, NY
Ahmed M. Albassam MD, Whitestone, NY
Panagiota Korenis MD, Eastchester, NY (I)
Ali Khadivi PhD, Bronx, NY (I)

AAPL BUSINESS MEETING (MEMBERS ONLY) 8:00 AM – 9:30 AM **CENTENNIAL BALLROOM D**

COFFEE BREAK **9:30 AM – 10:00 AM**

WORKSHOP 10:00 AM – 12:00 PM **CENTENNIAL BALLROOM D**

F21 ***So You're All Grown Up? Transitioning from Trainee to Expert***
Tobias Wasser MD, Hamden, CT
Simha Ravven MD, New Haven, CT
Brian Falls MD, Austin, TX (I)
Alexander Westphal MD PhD, New Haven, CT

PANEL 10:00 AM – 12:00 PM **MINERAL D-E**

F22 ***Genetic Explanations of Behavior in Legal Contexts***
Steven K. Hoge MD, New York, NY
Maya Sabatello PhD LLB, New York, NY (I)
Nicholas Scurich PhD, Irvine, CA (I)

PANEL 10:00 AM – 12:00 PM **MINERAL F-G**

F23 ***Gender Issues in Correctional Settings***
Gender Issues Committee
Tara Collins MD MPH, San Francisco, CA
Anna Glezer MD, San Francisco, CA
Susan Hatters Friedman MD, Cleveland Heights, OH
Brian Holoyda MD, St. Louis, MO
Aimee Kaempf MD, Tucson, AZ

PANEL — 10:00 AM – 12:00 PM — **AGATE**

F24 ***Assessments of Speech: From Trigger Warning to True Threat***

Jessica Ferranti MD, Sacramento, CA
Barbara McDermott PhD, Sacramento, CA (I)
Charles Scott MD, Sacramento, CA

WORKSHOP — 10:00 AM – 12:00 PM — **MINERAL A-C**

F25 ***Digital Automation for the Expert Witness***
Technology Committee

Andrew Nanton MD, Tualatin, OR
Alan Newman MD, San Francisco, CA

LUNCH (TICKET REQUIRED) — 12:00 PM – 2:00 PM — **CENTENNIAL BALLROOM A-C**

F26 ***The Dangers of Adversarialism in the Legal System and Elsewhere***

Professor Carrie Menkel-Meadow, Irvine, CA (I)

DEBATE — 2:15 PM – 4:00 PM — **CENTENNIAL BALLROOM D**

F27 ***The Goldwater Rule: Time to Move On?***
Ethics Committee

Saul Faerstein MD, Beverly Hills, CA
Donald Meyer MD Cambridge, MA
Wade Myers MD, Providence, RI
Karen Rosenbaum MD, New York, NY
Rebecca W. Brendel, MD JD, Boston, MA (I)

WORKSHOP — 2:15 PM – 4:00 PM — **MINERAL D-E**

F28 ***Does Life Really Go On after a LWOP Sentence?***

Rosa E. Negron Munoz MD, Lakeland, FL
Julia J. Williamson JD, Bartow, FL (I)
Orville D. Wallen BS, Brandon, FL (I)

WORKSHOP — 2:15 PM – 4:00 PM — **MINERAL F-G**

F29 ***APA Council on Psychiatry and the Law: Update***

Steven K. Hoge MD, New York, NY
Debra Pinals MD, Ann Arbor, MI

RESEARCH IN PROGRESS #2 — 2:15 PM – 4:00 PM — **AGATE**

F30 ***Criminal Responsibility in Frontotemportal Dementia***

Vivek Datta MD MPH, San Francisco, CA
Eric Rafla-Yuan MD, San Diego, CA
Dale McNiel PhD ABPP, San Francisco, CA (I)
Renee Binder MD, San Francisco, CA

F31 ***Oversight Body Questions Regarding NGRI Acquittees***

Michael Moravecek PsyD, Middletown, CT (I)

F32 ***Supervision for NGRI and MDO: Risks, Needs, Responsivity***

Jeremy Colley MD, New York, NY
Melinda DiCiro PhD, Sacramento, CA (I)

COURSE — 2:15 PM – 6:15 PM — **MINERAL A-C**

F33 ***Assessment and Treatment of Problematic Sexual Interests***
Sexual Offenders Committee

R. Gregg Dwyer MD EdD, Charleston, SC
J. Paul Fedoroff MD, Ottawa, ON, Canada
Lisa Murphy MCA, Ottawa, ON, Canada (I)
Charles Scott MD, Sacramento, CA

AUDIOVISUAL SESSION (PEER REVIEW) 4:15 PM – 6:15 PM **CENTENNIAL BALLROOM D**

F34 ***Murder Most Foul: Assessing Moral Wrongfulness in the Insanity Defense***
Peer Review Committee

David Rosmarin MD, Newton, MA
Ezra E.H. Griffith MD, New Haven, CT
Stephen Noffsinger MD, Hudson, OH
Phillip Resnick MD, Cleveland, OH

PANEL 4:15 PM – 6:15 PM **MINERAL D-E**

F35 ***To Get to the Other Side: Reentry Planning in Corrections***
Community Forensics and Correctional Psychiatry Committee

Merrill Rotter MD, Bronx, NY
Elizabeth Ford MD, New York, NY
Jackie Landess MD, JD, St. Louis, MO
Li-Wen Lee MD, New York, NY
Nubia Lluberes MD, Missouri City, MO
William Newman MD, Saint Louis, MO

PANEL 4:15 PM – 6:15 PM **MINERAL F-G**

F36 ***Responses to the New Executive Orders on Immigration***
Cross Cultural and Liaison with Forensic Sciences Committees

Varendra Gosein MD, Larkspur, CA
Lauren Groth Esq, Boulder, CO (I)
Maya Prabhu MD, New Haven, CT
Karen Rosenbaum MD, New York, NY
Barry Roth MD, Brookline Village, MA

RESEARCH-IN-PROGRESS #3 4:15 PM – 6:15 PM **AGATE**

F37 ***Drug Use, Drug Policy, and Violence in America: A Review***

Benjamin Goldberg, MA MD, Napa, CA

F38 ***Violent Ideation and Behavior in Youths With Early Psychosis***

Stephanie A. Rolin MD MPH, New York, NY (I)
Leslie Marino MD MPH, New York, NY (I)
Ilana Nossel MD, New York, NY (I)
Barry Rosenfeld PhD, Bronx, NY (I)
Merrill Rotter MD, Bronx, NY
Lisa Dixon MD MPH, New York, NY (I)

F39 ***Countertransference and Vicarious Trauma in Forensic Practice***

Alcina Barros MD, Porto Alegre, Brazil
Claudio Eizirik PhD, Porto Alegre, Brazil (I)
Simone Hauck PhD, Porto Alegre, Brazil (I)
Pricilla Laskoski MS, Porto Alegre, Brazil (I)
Stefania Teche MD, Porto Alegre, Brazil
Carolina Padoan MS, Porto Alegre, Brazil (I)

F40 ***Violence in Forensic Hospitals: Links to Childhood Violence***

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

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

F1 THE CASE FOR LANDMARK CASES: SUPPORT FOR SEQUENTIAL SEMINAR

Merrill R. Rotter MD, Bronx, NY
Jeremy H. Colley MD, New York, NY
Elizabeth B. Ford MD, New York, NY
Howard L. Forman MD, New York, NY

EDUCATIONAL OBJECTIVE
To demonstrate the utility of and learning opportunities provided by including a stand-alone seminar in Landmark Cases as part of Forensic Fellowship training

SUMMARY
The ACGME requirements for Graduate Medical Education in Forensic Psychiatry include demonstrating competence in "ethical, administrative, and legal issues in forensic psychiatry… history of forensic psychiatry… roles and responsibilities of forensic psychiatrists… basic civil procedure… basic criminal procedure…fundamentals of law, statutes, and administrative regulation." While none of the above require a separate curriculum in Landmark Cases, in this presentation, we will argue that many of these pedagogic goals are enhanced by a stand-alone seminar approach. For this poster, the authors reviewed the 130 cases listed by the AAPL as of 2014. References to earlier landmark cases were noted, along with the specific legal issue for which they were cited. The number of times each landmark case was cited was tallied, as were the number of references to specific legal issues. Utilizing these data and specific case examples, we will describe, narratively, and demonstrate, graphically how a stand-alone, chronologically-organized, in-depth case discussion-based seminar can illuminate the history of forensic psychiatry, the relationship between psychiatry and broad social and legal trends, including civil rights, federalism, law enforcement, and the role of government in serving or supporting underserved populations with and without mental illness.

REFERENCES
Appelbaum PS: Almost a Revolution: Mental Health Law and the Limits of Change. New York, NY: Oxford University Press, 1994
Rotter M, Forman H: The Case for Landmark Cases in Principles and Practice of Forensic Psychiatry. 3rd ed. Rosner R & Scott C (eds). Boca Raton, FL: CRC Press, 2016

QUESTIONS AND ANSWERS
All but one of the following are reasons for which Robinson v. California (1962) was cited in subsequent Landmark Cases:
a. Evolving standards of decency
b. Application of 8th amendment to states
c. Dangerousness
d. Balancing severity of punishment with severity of offense
e. Fluidity in defining civil vs. criminal procedures
ANSWER: c

Which of the following is not a definition of the 14th amendment guarantee of liberty utilized in Landmark Cases?
a. Confinement
b. Safety
c. Medication refusal
d. Sanity
e. Right to counsel
ANSWER: e

F2 COMMUNICATION DISORDERS AND JUVENILE SEX OFFENDER TREATMENT

Samuel J. House MD, Sherwood, AR
John M. Casey MD, Little Rock, AR
Martin R. Watts MD, Little Rock, AR
Stacy M. Simpson MD, Little Rock, AR
Steven Domon MD, Little Rock, AR
Tiffany A. Howell PhD, Little Rock, AR
Zachary N. Stowe MD, Little Rock, AR

EDUCATIONAL OBJECTIVE
The educational objective is to present new preliminary scientific data obtained through a chart review concerning the possible association between juvenile sexual offense and communication disorders.

SUMMARY
According to the 2014 Uniform Crime Reports by the FBI which analyzed arrest reports from 6,082 agencies, persons under the age of 18 years accounted for 25,890 arrests for violent crimes, 1,501 of which occurred for rape (Uniform Crime Reports, 2015). Arrests of persons of all ages for other, non-violent sexual offenses excluding rape and prostitution numbered 29,784 in 2014, of which 4,910 were accounted by persons under the age of 18 (Uniform Crime Reports 2015). While investigations regarding the development and risk factors of juvenile sexual offenders (JSOs) have shown promising results, the possible connections to communication disorders has received limited attention. This preliminary retrospective chart review of 136 male juvenile sexual offenders investigates the possible impact of communication disorders on treatment completion from an inpatient treatment program. A total of 38 JSOs with communication disorders were examined for association between diagnosis and program completion. These outcomes were compared to 31 JSOs without communication disorders, matched for race, intelligence quotient, and age. Through this analysis, we hope to offer an additional tool to assist in the successful completion of treatment of JSOs, as well as inform future studies of communication disorders in this population.

REFERENCES
Seto M, Lalumiere M.: What is so special about male adolescent sexual offending? A review and test of explanations through meta-analysis. Psychol Bull 136(4): 526-75, 2010
Snow P, Powell M: What's the story? An exploration of narrative language abilities in male juvenile offenders. Psychol Crime Law 11(3): 239-53, 2005

QUESTIONS AND ANSWERS
Compared to children without communication difficulties, children with speech and language impairments have _____ risk of developing psychiatric disturbances.
a. Increased
b. Decreased
c. Equal
ANSWER: a

Studies have indicated that juvenile males with communication difficulties are ____ likely to be associated with criminal behavior than juvenile males without communication difficulties.
a. More
b. Less
c. Equally as likely
ANSWER: a

F3 **CONDITIONAL RELEASE OF NGRI ACQUITTEES: OUTCOMES AND TRENDS**

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EDUCATIONAL OBJECTIVE
The educational objective is to present new preliminary outcome data obtained through a retrospective analysis of an existing database of defendants acquitted by reason of mental disease or defect and subsequently committed to a conditional release program concerning the identification of factors that predict success or failure in the program.

SUMMARY
The Act 911 Program in the state of Arkansas, officially known as the "Conditional Release Program," initiated changes in the procedures relating to the defense, acquittal, and commitment of individuals with mental disease or defect. The primary responsibility of the program is to monitor clients who have been conditionally released from the Arkansas State Hospital. Additionally, the program was initiated to assist NGRI acquittees with treatment compliance, obtaining medications post discharge, maintaining safe behaviors in the community, and refraining from future criminality. Research conducted on similar programs in other states has found varying degrees of success with their conditional release programs, as well as trends or indicators that NGRI acquittees will or will not successfully complete their conditional release. This preliminary study of 585 NGRI acquittees investigates the factors which may contribute to an individual's successful completion, revocation, or extension of the Act 911 Conditional Release Program. Through this analysis, we hope to offer additional tools in the risk assessment of conditionally released persons as well as provide a better understanding of the program's strengths and weaknesses.

REFERENCES
Ark. Stat. Ann. § 5-2-315 (2017)
Monson CM, Gunnin DD, Fogle MH, et al: Stopping (or slowing) the revolving door: factors related to NGRI acquittees' maintenance of a conditional release. Law Hum Behav 25: 257-67, 2001

QUESTIONS AND ANSWERS
The objectives of conditional release program in Arkansas include all of the following except:
a. Assisting acquittees with treatment compliance
b. Informing the community of potentially dangerous individuals
c. Assisting acquittees obtain medications post discharge
d. Helping acquittees maintain safe behaviors in their communities
ANSWER: b

Conditional release programs for NGRI acquittees nation-wide have found ____ results regarding successful completion by acquittees.
a. Mostly positive
b. Mostly negative
c. Mixed
ANSWER: c

F4 SURVEY OF TREATMENT REFUSAL BY DEFENDANTS FOUND IST

Amam Saleh MD, Worcester, MA

EDUCATIONAL OBJECTIVE
Attendees will learn that treatment of forensic patients with effective and much needed psychotropic medication continues to be an issue. Attendees will also learn that a small but significant proportion of forensic patients receive no psychotropic medication treatment. Data about this population remains non-specific and unclear.

SUMMARY
A proportion of IST (Incompetent to stand trial) defendants committed to mental facilities refuse psychotropic medication. Some of these defendants receive no medication treatment despite being in a facility for lengthy periods. This survey was aimed at estimating the proportion of patients who receive no medication and ascertaining the reasons for such an outcome. Using SurveyMonkey, we collected data from administrators of forensic services in the United States. The survey response rate was 44.23% (23/52). Most states reported between 10-50 petitions for involuntary medication treatment in the past year. One in five reported more than 50 such petitions. All respondents (100%) indicated that they had discharged patients who received no treatment with psychotropic medication in the past year. Respondents gave highest average rating to "Failed to meet Sell criteria" and "Procedure to obtain override of refusal too difficult or time consuming" respectively as reasons for no treatment with medication. Persons with mental illnesses when committed for competency restoration find a rare opportunity to receive long-term and usually effective treatment for their mental illness. This survey indicates that while most defendants receive medication treatment a small but significant number go untreated despite being committed for lengthy periods.

REFERENCES
Miller RD: Hospitalization of criminal defendants for evaluation of competence to stand trial or for restoration of competence: clinical and legal issues. Behav Sci Law 21(3): 369-391, 2003
Field P: Needs of mentally ill often untreated in jails. Available at http://www.lcsun-news.com/story/life/wellness/2015/07/30/pamela-field-needs-mentally-ill-often-untreated-jails/32018123/. Accessed September 12, 2017

QUESTIONS AND ANSWERS
What percentage of the responding states/jurisdictions had discharged patients without any psychotropic medication treatment in the past year?
a. 25%
b. 50%
c. 75%
d. 100%
e. None
ANSWER: d

Of the following reasons for no treatment with psychotropic medication in the survey, which one received the highest average rating from respondents?
a. Did not need medication
b. Failed to meet dangerousness criteria
c. Procedure to obtain override of refusal too difficult or time consuming
d. Failed to meet Sell criteria
e. Other
ANSWER: d

F5 WHY INCOMPETENT AND UNRESTORABLE?

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EDUCATIONAL OBJECTIVE

To identify specific static (demographic) and dynamic (clinical) factors influencing incompetence and draw a more precise picture of the unrestorable patient and offer support for forensic evaluators identifying evaluees as unrestorable.

SUMMARY

In the forensic literature the most common factors associated with incompetence to stand trial (IST) are older age, a less serious charge, and diagnoses of intellectual developmental disorders, cognitive disorders, and psychosis. We present data from a sample of 53 inpatients at a state psychiatric facility found incompetent to stand trial and identify the correlates of incompetence, from demographic data and severity of charges to treatment adherence, severity of illness, and violent behavior. Of 53 IST patients, the majority was male (72%), aged 41-60 years old (45%) and had a history of prior hospitalization (75%). The two most common diagnoses were psychotic disorders (75%) and substance use (57%); the third most common diagnosis was cognitive disorder (30%). 83% were adherent to their medication and only 32% required emergency medications to treat agitation or violent behavior. The mean hospital length of stay (LOS) for the group was 119 days. This study reproduces previous incompetence data in the forensic literature. Unlike other incompetence studies, however, we also explored treatment adherence by monitoring refused doses of psychotropic medication and categorizing the refusals by medication class and number of emergency episodes.

REFERENCES

Mossman D: Predicting restorability of incompetent criminal defendants. J Am Acad Psychiatry Law 35:34-43, 2007
Morris D, DeYoung N: Long-term competence restoration. J Am Acad Psychiatry Law 42:81-90, 2014

QUESTIONS AND ANSWERS

What is the most common diagnosis associated with incompetence to stand trial?
a. Mood disorders
b. Cognitive disorders
c. Substance use disorders
d. Psychotic disorders
ANSWER: d

What is the mean hospital length of stay (LOS) for incompetent defendants in the District of Columbia?
a. 65 days
b. 119 days
c. 180 days
d. 334 days
ANSWER: b

F6 WHEN LEGAL RIGHTS AND CLINICAL NEED COLLIDE: INVOLUNTARY ECT

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Stuart Anfang MD, Springfield, MA

EDUCATIONAL OBJECTIVE

To discuss the trend towards increasing judicial involvement in the implementation of involuntary ECT throughout the U.S., present the specific legal requirements to authorize involuntary ECT in MA and explore, via literature review and a case report, potential for negative impact on patient care/safety resulting from these legal requirements.

SUMMARY
Electroconvulsive therapy is one of modern psychiatry's most effective treatment modalities for a variety of mood and thought disorders. Nevertheless the procedure remains controversial and stigmatized, and over time has come under increasingly stringent regulations in many states. Under the 1983 Rogers decision in Massachusetts, legal proceedings are often the limiting step for ECT induction in severely ill patients deemed to lack the capacity to consent. Although such state regulations are created to protect patient rights and due process, some psychiatrists voice concern that these additional hurdles may delay treatment, prolonging suffering and endangering patients. This case report describes the hospital course of a 36-year-old female with a history of bipolar disorder with psychotic features and multiple previous suicide attempts, who presented upon transfer from an outside hospital due to a high risk 33-week pregnancy in the setting of minimal oral intake secondary to depression and paranoid delusions. Inpatient treatment lasted 3.5 months, spanning her delivery and involving 2 separate civil commitment hearings before involuntary ECT was legally authorized. Once ECT began, the patient, who had shown minimal improvement on oral antipsychotic medications, rapidly recovered within 3 weeks.

REFERENCES
Harris V: Electroconvulsive therapy: administrative codes, legislation, and professional recommendations. J Amer Acad Psych Law 34:406–411, 2006
Rogers v. Commissioner of the Dept. of Mental Health, 390 Mass. 489 (1983)

QUESTIONS AND ANSWERS
What legal process is needed for ECT to be administered on an involuntary basis in MA?
a. Treating psychiatrist must determine, by exam, that patient lacks capacity to refuse this treatment; treating psychiatrist then may order ECT once capacity status is documented.
b. Treating psychiatrist must obtain written agreement from at least 1 other qualified physician regarding necessity of ECT, in addition to documenting patient's lack of capacity to refuse treatment.
c. A judge grants approval via civil commitment and substituted judgment treatment plan (antipsychotic medications or ECT) at court hearing after evidence is presented by treating physician in an adversarial trial process; patient and physician are both represented by lawyers; patient has option to testify; number and timeframe of ECT treatments must be specified.
d. Treating psychiatrist presents the case, including capacity assessment, indications for ECT, risks/benefits of the procedure, alternative treatments, and associated prognoses, to a judge, who grants or withholds approval for the procedure via an expedited process without trial.
ANSWER: c

For a pregnant patient, in what situations may ECT be considered first line treatment?
a. Never. ECT should not be used for pregnant patients.
b. In the setting of life-threatening mood and/or psychotic disorders.
c. In the setting of psychiatric decompensation, but only during the first trimester.
d. If the patient is currently stable, and elects to discontinue her psychiatric medication.
ANSWER: b

F7 EXPANDING TARASOFF-- THE IMPLICATIONS OF VOLK V. DEMEERLEER

Kayla Fisher MD JD, Sacramento, CA

EDUCATIONAL OBJECTIVE
This poster will review the Tarasoff duty and provide details of the Washington State case of Volk v. De Meerleer, which expands the previous Tarasoff duty in that state. The potential implications for forensic psychiatry will be presented, including impacts on confidentiality and increased liability associated with treating complex patients.

SUMMARY
Psychiatrists have long recognized their legal duty to protect an identified victim from a patient's serious threat of harm, as required by the ruling in Tarasoff v. Regents of the University of California in 1976. As a result of Tarasoff, psychiatrists have a duty "to use reasonable care to protect the intended victim." The duty is not absolute, but requires that reasonable preventive measures be taken. Now, the Washington State Supreme Court has expanded the Tarasoff duty for clinicians of that state through their ruling in Volk v. DeMeerLeer. In their ruling, the Court held that the clinician has a duty to "foreseeable victims"---even if never identified by the patient. This ruling has troublesome implications, including: 1) increasing liability; 2) eroding patient expectations of confidentiality; 3) decreasing motivation to integrate mental health and general health care; 4) increasing involuntary commitment referrals; 5) fewer clinicians willing to work with patients at risk for violence and 6) placing unreasonable burdens on clinicians. After a review of the Tarasoff requirements along with the general facts and ruling in Volk v. DeMeerLeer, this poster will explore these implications and their potential impacts on forensic psychiatry.

REFERENCES
Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976)
Felthous A: Warning a potential victim of a person's dangerousness: clinician's duty or victim's right? J Amer Acad Psych Law 34(3):338-348, 2006

QUESTIONS AND ANSWERS
In Volk v. DeMeerleer, the Washington Supreme Court held:
a. There is a minimum length of involuntary commitment that must follow if a patient expresses with intent to kill another person.
b. The psychiatrist must provide the intended victim with a list of the local police departments.
c. The Tarasoff warning must be witnessed by another individual
d. The psychiatrist had a duty to protect foreseeable victims
ANSWER: d

Anticipated outcomes of Volk v DeMeerleer include all but which of the following:
a. More reasonable psychiatric malpractice premiums in Washington state
b. Lowered patient expectations of confidentiality
c. Increased referrals for involuntary commitments
d. Fewer clinicians willing to work with potentially violent patients
ANSWER: a

F8 "BAD" PATIENTS OR BAD DIAGNOSIS: WHAT DOES ASPD PREDICT?

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Ali Khadivi PhD, Bronx, NY
Katya Frischer MD, Bronx, NY

EDUCATIONAL OBJECTIVE
This study 's objective is to assess the relevance and usefulness of Antisocial Personality Disorder diagnosis as predictor of clinical outcomes (length of stay, inpatient aggression/violence) in a civil psychiatric hospital setting.

SUMMARY
Studies have called into question the reliability, validity and clinical utility of Antisocial Personality Diagnosis (ASPD) in forensic psychiatry settings. Published results have included poor inter-rater reliability in ASPD diagnosis, as well as limited predictive validity in violence risk assessment. While clinicians in civil psychiatric settings raise frequent concerns about managing individuals with ASPD, there are few comparable studies about the clinical usefulness of ASPD diagnosis in civil settings. In this study we present a sample of 120 consecutively civilly committed inpatients at a community-based civil hospital, whose admission work-up included an evaluation for ASPD. The ASPD diagnosis was made using the SCID II–cluster B module. Utilizing data collected through retrospective chart review, we compare subjects who were assessed as having co-morbid ASPD with those who did not on descriptive variables including: co-morbid diagnosis, age, gender, substance abuse, legal history, and violence history, as well as outcome variables including: violent and non-violent inpatient incidents and length of stay. The clinical implications of co-morbid diagnosis of ASPD for both treatment planning and inpatient management will be discussed.

REFERENCES
Freedman R, Lewis DA, Michels R, et al: The initial field trials of DSM-5: new blooms and old thorns. Am J Psychiatry 170(1):1-5, 2013
Edens JF, Kelley SE, Lilienfeld SO, et al: DSM-5 antisocial personality disorder: predictive validity in a prison sample. Law Hum Behav 39(2):123-129, 2015

QUESTIONS AND ANSWERS
According to previous studies, which of the following Antisocial Personality Disorder-related traits showed the best predictive validity for institutional misconduct, aggression, and/or violence in prison settings?
a. Remorselessness
b. Childhood conduct issues
c. Impulsivity
d. Deceitfulness
e. None of the above
ANSWER: b

According to the initial DSM-5 field trails, which of the following showed better diagnostic inter-rater reliability than Antisocial Personality Disorder?
a. Obsessive-Compulsive Personality Disorder
b. Bipolar II Disorder
c. Borderline Personality Disorder
d. Hoarding Disorder
e. All of the above
ANSWER: e

F9 **FECAL FALLACY – MANAGING THE DISORDER AND THE DOER**

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Soniya Hirachan MD, Saint Peter, MN

EDUCATIONAL OBJECTIVE
To present a protocol for managing individuals who engage in smearing and ingesting feces in psychiatric and correctional settings.

SUMMARY
Coprophagia (ingestion of feces) and Scatolia (fecal smearing) is associated with many medical conditions. These conditions can also be manifestations of protest in many individuals. Despite being commonly found in prisons and psychiatric facilities, little work has been done on how to manage it from a psychiatric standpoint. Most facilities have clear guidelines on how staff should clean and disinfect the contaminated areas however, there is little information available on how to psychiatrically manage this behavior. In the article Scatolia – Psychosis to Protest published in 1996, the authors underscored the difficulties of a protest-fecal smearing from a psychotic manifestation. The authors also stated there was no evidence to suggest that severely mentally impaired people who engage in fecal smearing cannot produce this behavior as a form of protest. In this poster we propose a three pronged algorithm as a first step for the management of this behavior. The algorithm details steps in identifying the cause of the fecal smearing and how to reduce or eliminate its occurrence while also support the staff members and other patients or inmates who are exposed to this behavior by virtue of sharing a space with the feces smearer.

REFERENCES
Mason T: Scatolia: psychosis topProtest. Journal of Psychiatric and Mental Health Nursing 3:303-31, 1996
Josephs K, Whitwell J, Parisi J, et al: Coprophagia in neurologic disorders. J Neurol 263:1008–1014, 2016

QUESTIONS AND ANSWERS
What are three conditions associated with corprophagia and scatolia?
ANSWER: Neurodegenerative Dementia, Seizures, Schizoaffective Disorder, Frontal lobe tumor, Steroid Psychosis

What is scatolia?
a. the act of fecal smearing
b. the act of eating feces
c. abnormal interest and pleasure in feces and defecation
ANSWER: a

F10 **CAN NALTREXONE CURE ANTISOCIAL PERSONALITY DISORDER?**

William Levitt MD, Hackensack, NJ
Steven Fishbein MSIV, Paramus, NJ

EDUCATIONAL OBJECTIVE
Dysregulation of the endogenous opioid system may be at the foundation of antisocial personality. The impulse control features of AsPD can be related to the dysregulation of the endogenous opioid system. We will attempt to examine the role of naltrexone in combating AsPD.

SUMMARY
The DSM–5 defines antisocial personality disorder (AsPD) as a pervasive pattern of disregard for and violation of the rights of others. Features seen frequently include failure to conform to social norms, unlawful behavior, deceitfulness, impulsivity, aggressiveness, reckless disregard for others and a lack of remorse. The mechanism for ASPD is not yet known, but dopaminergic stimulation is thought to play an integral role in the reward circuit of the brain via the mesolimbic dopamine pathway from the VTA to the NAcc. The endogenous opioid system (EOS) modulates and is modulated

by dopamine release (Roth-Deri,2016). Therefore the role that the EOS plays in reward processing should be studied in antisocial behavior. Measures of the EOS can be used to predict decision-making behaviors—especially impulsiveness and delayed gratification (Love, 2009). Naltrexone is well documented to affect the reward pathway and has become a topic of study in the field of impulse control, playing a key role in kleptomania (Aydin et al. 2012), compulsive sexual behavior (Raymond et al., 2010), impulsive behavior associated with Parkinson 's disease (Weintraub et al, 2010), and overeating (Rebello, 2016). We propose expanding this experimental use of Naltrexone to decrease impulsivity in ASPD.

REFERENCES

Roth-Deri I, Green-Sadan T, Yadid G: Beta-endorphin and druginduced reward and reinforcement. Prog Neurobiol 86(1): 1–21, 2008

Bandelow B, Wedekind D: Possible role of a dysregulation of the endogenous opioid system in antisocial personality disorder. Hum Psychopharmacol Clin Exp 30:393–415, 2015

QUESTIONS AND ANSWERS

What kind of impulse disorders has naltrexone been investigated to treat?
ANSWER: kleptomania (Aydin et al. 2012), compulsive sexual behavior (Raymond et al., 2010), impulsive behavior associated with Parkinson 's disease (Weintraub et al, 2010), and overeating

How is the naltrexone proposed to decrease impulsivity in ASPD?
ANSWER: Via its effect on the endogenous opioid system

F11 NEUROPSYCHOLOGICAL PROFILES OF MURDERERS OF CHILDREN

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Michael Brook, PhD, Chicago, IL
Robert Hanlon, PhD, Chicago, IL
Saritha Teralandur, MS, Chicago, IL

EDUCATIONAL OBJECTIVE

This poster will help viewers gain an understanding of the heterogeneity of the psychological and neuropsychological functioning of offenders charged with the murder of a child. Specifically, this poster focuses on differences between those who did and did not kill an adult in the same offense as killing a child.

SUMMARY

Despite a disproportionate media focus on women with severe mental illness who murder their children, homicides of children occur in a variety of contexts. This study examined the demographic, neuropsychological, and psychological characteristics of homicide offenders who murdered children. Participants were 33 men and women convicted of murdering one or more children, referred for forensic neuropsychological evaluations conducted by the senior author. Evaluations included clinical interview, comprehensive neuropsychological assessment using widely used tests, and review of pertinent records. We also examined group differences by presence or absence of adult victims. Psychopathology, head trauma, and histories of special education were prevalent. Mean scores on neuropsychological tests were average to low average in many domains, including overall intellectual functioning (FSIQ=85.5), attentional functions, immediate and delayed verbal memory, abstract reasoning, executive functioning, inhibition, and verbal skills. However, those who had also killed adults (n=14) had higher scores in domain, including overall intellectual functioning, executive functioning, verbal memory, and verbal fluency. This study corroborates and expands upon studies that demonstrated heterogeneous psychological and intellectual functioning among offenders who kill children. Our findings may indicate the greater neurocognitive capacity needed to kill adults and multiple victims. Such differences have implications for defining subtypes of offenders.

REFERENCES

Hanlon RE, Brook M, Stratton J, et al: Neuropsychological and intellectual differences between types of murderers: affective/impuulsive versus predatory/instrumental/premeditated homicide. Criminal Justice and Behavior 40(8):933-948, 2013

Bourget D, Grace J, Whitehurst L: A review of maternal and paternal filicide. J Amer Acad Psych Law 35(1):74-82, 2007

QUESTIONS AND ANSWERS

In this study, homicides that had both child and adult victims more likely to be _____
a. premeditated
b. impulsive
c. attempted suicides
d. kidnappings
ANSWER: a

In which cognitive domain did those who killed adults perform higher than those who killed solely children?
a. overall intellectual functioning,
b. executive functioning
c. verbal reasoning
d. verbal memory
e. all of the above
f. none of the above
ANSWER: e

F12 **ABUSE HISTORIES AND TREATMENT OF JUVENILE SEX OFFENDERS**

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Samuel J. House MD, Sherwood, AR
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Steven Domon MD, Little Rock, AR
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EDUCATIONAL OBJECTIVE
The objective is to present new preliminary scientific data obtained through chart review concerning the potential association between juvenile sexual offenses and histories of abuse.

SUMMARY
There is a disproportionate amount of research involving victims of sexual offenses as compared to the perpetrators. Some studies have examined a link between exposure to trauma and later perpetration of violence and criminal behavior. Previous studies have found that adult male sex offenders have a significantly higher rate of adverse childhood experiences than the general population, but to date there is little evidence on whether juvenile sex offenders have similar histories. This retrospective chart review of 196 male juvenile patients who participated in an inpatient sex offender treatment program investigated the hypotheses that an increased incidence of abuse history existed in this population, and that among those who participated in treatment, patients with abuse histories would be less likely to complete the program. Preliminary analyses revealed that 33.3% of patients graduated from the program, and 76% of all patients had a history of at least one type of abuse. Further analyses will examine the relationship between trauma and treatment completion, their interactions with psychiatric illness and other factors, and the correlation with perpetration of other offenses. The considerably high prevalence of abuse victimization in this group suggests a potential target for identifying risk factors for perpetration of sexual offenses.

REFERENCES
Levenson JS, Willis GM, Prescott DS: Adverse childhood experiences in the lives of male sex offenders implicaions for trauma-informed care. Sexual Abuse 28(4):340-359, 2016
Lansford JE, Miller-Johnson S, Berlin LJ, et al: Early physical abuse and later violent delinquency: a prospective longitudinal study. Child Maltreatment 12(3):233–245, 2007

QUESTIONS AND ANSWERS
Adult male sex offenders have a _____ incidence of adverse childhood experiences when compared to the general population.
a. Higher
b. Lower
c. Equal
ANSWER: a

Juveniles with a history of physical abuse have a(n) _____ risk of offending.
a. Equal
b. Increased
c. Decreased
ANSWER: b

F13 VIOLENCE RISK ASSESSMENT IN THE TREATMENT OF EARLY PSYCHOSIS

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Yael Holoshitz MD, New York, NY
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Jean-Marie Bradford MD, New York, NY
Barry Rosenfeld PhD, Bronx, NY
Merrill Rotter MD, Bronx, NY
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EDUCATIONAL OBJECTIVE
To review implementation of structured violence risk assessment in people receiving treatment for first-episode of psychosis

SUMMARY
Violence occurs at high rates (approximately 30%) among people with first-episode psychosis, with rates of serious violence estimated above 15%. However, questions remain regarding whether routine psychosocial assessments and treatment planning are sufficient to address identified risk factors for violence in this population. The purpose of this study is to assess the utility of violence risk assessment tools in a population of people receiving treatment for first-episode psychosis. Violence risk assessment is being implemented at a coordinated specialty care clinic in Manhattan, providing treatment to people ages 16 to 30 who are presenting within two years of the onset of non-affective psychosis. Violence risk is being measured with: (1)Fordham Risk Screening Tool (FRST) and (2) HCR-20 Clinical Subscale. The FRST is a rapid 5-question screening tool. The HCR-20 is a more intensive risk assessment consisting of 20 items that assesses the acute risk of violence based on historical, clinical and risk management items. Scores on the FRST and HCR-20 will be calculated, with attention to the particularly salient risk factors in this population. The utility of the FRST screening tool will be assessed in terms of its ability to identify individuals who require further violence risk assessments.

REFERENCES
Large MM, Nielssen O: Violence in first-episode psychosis: a systematic review and meta-analysis. Schizophr Res 125(2-3): 209-20, 2011
Nicholls TL, Ogloff JR, Douglas KS: Assessing risk for violence among male and female civil psychiatric patients: the HCR-20, PCL:SV, and VSC. Behav Sci Law 22(1):127-58, 2004

QUESTIONS AND ANSWERS
What are tools to assess violence risk?
a. Brief Psychiatric Rating Scale
b. Historical Clinical Risk Management-20 (HCR-20)
c. Structured Clinical Interview for DSM-5 (SCID-5)
d. All of the above
ANSWER: b

What is the prevalence of violence or aggression among individuals experiencing first-episode of psychosis?
a. 10%
b. 30%
c. 80%
ANSWER: b

F14 CLINICAL AND LEGAL NEEDS ACCOMPANYING UNACCOMPANIED CHILDREN

Makeda Jones-Jacques MD, Brooklyn, NY
Merrill Rotter MD, Bronx, NY

EDUCATIONAL OBJECTIVE
To describe the mental health care needs and management of unaccompanied minors facing immigration proceedings

SUMMARY
Over the past few years, there has been a surge of unaccompanied minors who have crossed the border due to increased gang or cartel violence, poverty in their countries, and family reunification. Recent developments in immigration and deportation policy have increased the exposure of these children and adolescents to detention, immigration proceedings and risk of removal. Their past history, identified clinical needs, and legal situation can

directly affect their current condition, which, in turn may have legal relevance. Thus for providers and examiners, treatment, advocacy and forensic evaluation are often intertwined. In this poster we outline the most frequent forensic legal and clinical considerations in evaluating recently immigrated minors facing possible deportation; we present case examples that describe the clinical work being provided for them within a program that specializes in their care, and discuss how immigration-related proceedings affect the clinical needs and how these clinical needs may inform immigration-related decision-making.

REFERENCES

Stark B, Shapiro A, Muniz De La Pena C, et al: Terra firma: medical-legal care for unaccompanied immigrant garifuna children. Harvard J of African American Public Policy 21:97-104, 2015

A Guide to Children Arriving at the Border: Laws, Policies and Responses. American Immigration Council. Available at https://www.american immigrationcouncil.org/research/guide-children-arriving-border-laws-policies-and-responses. Accessed September 4, 2017

QUESTIONS AND ANSWERS

Under current ICE protocol, what are the most common types of mental health issues that unaccompanied minors are screened for?

a. Suicide

b. Abuse, neglect or abandonment by one or both parents

c. Physical or mental abuse suffered from a crime

d. Psychosis

e. All of the above

ANSWER: e

How long does ICE have to hold unaccompanied minors before they are to be released or provided appropriate placement within the United States?

a. 24 Hours

b. 7 Days

c. 3 Day or 72 Hours

ANSWER: c

F15 BEYOND THE SLIDING SCALE: CONTEXT AND DECISIONAL CAPACITY

Rocksheng Zhong MD, New Haven, CT

EDUCATIONAL OBJECTIVE

This poster will teach attendees about the theory and practice of decisional capacity assessment. It proposes a comprehensive framework for assessing decisional capacity in difficult cases that involve partial impairment of decisional abilities.

SUMMARY

The dominant model of capacity assessment is based upon an individual's abilities to express a choice, understand, appreciate, and reason through a decision. The decision's risks and benefits guide the evaluating clinician's judgment about whether the person has adequate capacity, such that more consequential decisions require correspondingly better performance on these abilities, a concept called the sliding scale of capacity. Despite advances in the theory and practice of decisional capacity assessment, clinicians can encounter difficulties in cases when one or more abilities are partially impaired. This poster proposes a framework to guide how sliding scale and other contextual considerations can inform complex clinical capacity assessments. Specifically, in addition to the routine assessment of risks and benefits undertaken in any capacity evaluation, evaluators should take into account the risks and benefits of the manner in which an intervention is administered, as well as surrogates' and primary medical/surgical teams' views. These essential contextual factors can help to clarify difficult capacity assessments.

REFERENCES

Saks ER, Jeste DV: Capacity to consent to or refuse treatment and/or research: theoretical considerations. Behav Sci Law 24(4):411-29, 2006

Kontos N, Querques J, Freudenreich O: Capable of more: some underemphasized aspects of capacity assessment. Psychosomatics 56(3):217-26, 2015

QUESTIONS AND ANSWERS

The elements of decisional capacity include all of the following EXCEPT:
a. Understanding relevant information
b. Communicating a choice
c. Reasoning about treatment options
d. Having a mental illness
e. Appreciating the situation and its consequences
ANSWER: d

The sliding scale principle states that the stringency of the test applied _____ the seriousness of the likely consequences of patients' decisions.
a. is directly proportional to
b. is inversely proportional to
c. is independent of
ANSWER: a

F16 A HISTORY OF RACIALLY SEGREGATED AMERICAN STATE HOSPITALS

Paul Noroian MD, Westborough, MA

EDUCATIONAL OBJECTIVE

To review the unique phenomenon of segregated state psychiatric hospitals in the United States and how the care they provided was shaped by the law and by social movements.

SUMMARY

Separate state hospitals were created for African Americans in the US starting in the 1800s. The facilities expanded to include thousands of patients, with integration eventually occurring as a result of the Civil Rights Act of 1964. The history of these facilities is largely forgotten. This poster will review the creation of segregated state psychiatric hospitals in the United States and how the care they provided was influenced by social movements including the Right to Treatment and Civil Rights movements.

REFERENCES

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Wyatt v. Stickney, 344 F. Supp. 387 (M.D. Ala. 1972)

QUESTIONS AND ANSWERS

Which case established minimum standards for humane psychiatric care in Alabama state hospitals?
a. Rogers v. Commissioner
b. Lake v. Cameron
c. Wyatt v. Stickney
d. Youngberg v. Romeo
ANSWER: c

Whose 1960 article in the Journal of the American Bar Association proposed a constitutional right to treatment for committed psychiatric patients?
a. Ricky Wyatt
b. Isaac Ray
c. Judge Bazelon
d. Morton Birnbaum
ANSWER: d

F17 ASYLUM EVALUATIONS IN A FORENSIC PSYCHIATRY FELLOWSHIP

Peter S. Martin MD MPH, Buffalo, NY
Melissa D. Heffler MD, Buffalo, NY
Kim Griswold MD, Buffalo, NY

EDUCATIONAL OBJECTIVE

To expand the cultural competency of a forensic psychiatry fellow in a unique training opportunity that provides benefits to several groups

SUMMARY

Victims of torture and ongoing persecution seeking asylum in the United States often go through a complicated and arduous process. It is not uncommon for these individuals to have experienced events that have significant

psychiatric sequelae, such as PTSD and depression. Here, we will discuss how the Human Rights Initiative at UB, a medical student-run group, has implemented an evaluation process comprising physical examinations and psychological evaluations for those seeking asylum who have been victims of torture. In this model, medical students help organize the evaluations; sit in for the evaluation and act as scribes; and produce a draft of an affidavit used as evidence to document the abuses that were inflicted upon the asylum seeker. We will focus on expanding evaluable training opportunities by involving a forensic psychiatry fellow in the evaluation process. Fellows performing these evaluations have a unique experience to develop cultural competency in concordance with several ACGME Forensic Psychiatry Milestones. It also allows for the fellow to testify in Immigration Court. Furthermore, it creates an environment to involve medical students and have the fellow guide discussions involving diagnostic formulations, writing affidavits, and learning more about the discipline of Forensic Psychiatry.

REFERENCES

Meffert S, Musalo K, McNiel D, et al: The role of mental health professionals in political asylum processing. J Amer Acad Psych Law 38(4): 479-489, 2010
Prabhu M, Baranoski M: Forensic mental health professionals in the immigration process. Psychiatr Clin North Am 35(4): 926-46, 2012

QUESTIONS AND ANSWERS

What is one opportunity provided with having forensic psychiatry fellows perform asylum evaluations?
a. Providing treatment to an underserved population
b. Helping increase bias towards evaluees
c. Improving cultural competency
d. Learning how to not use interpreters effectively
e. Improving one's CV
ANSWER: c

Who is involved in this model for performing asylum evaluations?
a. Parents of evaluee
b. Forensic psychiatry fellow, medical students, and the evaluee
c. Friends of evaluee
d. Children of evaluee
e. Local news organizations
ANSWER: b

F18 MENTAL HEALTH OUTCOMES OF THE POST-CRITICAL INCIDENT SEMINAR

Joseph Cheng MD PhD, Charleston, SC
J. Eric Skidmore D.Min., Columbia, SC
R. Gregg Dwyer MD EdD, Charleston, SC

EDUCATIONAL OBJECTIVE

The objectives of this presentation are to: (1) provide a methodological and cultural understanding of the current iterations of the Post-Incident Critical Incident Seminar series by the South Carolina Law Enforcement Assistance Program; and (2) elucidate the longitudinal course of mental health, specifically mood and anxiety, in law enforcement participants.

SUMMARY

In the performance of their duties as first responders, law enforcement officers (LEOs) are subject to stressors that increase the risk of mental health disorders such as PTSD, depression, anxiety, and alcohol/substance use disorders. The South Carolina Law Enforcement Assistance Program (SCLEAP) conducts a Post Critical Incident Seminar (PCIS) for LEOs exposed to trauma that may impact their mental health and fitness for duty. The PCIS is a multiday program that provides supportive and educational interventions and follow-up referrals for stress management and associated issues. SCLEAP has amassed a database with descriptive data and scales for depression and anxiety on a longitudinal basis from PCIS participants. This presentation will review the mental health outcomes among PCIS participants who were followed longitudinally with self-report scales up to six months from PCIS participation. These data and analyses are relevant and informative to the ongoing process of PCIS programmatic and research development underway in South Carolina and a growing number of collaborating states. This presentation coincides with the theme, "The Search for Truth," by bringing to light mental health issues of a population uniquely exposed to trauma with potential for stress-related psychiatric sequelae, yet who are often reticent to engage in mental healthcare.

REFERENCES

Marchand A, Nadeau C, Neaulieu-Prevost D, et al: Predictors of posttraumatic stress disorder among police officers: A prospective study. Psychol Trauma 7: 212-21, 2015
Fox J, Desai MM, Britten K, et al: Mental-health conditions, barriers to care, and productivity loss among officers in an urban police department. Conn Med 76:525-31, 2012

QUESTIONS AND ANSWERS

All of the following statements are true, except:
a. Mental health conditions among police officers are common
b. Mental health conditions among police officers are costly
c. Most officers have accessed mental health services
d. Among officers, PTSD, depression, and alcohol abuse are most common mental health issues.
ANSWER: c

Which of the following strongly contribute to the development of PTSD symptomatology in law enforcement officers?
a. pretraumatic factors (i.e., emotional coping strategies and number of children)
b. peritraumatic factors (i.e., physical and emotional reactions and dissociation)
c. posttraumatic factors (i.e., autism spectrum disorder, depression symptoms)
d. All of the above
ANSWER: d

F19 FALSE PREGNANCIES, FALSE NARRATIVES: PSEUDOCYESIS AND CRIME

Michelle T. Joy MD, Philadelphia, PA
Ijeoma Jennifer Njoku MD, Philadelphia, PA
Sundeep Virdi MD JD, New York, NY

EDUCATIONAL OBJECTIVE

Attendees will be able to define pseudocyesis and describe its characteristics. The poster will explain the potential relationship between pseudocyesis and crime with a particular focus on infant kidnapping and cases involving violence. Attendees will also better understand the potential relationship of pseudocyesis claims to criminal cases.

SUMMARY

The case of Lisa Montgomery, who murdered pregnant Bobbi Jo Stinnett to steal her fetus in 2004, calls for an inquiry into the analysis of violence involving pregnancy. More specifically, Lisa Montgomery's defense posited that pseudocyesis explained her behavior at the time of the crime. This poster uses the case of Lisa Montgomery as a lens to investigate historical intersections between child stealing and pregnancy, including pseudocyesis, malingered pregnancy, delusional pregnancy, and miscarriage. It reviews characteristics of offenders and crimes involving nonfamily infant kidnapping, particularly as related to claims of pregnancy, and epidemiology of concurrent violence in this type of crime. In addition, a review of criminal cases involving infant abduction describes the types and successes of defenses used as well as the outcomes obtained.

REFERENCES

Cohen, Lewis M: A current perspective of pseudocyesis. Am J Psychiatry 139(9): 1140-1144, 1982
d 'Orb PT: Child stealing and pseudocyesis. The British Journal of Psychiatry 141(2):196-198, 1982

QUESTIONS AND ANSWERS

What is the most commonly reported sign or symptom in pseudocyesis?
a. Enlarged belly
b. Menstrual changes
c. Nausea/vomiting
d. Lactation
ANSWER: b

What percentage of nonfamily infant kidnapping cases involve violence?
a. 5%
b. 15%
c. 50%
d. 80%
ANSWER: b

F20 POSITIVE COUNTERTRANSFERENCE FOR THE PSYCHOPATHIC PATIENT

Paulina Riess MD, Mamaroneck, NY
Ahmed M. Albassam MD, Whitestone, NY
Panagiota Korenis MD, Eastchester, NY
Ali Khadivi PhD, Bronx, NY

EDUCATIONAL OBJECTIVE
An examination of positive countertransference for the psychopathic patient though a review of literature focusing on countertransference, along with the means to cross barriers of negative countertransference when navigating similar cases.

SUMMARY
Developing positive countertransference remains challenging for some clinicians when faced with particularly difficult patients. Ability to empathize with such patients can often lead to development of alliance and positive relationships, however, certain patients, particularly psychopaths, challenge a clinician's ethics and fundamental moral beliefs. Most of the available literature on this topic suggests that developing empathy for these patients among psychiatrists is challenging and often occurs in the context of voyeuristic curiosity. Implementing Racker's concept of countertransference, we argue that genuine empathy for such patients is possible. In this poster, we describe the experience of two residents, in a forensic setting, who provided psychotherapy for a male patient with prominent psychopathic features. Both residents were able to effectively engage the patient by developing concordant identification with him. Literature focusing on countertransference, along with the means to cross barriers of negative countertransference when navigating similar cases will also be reviewed.

REFERENCES
Kristiansson M: Incurable psychopaths? J Am Acad Psych Law 23(4), 1995
Alvarez A: Motiveless malignity: problems in the psychotherapy of psychopathic patients. Journal of Child Psychotherapy 21(2):167-182, 1995

QUESTIONS AND ANSWERS
Most of the available literature on this topic suggests that developing empathy for psychopathic patients among psychiatrists is:
a. Challenging
b. Frequent
c. Rare
ANSWER: a

Ability to empathize with such patients can often lead to development of:
a. Negative transference
b. Alliance and positive relationships
c. Voyeuristic curiosity
ANSWER: b

F21 SO YOU'RE ALL GROWN UP? TRANSITIONING FROM TRAINEE TO EXPERT

Tobias Wasser MD, Hamden, CT
Simha Ravven MD, New Haven, CT
Brian Falls MD, Austin, TX
Alexander Westphal MD PhD, New Haven, CT

EDUCATIONAL OBJECTIVE
To appreciate the practical and business-related considerations when beginning a forensic private practice, identify ethical issues encountered in private practice and strategies to navigate them and apply this knowledge in starting forensic practice or preparing forensic fellows to make this transition.

SUMMARY
During the course of fellowship, forensic fellows are tasked with learning a large volume of knowledge at the interface of psychiatry and the law and must develop a specialized skill set to translate this knowledge into practice. Despite thorough forensic training, there are practical elements to making the transition from trainee to practicing forensic psychiatrist that new graduates may not be prepared for. In this workshop, the presenters will spend approximately thirty minutes reviewing pragmatic aspects of the transition from trainee to practicing forensic

psychiatrist, including some of the complex ethical issues that forensic psychiatrists frequently encounter. Topics covered will include the business aspects of opening a private forensic practice, identifying a referral base, malpractice insurance, understanding the local dynamics of court-ordered vs. private evaluations, and academic affiliation considerations. In the remaining hour, participants will be presented with case examples of challenging situations which they might encounter when beginning a private practice. Participants will break up into small groups, devise a strategy for how to approach each situation, and then reconvene as a larger group to share their strategies. The presentation is geared toward current/recent fellows, those involved in teaching fellows, and others interested in establishing a private forensic practice.

REFERENCES

Gutheil TG: The Psychiatrist as Expert Witness. Arlington, VA: American Psychiatric Publishing, Inc., 2009
Pinals D: Forensic psychiatry fellowship training: developmental stages as an educational framework. J Am Acad Psychiatry Law 33:317–23, 2005

QUESTIONS AND ANSWERS

A physician who maintains affiliation with an academic institution by volunteering a certain amount of time to teach or provide supervision, but is not financially compensated is usually referred to as:
a. Academic faculty
b. Clinical faculty
c. Non-faculty participant
d. Volunteer
ANSWER: b

In business, the acronym LLC stands for:
a. Limited Liability Company
b. Liability Limiting Corporation
c. Loss and Limits Capitation
d. Labels and Lapels Company
ANSWER: a

F22 GENETIC EXPLANATIONS OF BEHAVIOR IN LEGAL CONTEXTS

Steven K. Hoge MD, New York, NY
Maya Sabatello PhD LLB, New York, NY
Nicholas Scurich PhD, Irvine, CA

EDUCATIONAL OBJECTIVE

To identify the ways in which psychiatric and behavioral genetic evidence have been used in legal settings, and to present data from two sets of experimental studies examining their impact on determinations of responsibility for antisocial behavior and on suitability for child custody in divorce contexts.

SUMMARY

Advances in understanding genetic predispositions to behavioral and neuropsychiatric syndromes are in the sights of the legal profession. With data suggesting substantial genetic contributions to the risk for criminal behavior, attorneys have begun to use genetic evidence in their clients' defense. In addition, the first signs that genetic data may be of interest to the civil justice system have begun to appear. As is true whenever scientific data are introduced in court, these developments hold potential for assisting judges and juries with some of the difficult judgments they face—but also bring a substantial risk of misinterpretation and misuse. This panel will begin with an overview of the actual and potential uses of psychiatric and behavioral genetic information in criminal and civil proceedings. Then, data will be presented from experimental studies of the effects of genetic explanations for behavior on perceptions of offenders and decisions on punishment in representative samples of the US population. Finally, findings will be discussed from a study of family court judges on the impact of psychiatric genetic evidence on decisions regarding child custody in divorce proceedings. Attendees will be invited to consider the future of genetic evidence in court.

REFERENCES

Appelbaum PS: The double helix takes the witness stand: behavioral and neuropsychiatric genetics in court. Neuron 82:946-949, 2014
Scurich N, Appelbaum PS: The blunt-edged sword: genetic explanations of misbehavior neither mitigate nor aggravate punishment. Journal of Law and the Biosciences 3(1):140-157, 2016

QUESTIONS AND ANSWERS

Which of the following is the most likely use of behavioral genetic evidence in criminal proceedings?
a. demonstrating incompetence to stand trial
b. establishing an insanity defense
c. mitigating punishment
d. adjudicating guilt
ANSWER: c

All of the following are likely to represent uses of genetic evidence in civil cases, except:
a. decisions regarding child custody
b. determinations of damages from torts
c. identification of reasonable person standards
d. assessments of testamentary capacity
ANSWER: d

F23 GENDER ISSUES IN CORRECTIONAL SETTINGS

Tara Collins MD MPH, San Francisco, CA
Anna Glezer MD, San Francisco, CA
Susan Hatters Friedman MD, Cleveland Heights, OH
Brian Holoyda MD, St. Louis, MO
Aimee Kaempf MD, Tucson, AZ

EDUCATIONAL OBJECTIVE

This panel is intended to update forensic mental health professionals on gender-related challenges in correctional settings to inform and improve care of female and transgender inmates.

SUMMARY

In the United States, the number of individuals in correctional settings has increased dramatically since the 1980s with approximately 6.8 million people under correctional supervision (jail, prison, probation or parole) at year-end 2014. Each year, there are approximately 11.4 million admissions to jail and over 600,000 admissions to prison. Mass imprisonment has led to new challenges in managing increasingly diverse inmate populations. One such challenge includes managing women and transgender inmates in a system designed for an all-male population. Women represent the fastest-growing segment of correctional populations, and transgender individuals are found at a higher rate in the penal system than in the general population. Correctional systems face a variety of challenges relating to gender as they aim to attend to human rights issues along with legal mandates. Such issues include ensuring safety and appropriate housing, addressing gender-specific differences in mental disorders among inmates, protecting individuals from victimization and sexual assault, treating gender dysphoria, caring for pregnant and postpartum inmates, and confronting dilemmas associated with parenting and family separation. Mental health professionals working in correctional settings should be aware of such gender-related challenges in order to provide appropriate, targeted care to female and transgender inmates.

REFERENCES

Glezer A, McNiel DE, Binder RL: Transgender and incarcerated: a review of the literature, current policies and laws, and ethics. J Am Acad Psychiatry Law 41:551-9, 2013
Hall RC, Hatters Friedman S, Jain A: Pregnant women and the use of corrections restraints and substance use commitment. J Am Acad Psychiatry Law 43:359-68, 2015

QUESTIONS AND ANSWERS

Which of the following is true regarding incarcerated women?
a. Mental illness and PTSD are common in this population.
b. They are most commonly incarcerated for non-violent offenses.
c. They have higher rates of mental illness than their male counterparts.
d. Approximately two-thirds to three-quarters are mothers to children under 18.
e. All of the above
ANSWER: e

Which of the following is true regarding transgender inmates?
a. Most are housed according to biological/natal gender.
b. Most are housed according to self-identified gender.
c. They are exposed to less violence than the general inmate population.
d. Treatment of gender dysphoria is consistent across institutions.
e. They have lower rates of physical and mental illness than their cis-gender counterparts.
ANSWER: a

F24 ASSESSMENTS OF SPEECH: FROM TRIGGER WARNING TO TRUE THREAT

Jessica Ferranti MD, Sacramento, CA
Barbara McDermott PhD, Sacramento, CA
Charles Scott MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

Participants will trace the development of a broadening view of verbal threat in the United States from "microaggressions" and "trigger warnings" to the "true threat." The participant will consider our culture's evolving hypervigilance on speech in the context of tensions between desire for safety and the value of free speech.

SUMMARY

The First Amendment protects freedom of speech as an essential right of Americans. It has long been established that a "true threat" is not afforded protection because the law recognizes that a verbal threat can cause harm, even if the threat is never carried out. The last decade has seen an expansion of formal and informal claims of emotional harm due to verbal content conveyed in statements as well as college curricula. A new language has developed describing verbal content that some individuals claim causes emotional harm, to include "microaggression" and "triggers." Some college campuses now offer "safe spaces" where individuals can retreat from what they consider to be emotionally traumatic or provoking language. A culture of "vindictive protectiveness" characterized by heightened vigilance on speech and retaliatory litigiousness will be discussed. We will consider the effects on our institutions of higher learning as well as implications for forensic psychiatry. The evaluation of emotional distress claims will be discussed, with relevant case examples provided. Pertinent case law will be reviewed as we discuss the ever present tension between physical and psychological safety and civil liberties in this evolving area of forensic practice.

REFERENCES

Elonis v. United States, 134 S. Ct. 2819 (2014)
Lukiannoff G, Haidt J: The Coddling of the American Mind. Available at https://www.theatlantic.com/magazine/archive/2015/09/the-coddling-of-the-american-mind/399356/. Accessed September 4, 2017

QUESTIONS AND ANSWERS

A microaggression is defined as:
a. Small actions or words that seem on their face to have no malicious intent but that are thought of as a kind of violence.
a. Small actions or words that are understood to have malicious intent meant to belittle, intimidate or discourage the recipient.
b. Any small physical or verbal action that subjectively intends to convey a covert message to demean the recipient.
c. Any small action or words that perpetuate racial stereotypes and devalues diversity.
ANSWER: a

A true threat is defined as:
a. A verbal statement of impending action that is determined to be likely to be carried out.
b. A verbal statement that causes damage or injury or incites a breach of the peace, even if it is never carried out.
c. A verbal statement that conveys factually true content and that is subjectively experienced as distressing or threatening by the recipient.
d. A verbal statement that conveys factually true content and that is objectively experienced as distressing or threatening by the recipient.
ANSWER: b

F25 DIGITAL AUTOMATION FOR THE EXPERT WITNESS

Andrew Nanton MD, Tualatin, OR
Alan Newman MD, San Francisco, CA

EDUCATIONAL OBJECTIVE

Participants will develop competency in using electronic tools to automate routine tasks of an expert witness.

SUMMARY

Two members of the AAPL technology committee will review recent advances in digital automation. This type of automation can be useful in reducing error and overhead in a routine forensic workflow. By handing off tasks to a computer, psychiatric experts can make better and more satisfying use of their time. Topics will include document assembly, generation of annotation summaries of PDFs, and the use of automated tools for communication and billing. The presentation will also delve briefly into more advanced topics for the technically inclined, such as screening large-volume digital evidence with automated tools. This applies to exhibits such as FaceBook or Twitter accounts, where it is either not feasible or low-yield to review the material by hand.

REFERENCES
The Efficient Lawyer 's Guide to Word. Availabel at https://legalofficeguru.com/downloads/efficient-lawyers-guide-to-word/. Accessed September 4, 2017
Sparks D: The Workflow Video Field Guide. Available at https://www.macsparky.com/workflowapp/. Accessed September 4, 2017

QUESTIONS AND ANSWERS
Why should I take the time to automate parts of my work?
a. More efficient use of time
b. Reduction of error
c. Increased job satisfaction by reducing tedium
d. Improved understanding of technology
e. All of the above
ANSWER: e

What term do lawyers use to refer to reusing parts of documents with customization specific to the relevant context?
a. Robo-lawyering
b. Document Assembly
c. Cut and Paste
d. Templating
e. Evidence-Based Law
ANSWER: b

F26 THE DANGERS OF ADVERSARIALISM IN THE LEGAL SYSTEM AND ELSEWHERE

Professor Carrie Menkel-Meadow, Irvine, CA

EDUCATIONAL OBJECTIVE
Participants will be able to (1) understand the differences between legal, philosophical and scientific approaches to finding "truth"; and (2) appreciate the limitations of the adversarial system and compare it with other legal models, including the European inquisitorial system.

SUMMARY
This talk will focus on several challenges for the modern legal system in finding facts and resolving disputes and legal issues. First, it will focus on developments in intellectual history challenging our conceptions of "knowable" facts from the adversary presentation of evidence in modern legal trials (see Mental-Meadow, "The Trouble with the Adversary System in a Post-Modern Society, " William & Mary Law Review), as contrasted with scientific models and methods of "proof," and contrasted further to other legal models, such as the European "inquisitorial" system, as well as challenges to modern conceptions of "truth." Secondly, the presentation will focus on modern developments in more hybridized forms of dispute resolution, such as mediation, ombuds, fact-finding, conciliation and arbitration, which place different emphases on fact finding (past focus) vs problem solving (future focus). Implications for presentations of "evidence" data, information and parties' needs and interests in processes different from formal legal trials will be explored. Different goals and issues of liability, responsibility, deterrence, public knowledge and transparency vs. party-oriented issues (including self-determination, therapeutic and healing values, and confidentiality) in dispute resolutions are explained and explored.

REFERENCES
Menkel-Meadow C: The trouble with the adversary system in a post-modern, multi-cultural world. Journal of the Institute for the Study of Legal Ethics 1: 49-77, 1996.
Menkel-Meadow C: Compromise, negotiation and morality. Negotiation Journal 26: 483-499, 2010

QUESTIONS AND ANSWERS
Which of the following is not a hybridized form of dispute resolution?
a. Mediation
b. Ombuds
c. Psychotherapy
d. Conciliation
e. Arbitration
ANSWER: c

How is fact-finding different from problem solving?
a. Fact-finding takes longer than problem solving.
b. Fact-finding involves more people than problem solving.
c. Fact-finding is a scientific strategy, while problem solving is a legal strategy.
d. Fact-finding places emphasis on the past, while problem solving places emphasis on the future.
ANSWER: d

F27 THE GOLDWATER RULE: TIME TO MOVE ON?

Saul Faerstein MD, Beverly Hills, CA
Donald Meyer MD Cambridge, MA
Wade Myers MD, Providence, RI
Karen Rosenbaum MD, New York, NY
Rebecca W. Brendel, MD JD, Boston, MA

EDUCATIONAL OBJECTIVE

Participants will hone their own capacity for an ethical analysis of psychiatrists' conflicting ethical duties to educate the public and to refrain from trying to enter public debate as an expert when they lack data from an examination and that individual's waiver.

SUMMARY

In a year when post truth entered the English language and alternative facts rebranded intentional deceit, when reasoned opinion gave way to tweeted opinion, what is the right and responsibility of forensic psychiatrists as citizen professionals to opine about public figures? In 1969 Fact Magazine was successfully sued for malice by former presidential candidate Barry Goldwater in response to an article that included a survey of psychiatrists' opinions of the candidate's fitness for office. In 1973 the APA adopted Ethics Rule 7.3 which allowed member psychiatrists to speak to the media about psychiatric "issues in general" but proscribed professional opinions about individuals in the absence of both an actual examination and a waiver. The Goldwater Rule was crafted to constrain ad hominem psychiatric opinions in public discourse and in the democratic process. How then shall the public forum reasonably benefit from our field's relevant expertise? Is all expert psychiatric commentary on public figures to be barred while others fill the void? Doesn't the public have a right to know our opinions and then make its own judgment? Will forensic psychiatrists, trained to be disinterested educators, avoid undermining their profession in the public forum, an arena for partisans with an agenda?

REFERENCE

Kroll J, Pouncey C: The ethic's of APA's goldwater rule. J Am Acad Psych Law 44(2):226-35, 2016
Friedman RA: The role of physicians and mental health professionals in discussions of public figures. JAMA 300(11):1348-50, 2008

QUESTIONS AND ANSWERS

A psychiatrist writes an article about a deceased historical figure titled, "In the Mind of a Poet" for a national literary magazine and comments on the individual's diagnosis and other psychopathology. The psychiatrist has a waiver from the executor of the estate and has had access to the decedent's medical records as well as in person interviews with some friends and family.
a. The psychiatrist has behaved ethically.
b. The psychiatrist was unethical because the waiver was not valid since the right of consent dies with the decedent.
c. The psychiatrist was unethical by practicing outside her expertise by being a historian.
d. The educational value of the article outweighs the invasion of this individual's privacy.
e. The psychiatrist's actions are below the standard of care and grounds for a malpractice suit as in Roe v Doe.
ANSWER: a

Which of the following psychiatrists may ethically make a non-confidential diagnosis of a living individual without having conducted an examination?
a. A psychiatrist serving as an expert witness.
b. A psychiatrist serving as a fact witness.
c. A forensic psychiatrist writing a "psychobiography."
d. A correctional psychiatrist working in a prison.
e. An APA District Branch president writing an Op Ed letter.
ANSWER: a

F28 DOES LIFE REALLY GO ON AFTER A LWOP SENTENCE?

Rosa Negron Munoz MD, Lakeland, FL
Julia Williamson JD, Bartow, FL
Orville Wallen BS, Brandon, FL

EDUCATIONAL OBJECTIVE
To discuss The Sentencing Project "Life Goes On: The Historic Rise In Life Sentences in America" report. Discuss seniors, as a special population, who are sentenced to LWOP in Polk County, Florida. Audience will be encouraged to discuss other areas of interest related to the topic in their State.

SUMMARY
In 2013, The Sentencing Project, released its report "Life Goes On: The Historic Rise in Life Sentences in America." This report looks at the continued rise of Life and LWOP sentences in the United States since the 1980s. Demographics, type of crime committed and distribution by states as reported in 2012 are some of the areas discussed. Special populations continue to rise in corrections, the elderly population being one of them. Despite this there is no mention of the elderly/aging population in the report. Julia J. Williamson, JD, of the Public Defender's Office in Polk County, Florida noticed an increase in LWOP sentences for the elderly with no prior criminal history and no prior history of any type of institutionalization. She also observed that elderly people sentenced to LWOP would die within one to two years of incarceration after the sentence. The workshop will allow discussion of the reasons and findings of ten such cases in Polk County Florida. The audience will be encouraged to discuss epidemiology, other special populations, recommendations, and other areas of interest related to the topic in their State.

REFERENCES
Nellis AP: The Sentencing Project. Available at http://www.sentencingproject.org. Accessed September 4, 2017
Office of Financial Management. Available at www.ofm.wa.gov/sgc/meetings/2016/01/incarceration_elderly_inmates.pdf. Accessed September 4, 2017

QUESTIONS AND ANSWERS
Which of the following states had the highest total of LWOP sentences in 2012?
a. California
b. Florida
c. Pennsylvania
d. Texas
ANSWER: b

What percentage of inmates older than 55 years old is considered to have a mental illness?
a. 10%
b. 15%
c. 20%
d. 25%
ANSWER: c

F29 APA COUNCIL ON PSYCHIATRY AND THE LAW: UPDATE

Steven Hoge MD, New York, NY
Debra Pinals MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE
To inform AAPL members about the ongoing work of the APA Council on Psychiatry and the Law

SUMMARY
This workshop will provide an overview of the process by which the Council on Psychiatry and Law develops APA policy documents, such as Position Statements and Resource Documents. The goal of the workshop is to provide an update on recent and ongoing issues that the Council is addressing. This workshop will provide AAPL members with an opportunity to provide feedback to the Council regarding a range of important areas. Dr. Hoge will provide an overview of the process. Dr. Pinals will discuss development of policy regarding police interactions with persons with mental illness. Dr. Appelbaum will discuss physician-assisted death for psychiatric indications. Dr. Hoge will discuss the ongoing development of an APA Position Statement on sexually violent predator commitment laws. These topic areas may be changed if more important issues arise prior to the Annual Meeting.

REFERENCES
Reuland M, Schwarzfeld M, Draper L: Law Enforcement Responses to People with Mental Illnesses: A guide to research-informed policy and practice. Available at www.tcbmds.org/.../law_enforcement_responses._guide_for_research.pdf. Accessed September 4, 2017
Zonana H, Abel G, Bradford J: et al: American Psychiatric Association Task Force Report on Dangerous Sex Offenders. Washington, DC: American Psychiatric Press, 1999

QUESTIONS AND ANSWERS
Of the people shot and killed by the police in the US, about what percentage have mental illness?
a. 10%
b. 25%
c. 50%
d. 65%
ANSWER: b

In SVP commitments, Not Otherwise Specified (NOS) or Not Elsewhere Classified (NEC) diagnoses serve for the basis of commitment
a. Never, courts have ruled that such diagnoses are not sufficient
b. These are the most common diagnoses
c. These are the second most common diagnoses
d. These are rarely used
ANSWER: c

F30 CRIMINAL RESPONSIBILITY IN FRONTOTEMPORAL DEMENTIA

Vivek Datta MD MPH, San Francisco, CA
Eric Rafla-Yuan MD, San Diego, CA
Dale McNiel PhD ABPP, San Francisco, CA
Renée Binder MD, San Francisco, CA

EDUCATIONAL OBJECTIVE
To understand how the neuroanatomical substrates affected by frontotemporal dementia (FTD) lead to criminal behavior in affected individuals, and know how criminal cases involving defendants with FTD have been litigated.

SUMMARY
Frontotemporal Dementias are a group of neurodegenerative diseases that affect the frontal and temporal lobes leading impairments in moral reasoning, emotional empathy, and impulse control, with preserved cognition. A recent study found that almost 40% of patients with behavioral variant FTD presenting to a memory clinic had engaged in criminal behavior. However there has been no prior systematic research into how courts have litigated criminal cases where the defendant claims to have FTD. The present study reviews how cases where expert testimony regarding FTD in criminal defendants was presented were litigated. We will then review how the outcomes in these cases compare with our evolving understanding of the neurobiology of FTD and its implications for criminal competency and responsibility in FTD.

REFERENCES
Mendez MF: The unique predisposition to criminal violations in frontotemporal dementia. J Am Acad Psychiatry Law 38:318-23, 2010
Liljegren M, Naasan G, Telmlett J, et al: Criminal behavior in frontotemporal dementia and alzheimer disease. JAMA Neurol 72:295-300, 2015

QUESTIONS AND ANSWERS
Defendants with frontotemporal dementia would be least likely to be found not guilty by reason of insanity under which of the following tests for insanity?
a. M'Naughten
b. Model Penal Code
c. Irresistible impulse
d. Product test
ANSWER: d

Loss of emotional empathy in frontotemporal dementia best correlates with degeneration of:
a. the orbitofrontal cortex
b. the dorsolateral prefrontal cortex
c. the ventromedial prefrontal cortex
d. the right anterior temporal lobe
ANSWER: d

F31 **OVERSIGHT BODY QUESTIONS REGARDING NGRI ACQUITTEES**

Michael Moravecek PsyD, Middletown, CT

EDUCATIONAL OBJECTIVE
Participants will be able to identify the common types of questions asked by oversight bodies during testimony regarding NGRI acquittees and better prepare for testimony regarding NGRI acquittees based on the make-up of the oversight body receiving the information.

SUMMARY
In the United States, individuals who commit crimes while influenced by serious mental illness do not receive the same consequences as individuals who commit crimes and do not have a mental illness. Following their adjudication, states and the federal government employ a variety of techniques to oversee these individuals. The investigator in this study is in the process of reviewing the transcripts of all hearings involving the oversight body for NGRI acquittees in Connecticut held in the 2015 calendar year. After a review of the hearings, the questions asked by the oversight body were separated by category. The questions were determined to fall into eleven major categories. The majority of the questions pertained to the type of treatment and monitoring the acquittee was going to receive in the community. The next most common type of question pertained to risk assessment and further treatment considerations in the hospital. Other major categories of questioning focused on the acquittee's insight into his or her mental illness, money issues, diagnosis, treatment engagement and compliance, psychiatric symptoms, and psychiatric medications. This study was granted an exemption by the Institutional Review Board of the State of Connecticut's Department of Mental Health and Addiction Services.

REFERENCES
Norko MA, Wasser T, Magro H, et al: Assessing insanity acquittee recidivism in Connecticut. Behav Sci Law 34: 423-443, 2016
Green D, Belfi B, Griswold H, et al: Factors associated with recommitment of NGRI acquittees to a forensic hospital. Behav Sci Law 32: 608-626, 2014

QUESTIONS AND ANSWERS
When preparing for testimony regarding an NGRI acquittee, which of the following is not an area you would be likely to address in great detail based on the information in the current study?
a. Information related to the acquittee's current risk factors
b. Details about the treatment and supervision available in a community program an acquittee will be attending
c. The level of treatment engagement the acquittee is currently engaged in
d. The mental health history of the acquittee's family
ANSWER: d

What is the most common type of question about NGRI acquittees asked by the oversight body investigated in the current study?
a. The level of insight the acquittee has into their mental illness
b. The level of engagement in treatment the acquittee has demonstrated
c. The types of community treatment programs, monitoring and supports that are in place in the community for the acquittee
d. Whether or not the acquittee is compliant with their medication
ANSWER: c

F32 **SUPERVISION FOR NGRI AND MDO: RISKS, NEEDS, RESPONSIVITY**

Jeremy Colley MD, New York, NY
Melinda DiCiro PhD, Sacramento, CA

EDUCATIONAL OBJECTIVE
To understand the similarities difference in clinical characteristics, risk factors for re-offending and treatment needs among NGRI acquitees compared to Mentally Disorder Offenders when released to supervision in the community in California.

SUMMARY
Patients committed to the California State Hospitals following a Not Guilty by Reason of Insanity (NGRI) determination and those committed as Mentally Disordered Offenders (MDO) have been observed to differ in both their violence risk and treatment needs. The NGRI patients are perceived to need greater levels of psychiatric intervention, while the MDO patients are perceived to need interventions targeting criminal behavior. Nevertheless, whether these differences are also reflected in the released group and whether post-discharge community resources accommodate these observed differences is unclear. The Risk, Needs, Responsivity (RNR) Model has gained widespread acceptance as the gold standard for treating forensic patients. We will identify and compare the risk factors of the released groups, analyze variability of the factors within each group, and conduct cluster analyses for risks and needs for released patients as a whole. The results may show whether specialized placements, geared toward the predominant risk factors and needs of the commitment groups is indicated. Alternatively, the results may show intragroup variability, suggesting the need for continued individualized placement, and clusters of "high psychiatric" and high criminogenic needs, warranting specialized treatment hubs. A strategy for community treatment of released patients will be proposed, considering these results.

REFERENCES
Penney S, Morgan A, Simpson A: Assessing illness and non-illness based motivations for violence in persons with major mental illness. Law & Human Behav 40(1):42-49, 2016
Bonta J, Wormith S: Applying the risk-need-responsivity principles to offender assessment, in What Works in Offender Rehabilitation: An Evidence-Based Approach to Assessment and Treatment. Hoboken, NJ: Wiley-Blackwell, 2013, pp 71-93

QUESTIONS AND ANSWERS
The primary precipitants to community release revocation for NGRI acquitees and MDOs in the studied group included the following:
a. Substance Abuse
b. Noncompliance with Treatment
c. Psychotic Decompensation
d. All of the above
ANSWER: d

According the Andrews and Bonta's (2016), Risk, Need, and Responsivity model, the following factors will underlie community release revocation for NGRI acquitees and MDOs.
a. Criminogenic Factors
b. Clinical Factors
c. Severity of Committing Offense
ANSWER: a

F33 ASSESSMENT AND TREATMENT OF PROBLEMATIC SEXUAL INTERESTS

R. Gregg Dwyer, MD EdD, Charleston, SC
J. Paul Fedoroff MD, Ottawa, ON, Canada
Lisa Murphy MCA, Ottawa, ON, Canada
Charles Scott MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
Provide practical and effective strategies for the assessment of sexual offenders and people with problematic sexual interests. Review the current state of treatment of adults and adolescents with paraphilic interests from Canadian and American perspectives. Evidence to support a new paradigm for the understanding of paraphilic disorders will be provided.

SUMMARY
This course is intended to provide forensic psychiatrists with an update on the current state of assessment and treatment of people with problematic sex interests including special populations (e.g. adolescents, women and people with intellectual disabilities). It will be of use to psychiatrists who are currently assessing or treating sex offenders as well as psychiatrists wishing to keep up to date on the state of the art of this important and rapidly evolving area of forensic psychiatry. Best practices used from both Canadian and American perspectives will be reviewed. A practical overview of penile tumescence testing and ways of improving its validity and reliability will be covered. Utilization of visual aids will provide the audience with a clear understanding of assessment procedures and reports. Research on innovative measures for assessment of sexual interest will also be discussed. The current state of treatment of adults and adolescents with paraphilic interests will be reviewed along with evidence to support a new paradigm for the understanding of paraphilic disorders. Case studies will be used to provide practical information on successful treatment options for specific paraphilic disorders. Attendees are encouraged to bring case details for group discussion.

REFERENCES
Murphy L, Bradford J, Fedoroff JP: Treatment of Paraphilias and Paraphilic Disorders. In G.O. Gabbard, Gabbard's Treatment of Psychiatric Disorders (5Th Ed). Arlington, VA: American Psychiatric Publishing, 669-694, 2014
Ryan E, Otonichar J: Juvenile sex offenders. Curr Psychiatry Rep 18: 67, 2016

QUESTIONS AND ANSWERS
Concerning PPG:
a. It is part of the DSM-5 diagnostic criteria for pedophilia
b. It is designed to determine guilt or innocence for specific sex offenses
c. It cannot be used in men with erectile dysfunction
d. It is not reliable and valid measure of sexual arousal patterns in offenders with intellectual disability
e. None of the above
ANSWER: e

Which of the following is CORRECT in regard to the treatment of juvenile sex offenders?
a. SSRIs are not recommended due to their lack of proven efficacy and black box warning of increased suicide risk
b. Antiandrogens should be used as a first line treatment in those youth with a contact offense
c. Juveniles who complete a treatment program have less sexual recidivism than those who drop out
d. The PCL-YV is a strong predictor in juveniles of future sexual recidivism
ANSWER: c

F34 MURDER MOST FOUL: ASSESSING MORAL WRONGFULNESS IN THE INSANITY DEFENSE

David Rosmarin MD, Newton, MA
Ezra E.H. Griffith MD, New Haven, CT
Stephen Noffsinger MD, Hudson, OH
Phillip Resnick MD, Cleveland, OH

EDUCATIONAL OBJECTIVE
This is a Peer Review of the reports and video testimony of Dr. Resnick and Dr. Noffsinger in a murder case involving a man with schizophrenia. Only AAPL members will be admitted except with permission of Dr. Rosmarin.

SUMMARY
One element of insanity evaluations involves quoting the defendant, especially when the defendant makes statements about motives and state of mind. Often months later, sometimes after antipsychotic treatment that changes one 's interpretation of past thoughts, the defendant may make remarks that support or sink his case. Here, context and understanding of memory 's impermance are as important as apparent contradictions. Especially in murder cases, the case for memorializing the demeanor and statements of both expert and defendant seems stronger in nuanced or complex assessments. Moral wrongfulness may be assessed based on whether the defendant knew his behavior was morally wrong (subjective standard) versus whether he knew society viewed it as wrong (objective standard). As is frequent, this defendant may have relied on God 's approval for his killing. Another issue that will be raised is the use of deferring to the finder of fact as to whether a symptom and resulting belief is true, misremembered, or malingered. This may be viewed as ethical because part of truth-telling by experts is the demand to state when a certain matter cannot be opined about with reasonable medical certainty. Lastly, there is the intersection between reasonable medical certainty and beyond reasonable doubt.

REFERENCES
VIDEO RECORDING OF FORENSIC PSYCHIATRIC EVALUATIONS AAPL TASK FORCE Approved by the AAPL Executive Council May 31, 1998 Revised May 2013
AAPL Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense Reviewed and approved by the Council of the American Academy of Psychiatry and the Law on May 19, 2013.

QUESTIONS AND ANSWERS
The insanity standard in Ohio: Ohio Revised Code 2901.01(A)(14) defines insanity as "A person is "not guilty by reason of insanity" relative to a charge of an offense only if the person proves, in the manner specified in section 2901.05 of the Revised Code, that at the time of the commission of the offense, the person did not know, as a result of a severe mental disease or defect, the wrongfulness of the person 's acts."
What type of rule is this;
a. ALI standard
b. Original M'Naghten—no other information needed—applies only to knowledge of illegality
c. Like all M'NAghten type standards, it depends whether wrongfulness includes moral wrongfulness
ANSWER: c

The relevant section defining aggravated murder in Ohio is: No person shall purposely cause the death of another or the unlawful termination of another's pregnancy while committing or attempting to commit, or while fleeing immediately after committing or attempting to commit, kidnapping, rape, aggravated arson, arson, aggravated robbery, robbery, aggravated burglary, burglary, trespass in a habitation when a person is present or likely to be present, terrorism, or escape.
Aggravation in this regard means:
a. Upsetting the legal applecart
b. Causing severe personal distress to victims
c. Actions that increase the severity of the underlying crime
ANSWER: c

F35 TO GET TO THE OTHER SIDE: REENTRY PLANNING IN CORRECTIONS

Merrill Rotter MD, Bronx, NY
Elizabeth Ford MD, New York, NY
Jackie Landess MD, JD, St. Louis, MO
Li-Wen Lee MD, New York, NY
Nubia Lluberes MD, Missouri City, MO
William Newman MD, Saint Louis, MO

EDUCATIONAL OBJECTIVE
To enhance participants' understanding and appreciation of the real possibilities for reentry planning from within a correctional setting, taking into account the challenges inherent in discharge planning from that setting.

SUMMARY
Advocates for both enhanced community mental health and improved public safety are increasingly addressing the overrepresentation of individuals with mental illness in the criminal justice system by ensuring their clinical and recidivism-risk related needs are met while in the community. To the end, collaboration between the providers of incarceration-based clinical services and those in the community as part of diversion or reentry planning is a critical element. However, this cross-system coordination can be challenging for both those inside and outside the walls. In this presentation, we will review administrative and programmatic efforts to address these challenges and make the most of the opportunities available. Following an introduction by Dr. Rotter, Drs. Lee and Ford will discuss their incarceration-based re-entry work in New York State prison and New York City jail, respectively. Dr. Landess will describe innovative collaborative programming in St. Louis and Dr. Lluberes will provide the correctional clinician perspective. Dr. Newman, as discussant, will lead the audience feedback session during which time audience members will be encouraged to brainstorm with the panelists on the opportunities for and challenges to integrating re- planning into institutional clinical work.

REFERENCES
Osher F, Steadman HJ, Barr H. (2003) A Best Practice Approach to Community Reentry From Jails for Inmates With Co-Occurring Disorders: The APIC Model. Crime & Deliquency. 49(1), pp. 79-96.
Haimowitz S. (2004) Slowing the Revolving Door: Community Reentry of Offenders With Mental Illness.Psychiatric Services 55(4).

QUESTIONS AND ANSWERS
Which of the following is not characteristic of successful reentry planning programs:
a. Assessment
b. Planning
c. Insanity defense evaluation
d. Coordination
e. Identification
ANSWER: c

Which of the following are expected objectives of good reentry planning for individuals with serious mental illness:
a. Increase clinical stability
b. Decrease criminal recidivism
c. Competitive employment
d. a and b
e. All of the above
ANSWER: d

F36 RESPONSES TO THE NEW EXECUTIVE ORDERS ON IMMIGRATION

Varendra Gosein MD, Larkspur, CA
Lauren Groth Esq, Boulder, CO
Maya Prabhu MD, New Haven, CT
Karen Rosenbaum MD, New York, NY
Barry Roth MD, Brookline Village, MA

EDUCATIONAL OBJECTIVE

Audience members will have a greater understanding of the 2017 Executive Orders with regard to Immigration, and their impact on immigrant, asylum-seeking and refugee patients; audience members will learn about roles for forensic psychiatrists in immigration legal proceedings, the development of legal briefs and the civil society public policy process.

SUMMARY

There is a long tradition of forensic psychiatrists collaborating with immigration clinics to provide mental health evaluations for asylum-seekers, refugees and immigrants. The new administration 's Executive Orders significantly narrow the categories of individuals who may be allowed to resettle or remain in the US; this raises questions about the trajectory of these collaborations and the responsibilities of psychiatrists to advocate for these groups. Lauren Groth is an attorney with the International Refugees Assistance Project. She will provide an update on the Immigration Executive Orders and describe the legal advocacy which emerged to assist individuals detained at airports around the country in January 2017. Dr. Karen Rosenbaum will consider what professional, ethical and personal obligations might arise in the context of evolving immigration and enforcement actions. Dr. Barry Roth will discuss his coordination of medical experts on an amicus brief challenging the treatment of immigrant detainees as well as the implementation of the Istanbul Protocol, an international benchmark for forensic investigation and documentation. Dr. Varendra Gosein will describe his work with Tibetan asylum-seeking victims of torture and changing deportation standards. Dr. Maya Prabhu will consider the challenges of meeting persecution standards with LGTB clients.

REFERENCES

Aggarwal NK, "Adapting the Cultural Formulation for Clinical Assessments in Forensic Psychiatry." J Am Acad Psychiatry Law 40:1:113-118 (2012)
Korngold C et al., Mental Health and Immigrant Detainees in the United States: Competency and Self-Representation. J Am Acad Psychiatry Law. 2015 Sep;43(3):277-81.

QUESTIONS AND ANSWERS

Which class action lawsuit on behalf of immigration detainees with mental disabilities resulted in establishing their right to legal representation if they are determined not competent to represent themselves?
a. Franco-Gonzales v. Holder.
b. Gideon v. Wainwright.
c. Jaadan v. Gonzales.
d. Indiana v Edwards.
ANSWER: a

Which of the following is NOT a potential basis for an asylum claim under the 1951 Refugee Claim?
a. Persecution on the basis of race
b. Persecution on the basis of gender
c. Persecution on the basis of religion
d. D Persecution on the basis of political opinion.
ANSWER: B.

F37 DRUG USE, DRUG POLICY, AND VIOLENCE IN AMERICA: A REVIEW

Benjamin Goldberg MA MD, Napa, CA

EDUCATIONAL OBJECTIVE

This presentation will inform the forensic professional on the latest data and research on drug use, violence risk, criminology, and economics to clarify the controversial and complex relationships between drugs and violent behavior. The presentation will stimulate policy discussion and answer practical concerns regarding addiction, violence risk, and public policy.

SUMMARY
Although it is widely accepted that violent crime is frequently associated with illicit drugs in the United States, the nature of the relationship between drugs and violence remains controversial. The widespread belief in the United States that the use of illicit drugs is a key driver of violent crime has been used to support prohibitionist drug laws for more than a century. Yet the evidence supporting this belief is weak. This presentation synthesizes crime statistics with research in criminology, economics, addiction, and violence to clarify the relationships between drug use, drug policy, and violence in the United States. This synthesis explores how the illicit drug markets themselves are responsible for far more drug-related violence in America than drug users themselves. This synthesis also illustrates parallels between the violence associated with early 20th century alcohol Prohibition, the crack cocaine markets of the late 20th century, and ongoing drug-related violence today.

REFERENCES
Tomilson MF, Brown M, Hoaken PNS: Recreational drug use and human aggression behavior: a comprehensive review since 2003. Aggression and Violent Behavior 27:9-29, 2016
Goldstein PJ: Drugs, violence, and federal funding: a research odyssey. Substance Use & Misuse 33(9):1915-1936, 1998

QUESTIONS AND ANSWERS
Which type of drug-related crime is most problematic?
a. Psychopharmacological
b. Economic-compulsive
c. Systemic
ANSWER: c

Which of the following substances is most commonly associated with violent behavior?
a. Alcohol
b. Cannabis
c. Methamphetamine
d. PCP
ANSWER: a

F38 VIOLENT IDEATION AND BEHAVIOR IN YOUTHS WITH EARLY PSYCHOSIS

Stephanie A. Rolin MD MPH, New York, NY
Leslie Marino MD MPH, New York, NY
Ilana Nossel MD, New York, NY
Barry Rosenfeld PhD, Bronx, NY
Merrill Rotter MD, Bronx, NY
Lisa Dixon MD MPH, New York, NY

EDUCATIONAL OBJECTIVE
To review prevalence of violent ideation and violent behavior in youths receiving treatment for first-episode psychosis and to identify risk factors for violent ideation and violent behavior in youths receiving treatment for first-episode of psychosis.

SUMMARY
Recent studies suggest that one-third of individuals experiencing a first-episode of psychosis (FEP) have engaged in recent violent behavior. The purpose of this study is to analyze the prevalence of violent ideation and behavior in a population of youths with FEP first entering FEP treatment, and to identify factors associated with violence. This is a secondary data analysis on data from OnTrackNY, a network of coordinated specialty care clinics providing early intervention services to youths (ages 16-30) experiencing FEP. Individuals endorsing violent ideation or behavior are compared to those without violent ideation or behavior. Measurements include substance use, psychiatric symptom severity, service use and functioning. A total of 366 young adults, with a mean age of 20.7 (SD= 3.3) years were included in the analysis. 32.6% of individuals were reported to have violent ideation or behavior at baseline. Violent ideation or behavior was associated with lower level of educational achievement, not being currently engaged in work, recent psychiatric emergency room visits, marijuana use, higher psychiatric symptom burden, and lower level of functioning. Violent ideation and behavior are high within a population of youths with FEP entering treatment and are associated with a number of psychosocial risk factors.

REFERENCES
Dean K, Walsh E, Morgan C: Aggressive behaviour at first contact with services: findings from the AESOP first episode psychosis study. Psychological Medicine 37(4):547-557, 2007
Large MM, Nielssen O: Violence in first-episode psychosis: a systematic review and meta-analysis. Schizophr Res 125(2-3):209-20, 2011

QUESTIONS AND ANSWERS
What are risk factors for violence among individuals experiencing first-episode of psychosis?
a. Not being engaged in work
b. Drug use
c. Lower level of educational achievement
d. All of the above
ANSWER: d

What is the prevalence of violence or aggression among individuals experiencing first-episode of psychosis?
a. 10%
b. 30%
c. 80%
ANSWER: b

F39 **COUNTERTRANSFERENCE AND VICARIOUS TRAUMA IN FORENSIC PRACTICE**

Alcina Barros MD, Porto Alegre, Brazil
Claudio Eizirik PhD, Porto Alegre, Brazil
Simone Hauck PhD, Porto Alegre, Brazil
Pricilla Laskoski MS, Porto Alegre, Brazil
Stefania Teche MD, Porto Alegre, Brazil
Carolina Padoan MS, Porto Alegre, Brazil

EDUCATIONAL OBJECTIVE
The audience will be able to assess the interference of countertransference and vicarious trauma in forensic psychiatric practice, specifically in the context of sexual crimes; and explore their repercussions on the quest for neutrality and in the expert mental health.

SUMMARY
Psychologists and psychiatrists who perform forensic expert reviews of sex offenders are a particular group of individuals who experience varied and intense countertransference feelings, being exposed to the potential risk of vicarious traumatization. This cross-sectional study intends to determine the association between countertransference reactions triggered by the latest expert interview with a sex offender and the occurrence of vicarious traumatization in forensic experts . The correlation between the intensity of countertransference in this situation (measured by Assessment of Countertransference Scale - ACS) and the degree of vicarious traumatization (measured by Trauma and Attachment Belief Scale - TABS) will be performed using the Pearson's r test. The study of the ego defense mechanisms - using the Defensive Style Questionnaire (DSQ-40) will be performed. This study has the potential to show the correlation between countertransference reactions and the risk of vicarious traumatization in forensic psychologists and psychiatrists in the context of an expert evaluation of sex offenders. In addition, important aspects of forensic practice, such as neutrality in the production of medical and legal documents and maintaining the professional's mental health may be questioned according to the survey results.

REFERENCES
McCann L, Pearlman LA: Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress 3(1): 131-49, 1990
Reeder DJ, Schatte DJ: Managing negative reactions in forensic trainees. J Am Psychiatry Law 39(2):217-21, 2011

QUESTIONS AND ANSWERS
Why is it important to assess countertransference and vicarious trauma in a forensic setting?
a. There is no vicarious trauma in forensic psychiatric evaluations.
b. Countertransference only occurs in a patient-therapist interaction
c. Because we must care about the expert mental health and also his/her ability to maintain neutrality
ANSWER: c

What is Vicarious Trauma?
a. It is a delusional state
b. It is a direct post-traumatic stress disorder
c. It is a transformation of the helper's inner experience, resulting from empathic engagement with clients' trauma material
ANSWER: c

F40 VIOLENCE IN FORENSIC HOSPITALS: LINKS TO CHILDHOOD VIOLENCE

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

EDUCATIONAL OBJECTIVE

To understand how exposure to violence or abuse as a child may be linked with violent behavior prior to and during forensic hospitalization; to explore the biopsychosical factors involved in the onset of violent behaviors; and to identify these critical factors, which can allow for early intervention in the vulnerable population.

SUMMARY

The purpose of this study is to consider how childhood exposure to violence or abuse may contribute to the onset of violent behaviors in individuals with severe mental illnesses; many of these patients may ultimately be hospitalized in a forensic setting. Furthermore, the perpetration of violent behaviors once hospitalized will be explored, to determine the role of childhood exposure in such behaviors. There is a plethora of research that supports the underlying principle that violence is a learned behavior; furthermore, there is research that confirms that violence increases when substance abuse is a comorbidity. However, there is a dearth of data that addressees how other psychosocial or demographic variables, such as socioeconomic status, education, race, and age (amongst other factors), may be implicated in exposure to childhood violence and abuse. In this study, we seek to examine the variables that may contribute to exposure to childhood violence or abuse. Furthermore, we aim to investigate the relationship between this childhood exposure and the subsequent development of violent behaviors, prior to and during forensic hospitalizations.

REFERENCES

Swartz MD, Swanson JW, Hiday VA, et al: Violence and severe mental illness: the effects of substance abuse and nonadherence to medication. Am J of Psychiatry 155(2):226-231, 1998
Swanson J, Swartz M, Estroff S, et al: Psychiatric impairment, social contact, and violent behavior: evidence from a study of outpatient-committed persons with severe mental disorder. Social Psychiatry and Psychiatric Epidemiology 33(1): S86-S94, 1998

QUESTIONS AND ANSWERS

Of the following, WHICH of the following are useful in managing violence within inpatient forensic psychiatric units:
a. PRN medications
b. seclusion rooms
c. tasers
d. A and B
e. none of the above
ANSWER: d

Increased violence has been associated with WHICH of the following:
a. substance use
b. exposure to violence
c. lower socioeconomic status
d. all of the above
e. none of the above
ANSWER: d

SATURDAY, OCTOBER 28, 2017

POSTER SESSION C — 7:00 AM – 8:00 AM/ 9:30 AM – 10:15 AM — **CENTENNIAL BALLROOM FOYER**

S1 ***Bringing the Invisible to Light: Restoring the Female Inmate***
Ann M. Joseph MD, Highlands Ranch, DO
Brittany Remmert PsyD, Atlanta, GA (I)

S2 ***After the Smoke Clears: Stress Management & Law Enforcement***
R. Ryan Leahy MD, Miami Beach, FL

S3 ***Borderline and Antisocial Traits Among Inmates in a Jail Setting***
Corey M. Leidenfrost PhD, Buffalo, NY (I)
Peter S. Martin MD MPH, Buffalo, NY
Daniel Antonius PhD, Buffalo, NY (I)

S4 ***Mental Health of Sexual Minority Justice Youth***
Matthew Hirschtritt MD MPH, San Francisco, CA
Emily Dauria PhD MPH, San Francisco, CA (I)
Brandon Marshall PhD, Providence, RI (I)
Marina Tolou-Shams PhD, San Francisco, CA (I)

S5 ***Aggression on Co-Ed vs. Single Gender Forensic Units***
Kayla Fisher MD JD, Sacramento, CA
Sean Evans PhD, Highland, CA (I)

S6 ***LGBT People: Greater Risk in Jail & Greater Risk of Jail?***
Alexander Berger DO, Philadelphia, PA (I)
Merrill Rotter MD, Bronx, NY

S7 ***Predictors of Competency Restoration on a Jail-Based Unit***
David Halverson MD, Atlanta, GA (I)
Glenn J. Egan PhD, Atlanta, GA (I)
Peter Ash MD, Atlanta, GA

S8 ***Inmate Assault on Prison Staff: Worker's Comp Perspective***
Manish Fozdar MD, Wake Forest, NC
Robert Granacher MD MBA, Lexington, KY
Robert Trestman PhD MD, Roanoke, VA
Denise Kellaher DO, Folson, CA

S9 ***IM Medication Use for Violence in a Forensic Psychiatry Unit***
Forensic Hospital Services Committee
Bipin R. Subedi MD, Brooklyn, NY
Nadia Oryema, New York, NY (I)

S10 ***Enhancing Services in a Juvenile Detention Setting***
Peter S. Martin MD MPH, Buffalo, NY
Daniel Antonius PhD, Buffalo, NY (I)
Corey Leidenfrost PhD, Buffalo, NY (I)

S11 ***Criminal Background as Part of Aggression Risk Assessment***
Katrina Shchupak MD, Philadelphia, PA (I)

S12 ***Solitary Confinement in the Mentally Ill, Unconstitutional?***
Ijeoma Jennifer Njoku MD, Philadelphia, PA

S13 ***...And Therapeutic Justice for All***
Jennifer K. Brundrick MD, Aurora, CO (I)

S14 ***SVPs who Recidivate while Civilly Committed: A Case Series***
Jeremy H. Colley MD, New York, NY
Melinda DiCiro PhD, Sacramento, CA (I)

S15 ***Should ASPD Count for SVP Commitment in California?***
Jeremy H. Colley MD, New York, NY
Melinda DiCiro PhD, Sacramento, CA (I)
James Rokop PhD, Sacramento, CA (I)

S16 ***Psychiatric Clearance for Jail: A Review of the Literature***
Jonathan Dunlop MD JD, Ann Arbor, MI
Debra A. Pinals MD, Ann Arbor, MI

S17 ***Resentencing Evaluations: A Review***
Jason R. Hall PhD, Tampa, FL (I)

S18 ***Solitary Across Three States***

Amina Z. Ali MD, New York, NY (I)
Sabina Fink MD, Bronx, NY (I)
Katya Frischer MD JD, New York, NY

S19 ***Validation of the "See, Think, Act Scale"***

Bonnie Siu Wei-man MD, Tuen Mun Hong Kong (I)

S20 ***Jefferson County MHC: A Phenomenological Exploration***

Nadia Y. Tayeb MD, Hoover, AL
John Dantzler PhD, Birmingham, AL (I)

WORKSHOP 8:00 AM – 10:00 AM **CENTENNIAL BALLROOM D**

S21 ***Creating Empathy for Insanity Acquittees in the Community***

John Kastner ACCT, Toronto, Canada (I)
Michael A. Norko MD, New Haven, CT

PANEL 8:00 AM – 10:00 AM **MINERAL D-E**

S22 ***"Treatment" of ASPD in Corrections: Hopeful or Hopeless?***

Ayesha Ashai MD, Baltimore, MD
Christoper Fischer MD, Sacramento, CA
Ariana Nesbit MD, Sacramento, CA
Charles Scott MD, Sacramento, CA

PANEL 8:00 AM – 10:00 AM **MINERAL F-G**

S23 ***Fit to Fly Post Germanwings? Keeping Air Travel Safe***

Michael Berry MD, Washington, DC (I)
Charles Chesanow DO, Washington, DC (I)
Jeff Guina MD, Ann Arbor, MI
Debra Pinals MD, Ann Arbor, MI
Harold Pinsky DDS, Ann Arbor, MI (I)

WORKSHOP 8:00 AM – 10:00 AM **GRANITE**

S24 ***Juvenile Resentencing: The Connecticut Experiment***

Paul A. Bryant MD, New Haven, CT
Madelon Baranoski PhD, New Haven, CT (I)
Kristen Bell JD PhD, New Haven, CT (I)
Tanuja Gandhi MD, New Haven, CT

WORKSHOP 8:00 AM – 10:00 AM **AGATE**

S25 ***Drugs in the House? Controlled Substances in Corrections***

Gregory Sokolov MD, Davis, CA
Ryan Wagoner MD, Lutz, FL

COURSE (TICKET REQUIRED) 8:00 AM – 12:00 PM **MINERAL A-C**

S26 ***Psychological Testing in Forensic Psychiatric Evaluations***

B. Thomas Gray PhD, ABPP, Pueblo, CO (I)
Rose Manguso PhD, ABPP, Pueblo, CO (I)
Richard Martinez MD, Denver, CO

COFFEE BREAK **10:00 AM – 10:15 AM**

WORKSHOP 10:15 AM – 12:00 PM **CENTENNIAL BALLROOM D**

S27 ***Evaluating Malingered ADHD: Pay Attention!***

Barbara McDermott PhD, Sacramento, CA (I)
Charles Scott MD, Sacramento, CA

WORKSHOP — 10:15 AM – 12:00 PM — **MINERAL D-E**

S28 ***Soul Space Behind Bars - Clergy/Clinician Collaborations***

Krista Burkholder BSW, Canon City, CO (I)
Michael Champion MD, Honolulu, HI
Catherine Dumas BA, Durham, NC (I)
Dan Leetch MA, Pueblo, CO (I)
Michael A. Norko MD, Durham, CT

WORKSHOP — 10:15 AM – 12:00 PM — **QUARTZ**

S29 ***Hotshots: Forensic Implications of Sexting***

Susan Hatters-Friedman MD, Cleveland, OH
Brian Holoyda MD, St. Louis, MO
Renee Sorrentino MD, Boston, MA

PANEL — 10:15 AM – 12:00 PM — **MINERAL F-G**

S30 ***A Proposed Resource Document on Forensics in Psychiatry***
Forensic Training in General Psychiatry Residency Committee

Julie Alonzo-Katzowitz MD, Austin, TX
William Cardasis MD, Ann Arbor, MI
Cathleen Cerny MD, Cleveland, OH
Jessica Ferranti MD, Sacramento, CA
Stephen Noffsinger MD, Hudson, OH

WORKSHOP — 10:15 AM – 12:00 PM — **AGATE**

S31 ***Slipping Through the Cracks: ID/DD in Correctional Settings***
Corrections and Developmental Disability Committees

Rosa Negron-Munoz MD, Lakeland, FL
Susan Parke MD, New Haven, CT
Alexander Westphal MD, New Haven, CT
Elizabeth Ford MD, New York, NY

LUNCH (TICKET REQUIRED) — 12:00 PM – 2:00 PM — **CENTENNIAL BALLROOM A-C**

S32 ***Graves Injustice***

Anthony Graves, Houston, TX (I)

WORKSHOP — 2:15 PM – 4:00 PM — **CENTENNIAL BALLROOM D**

S33 ***White Collar Crime***

Steven Simring MD MPH, New York, NY
Charles Scott MD, Sacramento, CA

WORKSHOP — 2:15 PM – 4:00 PM — **MINERAL A-C**

S34 ***Attacking Forensic Psychiatric Testimony***

Stephen Noffsinger MD, Hudson, OH
Sherif Soliman MD, Hinckley, OH
Adam Fried JD, Cleveland, OH (I)
Carolyn Dessin JD, Akron, OH (I)

WORKSHOP — 2:15 PM – 4:00 PM — **MINERAL D-E**

S35 ***Suicide in Juvenile Confinement***
Child and Adolescent Psychiatry Committee

Eileen P. Ryan DO, Columbus, OH
Stephen Billick MD, New York, NY
Lindsay Hayes MS, Mansfield, MA (I)
Joseph Penn MD, Conroe, TX
Christopher Thompson MD, Los Angeles, CA
Cheryl Wills MD, Cleveland, OH

PANEL 2:15 PM – 4:00 PM **MINERAL F-G**

S36 ***Doc, My TV Really is Listening to Me!***

George David Annas MD MPH, Syracuse, NY
James Knoll IV MD, Syracuse, NY
Diana Kurlyandchik MD, Guilford, CT
Melissa Spanggaard DO, Tucson, AZ

PANEL 2:15 PM – 4:00 PM **AGATE**

S37 ***Breaking Bad: Criminal Behavior in Hospitals and Prisons***
Criminal Behavior Committee

KyleeAnn Stevens MD, Shakopee, MN
Michael Champion MD, Honolulu, HI
Charles Dike MD, MRCPsy, Cheshire, CT
Joy Stankowski MD, Cleveland, OH
Robert Trestman MD PhD, Roanoke, VA

PAPER SESSION #2 2:15 PM – 4:00 PM **GRANITE**

S38 ***Forensic Implications of Pseudologia Fantastica***

Richard Frierson MD, Columbia, SC
Kaustubh Joshi MD, Columbia, SC

S39 ***Distributional Properties of the Atypical Presentation Scale***

Douglas Mossman MD, Cincinnati, OH
Wendi Wang BA, Cincinnati, OH (I)
Christopher Marett MD, Cincinnati, OH

S40 ***When Is a Smartphone App a Regulated Medical Device?***

James Armontrout MD, San Francisco, CA
Renée Binder MD, San Francisco, CA
Marsha Cohen JD, San Francisco, CA (I)
Dale McNiel PhD, San Francisco, CA (I)
John Torous MD, Boston, MA (I)

COFFEE BREAK **4:00 PM – 4:15 PM**

WORKSHOP 4:15 PM – 6:15 PM **CENTENNIAL BALLROOM D**

S41 ***Assessing Terrorism Risk in Asylum Evaluations***
Human Rights Committee

Emily Keram MD, Santa Rosa, CA
Danielle Kushner MD, New York, NY
Swati Shivale MD, Atlanta, GA

WORKSHOP 4:15 PM – 6:15 PM **MINERAL D-E**

S42 ***Therapeutic Risk Management of the Suicidal Patient***
Suicidology and Correctional Psychiatry Committees

Darren Lisch MD, Denver, CO
Bridget Matarazzo PsyD, Denver, CO (I)
Sarra Nazem PhD, Denver, CO (I)
Hal Wortzel MD, Aurora, CO

PANEL 4:15 PM – 6:15 PM **MINERAL F-G**

S43 ***Older Adults and Prison Release: Clinical and Legal Issues***

William Bryson MD, Seattle, WA
Bruce Gage MD, Tumwater, WA
Jennifer Piel MD, JD, Seattle, WA
Brie Williams MD, San Francisco, CA (I)

WORKSHOP 4:15 PM – 6:15 PM **AGATE**

S44 Homicidal Juveniles: Can Bad Boys Be Good Men?

Anne McBride MD, Sacramento, CA
Barbara McDermott PhD, Sacramento, CA (I)
Charles Scott MD, Sacramento, CA

PANEL 4:15 PM – 6:15 PM **MINERAL A-C**

S45 AAPL Practice Resource on Prescribing in Corrections Correctional Psychiatry Committee

Anthony C. Tamburello, Glassboro, NJ (I)
Michael Champion MD, Honolulu, HI
Elizabeth Ferguson MD, Palm Coast, FL
Graham Glancy MB, Toronto, ON, Canada (I)
Jeffrey Metzner MD, Denver, CO
Joseph Penn MD, Conroe, TX
Robert Trestman MD PhD, Roanoke, VA

RESEARCH-IN-PROGRESS #4 4:15 PM – 6:15 PM **QUARTZ**

S46 Motivations for Bestiality: Exploring the Evidence

Brian Holoyda MD MPH MBA, St. Louis, MO

S47 Men Using the Internet to Solicit Sex from Minors

Mark Chapman MD, Chicago, IL
Jeffrey Danziger MD, Maitland, FL
Stephen Dinwiddie MD, Chicago, IL
Melanie Venable MD, Chicago, IL

S48 Noninvasive Infrared Thermodetection of Erectile Function

Renée Sorrentino MD, Weymouth, MA
Carlos Hidrovo PhD, Boston, MA (I)

S49 A Novel Approach to Maintaining Competence on Rikers Island

Marilyn Chen PhD, East Elmhurst, NY (I)
Angela Solimo MA, East Elmhurst, NY (I)
Li-Wen Lee MD, Albany, NY
Elizabeth Ford MD, New York, NY

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

S1 BRINGING THE INVISIBLE TO LIGHT: RESTORING THE FEMALE INMATE

Ann Joseph MD, Highlands Ranch, CO
Brittany Remmert PsyD, Denver, CO

EDUCATIONAL OBJECTIVE

The audience will learn about and examine the significant gap in competency restoration services for female defendants across the United States Audience members will list 3 specific needs incompetent female defendants have as it pertains to the justification of implementing a competency restoration program

SUMMARY

Female prisoners are the fastest growing sector of inmates. Many women that enter the criminal justice system are often socioeconomically disadvantaged, lack education, have a significant history of drug addiction and mental illness, and many have undergone significant physical and sexual abuse. In addition, women have gynecological and familial needs that are different from men. Restoration services and research on incompetent defendants has focused primarily on male defendants. Incompetent female defendants languish in jails across the United States without access to competency restoration services that take into consideration the special needs of women within the criminal justice system. Given the lack of restoration services available to females, we are proposing the development of the first jail-based competency restoration program specific to female defendants found incompetent to stand trial.

REFERENCES

Kois L, Pearson J, Chauhan P, et al: Competency to stand trial among female inpatients. Law and human behavior 37(4):231, 2013
Claire DA, Guidry D, Burnett DM, et al: Competency restoration treatment: differences between defendants declared competent or incompetent to stand trial. J Am Acad Psychiatry Law 40:89-97, 2012

QUESTIONS AND ANSWERS

How many jail-based competency restoration programs exist in the country specifically to restore incompetent female defendants?
a. 10
b. 5
c. 0
d. 15
ANSWER: c

Women, unlike their male counterparts, are more likely to report extensive histories of physical, sexual, and emotional abuse.
a. True
b. False
ANSWER: a

S2 AFTER THE SMOKE CLEARS: STRESS MANAGEMENT & LAW ENFORCEMENT

R. Ryan Leahy, Miami Beach, FL

EDUCATIONAL OBJECTIVE

To describe stressors seen in the law enforcement community and provide information to better manage the demands made on this unique group of persons.

SUMMARY

There are approximately 18,000 law enforcement agencies in the United States which employ 1.25 million sworn law enforcement personnel. The poster discusses the changing reality of law enforcement. Law enforcement is becoming increasingly dangerous. Fatalities rose in 2016 to their highest level in 5 years: ambush style attacks accounted for 1/3 of all shooting deaths. Law enforcement officers (LEO's) encounter multiple stressors including: taking a life, being assaulted, having a partner killed, dealing with crime victims and abused children. The law enforcement workplace is a stressful arena as well, compounded by the increased scrutiny of the news and social media. LEO's have higher rates of suicide than occur in the general population. They are at increased risk for alcohol abuse, mental health issues, medical issues, and relationship problems. Finally, the poster provides some suggestions to improve mental health including stress inoculation, resilience training, and mindfulness. Critical

incident stress debriefings are described for those who undergo traumatic critical incidents. Suggestions for understanding the police subculture which often discourages LEO's from admitting weakness or seeking help are given for the mental health providers who will work with this population.

REFERENCES

Mental Fitness: Combating Stress on the Job. Available at https://www.fopconnect.com/article/surviving-the-x/mental-fitness/. Accessed February 26, 2017
Meichenbaum D: Handbook for Treating PTSD in Military Personnel. Edited by Moore B, Penk W. New York, NY: Guiliford Press, 2011, pp 325-344

QUESTIONS AND ANSWERS

Which of the following characteristics have been found among resilient individuals
a. Adaptive Task-Oriented Coping Style
b. Cognitive Flexibility
c. Meaning-Making
d. Regulation of Strong Negative Emotions
e. All of the above
ANSWER: e

Which of the following have been identified as day to day psychological stressors that law enforcement officers are routinely exposed too.
a. Administrative stresses
b. Ambiguity
c. Constant scrutiny
d. Depersonalization
e. All of the above
ANSWER: e

S3 BORDERLINE AND ANTISOCIAL TRAITS AMONG INMATES IN A JAIL SET

Corey M Leidenfrost PhD, Buffalo, NY
Peter S. Martin MD MPH, Buffalo, NY
Daniel Antonius PhD, Buffalo, NY

EDUCATIONAL OBJECTIVE

Increase knowledge regarding the need for more intensive treatment for individuals with higher antisocial and borderline traits within a correctional setting.

SUMMARY

Recent research demonstrates an association between antisocial/borderline personality traits and higher levels of psychological distress, greater suicide risk, and poorer quality of life among incarcerated offenders. This has led researchers to speculate that more intensive mental health treatment is necessary for these offenders. To extend these findings and ideas, we examined data on incarcerated offenders on a specialized treatment unit About 25% of the sample exhibited high antisocial and borderline traits by achieving on the relevant Personality Assessment Inventory (PAI) scales. Individuals in the high groups, compared to the low groups, showed significantly higher psychological distress, including increased self-reported (PAI) anxiety, mania, and stress, as well as observed (BPRS) affective symptoms. Also, individuals in the high borderline group reported higher suicidal ideation (PAI) and lower well-being (SOS-10). Importantly, the need for more intensive treatment for those in the high groups was supported by these individuals scoring higher on the PAI Level of Care Index. Our findings indicate that offenders with higher levels of borderline and antisocial traits have more severe psychiatric complications and require more intensive treatment.

REFERENCES

Black DW, Gunter T, Allen J, et al: Borderline personality disorder in male and female offenders newly committed to prison. Comprehensive Psychiatry 48:400-405, 2007
Black DW, Gunter T, Loveless P, et al: Antisocial personality disorder in incarcerated offenders: Psychiatric comorbidity and quality of life. Annals of Clinical Psychiatry 22:113-120, 2010

QUESTIONS AND ANSWERS

Which group showed a higher risk for lethality?
a. Those with high borderline personality traits
b. Those with high antisocial personality traits
c. Both groups had a higher risk for lethality
d. Neither group had an association with lethality risk
ANSWER: a

Based on our results, why may individuals with more borderline and antisocial traits need more intense treatment in a jail environment?
a. They tend to malinger more about symptoms.
b. They cause more behavioral problems
c. They had more psychiatric and psychological distress and their LOCI scores were higher.
d. They do not need more intensive treatment
ANSWER: c

S4 MENTAL HEALTH OF SEXUAL MINORITY JUSTICE YOUTH

Matthew Hirschtritt MD MPH, San Francisco, CA
Emily Dauria PhD MPH, San Francisco, CA
Brandon Marshall PhD, Providence, RI
Marina Tolou-Shams PhD, San Francisco, CA

EDUCATIONAL OBJECTIVE

This research aims to: (1) improve the quality of psychiatric services delivered to sexual minority, court-involved, non-incarcerated (CINI) youth and (2) address gaps in knowledge and establish a foundation for subsequent practice-driven research by describing demographic and clinical characteristics of this unique population.

SUMMARY

The behavioral and psychological profiles of court-involved, non-incarcerated (CINI) youth are not well characterized, despite the fact that CINI youth comprise approximately 80% of justice-involved youth. Further, even less is known about sexual-minority CINI youth – a particularly vulnerable, marginalized group at elevated risk for mental-health problems and high-risk behaviors. We examined the prevalence of sexual-minority status among CINI youth (N=424, ages 12-18), and compared risk behaviors and psychiatric symptoms between sexual-minority and non-sexual-minority youth. Nearly one-third of adolescents (N=134, 31.6%) identified as sexual minorities by various definitions: same-sex attraction (N=80, 18.9%); non-heterosexual orientation (N=82, 19.3%); same-sex sexual behavior (N=44, 10.4%); victimization due to sexual orientation or gender identity (N=74, 17.5%); and gender nonconformity (N=2, 0.5%). Sexual minority and non-sexual-minority youth did not differ in rates of recent self-reported delinquent behavior (NYS-Delinquency Scale range: 0-23, M=2.4±2.7 vs 1.9±2.5, t(393)=-1.900, P=.06); however, sexual minority youth were more likely to report lifetime illicit drug use (67.2% vs 46.6%, chi^2(1)=15.63, P<.0001) and elevated affective dysregulation on the abbreviated Structured Interview for Disorders of Extreme Stress (range: 1-24, M=14.5±4.7 vs 12.0±3.9, t(393)= -5.448). These novel data suggest that CINI sexual minority youth require tailored prevention efforts relative to their non-sexual-minority counterparts.

REFERENCES

Mustanski BS, Garofalo R, Emerson EM: Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. Am J Public Health 100(12):2426-2432, 2010
Tolou-Shams, M, Rizzo CJ, Conrad SM, et al: Predictors of detention among juveniles referred for a court clinic forensic evaluation. J Am Acad Psychiatry Law 42(1):56-65, 2014

QUESTIONS AND ANSWERS

Which of the following is NOT true regarding court-involved, not incarcerated (CINI) adolescents?
a. Co-occurring substance use and psychiatric illness is associated with increased risk of detention.
b. They comprise a minority of adolescents involved in the juvenile justice system.
c. Rates of sexually transmitted infections among this population are higher than those for non-court-involved adolescents.
d. Rates of psychiatric treatment among this population are lower than those for non-court-involved adolescents.
ANSWER: b

Sexual-minority CINI youth, compared with their non-sexual-minority CINI peers, are at higher risk for:
a. Illicit substance use
b. Depression
c. Suicidal ideation
d. High-risk sexual behavior
e. All of the above
ANSWER: e

S5 **AGGRESSION ON CO-ED VS. SINGLE GENDER FORENSIC UNITS**

Kayla Fisher MD JD, Sacramento, CA
Sean Evans PhD, Highland, CA

EDUCATIONAL OBJECTIVE
Violence reduction on forensic units continues to be of interest in providing safety to patients and clinicians, yet little data exists on the effects of co-ed vs. single-gender units. This poster provides data collected in a 1500-bed forensic facility showing significant aggression rate differences exist between co-ed and single-gender units.

SUMMARY
Violence reduction on forensic units has received considerable attention in the literature, yet little data exists regarding aggression rate comparisons on single-gender vs. co-ed units. This poster provides data obtained from a 1500-bed forensic facility within a corrections-secured perimeter. This set of data found that, overall, single-gender forensic units had a lower aggression rate when compared with co-ed units. The decreased aggression rate was observed in both patent to patient and patient to staff interactions. Severity of aggression was also slightly increased on co-ed units. These differences were observed despite the hospital 's practice of putting men deemed most violence on single-gender units. The poster will discuss factors which may contribute to the increased violence on co-ed units and opportunities for further research.

REFERENCES
Fisher K: Inpatient violence. Psychiatr Clin North Am 39(4):567-577, 2016
Warburton K, Stahl S: Violence in Psychiatry. Cambridge, UK: Cambridge University Press, 2016

QUESTIONS AND ANSWERS
This set of data suggests that which of the following are true regarding forensic psychiatry units:
a. No differences in overall aggression rates exist on co-ed vs. single gender units.
b. Co-ed units have less overall rates of aggression
c. Single gender units have less overall rates of aggression than co-ed units.
d. Co-ed units have less lethal aggression than single gender units.
ANSWER: c

When comparing co-ed vs. Single gender forensic psychiatry units, this data showed the following:
a. Patient to staff aggression rates were greater on single gender units.
b. Patient to patient aggression rates were greater on single gender units.
c. Although patient to staff aggression rates were less on single gender units, no difference in patient to patient aggression rates were observed.
d. Both patient to patient and patient to staff aggression rates were decreased on single gender units as compared to co-ed units.
ANSWER: d

S6 **LGBT PEOPLE: GREATER RISK IN JAIL & GREATER RISK OF JAIL?**

Alexander Berger DO, New York, NY
Merrill Rotter MD, Bronx, NY

EDUCATIONAL OBJECTIVE
To explain the over-representation of LGBT people in the criminal justice system and understand the factors that may put them at greater risk of re-offending and incarceration.

SUMMARY
Lesbian, Gay, Bisexual, and Transgender (LGBT) people are over-represented in the criminal justice system. According to the National Inmate Survey from 2011-2012, 7.9% of people in state or federal prisons identified as

LGBT, whereas 4.1% of the general population identify as LGBT according to the latest Gallup poll. The reasons for this disproportionate prevalence are not entirely clear. The risk-needs-responsivity (RNR) model for understanding criminal recidivism proposes that there are factors that are directly associated with repeated criminal behavior (e.g. antisocial traits and substance use). The RNR model also recognizes that there are individual characteristics which do not directly drive criminal behavior, but may exacerbate one or more of the so-called "criminogenic" needs, and/or make addressing those needs more difficult; thus increasing the risk for recidivism, albeit indirectly. In this poster, we apply the RNR model and the model's criminogenic needs and responsivity factors to highlight characteristics that may be associated with the LGBT population, which either directly or indirectly, help explain the over-representation in jails and prisons, and can point to the way to more effective recidivism-reducing interventions.

REFERENCES

Unjust: How the Broken Criminal Justice System Fails LGBT People. Available at http://www.lgbtmap/criminaljustice. Accessed September 4, 2017
Barber-Rioja V, Rotter M: Risk Assessment: Risk Management, Re-entry and Recovery. In Henry A. Dlugacz (Ed.), Reentry Planning for Offenders with Mental Disorders: Policy and Practice. Kingston, NJ: Civic Research Institute, 2015

QUESTIONS AND ANSWERS

Which of the following are challenges faced by LGBT people upon reentry?
a. Lack of LGBT competency in probation and parole
b. Housing discrimination
c. Employment discrimination
d. All of the above
ANSWER: d

Which factors may be responsible for the overrepresentation of LGBT People in the Criminal Justice System?
a. Discrimination in housing causing homelessness
b. Discrimination in legal proceedings
c. LGBT people are more violent
d. choices a and b
ANSWER: d

S7 PREDICTORS OF COMPETENCY RESTORATION ON A JAIL-BASED UNIT

David Halverson MD, Atlanta, GA
Glenn Egan PhD, Atlanta, GA
Peter Ash MD, Atlanta, GA

EDUCATIONAL OBJECTIVE

To understand factors that predict restoration of competency on a jail-based unit and appreciate the differences between predictors on jail-based units when compared to predictors in patients on hospital-based units.

SUMMARY

Criminal defendants who have been found incompetent to stand trial (IST) have traditionally been transferred from county jails to state mental hospital forensic psychiatric inpatient units for restoration. In a relatively small number of jurisdictions, specialized competency restoration mental health units have been established in jails. In jail settings, different parameters for treatment may apply. For example, in our jail restoration unit, the jail's policy does not allow involuntary medication except in emergencies, even with a Sell order, unlike in the state hospital. This study examines predictors of restoration in over 500 defendants treated on a jail-based unit in the past 6 years and compares them to outcomes in state hospital units.

REFERENCES

Mossman D: Predicting restorability of incompetent criminal defendants. J Am Acad Psychiatry Law 35:34-43, 2007
Rice K, Jennings JL: The ROC program: accelerated restoration of competency in a jail setting. Journal of Correctional Health Care 20:59-69, 2014

QUESTIONS AND ANSWERS

Which of the factors below is most strongly associated with failure to restore competency to stand trial?
a. Age > 50
b. IQ < 70
c. Active psychosis due to schizophrenia
d. A prior history of > 3 hospitalizations
e. Misdemeanor charge
ANSWER: b

Advantages of jail-based competency restoration units include:
a. More rapid institution of restoration services
b. Optimizing use of limited forensic hospital beds
c. Matching treatment needs to the intensity of delivered services
d. Establishing a continuum of restoration services
e. All of the above
ANSWER: e

S8 INMATE ASSAULT ON PRISON STAFF: WORDER'S COMP PERSPECTIVE

Manish Fozdar MD, Wake Forest, NC
Robert Granacher MD MBA, Lexington, KY
Robert Trestman PhD MD, Roanoke, VA
Denise Kellaher DO, Folson, CA

EDUCATIONAL OBJECTIVE

Mental health of prison staff is a much less discussed topic in the forensic psychiatry. Participants will be informed of the statistics, demographics, neuropsychiatric presentations, and worker's compensation related issues about the victims of inmate assault. The discussion would focus on prevention and treatment strategies through a multidisciplinary approach.

SUMMARY

Inmate assaults on correctional staff present many challenges for a forensic psychiatry practitioner in the context of worker's compensation claims. There is a wide body of extant literature on occupational burnout amongst correctional officers. Occupational hierarchy and bureaucracy of the correction setting, cynicism, social support, racial factors, and many other factors have been debated in the literature. This presentation will focus on some of the most common neuropsychiatric presentations of the victims of the inmate assaults. The panel will focus on three most common presentations- traumatic brain injury, PTSD/Depression, and chronic pain. The panel comprises experts who have worked in the civil setting and correctional setting. Each presenter will bring a unique perspective on the evaluation and management of these victims. Worker's compensation issues such as maximum medical improvement and return to work will be explored as they present unique challenges for this cohort. Audience participation will be strongly encouraged. Future research ideas will be proposed.

REFERENCES

Konda S, Reichard A, Tiesman H: Occupational Injuries among U.S. Correctional Officers, 1999-2008. Journal of Safety Research 43(3):181-186, 2012
Trestman R, Appelbaum K, Metzner J: Oxford Textbook of Correctional Psychiatry. Oxford, England:Oxford University Press, 2015

QUESTIONS AND ANSWERS

PTSD among correctional officers is:
a. comprised of the highest number of worker compensation claims.
b. estimated to occur at rates as high as combat Veterans.
c. screened for on standard medical evaluations.
d. not covered under the Americans with Disabilities Act of 1990.
ANSWER: b

In correctional settings, workers comp claims of chronic pain:
a. are infrequent and readily resolved.
b. lend themselves to objective evaluation and effective treatment.
c. while common, still typically result in return to work with no restrictions.
d. are difficult to evaluate and often reflect ongoing work stress.
ANSWER: d

S9 IM MEDICATION USE FOR VIOLENCE IN A FORENSIC PSYCHIATRY UNIT

Bipin R. Subedi MD, Brooklyn, NY
Nadia Oryema, New York, NY

EDUCATIONAL OBJECTIVE

Attendees will gain an understanding of the outcomes and patient characteristics associated with various formulations of short-acting intramuscular (IM) psychotropics in the management of acute violence. We will also encourage clinicians to reflect on how they determine which IMs to use in aggressive patients.

SUMMARY

Intramuscular medications may be required in situations of significant patient agitation/violence. Presently there are few head-to-head studies comparing the efficacy of intramuscular medications in reducing violence on psychiatric inpatient units. Many of the studies that do exist have been conducted outside of North America, where the medications available and protocols employed cannot be generalized to individual inpatient environments. Furthermore, many studies make comparisons of varying formulations of psychotropic medications (i.e. oral and IM) and dosages used are frequently not in line with those used in all clinical settings. Given the dearth of information available on this topic, we will present data from a study performed on an acute inpatient forensic psychiatric unit assessing outcomes and patient characteristics associated with various forms of intramuscular medications in managing acute violence. We will additionally present patient characterization data, and contrast individuals who were involved in an incident of violence and received IM medication to those who did not.

REFERENCES

Tuddenham L, Logan J: Psychotropic drugs given for aggressive incidents in a special hospital. Journal of Forensic Psychiatry and Psychology 16(1):85-91, 2005
Citrome L: Comparison of intramuscular ziprasidone, olanzapine, or aripiprazole for agitation: a quantitative review of efficacy and safety. J Clin Psychiatry 68(12):1876-85, 2007

QUESTIONS AND ANSWERS

According to the available studies, medication is used to manage acute agitation in the inpatient psychiatric setting:
a. 10% of the time
b. 50% of the time
c. 30% of the time
d. 60% of the time
ANSWER: c

The following combination of medications was used most often to treat acute agitation/violence in the forensic inpatient setting:
a. Haldol 5 mg, Ativan 2 mg
b. Haldol 10 mg, Ativan 2 mg
c. Thorazine 25 m, Ativan 2 mg
d. Olanzapine 10 mg
ANSWER: a

S10 ENHANCING SERVICES IN A JUVENILE DETENTION SETTING

Peter S. Martin MD MPH, Buffalo, NY
Daniel Antonius PhD, Buffalo, NY
Corey Leidenfrost PhD, Buffalo, NY

EDUCATIONAL OBJECTIVE

Describe how a comprehensive mental health treatment approach can be implemented in a youth secure detention facility, including improving educational and clinical services

SUMMARY

Youth incarcerated in juvenile detention settings are at risk of presenting with or developing significant mental health and/or substance abuse problems. Developing comprehensive mental health delivery services that focus on early identification and treatment of mental health disorders in detention settings are critical for better care, prevention, reducing recidivism, and helping these youth become responsible adults. To address these concerns, we (Erie County Secure Detention, Buffalo, NY) are transforming our services to meet expanding needs. This presentation will focus on two critical areas: training and clinical services. To facilitate teaching and training, we have

expanded opportunities for trainees, including medical students, general psychiatry residents, child and adolescent psychiatry fellows, and forensic psychiatry fellows, involving direct clinical care and court-ordered assessments. Clinically, our services have been standardized with a comprehensive intake assessment that includes screening for human trafficking, evidence-based risk assessment, and a goal-oriented achievement plan. Intake assessment is conducted by trained masters-level social workers to ensure reliability. Standard Operating Procedures have been revised to exceed current national standards in the field (i.e. JDAI and NCCHC). Importantly, the transformation is a collaborative partnership between key community organizations, including the University at Buffalo Psychiatry Department. Future directions will be discussed.

REFERENCES

Pajer K, Kelleher K, Gupta R, et al: Psychiatric and medical health care policies in juvenile detention facilities. J Am Acad Child Adolesc Psychiatry 46(12):1660-7, 2007

Desai R, Goulet J, Robbins J, et al: Mental health care in juvenile detention facilities: a review. J Am Acad Psychiatry Law 34(2):204-214, 2016

QUESTIONS AND ANSWERS

What opportunities are present for improvement of mental health in a secure detention facility for youth?
ANSWER: Expanding psychiatric training opportunities and providing standardized and expanded mental health treatment.

In what way can an intake evaluation lethality assessment be improved?
ANSWER: By using an evidence-based assessment.

S11 CRIMINAL BACKGROUND AS PART OF AGGRESSION RISK ASSESSMENT

Katrina Shchupak MD , Philadelphia, PA

EDUCATIONAL OBJECTIVE

To increase knowledge of risk assessment for aggression when evaluating patients in a psychiatric emergency setting. This study will determine if there is a higher incidence of aggression associated with various types of criminal histories in order to help individualize pre-emptive de-escalation techniques and decrease use of restraints.

SUMMARY

There is much written in the literature on psychiatric risk assessment of violence, some of the highest predictors of which include a prior history of violence and substance use. For those working in a Psychiatric Emergency Service setting, predicting violence is crucial for the safety of both staff and patients. This study aims to further the available knowledge by determining if there is also an association between criminal background and aggression in a Crisis Response Center, specifically if there is a higher likelihood of aggression and use of restraints associated with specific types of criminal histories. This will be done by retroactively looking at patients seen within a 3 month period in the Episcopal Hospital Crisis Response Center and comparing publicly available criminal histories with incidents of aggression and restraint use. Further, we will also evaluate severity of aggression, using injury to staff or other patients as a marker, in order to see if there is a difference between more or less severe aggression in correlation to criminal history. This will ultimately help individualize de-escalation techniques by identifying high-risk patients early in the triage process, with the hope of decreasing the need for use of restraints.

REFERENCES

Buchanan A, Binder R, Norko M, et al: Resource Document on Psychiatric Violence Risk Assessment. FOCUS 13(4): 490-498, 2015

Knox D, Holloman G: Use and avoidance of seclusion and restraint: consensus statement of the American Association for Emergency Psychiatry Project Beta seclusion and restraint workgroup. Western Journal of Emergency Medicine 13:1201, 2011

QUESTIONS AND ANSWERS

When following the least restrictive intervention model of aggression management in a psychiatric emergency setting, which should be tried first?

a. Placing patient in a seclusion room

b. Involving patient in decisions about medication to be administered

c. Using a show-of-force

d. Waiting for patient to calm down on their own

ANSWER: b

All of the following are risk factors for violence EXCEPT:
a. Sees self as victim
b. Drug and/or alcohol abuse
c. Male over 30
d. Young age at first arrest
ANSWER: c

S12 **SOLITARY CONFINEMENT IN THE MENTALLY ILL, UNCONSTITUTIONAL?**

Ijeoma Jennifer Njoku MD, Philadelphia, PA

EDUCATIONAL OBJECTIVE
To examine the effects of solitary confinement on inmates who are mentally ill and explore how segregated units pose a danger to the mentally ill population.

SUMMARY
In Fall 2015, the Community Legal Aid Society Inc. (CLASI) and the American Civil Liberties Union (ACLU) filed a suit against the Delaware Department of Corrections (DOC) over the treatment of the incarcerated mentally ill. CLASI's suit alleges that the DOC violates the Eight Amendment right, which prohibits cruel and unusual punishment of prisoners. The lawsuit accuses the DOC of deliberate indifference to the mental health of its mentally ill inmates by exposing them to solitary confinement conditions. Almost all prison systems in the United States have a solitary confinement model , referred to as segregation, which confines inmates for 23 to 24 hours without interaction with other inmates or access to facility programs. In addition to stripping inmates of rehabilitation, they are also stripped of pasttimes such as books, radio, and recreation time. This poster examines the effect of solitary confinement on the mentally ill population. It examines the practices of segregation units and the exacerbation of mental illness and lack of treatment for the mentally ill inmate. Furthermore, this poster takes a look at Delaware's DOC segregation policies and conduct and attempts to answer the question of solitary confinement amongst the mentally ill population being unconstitutional.

REFERENCES
Appelbaum K: American psychiatry should join the call to abolish solitary confinement. J Am Acad Psych Law 43(4):406-415, 2015
Glowa-Kollisch S, Kaba F, Waters A, et al: From punishment to treatment: the clinical alternative to punitive segregation. Int J Environ Res Public Health 13(2):182, 2016

QUESTIONS AND ANSWERS
What are the major concerns in regard to the mentally ill population in solitary confinement?
a. Exposure to criminals will make the mentally ill population vulnerable to becoming criminals
b. Litigation by the loved ones of mentally ill
c. Decompensation of illness and access to treatment
d. Mentally ill population will be forced to eat nutriloaf
ANSWER: c

What is the APA's stance on prolonged solitary confinement of inmates?
a. Short term exposure to solitary confinement is acceptable
b. No comment
c. The APA supports the department of corrections' protocol in the use of solitary confinment
d. Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided
ANSWER: d

S13 **...AND THERAPEUTIC JUSTICE FOR ALL**

Jennifer K Bundrick MD, Aurora, CO

EDUCATIONAL OBJECTIVE
After this presentation, the viewers should recognize the common psychiatric co-morbidities for gambling disorder. The audience should identify the high correlation between gambling disorder and illegal behavior. The viewers should be able to discuss the need for diversion programs to establish therapeutic justice for all mental illnesses, including gambling disorder.

SUMMARY
Gambling disorder is now recognized as an addiction disorder in the DSM-V. However, only a small percentage of these patients ever seek treatment for gambling. The majority of those with a gambling disorder have a co-morbid mental illness. Understanding the common psychiatric co-morbidities may trigger clinicians to screen these patients for gambling disorder, which may result in better treatment. Forensic psychiatrists should be particularly attuned to screen for gambling disorder, as 54-90% of Gamblers Anonymous (GA) members admitted committing illegal acts in order to obtain money for gambling, and those who engaged in gambling-related illegal behavior had a more severe gambling disorder. Additionally, prevalence studies of incarcerated individuals ranged from 5-38%. Treatments available for gambling disorder among inmates is sparse, and mainly consists of GA and occasionally counseling. Therapeutic justice is the concept that the focus for the criminal justice system should focus on rehabilitation and restoration, not just punishment and deterrence. There are almost 3,000 drug courts, but at present, only a handful of gambling courts. Despite the re-classification of gambling disorder from an impulse-control disorder to an addiction disorder and the high correlation between gambling disorder and criminal behavior, diversion courts for gambling disorder are a rarity.

REFERENCES
Lopez Gaston R: Psychiatric co-morbidity in gambling, in A Clinician's Guide to Working with Problem Gamblers. New York, NY: Taylor & Francis, 2015, pp 75-85
Moss C: Shuffling the deck: the role of the courts in problem gambling cases. UNLV Gaming Law Journal 6(2):145-175, 2016

QUESTIONS AND ANSWERS
What is a common co-morbid mental illness in those who suffer from gambling disorder?
a. Major Depressive Disorder
b. Alcohol Use Disorder
c. Narcissistic Personality Disorder
d. Anti-Social Personality Disorder
e. All of the Above
ANSWER: e

What is the estimated prevalence for problem gambling amongst incarcerated individuals?
a. 0%
b. 1-5%
c. 5-38%
d. 50-75%
e. 90%
ANSWER: c

S14 SVPS WHO RECIDIVATE WHILE CIVILLY COMMITTED: A CASE SERIES

Jeremy Colley MD, New York, NY
Melinda DiCiro PhD, Sacramento, CA

EDUCATIONAL OBJECTIVE
To explore characteristics of committed sexually violent predators who commit additional sexual offenses while confined for treatment, and to estimate the frequency at which this type of re-offending occurs.

SUMMARY
Whether those determined to be Sexually Violent Predators and committed to a state hospital would have indeed gone on to reoffend if not confined, is generally unknown. Nevertheless, it is likely that persons who would not go on to reoffend are committed as SVPs. This is the dilemma of the statistical necessity to commit a number of people who would not reoffend, also known as false positives, in order to prevent a sexually violent act that would be committed by a member of an individual's high risk group. Most research regarding sexual recidivism has focused on sexual offending in the community upon release from prison or the hospital (false negatives). Therefore, incidents of sexual offending while a person is confined and in treatment - true positives - provide an opportunity to explore a true positive determination. We explore the commitment evaluations, rates of treatment participation and lengths of confinement of eight sexually violent predators charged with a non-contact re-offense while being confined and treated at the state hospital. Demographics, diagnoses, index offense, history of offending, actuarial scale scores, and dynamic risk variables will be identified, tallied and analyzed for trends.

REFERENCES
Wollert R: Low base rates limit expert certainty when current actuarials are used to identify sexually violent predators. Psychology, Public Policy, and Law 12(1):56-85, 2006
Elwood R: Defining probability in sex offender risk assessment. International Journal of Offender Therapy and Comparative Criminology 60(16):1928-1941, 2016

QUESTIONS AND ANSWERS
What is the number needed to detain, in the context of civil commitment of sex offenders?
ANSWER: The number needed to detain is the number of people who must be civilly committed in order to prevent the commission of a single additional sexual offense, over some defined period of time.

What risk factors predicted that a civilly committed SVP would commit a sexual offense while confined and in treatment?
ANSWER: To be determined based on data presented.

S15 SHOULD ASPD COUNT FOR SVP COMMITMENT IN CALIFORNIA?

Jeremy H. Colley MD, New York, NY
Melinda DiCiro PhD, Sacramento, CA
James Rokop PhD, Sacramento, CA

EDUCATIONAL OBJECTIVE
Participants will be able to describe the relationship between antisocial personality disorder and sexual offending. Participants will be able to articulate how this disorder is used in SVP civil commitment cases across the U.S. and in California and controversies about its use.

SUMMARY
This presentation will discuss the use of antisocial personality disorder (ASPD) as a qualifying diagnosable mental disorder (affecting the emotional or volitional capacity that predisposes the person to the commission of criminal sexual acts) in California sexually violent predator evaluations. The use of this disorder absent a secondary diagnosis of a paraphilic disorder is challenging to apply in SVP evaluations. In fact, there is little statutory guidance on the definition of what may constitute a mental disorder or mental abnormality other than the requisite link to emotional or volitional control and sexual offending. Other states appear to vary on their explicit allowance of personality disorder as a qualifying disorder. California's SVP law is silent on the issue but evaluators still appear to be highly conservative in their use of ASPD as the sole qualifying diagnosable mental disorder. The result is that antisocial personality disorder, absent a paraphilia disorder co-diagnosis, is applied in only a minority of cases that are referred to the district attorney as meeting civil commitment criteria ("positive" cases). This presentation will discuss evidence for and against its use as a qualifying diagnosable mental disorder, and make recommendations to evaluators based on review of the most salient considerations.

REFERENCES
Miller HA, Amenta AE, Conroy MA: Sexually violent predator evaluations: empirical evidence, strategies for professionals, and research directions. Law and human behavior 29(1):29, 2005
Prentky RA, Janus E, Barbaree H, et al: Sexually violent predators in the courtroom: Science on trial. Psychology, Public Policy, and Law 12(4): 357, 2006

QUESTIONS AND ANSWERS
What are mechanisms for arguing that antisocial personality (ASPD) alone is a qualifying mental disorder for civil commitment under a Sexually Violent Predator statute (when the disorder is not explicitly listed by statute)?
a. Emotional and volitional impairment as inherent to ASPD.
b. Distinguishing offenders with ASPD from the typical recidivists.
c. ASPD with specialized sexual manifestations and trajectories.
d. Treatability of ASPD
e. All of the above.
f. A, b, and c.
ANSWER: f

What circumstances could be used to argue against the use of ASPD as a qualifying diagnosis?
a. Offenders with ASPD cannot be sufficiently distinguished from the typical recidivist.
b. An ASPD diagnosis can be more a function of socialization than of psychopathology per se.
c. ASPD is not treatable.
d. A and b.
e. All of the above
ANSWER: d

S16 **PSYCHIATRIC CLEARANCE FOR JAIL: A REVIEW OF THE LITERATURE**

Jonathan Dunlop MD JD, Ann Arbor, MI
Debra A. Pinals MD, Ann Arbor, MI

EDUCATIONAL OBJECTIVE
To improve knowledge of the service of forensic patients by examination of overlapping service delivery systems, specifically the correctional system and the psychiatric emergency room.

SUMMARY
Since the deinstitutionalization of the severely and persistently mentally ill, there has been increasing interaction and overlap between the criminal justice system and the mental health system. One nexus of this interaction occurs in the psychiatric emergency room, where providers may be asked by law enforcement to provide "psychiatric clearance" for an individual in custody prior to any separate process of psychiatric assessment within the jail. Ostensibly this evaluation is meant to determine whether the individual presents with acute psychiatric illness such that he or she might require an inpatient psychiatric hospitalization. A literature review was conducted for published, peer-reviewed articles discussing the concept of an evaluation for psychiatric clearance for jail. No articles specific to this type of evaluation were found. A brief summary of relevant literature regarding risk factors for suicide in jail will be presented. Suggestions for further research will also presented, particularly with regards to psychiatric emergency room provider awareness of risk factors unique to individuals in jail as well as provider attitudes towards individuals presenting in the custody of law enforcement and concern for malingering.

REFERENCES
Hayes L: National Study of Jail Suicide 20 Years Later. U.S. Department of Justice. National Institute of Corrections, NIC Accession, 2010
Walker LEA, Pann JM, Shapiro DL, et al: A Review of Best Practices for the Treatment of Persons with Mental Illness in Jail. New York, NY: Springer, 2016, pp 57-69

QUESTIONS AND ANSWERS
According to data presented in 2010 regarding jail suicides occurring in 2005-2006, what percentage of suicides occurred within the first 24 hours of confinement?
a. Less than 25%
b. 25-50%
c. 50-75%
d. Greater than 75%
ANSWER: a

Comparing urban jails to other jails, which of the following risk factors for suicide demonstrated inconsistency (i.e. less prevalent in urban jails vs other jails)?
a. Race
b. Gender
c. Intoxication
d. Method
ANSWER: c

S17 **RESENTENCING EVALUATIONS: A REVIEW**

Jason R. Hall PhD, Tampa, FL

EDUCATIONAL OBJECTIVE
1. To become familiar with case law relevant to resentencing evaluations 2. To learn domains and methods of assessment in resentencing evaluations 3. To be aware of ethical considerations in the context of resentencing evaluations

SUMMARY
In a series of recent cases, the United States Supreme Court has ruled that mandatory sentences of life without parole for juvenile offenders are unconstitutional. The Court has also ruled that individuals currently serving such sentences for crimes committed before the age of 18 must receive new sentencing hearings, in which the presiding court must take into account mitigating developmental and situational factors unique to youthful offenders. In many such cases, forensic experts are called upon by the courts to evaluate these factors, as well as the examinee's potential for rehabilitation and risk for re-offending. The aim of this poster is to educate forensic mental health professionals regarding the purpose, nature, and scope of resentencing evaluations. Specifically, the poster will present: (1) a review of relevant case law; (2) statistics regarding numbers and characteristics of presently incarcerated individuals affected by recent changes in the law; (3) suggested practices for conducting resentencing evaluations, including relevant domains and associated methods of assessment; and (4) special ethical considerations in these cases. Recommendations for future research on the comparative efficacy of assessment methods will also be discussed, with the ultimate aim of progressing toward best practice guidelines for resentencing evaluations.

REFERENCES
Larson K, DiCataldo F, Kinscherff R: Miller v. Alabama: Implications for forensic mental health assessment at the intersection of science and the law. New England Journal on Criminal and Civil Confinement 39:319-345, 2013
Straley N: Miller's promise: Re-evaluating extreme criminal sentences for children. Washington Law Review 89:963-1007, 2014

QUESTIONS AND ANSWERS
In which of the following cases did the Supreme Court rule that mandatory sentences of life without parole for non-homicide offenses are unconstitutional?
a. Miller vs. Alabama
b. Graham vs. Florida
c. Roper vs. Simmons
d. Montgomery vs. Louisiana
ANSWER: b

Which of the following is NOT one of the factors that Florida judges must take into account in a resentencing hearing?
a. The effects of familial or peer pressure on the defendant's actions
b. The age, maturity level, intellectual development, and mental/emotional health of the defendant at the time of the offense
c. The effectiveness of the defendant's legal counsel at the time of the original sentencing
d. The effect of immaturity, impetuosity, or failure to appreciate risks and consequences on the defendant's actions
ANSWER: c

S18 SOLITARY ACROSS THREE STATES

Amina Z. Ali MD, New York, NY
Sabina Fink MD, Bronx, NY
Katya Frischer MD JD, New York, NY

EDUCATIONAL OBJECTIVE
To describe the differences in solitary confinement across 3 states and discuss the advantages and disadvantages of each system in relation to mental health.

SUMMARY
On January 13, 2015, the New York City Board of Corrections voted to eliminate the use of solitary confinement for all inmates 21 and younger, putting Rikers Island at the forefront of national jail reform efforts. Solitary confinement has long been a correctional tool. According to data released by Rikers, 103 of the 497 inmates between the ages of 19-21 were held in solitary confinement. According to the Association of State Correctional Administrators (ASCA), approximately 70,000 inmates of any age are currently forced into confinement across the United States. 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. Although solitary confinement is used across the United States, each state defines solitary confinement differently. This poster will describe the similarities and differences in solitary confinement environments in 3 different facilities within 3 different states including New York, New Jersey and Connecticut. We will discuss how different jurisdictions manage adults in solitary confinement and address the impact of any differences on the mental health of inmates.

REFERENCES
Metzner J, Fellner J: Solitary confinment and mental illness in US prisons: a challenge to medical ethics. J Am Acad Psychiatry Law 38:104-8, 2010
Growing Up Locked Down: Youth in Solitary Confinement in Jails and Prisons Across the United States. https://www.aclu.org/report/growing-locked-down-youth-solitary-confinement-jails-and-prisons-across-united-states. Accessed September 4, 2017
Human Rights Watch. American Civil Liberties Union, 2012.

QUESTIONS AND ANSWERS
How many inmates are currently in confinement across the United States?
a. 10,000
b. 30,000
c. 70,000
d. 100,000
ANSWER: c

Solitary confinement can cause which the following psychological effects?
a. Anger
b. Paranoia
c. Psychosis
d. All of the above
ANSWER: d

S19 VALIDATION OF THE "SEE, THINK, ACT SCALE"

Bonnie Siu Wei-man MD, Tuen Mun, Hong Kong

EDUCATIONAL OBJECTIVE
There is no validated Chinese version of any scale to measure the level of relational security provided by a forensic psychiatric unit. This study validated the Chinese version of the "See, Think, Act Scale" (C-STA) and the relational security of the Forensic Psychiatric Department of Castle Peak Hospital was measured.

SUMMARY
This study aimed to validate the Chinese version of the See, Think, Act Scale (C-STA) and to measure the relational security of the Forensic Psychiatric Department of Castle Peak Hospital which provides territory-wide forensic psychiatric services in Hong Kong. The See, Think, Act Scale was first translated into Chinese, then back-translated into English for comparison, and subject to modification until alignment. Its face validity and content validity were evaluated through an expert panel's ratings and focus group discussion. Eighty-nine mental health professionals were recruited from six service units to measure the relational security of the Forensic Psychiatric Department using the C-STA. Cronbach's alpha and Pearson correlation coefficient were respectively used to assess the internal consistency and test-retest reliability of the instrument. One-way analysis of variance was used to test if there were sub-group differences in total relational security scores. Based on the Cronbach's alpha coefficient, the internal consistency was rated as excellent with all components exceeding 0.90. Test-retest reliability ranged from r=0.55 to r=0.80. A significant sex difference ($p<0.05$) in total relational security scores was found. The Chinese version of the See, Think, Act Scale is a valid and reliable instrument.

REFERENCES
Tighe J, Gudjonsson GH: See, think, act scale: preliminary development and validation of a measure of relational security in medium- and low-secure units. Journal of Forensic Psychiatry and Psychology 23(2):184-199, 2012
Schalast N, Redies M, Collins M, et al: EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards. Criminal Behaviour and Mental Health 18:49-58, 2008

QUESTIONS AND ANSWERS
Therapeutic security is the term used to describe the combination of three domains of security. They are physical security, procedural security and what else?
a. Mental security
b. Relational security
c. Occupational security
ANSWER: b

Among the domains of security, which one is the most complex and abstract one?
a. Physical security
b. Procedural security
c. Relational security
ANSWER: c

S20 **JEFFERSON COUNTY MHC: A PHENOMENOLOGICAL EXPLORATION**

Nadia Y. Tayeb MD, Birmingham, AL
John Dantzler PhD, Birmingham, AL

EDUCATIONAL OBJECTIVE
The goal of this poster is to educate providers about the role of mental health court in diverting eligible individuals with mental illness out of the criminal justice system to psychiatric treatment and case management and the experience of participants in the Jefferson County Mental Health Court.

SUMMARY
Mentally ill inmates are often released from custody the same or worse than when they were arrested (due to limited resources available to them while incarcerated), and frequently reoffend. Mental health courts (MHC) divert such individuals from the criminal justice system to treatment and case management to aid in their recovery and reduce recidivism. This phenomenological qualitative study examines the subjective experiences of Jefferson County MHC participants. Using an open-ended interview format, 15 participants were interviewed about their experience. Positive aspects of the structure of the MHC were personalized management, access to resources, structure, accountability, reintegration, emotional support, and frequent contact. Negative aspects included lack of forensic psychiatry involvement and gaps in linkage to a mental health provider. Positive impacts of participation were improved psychological well-being, reduced symptoms, and improved insight into psychiatric illness, behavior, relationships, and trust in the court system. The only negative aspect reported was the time commitment. The results were consistent with current literature that the MHC is effective and a therapeutic experience. Future research might compare courts that have involvement from forensic psychiatry with those that do not, or examine the long-term impact of linkage to primary care versus mental health specialists.

REFERENCES
Boothroyd RA, Poythress NG, McGaha A, et al: The Broward mental health court: Process, outcomes, and service utilization. International Journal Law and Psychiatry 26:55-71, 2003
Fisler C: Building trust and managing risk: a look at a felony mental health court. Psychology, Public Policy, and Law 11:587-604, 2005

QUESTIONS AND ANSWERS
What are some indicators of effectiveness of mental health courts traditionally measured/ studied?
a. Recidivism.
b. Psychosocial functioning.
c. Linkage to psychiatric treatment.
d. Clinical symptoms.
e. All of the above.
ANSWER: e

What are some positive aspects of the mental health court according to this phenomenological study that examined the subjective experiences of Jefferson County Mental Health Court participants?
a. Personalized case management and access to resources.
b. Structure, increased support and contact, and accountability.
c. Positive impact on participants' psychological state, behavior, and relationships.
d. Reduced symptoms and improved insight into mental illness.
e. All of the above.
ANSWER: e

S21 CREATING EMPATHY FOR INSANITY ACQUITTEES IN THE COMMUNITY

John Kastner ACCT, Toronto, ON, Canada
Michael A. Norko, MD, New Haven, CT

EDUCATIONAL OBJECTIVE

After viewing and assessing a recent documentary, Not Criminally Responsible: Wedding Secrets, attendees will discuss with the filmmaker its value in generating empathy for acquittees in the community, and be able to help plan effective public presentations to promote de-stigmatization of forensic patients in their home communities.

SUMMARY

The film is the sequel to the documentary NCR: Not Criminally Responsible, parts of which were screened at the 2015 AAPL annual meeting in a presentation entitled "De-stigmatizing Patients: A Filmmaker's Prescription." The new film, Not Criminally Responsible: Wedding Secrets, shows the impact of the earlier documentary: how it changed people's minds – including the victim and her family -- about sufferers who commit serious acts of violence. It follows the same acquittee, Sean Clifton, for 5 years, including the last two years in which he was granted an Absolute Discharge. The film explores whether it is possible to create empathy for an acquittee released from the hospital with no controls and no external requirement to take his medications. The 52-minute sequel will be screened, followed by audience participation in the development of practical suggestions for forensic professionals to use such public media to improve the lives of their patients. The filmmaker will discuss issues arising from the film, including the response of public audiences to viewing this film and the earlier documentaries, and the sequence of events leading to a wedding last summer attended by many of the figures from the original film, including the patient and the victim.

REFERENCES

Knelman M: How John Kastner Documentaries Changed Closed Minds. Impact of NCR: Not Criminally Responsible and Out of Mind, Out of Sight brings forgiveness for mentally ill offenders. Available at http://www.thestar.com/ent. Accessed September 4, 2017
Ballingall A: The stabber, the victim, the lost son, and the wedding. Available at https://www.thestar.com/news/insight/2016/11/12/the-stabber-the-victim-the-lost-son-and-the-wedding.html. Accessed February 26, 2017

QUESTIONS AND ANSWERS

Opening the inner workings of secure forensic treatment to public viewing carries each of the following benefits, except:
a. Increased public trust in safety and security
b. Improved judicial scrutiny of clinical decision-making
c. Enhanced empathy for insanity acquittees and people with serious mental illness
d. Heightened institutional awareness of policies and staff behaviors which need improvement
ANSWER: b

Which of the following factors is most strongly correlated with stigma reduction in the community following public presentations?
a. An enthusiastic and articulate speaker knowledgeable in mental health treatment modalities.
b. Emphasis on the recovery model in the contemporary development of mental health care.
c. Use of multiple points of social contact, including patient speakers, video, and participant interaction.
d. Advertisement of the event crafted to attract community members who are open-minded.
ANSWER: c

S22 "TREATMENT" OF ASPD IN CORRECTIONS: HOPEFUL OR HOPELESS?

Ayesha Ashai MD, Baltimore, MD
Christoper Fischer MD, Sacramento, CA
Ariana Nesbit MD, Sacramento, CA
Charles Scott MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

The attendees will understand the prevalence of antisocial personality disorder in a correctional setting and its relationship to aggression in jails and prisons. Research examining treatment outcomes for ASPD and psychopathy will be summarized. Practical guidelines on "lessons learned" from intervention studies and the NICE guidelines will be provided.

SUMMARY
Antisocial personality disorder (ASPD) is one of the most common diagnoses in inmates with studies indicating a prevalence of nearly 50% in correctional populations. Dr. Ashai will review the distinction between ASPD and psychopathy and research studies examining their relationship to institutional aggression. Dr. Nesbitt will highlight key research studies examining treatment outcomes for ASPD and psychopathy. In particular, the following questions will be addressed: 1. What is the quality of treatment outcome studies? 2. Does treatment cause more harm than good? 3. Does treatment participation predict outcome? and 4: Does intensity of treatment impact outcome? Dr. Scott will discuss "lessons learned" from the United Kingdom's Dangerous and Severe Personality Disorder treatment program and summarize the translation of this research to the development of correctional treatment programs. In particular, the application of cognitive behavioral principles to the development of offending behavior programs (OBPs) in jails and prisons will be discussed. Dr. Fischer will review the National Institute for Clinical Excellence (NICE) guidelines for the treatment, management, and prevention of antisocial personality disorder. The impact of treating comorbid disorders in reducing future offending behavior will be highlighted.

REFERENCES
Edens JF, Kelley SE, Lillienfeld SO, et al: DSM-5 antisocial personality disorder: predictive validity in a prison sample. Law Hum Behav 39:123-9, 2015
Maden A, Newman W: Antisocial Personality Disorder and Psychopathy. In Principles and Practice of Forensic Psychiatry, Third Edition (Editors: Rosner R and Scott C), New York, NY: CRC Press: Taylor & Francis, 2016

QUESTIONS AND ANSWERS
Which of the following is correct in regard to inmates with ASPD in prison?
a. The ASPD criteria of remorselessness predicts institutional misconduct over a one year period.
b. The diagnosis of ASPD does not identify those inmates who pose a serious threat in prison.
c. The diagnosis of ASPD predicts physical violence but not verbal aggression in prison.
d. Approximately 80% of inmates meet criteria for an ASPD diagnosis
ANSWER: b

One of the most important lessons learned from the Dangerous and Severe Personality Disorders Treatment Program in the United Kingdom was:
a. Although the programs were expensive to provide, future costs savings were achieved when examining the decrease in criminal recidivism.
b. Significant reductions in aggression were noted with a cognitive behavioral approach.
c. Inmate motivation in receiving treatment was an important indicator of outcome.
d. Transferring inmates to a hospital setting for treatment of DSPD resulted in improved outcomes due to the positive effects of the therapeutic milieu.
ANSWER: c

S23 FIT TO FLY POST GERMANWINGS? KEEPING AIR TRAVEL SAFE

Michael Berry MD, Washington, DC
Charles Chesanow DO, Washington, DC
Jeff Guina MD, Ann Arbor, MI
Debra Pinals MD, Ann Arbor, MI
Harold Pinsky DDS, Ann Arbor, MI

EDUCATIONAL OBJECTIVE
From this workshop, participants will be able to 1) discuss systemic reviews of cases of pilot mental illness and suicide by plane 2) describe regulatory framework of aviation safety, pilot fitness, and duty to protect issues from the aerospace psychiatric perspective; 3) describe developments in pilot peer assistance networking.

SUMMARY
In 2015, a co-pilot flying Germanwings flight 9525 deliberately pointed the airplane into descent, leading to his own death and that of 144 passengers and crew members. Subsequent investigation and review teams met to examine what had occurred and to consider potential lessons to maximize air safety. In this panel, aviation industry clinical leaders, including the U.S. Federal Air Surgeon and Federal Aviation Administration Chief Psychiatrist, along with a professional pilot and collaborating civilian and military forensic psychiatrists, discuss case scenarios of suicide-by-plane, evolving themes related to public safety responsibilities for psychiatrists treating pilots, and forensic trends in pilot evaluation for medical certification from an aerospace psychiatric perspective. Issues from Germanwings that will be presented include standards for fitness evaluations, duties of professionals to balance confidentiality and permissive or mandated reporting of potential harm, as well as the need for increased support

for pilots who might be concerned about revealing mental health challenges for fear of loss of medical certification and employment. The architects of the Delta Airlines Pilot Assistance Network will also describe their work and challenges providing support in the context of aviation and public safety. Panelists will review complex military and civilian case considerations.

REFERENCE
Federal Aviation Administration, Pilot Fitness Aviation Rulemaking Committee Report. Available at https://www.faa.gov/regulations_policies/rulemaking/committees/documents/index.cfm/document/information?documentID=2762. Accessed September 4, 2017

QUESTIONS AND ANSWERS

According to federal regulations, established standards for first class airline pilot medical certification includes no history of:
a. Depression
b. Anxiety disorder
c. PTSD
d. Psychosis
ANSWER: d

Dangerousness in pilots can be:
a. inadvertent due to a mental health condition
b. intentional as the result of a mental health condition
c. intentional as the result of radicalization or political beliefs unrelated to mental health conditions
d. all of the above.
ANSWER: d

S24 JUVENILE RESENTENCING: THE CONNECTICUT EXPERIMENT

Paul A. Bryant MD, New Haven, CT
Madelon Baranoski PhD, New Haven, CT (I)
Kristen Bell JD PhD, New Haven, CT (I)
Tanuja Gandhi MD, New Haven, CT

EDUCATIONAL OBJECTIVE

The workshop will review U.S. Supreme Court decisions affecting juvenile sentencing, present assessment strategies and policy statements as a background for describing a paradigm for involving forensic psychiatry in resentencing evaluations and prison and parole programming to address the special needs of juveniles with mental illness.

SUMMARY

Through decisions from 2005 to 2016, the U.S. Supreme Court has placed Eighth Amendment limitations on juvenile sentencing. As a result, approximately 2,500 individuals who had been sentenced to mandatory life without parole are now being considered for release or reduced sentencing. The Court's decisions cited evidence for the critical role that development plays in criminal behavior. Resentencing, however, must address another factor: the impact of mental illness on juvenile offenders and prison inmates. While both the APA and AACAP have published policy statements recommending that reviews of these individuals include a comprehensive mental health evaluation, little consensus and no clear guidelines direct what these evaluations should include, and states have responded in various ways. Connecticut uses parole hearings with a paradigm that incorporates assessment, management, and monitoring strategies. The inclusion of mental health and forensic psychiatric expertise can protect against unduly longer sentences for those with mental illness. In this workshop, the audience will participate in mock parole board hearings for cases of adults-sentenced-as-juveniles and will critique strengths and deficits in assessments and management plans. Discussion will focus on the role for forensic psychiatrists in developing assessment strategies, prison programming, and community follow-up for those eligible for resentencing.

REFERENCES

Bath E, Pope K, Ijadi-Maghsoodi R, et al: Juvenile life without parole: updates on legislative and judicial trends and on facilitating fair sentencing. J Am Acad Child Adolesc Psychiatry 54:343-7, 2015
Ash P: But he knew it was wrong: evaluating adolescent culpability. J Am Acad Psychiatry Law 40:21-32, 2012

QUESTIONS AND ANSWERS

Which U.S. Supreme Court case abolished mandatory life without parole sentences for juveniles convicted of crimes other than homicide?

a. Roper v. Simmons
b. Graham v. Florida
c. Miller v. Alabama
d. Adams v. Alabama
e. Hall v. Florida

ANSWER: c

Based on a Surgeon General's report, what percentage of boys commit a serious violent offense by age 17?

a. 5-10%
b. 10-20%
c. 20-30%
d. 30-40%
e. 40-50%

ANSWER: d

S25 DRUGS IN THE HOUSE? CONTROLLED SUBSTANCES IN CORRECTIONS

Gregory Sokolov MD, Davis, CA
Ryan Wagoner MD, Lutz, FL

EDUCATIONAL OBJECTIVE

A workshop presentation intended for providers who work with patients in correctional settings, focusing on an overview of commonly misused and diverted psychotropic medications; and an overview of the assessment and treatment of ADHD in correctional setting.

SUMMARY

ADHD has been reported to be overrepresented (as compared to community prevalence) in correctional settings and can cause significant morbidity in impacted individuals. Frequently, these individuals have difficulty following instructions, adhering to the jail/prison routine, and problems with educational programming. However, treating ADHD in a correctional setting presents special challenges for clinicians, as diversion and misuse of medications (e.g. benzodiazepines, stimulants, buproprion) can be problematic, leading to illicit substance use, even in correctional settings. This workshop presentation will focus on an overview of commonly misused medications in correctional settings, including discussion of alternative treatment strategies. In addition, a review of ADHD in correctional settings will be presented, including prevalence, assessment, and treatment modalities, including non-pharmacological interventions. Clinical case examples will be presented and audience members will be encouraged to present their own challenging clinical cases for discussion and review, including audience polls to assess knowledge and practice trends in this area.

REFERENCES

Appelbaum K: Attention deficit hyperactivity disorder in prison: a treatment protocol. J Am Acad Psychiatry Law 37:45–9, 2009

Pilkinton P, Pilkinton J: Prescribing in prison: minimizing psychotropic drug diversion in correctional practice. J Correct Health Care 20:95–104, 2014

QUESTIONS AND ANSWERS

Which of the following antidepressant medications is most commonly associated with diversion and misuse in the correctional facilities, due to its amphetamine-like properties?

a. venlafaxine
b. mirtazapine
c. bupropion
d. fluoxetine
e. nortriptyline

ANSWER: c

The reported prevalence of ADHD among prisoners ranges from:
a. 1 to 5%
b. 4 to 12%
c. 10 to 20%
d. 9 to 45%
e. >60%
ANSWER: d

S26 PSYCHOLOGICAL TESTING IN FORENSIC PSYCHIATRIC EVALUATIONS

B. Thomas Gray PhD, ABPP, Pueblo, CO
Rose Manguso PhD, ABPP, Pueblo, CO
Richard Martinez MD, Denver, CO

EDUCATIONAL OBJECTIVE

To provide information on the use of psychological testing in forensic mental health evaluations. Special attention will be devoted to identifying those tests appropriate for use by psychiatrists who have proper training, including some basic instruction on administration.

SUMMARY

It is commonplace for psychiatrists conducting forensic examinations to enlist the assistance of a psychologist to provide testing. This can be done for any of several different purposes, including diagnostic clarification, identification of feigning/exaggeration or underreporting of symptoms, or elucidation of specific forensic issues. Charles Scott has argued that forensic psychiatrists should be trained in the administration and interpretation of some psychological tests. Scott was clear in asserting that proper training was essential to the success of his proposal, and identified several important components. In his view, forensic psychiatrists should receive instruction in the use of certain evaluation tools, including consideration of appropriate use, limitations, reliability and validity, and the role of the tests in a comprehensive forensic evaluation. The purpose of this proposed course is to explore Scott's idea further and to provide basic information on general psychological testing. A variety of commonly used psychological tests will be reviewed, ranging from those with purely forensic applications, to more general personality and neuropsychological tests, including measures of malingering. The presentation will seek to identify instruments that can most properly be used by forensic psychiatrists, including introductory instruction in the administration of one or more of those tests

REFERENCES

Scott CL: Believing doesn't make it so: forensic education and the search for truth. J Am Acad Psychiatry Law 41:18-32, 2013
Heilbrun K.: The role of psychological testing in forensic assessment. Law and Hum Behav 16:257-72, 1992

QUESTIONS AND ANSWERS

Statistically, as base rate of a phenomenon being assessed by a test increases:
a. Negative predictive accuracy of the test increases and positive predictive accuracy decreases.
b. Positive predictive accuracy of the test increases and negative predictive accuracy decreases.
c. Base rate has no impact on predictive accuracy of a test.
d. The false omission rate is the complement of positive predictive accuracy.
ANSWER: b

It is appropriate for a psychiatrist to administer the MMPI-2:
a. Under any circumstances.
b. When being supervised by a psychologist.
c. If the psychiatrist has obtained foundational training in psychological testing in general and use of the MMPI-2 in particular.
d. If the psychiatrist has obtained foundational training in psychological testing in general and use of the MMPI-2 in particular, and has read the test manual.
ANSWER: d

S27 EVALUATING MALINGERED ADHD: PAY ATTENTION!

Barbara McDermott PhD, Sacramento, CA
Charles Scott MD, Sacramento, CA

EDUCATIONAL OBJECTIVE

This workshop will train audience participants on the limitations of current assessment methodology in detecting feigned ADHD through case presentations and mock cross examinations. The presenters will demonstrate testing strategies to more accurately identify malingered ADHD and audience participants will be instructed to interpret and write up assessment results.

SUMMARY

Attention Deficit Disorder is increasingly common with up to 50% of criminal defendants and 10% of college students reportedly meeting ADHD diagnostic criteria. The diagnosis of ADHD relies primarily on self-report and collateral questionnaires that involve common symptoms but do not include imbedded measures of feigning. As a result, ADHD is easy to malinger in both criminal and civil litigation. This workshop will interact with attendees on two forensic cases, one criminal and one civil, in which ADHD is the claimed diagnosis. In the criminal case, audience participants will form an opinion as to the impact of an ADHD diagnosis on an "insanity" claim, specific intent, and possible mitigation. In the civil litigation case, audience participants will examine claimed ADHD on workplace performance and requested accommodations. Through a mock cross examination, audience participants will learn limitations of the psychiatric interview, self-report questionnaires, and common testing procedures in detecting feigned ADHD. Dr. Scott and Dr. McDermott will demonstrate the utility of specific performance validity tests in identifying feigned ADHD symptoms. Audience participants will be trained on the scoring and interpretation of these instruments and will practice mock write ups of these assessments.

REFERENCES

Jasinski LJ, Harp JP, Berry DTR, et al: Using symptom validity tests to detect malingered ADHD in college students. Clin Neuropsychol 25:1415-1428, 2011
Quinn CA: Detection of malingering in assessment of adult ADHD. Arch Clin Neuropsychol 18: 379-395, 2003

QUESTIONS AND ANSWERS

What percentage of feigned ADHD presentations are identified with failure of two or more symptom validity tests?
a. 20%
b. 40%
c. 60%
d. 100%
ANSWER: d

What percentage of college students are able to successfully feign ADHD on the Conner's Adult ADHD Rating Scale?
a. 10%
b. 20%
c. 40%
d. 90%
ANSWER: d

S28 SOUL SPACE BEHIND BARS - CLERGY/CLINICIAN COLLABORATIONS

Krista Burkholder BSW, Canon City, CO
Michael Champion MD, Honolulu, HI
Catherine Dumas BA, Durham, NC
Dan Leetch MA, Pueblo, CO
Michael A. Norko MD, Durham, CT

EDUCATIONAL OBJECTIVE

Attendees will be able to: 1) characterize the existing literature on clergy-clinician interactions in mental health care; 2) describe three ministry programs operating in local/national correctional facilities; 3) assess the potential in corrections for clergy-clinician collaboration and improved inmate outcomes; and 4) import ideas to their own practice locations.

SUMMARY

This workshop explores the role of chaplains in contemporary correctional settings and their potential interactions with mental health clinicians. Dr. Norko will provide a brief overview of the literature on clergy-clinician interaction in mental health care. Deacon Leetch will describe the Benedictine Oblate program he directs in prison and

the proposed "Four Levels of Happiness for Prisoners" program. Ms. Burkholder will introduce the work of New Horizons Ministry, which raises children born to incarcerated women, and reunites the mothers and children when the mothers return to the community. Ms. Dumas will discuss the Prison Ashram Project nationwide chaplaincy program and mindfulness stress reduction groups provided on North Carolina's death row through the Human Kindness Foundation and in coordination with the Central Prison psychology department. Dr. Champion will serve as discussant and will consider the potential for prison to be a transformative experience in the search for meaning, truth and inner expansion. The panel will share resources for clergy-clinician collaboration in correctional settings. Attendees will be invited to contribute their experiences with spiritual/pastoral programs in corrections, which will be documented and edited with a goal of future distribution as a resource guide to prison chaplains and clinicians.

REFERENCES

Larson DB, Hohmann AA, Kessler LG, et al: The couch and the cloth: the need for linkage. Hosp Comm Psychiatry 39:1064-1068, 1988

Pew Research Center: Religion in Prisons - A 50 State Survey of Prison Chaplains. Available at http://www.pewforum.org/2012/03/22/prison-chaplains-exec/. Accessed September 4, 2017

QUESTIONS AND ANSWERS

Approximately what percentage of prison chaplains believe that treatment for substance abuse and mental health problems during incarceration is critical for rehabilitation:

a. 10%
b. 30%
c. 50%
d. 80%
e. 95%

ANSWER: d

In a national survey of physicians' experience with chaplains, what percentage reported being satisfied or very satisfied with chaplains?

a. 15%
b. 30%
c. 50%
d. 70%
e. 90%

ANSWER: e

S29 **HOTSHOTS: FORENSIC IMPLICATIONS OF SEXTING**

Susan Hatters-Friedman MD, Cleveland, OH
Brian Holoyda MD, St. Louis, MO
Renee Sorrentino MD, Boston, MA

EDUCATIONAL OBJECTIVE

Participants will become aware of the prevalence and research regarding underage sexting. Participants will become familiar with the laws and legal implications of underage sexting. Participants will identify the ethical implications related to underage sexting and forensic challenges.

SUMMARY

Sexting generally refers to the act of sending sexually explicit electronic messages, primarily through the use of a cell phone. Research regarding the prevalence among teenagers has found that up to 28% of teenagers sent naked or seminude images of themselves or posted them online. The legal consequences of underage sexting vary from a misdemeanor to felony criminal charges. Since 2009 at least 24 states have enacted legislation to address youth sexting and in 2012 at least 13 other states have introduced bills or resolutions. For those states that have yet to pass laws related to sexting, individuals found guilty face potential prosecution under the state's or federal child pornography laws. Anyone convicted of a child pornography charge must also register as a sex offender including other potential consequences such as denial of college admission, ineligibility for student financial aid, and restrictions on employment and residence. Limited understanding of the prevalence and characteristics of underage sexting and the discrepancies in the laws pose unique challenges for the forensic evaluator. This workshop will review the research related to underage sexting, address the laws and legal issues and conclude with a discussion of the ethical implications and treatment challenges.

REFERENCES
Mitchel KJ, Finkelhor D, Jones LM, et al: Prevalence and characteristics of youth sexting: a national study. Pediatrics 129(13): 13-20, 2012
Sexting Legislation 2012. Available at http://www.ncsl.org/research/telecommunications-and-information-technology/sexting-legislation-2012.aspx. Accessed August 26, 2014

QUESTIONS AND ANSWERS
The legal consequences of sexting include:
a. Felony charges
b. Mandated sex offender treatment
c. Registration as a sex offender
d. All of the above
ANSWER: d

Teens who engage in sexting are more likely to have the following characteristic(s):
a. Mental illness
b. Disciplinary problems
c. Substance use
d. Problematic sexual behavior
ANSWER: c

S30 A PROPOSED RESOURCE DOCUMENT ON FORENSICS IN PSYCHIATRY

Julie Alonzo-Katzowitz MD, Austin, TX
William Cardasis MD, Ann Arbor, MI
Cathleen Cerny MD, Cleveland, OH
Jessica Ferranti MD, Sacramento, CA
Stephen Noffsinger MD, Hudson, OH

EDUCATIONAL OBJECTIVE
Participants will be able to understand the development of a resource document, discuss the purpose of a resource document, contrast it with other professional organization documents such as practice guidelines and position statements, and consider the utility of this resource document guiding forensic training in general psychiatry residency training programs.

SUMMARY
The AAPL Committee on Forensic Training in General Psychiatry Residency Programs recommended the creation of a resource document on forensic curriculum in general psychiatry training. The Accreditation Council for Graduate Medical Education (ACGME) requires that general psychiatry residents have an "experience" in forensic psychiatry inclusive of "evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability and competency." The general psychiatry milestones incorporate, but do not explicate, forensic psychiatry competencies. Because forensic psychiatric issues commonly appear across a variety of clinical settings, training in relevant forensic subjects is essential for general psychiatry trainees. This document develops guidelines for forensic psychiatry education and training for general psychiatry residents.

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

QUESTIONS AND ANSWERS
Related to teaching forensic psychiatry, significant challenges facing some general psychiatry training programs include:
a. Lack of forensic fellowship.
b. Lack of forensic-trained psychiatrists on faculty at the institution.
c. Lack of geographic proximity to forensic training sites such as state hospitals and correctional institutions.
d. All of the above.
ANSWER: d

The ACGME Psychiatry Milestones require that general psychiatry residents demonstrate competency in:
a. Assessing risk and determining level of care.
b. Assessing a legal competency.
c. Assessing disability due to mental impairment or substance use disorders.
d. Assessing personality and behavioral characteristics that define the construct of psychopathy.
ANSWER: a.

S31 SLIPPING THROUGH THE CRACKS: ID/DD IN CORRECTIONAL SETTINGS

Rosa Negron-Munoz MD, Lakeland, FL
Susan Parke MD, New Haven, CT
Alexander Westphal MD, New Haven, CT
Elizabeth Ford MD, New York, NY

EDUCATIONAL OBJECTIVE

To describe the prevalence and socio-legal demographics of individuals with ID/DD in correctional settings To understand the impact of DSM-5 changes on the treatment and evaluation of individuals with ID/DD in correctional settings To identify best practices in the treatment of this population

SUMMARY

Individuals with intellectual and developmental disabilities (ID/DD) are overrepresented in U.S. jails and prisons, yet are less likely to successfully negotiate plea bargains, have longer incarcerations, and have higher felony conviction rates than the general population. Incarcerated individuals with ID/DD are particularly vulnerable in correctional settings to victimization and may be unable to appropriately express their disabilities, making screening and identification difficult. In addition, jails and prisons rarely have the resources or expertise to manage and treat them. Community agencies tasked with the care of ID/DD populations similarly struggle to safely manage patients with a history of or current involvement in the criminal justice system. This workshop will focus on four main areas of concern, highlighting the relevant history and current practice for each: Identification and treatment in jails and prisons; the interface with local and state agencies with particular emphasis on re-entry and alternatives to incarceration; issues related to competence to stand trial; and issues related to the death penalty, including any impact as a result of the changes in DSM-5. Audience participation will be solicited throughout the workshop with specific questions, problem-solving tasks, and case examples to encourage discussion.

REFERENCES

Scheyett A, Vaughn J, Taylor M et al: Are we there yet? Screening processes for intellectual and developmental disabilities in jail settings. Intellectual and Developmental Disabilities 47(1):13-23, 2009
Atkins v. Virginia, 536 U.S. 304 (2002)

QUESTIONS AND ANSWERS

Which of the following most closely estimates rates of intellectual and developmental disabilities in U.S. correctional settings?
a. 75%
b. 50%
c. 1%
d. 10%
e. 25%
ANSWER: d

The Pathways to Justice® Program is:
a. A specialized mental health court for individuals with ID/DD
b. A training program for three primary audiences: law enforcement, legal professionals and victim service professionals that deal with ID/DD
c. A residential treatment facility specializing in the care of individuals with ID/DD involved in the criminal justice system
d. A mentoring agency for staff working with individuals with ID/DD
ANSWER: b

S32 GRAVES INJUSTICE

Anthony Graves, Houston, TX

EDUCATIONAL OBJECTIVE

SUMMARY

REFERENCES

QUESTIONS AND ANSWERS
ANSWER:

ANSWER:

S33 WHITE COLLAR CRIME

Steven S. Simring MD MPH, New York, NY
Charles Scott MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
In this workshop, participants will learn the characteristics of non-violent psychopathy and the white collar criminal, the special legal issues presented by non-violent and white collar crime, the roles played by forensic psychiatrist in dealing with these issues and the use of assessment instruments in non-violent psychopaths.

SUMMARY
The term "white collar crime" was initially coined by Sutherland in 1949 and defined as "a crime committed by a person of respectability and high social status in the course of his occupation." In 1996, the National White Collar Crime Center (NW3C) refined the definition as follows: "White collar crimes are illegal or unethical acts that violate fiduciary responsibility of public trust committed by an individual or organization, usually during the course of legitimate occupational activity, by persons of high or respectable social status for personal or organizational gain." Dr. Steven Simring will present case material about the ways in which white collar offenses are dealt with by the courts, and the roles played by forensic psychiatrists. Dr. Simring will be joined by an invited prosecutor specializing in economic crimes. This workshop will provide practical guidance on the forensic evaluation of individuals charged with "white collar crimes." Dr. Charles Scott will review the concept of the "corporate psychopath," exemplified by individuals who show no remorse or empathy for their crime victims. Research examining specific characteristics of corporate psychopaths and their impact on organizations will be highlighted. Dr. Scott will review various assessment instruments useful in assessing corporate psychopathy.

REFERENCES
Lilienfeld S, Andrews B: Development and preliminary validation of a self-report measure of psychopathic personality traits in noncriminal population. Journal of Personality Assessment 66:488–524, 2010
Benson ML, Manchak SM: The Psychology of White Collar Offending. New York, NY: Oxford University Press, 2015

QUESTIONS AND ANSWERS

What percentage of senior executives meet criteria as a "corporate psychopath"?
a. <1%
b. 1.5%
c. 3.5%
d. 5%
ANSWER: c

The FBI has created three categories of corporate fraud. What are they?
ANSWER: Falsification of financial information, self-dealing, obstruction of justice.

S34 ATTACKING FORENSIC PSYCHIATRIC TESTIMONY

Stephen Noffsinger MD, Hudson, OH
Sherif Soliman MD, Hinckley, OH
Adam Fried JD, Cleveland, OH
Carolyn Dessin JD, Akron, OH

EDUCATIONAL OBJECTIVE

Participants will learn how a senior litigator and law professor prepare for and participate in the cross examination of forensic mental health professionals at trial.

SUMMARY

Forensic psychiatrists testify only infrequently at trial, and therefore have few opportunities to perfect their skill in dealing with cross examination. Withstanding cross examination is an important skill to develop, yet most forensic psychiatrists are self-taught or taught by other forensic clinicians about how to effectively deal with cross examination. Forensic psychiatrists rarely receive instruction from experienced litigators about how to successfully negotiate the many pitfalls of cross examination. At this workshop: 1. Dr. Noffsinger and Dr. Soliman will introduce general concepts of cross examination. 2. Attorneys Adam Fried, Esq. and Carolyn Dessin, Esq. will discuss the methods that attorneys use to assess psychiatric evidence; prepare for cross-examination; and cross examine the psychiatric expert witness. 3. The presenters will discuss methods that the skilled expert witness may use to counter cross examination techniques. Participants will learn ten cross examination techniques commonly used by attorneys, and corresponding methods to effectively counter cross examination techniques.

REFERENCES

Brodsky SL: Coping with Cross-Examination and Other Pathways to Effective Testimony. Washington, DC: American Psychological Association Press, 2004
Strasburger LH, Miller PM, Commons ML, et al: Stress and the forensic psychiatrist: a pilot study. J Am Acad Psychiatry Law 31:18-26, 2003

QUESTIONS AND ANSWERS

Common cross examination techniques used to impeach expert witness testimony include demonstrating that the witness:
a. Is biased or prejudiced.
b. Has given prior inconsistent statements.
c. Has a bad reputation for truthfulness and veracity.
d. Has impaired perceptions or memory.
e. All of the above
ANSWER: e

In an effort to impeach an expert witness, an attorney may question the witness about which of the following?
a. Qualifications and training.
b. Completeness of database.
c. Facts inconsistent with the expert's opinions.
d. Methodology.
e. All of the above
ANSWER: e

S35 SUICIDE IN JUVENILE CONFINEMENT

Eileen P. Ryan DO, Columbus, OH
Stephen Billick MD, New York, NY
Lindsay Hayes MS, Mansfield, MA (I)
Joseph Penn MD, Conroe, TX
Christopher Thompson MD, Los Angeles, CA
Cheryl Wills MD, Cleveland, OH

EDUCATIONAL OBJECTIVE
Workshop participants will gain knowledge and confidence in their ability to evaluate and manage suicidal ideation, threats, self-injury, and suicide risk and to more effectively problem-solve with correctional administration around the management of potentially suicidal youth in confinement.

SUMMARY
There is a national shortage of child psychiatrists and a high need for quality psychiatric services in juvenile detention and correctional facilities. Therefore, general forensic and nonforensic psychiatrists are fulfilling a critical need for this vulnerable population. This workshop introduces participants to the challenges involved in suicide risk assessment and management in juvenile confinement. Psychiatrists working with the juvenile justice population must be aware of findings regarding juvenile correctional suicides, including the differences between suicide in adults and youth in confinement. Confinement presents unique risk factors for suicide in vulnerable youth. This workshop will address characteristics associated with an increased risk of suicide in youth as well as conditions associated with confinement, and provide a framework for evaluators to assess suicidal youth and provide treatment and management direction. In addition to performing evaluations of suicidal and/or self-injurious juveniles, forensic psychiatrists may be asked to help identify, develop, or implement interventions as well. Interventions at the individual and system levels are discussed with an emphasis on working with correctional administration around managing individual youth and balancing security and treatment. There will be breakout into small groups within the workshop for specific case discussion and critique, as well as sharing audience expertise.

REFERENCES
Hayes LM: Cornered: juvenile suicide in confinement—findings from the first national survey. Suicide Life-Threat Behav 39(4): 353-63, 2009
Abram KM, Choe JY, Washburn JJ, et al: Suicidal Ideation and Behaviors Among Youths in Juvenile Detention. J Am Acad Child Adolesc Psychiatry 47(3): 291-300, 2008

QUESTIONS AND ANSWERS
Conditions that increase the risk for suicide in juvenile confinement include:
a. Poor food and hard mattresses
b. Abusive correctional officers
c. Separation from loved ones, sleeping in locked rooms, and segregation
d. Psychiatric disorders and trauma history
e. c and d
ANSWER: e

Completed suicide in juvenile confinement
a. Is most likely to occur within the first 24 hours of detainment or incarceration
b. Is most likely to occur between 12am and 6am
c. Is most likely to occur during waking hours
d. Is more evenly distributed over time than among adults in confinement.
e. Can be managed by segregating the suicidal juvenile in a quiet room and checking on him or her every 15 minutes
ANSWER: c

S36 DOC, MY TV REALLY IS LISTENING TO ME!

George David Annas MD MPH, Syracuse, NY
James Knoll IV MD, Syracuse, NY
Diana Kurlyandchik MD, Guilford, CT
Melissa Spanggaard DO, Tucson, AZ

EDUCATIONAL OBJECTIVE
Understand the differentiation of true delusion, from ideas and normal odd beliefs, learn about the psychological theories behind why some are drawn to "fringe" beliefs and conspiracy theories and discover ways to improve critical thinking in forensic practice.

SUMMARY
From "Birthers," to "Truthers," our population is rife with followers of odd, "fringe," stories, that many commonly refer to as "Conspiracy Theories" (CTs). The followers of such beliefs often hold strong faith in them, to the point of appearing delusional. While there is great diversity among such followers, it appears that the vast majority are unlikely to suffer from SMI. Yet, at what point does the intensity of, or the belief itself, become delusional? Is there even a line to be crossed, or is something else at play? This panel will address some of the most firmly held "fringe" sounding beliefs and the general psychological theories driving some to believe in them. Where do the roles of politics, bias and denial fit in? When it comes to CTs, are those with SMI more vulnerable to manipulation by those who spread them? With the continued revelations of the extent of CIA spying, what we consider "real" is continuously being challenged, reminding us that we are far from being immune to our own biases leading to our own false beliefs. In the search for truth in a sea of fringe conspiracy, fake news, and government spying, how can we stay afloat?

REFERENCES
van Prooijen JW: Why Education Predicts Decreased Belief in Conspiracy Theories. Appl Cogn Psychol 31(1):50-58, 2017
Swami V, Weis L, Lay A, et al: Associations between belief in conspiracy theories and the maladaptive personality traits of the personality inventory for DSM-5. Psychiatry Res 236:86-90, 2016

QUESTIONS AND ANSWERS
In an attempt to shed light on why one's level of education appears to inversely correlate with one's belief in conspiracy theories (CTs), Jan-Willem van Prooijen (2017) found a positive correlation with which personality attributes and the belief in CTs, i.e. what trait(s) correlated with one being more likely to believe in CTs?
a. A belief in simple solutions for complex problems
b. Narcissism/Narcissistic traits
c. Feelings of powerlessness
d. Being prone to isolation
e. a and c
ANSWER: e

Of the following "Conspiracy Theories," which one, if any, has been proven true?
a. The United States never executed any mission to the Moon and the photos and video of the landing were all performed in a production studio. When confronted with the truth on camera, Buzz Aldrin punched investigator Bart Sibel in the face, to vent his supposed outrage at the suggestion he was part of a fraud, but in truth to lend credence to the cover-up.
b. Paul McCartney died accidentally in 1966, leading the band and producers to cover up his death and hire a look-alike and sound-alike to replace him (in an effort to continue strong record sales). However, the band members, including the new Paul, eventually felt the truth needed to come out, but were under the threat of death from the producers, so they decided to leave hints in their music, many of which appear in the popular album Sgt. Pepper's Lonely Hearts Club Band.
c. Kentucky Fried Chicken is not made from real chicken, but is actually made from headless chicken clones. After a staunch legal battle, a judge ordered that such headless clones do not meet the legal definition of "Chicken" and therefore the company was been forced to remove the word "Chicken" from its menu and resulted in the company changing its name from "Kentucky Fried Chicken" to its initials ("KFC,") in order to stay in compliance with the ruling.
d. The CIA performed mind control experiments, including using LSD on unwitting US Citizens in the mid 1950s through the mid 1960s. However, the CIA destroyed most of the records from this period, and the full details of the program remain a mystery. At least 2 deaths have occurred as a direct result but, to date, no one has been brought to justice for these deaths.
e. None of the above have been proven true
ANSWER: d

S37 BREAKING BAD: CRIMINAL BEHAVIOR IN HOSPITALS AND PRISONS

KyleeAnn Stevens MD, Shakopee, MN
Michael Champion MD, Honolulu, HI
Charles Dike MD, MRCPsy, Cheshire, CT
Joy Stankowski MD, Cleveland, OH
Robert Trestman MD PhD, Roanoke, VA

EDUCATIONAL OBJECTIVE
This panel will discuss the challenges presented by criminal behaviors conducted in state hospitals and prisons. Best practices around managing such behaviors will be reviewed and will include discussion of collaborative agreements between settings, environmental modifications, and treatment approaches to those engaging in such behaviors.

SUMMARY
Individuals engaging in criminal behaviors in controlled settings, such as hospitals and prisons, present some of the most challenging circumstances for clinicians and administrators to address. Limitations on consequences, environmental concerns, and ethical issues regarding legal action are some of the challenges presented. For example, pursuing criminal charges against patients is an issue rife with conflict. Further, use of security staff or police in the treatment milieu warrants careful consideration. Violence, disruption of the milieu, and cost to facilities has immeasurable cost to other patients and staff. The panel will discuss what is known about best practice solutions in handling high risk individuals in correctional and hospital settings. Addressing criminogenic risks and needs in the patient population is necessary in reducing the behaviors. Correctional facilities have taken steps to manage such challenges, including the START NOW program in Connecticut. Such work may transfer well into the state hospital environment, but requires collaboration between correctional facilities and hospital settings. Ultimately, the very issue of instrumental violence and other criminal behaviors must be addressed if the patients served are to have a successful transition to their communities.

REFERENCES
Kersten L, Cislo AM, Lynch M, et al: Evaluating START NOW: A Skills-Based Psychotherapy for Inmates with Behavioral Disorders. Psychiatric Services in Advance (doi: 10.1176/appi.ps.201400471). Published online August 17, 2015
Volavka J, Mohammad Y, Vitrai J, et al: Characteristics of state hospital patients arrested for offenses committed during hospitalization. Psychiatric Services 46(8):796-800, 1995

QUESTIONS AND ANSWERS
Violent behavior in hospital and correctional settings is:
a. Differentiated: hospital violence is impulsive and correctional violence is predatory.
b. Still unpredictable. Best practice is to be restrictive and prosecute any violence.
c. Manageable but requires a multilevel risk assessment culture and integrated interventions.
d. A reflection of our overall culture. We already are doing the best we can.
ANSWER: c

Violence due to a major mood or thought disorder can be addressed therapeutically, but violence due to a personality disorder:
a. Can only be contained within measures such as seclusion/restraints.
b. Cannot be managed in a hospital.
c. May respond to pharmacological interventions.
d. None of the above.
ANSWER: c

S38 FORENSIC IMPLICATIONS OF PSEUDOLOGIA FANTASTICA

Richard Frierson MD, Columbia, SC
Kaustubh Joshi MD, Columbia, SC

EDUCATIONAL OBJECTIVE
Pseudologia fantastica is an understudied entity. In a forensic context, it can significantly complicate the evaluation of capacity to stand trial and criminal responsibility. We review the current literature regarding pseudologia fantastica and present a case to highlight the clinical and forensic challenges it may create.

SUMMARY
Pseudologia fantastica, a specific form of pathological lying, is a psychological phenomenon that has been described in the literature for at least a century, but it is an understudied and poorly understood entity. Also referred to sometimes as pathological lying in the literature, pseudologia fantastica involves disproportionate fabrication that can be present for years or a lifetime. In a forensic context, it can significantly complicate the evaluation of capacity to stand trial and criminal responsibility. We review the current literature regarding pseudologia fantastica and present a case to highlight the clinical and forensic challenges it may create.

REFERENCES
Korenis P, Gonzalez L, Kadriu B, et al: Pseudologia fantastica: forensic and clinical treatment implications. Compr Psychiatry 56:17-20, 2015
Dike CC, Baranoski M, Griffith EEH: Pathological lying revisited. J Am Acad Psychiatry Law 33:342-9, 2005

QUESTIONS AND ANSWERS

What is the gender distribution for pseudologia fantastica?
a. Male predominantly
b. Female predominantly
c. Equal distribution
ANSWER: c

Which of the following are characteristics of pseudologia fantastica?
a. The deceptions are not entirely improbable and are often built upon a matrix of truth
b. The deceptions are enduring and stable over time
c. The deceptions are not told for personal profit per se and frequently have a self-aggrandizing quality
d. All of the above
ANSWER: c

S39 DISTRIBUTIONAL PROPERTIES OF THE ATYPICAL PRESENTATION SCALE

Douglas Mossman MD, Cincinnati, OH
Wendi Wang BA, Cincinnati, OH
Christopher Marett MD, Cincinnati, OH

EDUCATIONAL OBJECTIVE

At the conclusion of this presentation, attendees will describe the purpose of the Atypical Presentation Scale, summarize what mathematical models do and summarize how honestly responding competence evaluees respond on the APS.

SUMMARY

Although many defendants referred for evaluations of competence to stand trial (CST) attempt to feign mental illnesses or cognitive impairment, most structured CST assessment tools contain no measure designed to screen for malingering. To address this, Gothard and colleagues (1995) created the Atypical Presentation Scale (APS), an eight-item instrument with questions specific to courtroom processes. To date, only a few studies have examined the accuracy properties of the APS. This article describes results from a large group of CST evaluees (N=150) whose evaluations included administration of the APS. Our data permitted detailed exploration of how evaluees who were not otherwise feigning mental illness responded to APS items, which should help examiners efforts to distinguish between genuine and feigned incompetence. We also use our APS data to illustrate an approach to thinking about results obtained from forensic assessment instruments: the use of a mathematical model to represent basic features of a forensic evaluation as parameters that have an explicit relationship to the evaluation's outcome. We show how we tested models based on the trinomial distribution and a multilevel model that posits an overall process of responding modified by evaluee- and item-specific factors.

REFERENCES

Rogers R, Sewell KW, Grandjean NR, et al: The detection of feigned mental disorders on specific competency measures. Psychological Assessment 14:177-183, 2002
Pleskac TJ, Diederich A, Wallsten TS: Models of decision making under risk and uncertainty. In Oxford Handbook of Computational and Mathematical Psychology (Busemeyer JR, Townsend JT, Wang ZJ, Eidels A, eds.). New York, NY: Oxford University Press, 2015

QUESTIONS AND ANSWERS

A mathematical model:
a. Provides an abstract representation of a process that one cannot observe directly
b. Represents features of a real-world phenomenon via parameters that have an explicit relationship to the phenomenon
c. Lets investigators formulate and test hypotheses about the phenomenon
d. Should help explain what gave rise to empirical data
e. All the above
ANSWER: e

Based on the findings of this study, the Atypical Presentation Scale:
a. Detects many instances of malingered incompetence to stand trial but misidentifies a quarter of non-feigning evaluees
b. Is a helpful, stand-alone forensic assessment instrument for evaluating adjudicative competence
c. Generates results that fit a zero-inflated trinomial distribution
d. Generates results for incompetent and competent evaluees that are mathematically indistinguishable
e. All the above
ANSWER: c

S40 WHEN IS A SMARTPHONE APP A REGULATED MEDICAL DEVICE?

James Armontrout MD, San Francisco, CA
Renée Binder MD, San Francisco, CA
Marsha Cohen JD, San Francisco, CA
Dale McNiel PhD, San Francisco, CA
John Torous MD, Boston, MA

EDUCATIONAL OBJECTIVE
To better understand how mobile mental health applications are currently regulated and review case law related to mobile health applications.

SUMMARY
In recent years, software that is targeted toward the general public and designed to assist in the diagnosis and treatment of mental illness, or to promote general mental health, has expanded greatly. Regulation of more traditional healthcare providers and healthcare-associated devices is well established by statute, regulatory guidelines, and common law precedents. "Apps," in contrast, pose a novel regulatory challenge. In this paper we review the current regulatory guidelines that exist for psychiatric mobile mental health apps. We also review the current state of case law in the psychiatric mobile mental health realm.

REFERENCES
Mobile Medical Applications Guidance for Industry and Food and Drug Administration Staff. Available at http://www.fda.gov/downloads/MedicalDevices/.../UCM263366.pdf. Accessed February 16, 2017
Elenko E, Speier A, Zohar D: A regulatory framework emerges for digital medicine. Nat Biotechnol 33(7):697-702, 2015

QUESTIONS AND ANSWERS
Most available psychiatric mobile health apps:
a. Underwent formal review by the FDA before they were released
b. Were required to register with the State Medical Board in the state where they were developed before being made available to the public
c. Have been exempted from significant regulatory oversight
d. Were written with the outcomes of several key court cases in mind
e. Must comply with the privacy requirements of HIPAA because they transmit information about the user's health digitally
ANSWER: c

Which of the following is true about claims made by mobile health apps?
a. The Federal Trade Commission (FTC) has taken action against the makers of several apps for making claims that are not sufficiently supported by evidence
b. So far, no claims made by mobile health apps have fallen under legal or regulatory scrutiny
c. ERISA is the federal law that places limits on the claims an app manufacturer can make
d. Several large app designers have created a database of apps, called M*STAR, that provides public information about the evidence for many available apps
ANSWER: a

S41 ASSESSING TERRORISM RISK IN ASYLUM EVALUATIONS

Emily Keram MD, Santa Rosa, CA
Danielle Kushner MD, New York, NY
Swati Shivale MD, Atlanta, GA

EDUCATIONAL OBJECTIVE

This workshop will provide updated research on terrorism and radicalization with a focus on asylum seekers. Speakers will discuss the role of forensic psychiatrists and risk assessments in asylum evaluations given the changing political climate.

SUMMARY

The global refugee crisis has reached the highest level since World War II, primarily due to the ongoing Syrian conflict. Simultaneously, domestic terrorism incidents, such as the Orlando and San Bernardino attacks, have led to heightened concerns regarding radical Islamic terrorism developing in the United States. President Trump's Executive Order on Immigration Enforcement Improvements has brought into sharp focus ethical issues related to balancing international human rights with national security. Although research shows that the process of radicalization is multi-factorial and that more individuals hold radical views than are willing to engage in violent action, asylum seekers and refugees are increasingly unable to enter safe countries due the global fear of radicalization and terrorism. Thus, many asylum seekers and refugees are doubly victimized: persecuted at home and marginalized abroad. Given the heightened concern about terrorists entering the country, forensic evaluations, particularly risk assessments of asylum seekers, will likely be under increased scrutiny. This workshop will provide updated research regarding terrorism and radicalization, current risk assessments in asylum evaluations and future considerations for assessing the risk of "home grown terrorism." Audience participation will be elicited through case examples, response questions and collecting audience experiences related to key topics.

REFERENCES

Executive Order 13767 Border Security and Immigration Enforcement Improvements. Available at https://www.whitehouse.gov/the-press-office/2017/01/25/executive-order-border-security-and-immigration-enforcement-improvements. Accessed September 4, 2017

Sieckelinck S, Kaulingfreks F, De Winter M: Neither villains nor victims: towards an educational perspective on radicalisation. British Journal of Educational Studies 63(3):329-343, 2015

QUESTIONS AND ANSWERS

Which of the following may be present in individuals with a vulnerability to radicalization
a. Perceived injustices
b. Personal insecurities
c. Psychological deficits
d. A history of delinquency
e. All of these
ANSWER: e

According to United Nations High Commissioner for Refugees (UNHCR), approximately how many people were forcibly displaced from their homeland in 2015?
a. 500,000
b. 1 million
c. 10 million
d. 60 million
ANSWER: d

S42 THERAPEUTIC RISK MANAGEMENT OF THE SUICIDAL PATIENT

Darren Lisch MD, Denver, CO
Bridget Matarazzo PsyD, Denver, CO
Sarra Nazem PhD, Denver, CO
Hal Wortzel MD, Aurora, CO

EDUCATIONAL OBJECTIVE

Attendees will learn key components of a model for achieving therapeutic risk management of the suicidal patient: augmenting clinical risk assessment with structured instruments; stratifying risk in terms of both severity and temporality; developing and documenting a safety plan. Suggestions for applications in a correctional setting will be offered.

SUMMARY
Risk management is a necessity of psychiatric practice, and this requires a thoughtful approach to suicide risk assessment and management. Therapeutic risk management is a process based upon clinical risk management, one that is patient-centered, supportive of the treatment process, and maintains the therapeutic alliance. In this workshop, participants will be introduced to a model for achieving therapeutic risk management of the suicidal patient developed by the Rocky Mountain MIRECC. Key components of the model will be covered, with opportunities to practice implementation and documentation. Key elements of the model include: augmenting clinical risk assessment with structured instruments; stratifying risk in terms of both severity and temporality; and developing and documenting a safety plan. These components are readily accessible to mental health clinicians across various disciplines and treatment settings, and collectively yield a suicide risk assessment and management process (with attendant documentation) that ought to withstand the scrutiny that frequently comes in the aftermath of a patient suicide or suicide attempt. Suggestions for applications and accommodations in a correctional setting will be offered.

REFERENCES
Wortzel HS, Matarazzo B, Homaifar B: A model for therapeutic risk management of the suicidal patient. Journal of Psychiatric Practice 19(4): 323-326, 2013
Wortzel HS, Homaifar B, Matarazzo B, et al: Therapeutic risk management of the suicidal patient: stratifying risk in terms of severity and temporality. Journal of Psychiatric Practice 20(1):63-67, 2014

QUESTIONS AND ANSWERS
Safety plans are unlike no-harm contracts in that they:
a. Are legally binding
b. Provide patients with concrete steps to take to help navigate a crisis
c. Are dictated by the clinician
d. Seek assurances from persons potentially in crisis
ANSWER: b

Risk stratification that specifies severity for both acute and chronic:
a. Tends to emphasize static risk factors over dynamic risk factors and warning signs
b. Is time consuming and laborious
c. Can only be performed by physicians
d. Facilitates appropriate involuntary admissions while helping to avoid unnecessary hospitalizations
ANSWER: d

S43 OLDER ADULTS AND PRISON RELEASE: CLINICAL AND LEGAL ISSUES

William Bryson MD, Seattle, WA
Bruce Gage MD, Tumwater, WA
Jennifer Piel MD, JD, Seattle, WA
Brie Williams MD, San Francisco, CA

EDUCATIONAL OBJECTIVE
Participants will learn about the unique policies and challenging clinical scenarios that confront correctional psychiatrists when their older patients are released from prison.

SUMMARY
Older adults have been the fastest growing age demographic in United States prisons over the past two decades, and their ranks continue to rise even though the overall prison population has begun to decline in recent years. Most aging prisoners are eventually released from incarceration, and the process can be complicated by high burdens of mental illness, multimorbid chronic conditions, cognitive and functional impairment, common geriatric syndromes, and limited social support. We focus on how these geriatric issues impact release planning and what correctional mental health providers can do to support successful release and transition back to life in the community. We go into detail on compassionate release policies (also called extraordinary medical placement, early medical release, or medical parole), including recent updates to sentencing guidelines from the U.S. Sentencing Commission designed to reduce barriers to access to these underutilized programs. We emphasize the role that correctional psychiatrists can play in the compassionate release process. Finally, we describe what happens to older adults after release from prison, particularly with respect to correctional supervision outcomes, social reintegration, mental health needs, and psychiatric services utilization.

REFERENCES
Williams B, Rothman A, Ahalt C: For seriously ill prisoners, consider evidence-based compassionate release policies. Available at http://healthaffairs.org/blog/2017/02/06/for-seriously-ill-prisoners-con. Accessed September 4, 2017
Williams BA, Goodwin JS, Baillargeon J, et al: Addressing the aging crisis in U.S. criminal justice healthcare. Journal of the American Geriatric Society 60:1150-56, 2012

QUESTIONS AND ANSWERS
Recent revisions to the U.S. Sentencing Commission guidelines recommend which of the following conditions be present for individuals to be eligible for compassionate release?
a. They must have a short-term "terminal" prognosis.
b. They must have served at least 10 years of their sentence.
c. They must have served 10 years or 75% of their sentence, whichever is less.
d. They must be over the age of 75.
ANSWER: c

According to data from the National Survey on Drug Use and Health, which of the following is true for older adults with recent community correctional supervision compared to the general population of older adults?
a. More likely to need mental health treatment and less likely to receive it.
b. More likely to need mental health treatment and more likely to receive it.
c. Less likely to need mental health treatment and less likely to receive it.
d. Less likely to need mental health treatment and more likely to receive it.
ANSWER: b

S44 HOMICIDAL JUVENILES: CAN BAD BOYS BE GOOD MEN?

Anne McBride MD, Sacramento, CA
Barbara McDermott PhD, Sacramento, CA
Charles Scott MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
This workshop will provide training in instruments most useful in assessing recidivism risk in juvenile offenders. Structured professional judgment instruments will be demonstrated, using three cases of homicides committed by adolescents under 16. Participants will complete at least one SPJ tool during the workshop and make decisions based on assessments.

SUMMARY
The evaluation of violence risk has improved over the last several decades, although current research suggests that mental health professionals continue to be at best modestly accurate in our estimates of future violence. Area under the curve estimates, the statistic most frequently reported when evaluating the adequacy of risk instruments, are generally between .65-.70, suggesting a slight increase over chance. Typically estimates of risk are related to the determinations of individuals' lives and liberties, such as, for example, readiness for release from a secure facility. These estimates are extraordinarily important when evaluating juvenile homicide offenders, as in these cases, risk estimates can determine an adolescent's life course. This workshop will present three cases of juvenile homicide in which all victims were friends or family members. Structured professional judgment instruments will be presented and participants will be asked to assist in making standard determinations of risk and amenability to treatment, both of which are common in such assessments. The ethics of administering the assessments, particularly those that evaluate psychopathy or callous-unemotional traits, as well as of diagnosing adolescents with personality disorders or other pejorative labels, will be discussed.

REFERENCES
Mulvey EP, Schubert CA, Pitzer L, et al: An examination of change in dynamic risk of offending over time among serious juvenile offenders. Journal of Criminal Justice 45:48-53, 2016
Viljoen JL, MacDougall EAM, Cagnon NC, et al: Psychopathy evidence in legal proceedings involving adolescent offenders. Psychology, Public Policy and Law 16:254-283, 2010

QUESTIONS AND ANSWERS
In a study evaluating the use of psychopathy in juvenile court cases, _____ percentage of evaluators used the construct as evidence that the youth was not amenable to treatment.
a. Approximately 10%
b. Approximately 20%
c. Approximately 25%
d. Approximately 35%
ANSWER: b

In one study using a structured professional judgement tool with serious adolescent offenders, the authors found

_____

a. Overall risk estimates increased over a three year period
b. Personality and attitudinal factors evidenced no significant change over time
c. The risk domains of peer relationships and substance use evidenced an increase over time
d. Overall risk estimates decreased dramatically within the first year, then evidenced a gradual increase in the next two years

ANSWER: b

S45 AAPL PRACTICE RESOURCE ON PRESCRIBING IN CORRECTIONS

Anthony C. Tamburello, Glassboro, NJ
Michael Champion MD, Honolulu, HI
Elizabeth Ferguson MD, Palm Coast, FL
Graham Glancy MB, Toronto, ON, Canada
Jeffrey Metzner MD, Denver, CO
Joseph Penn MD, Conroe, TX
Robert Trestman MD PhD, Roanoke, VA

EDUCATIONAL OBJECTIVE

Participants will gain a better appreciation for the depth and breadth of the content of the AAPL Practice Resource on Prescribing in Corrections. Participants will be able to describe suggestions for application of the document, including: education, training, maintenance of certification, and opportunities for research.

SUMMARY

Prescribing in jails and prisons is different than it is in the community. While there are high rates of serious mental illness in these settings, there is also a high rate of comorbidity (for example, personality disorders and substance use disorders), malingering, and medication misuse. Operational requirements and medication formulary restrictions further complicate matters. At the recommendation of the Correctional Psychiatry Committee, AAPL charged a work group of experts on psychiatric practice and mental health administration in jails and prisons with the development of a resource document on prescribing in these settings. A proposed draft was presented at the 2016 AAPL Annual Meeting, and feedback on this was incorporated into the document. This panel will present in greater detail the content of the AAPL Practice Resource on Prescribing in Corrections. We will further discuss the implications and intended applications for it, including education of students, training of residents and fellows, orientation of new providers; use in maintenance of certification activities; and identification of opportunities for research.

REFERENCES

American Psychiatric Association, Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prisons: Psychiatric services in correctional facilities, Third edition. Arlington, Virginia: American Psychiatric Association, 2016

Qaseem A, Kansagara D, Forciea MA, et al: Management of Chronic Insomnia Disorder in Adults: A Clinical Practice Guideline From the American College of Physicians. Ann Intern Med 165(2):125-33, 2016

QUESTIONS AND ANSWERS

Which of the following will best ensure continuity of medication treatment for incarcerated individuals returning to the community?

a. Prescription of medications readily available and not cost-prohibitive in the community
b. Only prescribing medications available on the correctional medication formulary
c. Only prescribing medications in crushed or liquid form
d. Civil commitment

ANSWER: a

Consistent with the 2016 Guideline by the American College of Physicians, which of the following is recommended as first-line treatment for chronic insomnia in adults?

a. Sedating antidepressants
b. Benzodiazepines
c. Cognitive behavioral therapy
d. No treatment

ANSWER: c

S46 MOTIVATIONS FOR BESTIALITY: EXPLORING THE EVIDENCE

Brian Holoyda MD MPH MBA, St. Louis, MO

EDUCATIONAL OBJECTIVE

Describe existing classification schemes for bestiality and their strengths and weaknesses, review literature on human-animal intercourse to identify motivations for the behavior and propose a novel motivational classification scheme of bestiality to guide the assessment of offenders.

SUMMARY

Human-animal sexual intercourse, also known as bestiality, has been of interest to the psychiatric community since the mid-20th century when Alfred Kinsey first published findings suggesting that bestiality was a relatively common phenomenon. Since that time research on bestiality has been polarized. Studies on human-animal sex within correctional samples suggest that a history of childhood bestiality, similar to a history of childhood animal abuse, predicts future violent offending in adulthood. At the same time, there is a body of research on community samples that identifies a group of self-identified "zoophiles," or individuals who engage in sex with animals as a means of demonstrating love and/or having a relationship with the animal. There has been no concerted effort to synthesize these disparate findings or to understand individuals' motivations for engaging in bestiality. I propose a novel motivational classification scheme of bestiality based on available research on the behavior, which may be utilized by the court and forensic psychiatric evaluators to identify individuals whose engagement in sex with animals may pose a risk for future interpersonal offending.

REFERENCES

Hensley C, Tallichet SE, Singer SD: Exploring the possible link between childhood and adolescent bestiality and interpersonal violence. J Interpers Violence 21:910 –23, 2006

Aggrawal A: A new classification of zoophilia. J Forensic & Legal Med 18:73– 8, 2011

QUESTIONS AND ANSWERS

Which of the following represents a "secondary gain" motivation for engaging in sex with an animal?

a. A farm boy who attempts intercourse with an animal because of a lack of consenting human partners.
b. A man who has sex with a donkey because his culture condones such behavior as a means of improving his virility prior to marriage.
c. A young boy who repeatedly engages in cruel sexual torture of neighborhood cats.
d. A female prostitute who has sex with a dog at the request of her client.

ANSWER: c

Which of the following does research not support as a common reason for humans to engage in sex with animals?

a. Desire for love and affection.
b. Means of inflicting harm or pain.
c. Delusions regarding improved sexual potency derived from the act.
d. Lack of consenting human partners.

ANSWER: d

S47 MEN USING THE INTERNET TO SOLICIT SEX FROM MINORS

Mark Chapman MD, Chicago, IL
Jeffrey Danziger MD, Maitland, FL
Stephen Dinwiddie MD, Chicago, IL
Melanie Venable MD, Chicago, IL

EDUCATIONAL OBJECTIVE

The objective is to present research findings from a study of men charged with using the Internet to solicit sex from minors. The findings add to a growing body of literature that characterizes the psychopathology and risk factors of sexual offenders against minors.

SUMMARY

Sexual predation on children is recognized as a significant social problem, but offenders are a heterogeneous group. Identification of individuals who have a higher likelihood of committing contact offenses and/or reoffending can allow legal systems to better manage their resources and clinical systems to better develop treatment plans and risk assessments to manage these individuals in correctional and community settings. Internet sexual offenders against children have not been studied extensively. The purpose of the study was to characterize the demographics, psychopathology, legal history, psychological profiles, and recidivism risk of 100 men referred by defense attorneys after being charged

with traveling to meet minors for sexual purposes, and who used the Internet or electronic devices to solicit sex from minors. The minors were fictional and portrayed by undercover officers as part of sting operations. Assessment included clinical forensic psychiatric interview, Minnesota Multiphasic Personality Inventory -2, Static-99 and Abel Assessment for Sexual Interests. In this sample, no striking patterns of psychopathology emerged, nor did subjects demonstrate highly deviant patterns of sexual arousal or elevated risk for reoffense. The results of the study will be presented as primarily aggregate findings with the goal of providing a general profile of this specific population.

REFERENCES

Ly T, Murphy L, Fedoroff J: Understanding online child sexual exploitation offenses. Current Psychiatry Reports 18(8), 2016
Seto M, Hanson R, Babchishin K: Contact sexual offending by men with online sexual offenses. Sexual Abuse: A Journal of Research and Treatment 23(1): 124-45, 2010

QUESTIONS AND ANSWERS

Compared to contact offenders, online offenders are more likely to have:
a. Post-secondary education
b. Higher rates of childhood abuse
c. Lower incomes
d. A history of sexual offenses
ANSWER: a

Approximately what percentage of online sexual offenders have been arrested for or convicted of previous contact sexual offenses?
a. 5%
b. 15%
c. 25%
d. 40%
ANSWER: b

S48 NONINVASIVE INFRARED THERMODETECTION OF ERECTILE FUNCTION

Renée Sorrentino MD, Weymouth, MA
Carlos Hidrovo PhD, Boston, MA

EDUCATIONAL OBJECTIVE

To educate the audience about a new technology for the detection of sexual arousal, review the limitations of the current technologies for the detection of sexual arousal and discuss the forensic implications of the new technology.

SUMMARY

More than 90% of child sexual abuse perpetrators are men (Douglas & Finkelhor, 2005). The detection of diagnosis of pedophilia is difficult, as most pedophiles do not readily report their sexual interest. As a result, objective measures have been created to assist in the diagnosis of pedophilia. The gold standard for the detection of pedophilia is the penile plethysmograph (PPG). Other measures of sexual arousal include the volumetric plethysmography and the Abel Screening of Sexual Interests Test. The current technologies for the detection of sexual arousal are both cumbersome and inaccurate. Infrared thermal imaging is an effective non-invasive technique used to diagnose medical conditions such as peripheral vascular diseases (Bagavathiappan et al, 2009). Studies support the validity of infrared thermographs as a measure of sexual arousal (Abramson et al, 1981). More specifically, temperature changes of the genitals during sexual arousal have been significantly correlated with subjective continuous and discrete reports of sexual arousal (Kukkonen et al, 2010). This research seeks to develop a nonintrusive IR thermograph (NIT) system and compare the use of infrared thermographs vs. PPG in the detection of sexual arousal in men.

REFERENCES

Kukkonen T, Binik Y, Amsel R et al: An evaluation of the validity of thermography as a physiological measure of sexual arousal in a non-university adult sample. Archives of Sexual Behavior 39:861-873, 2010
Bagavathiappan S, Saravanan T, Philip J et al: Infrared thermal imaging for detection of peripheral vascular disorders. J of Medical Physics 34: 43-47, 2009

QUESTIONS AND ANSWERS

What is the most reliable objective test for pedophilia?
a. Circumferential PPG
b. Abel test of sexual interest
c. Abel-Becker card sort test
d. Volumetric PPG
ANSWER: d

What is the sensitivity and specificity of circumferential phallometric testing in pedophiles?
a. greater than or equal to 55% with a specificity of over 95%
b. greater than or equal to 75% with a specificity of over 95%
c. greater than or equal to 85% with a specificity of over 95%
d. unknown
ANSWER: a

S49 A NOVEL APPROACH TO MAINTAINING COMPETENCE ON RIKERS ISLAND

Marilyn Chen PhD, East Elmhurst, NY
Angela Solimo MA, East Elmhurst, NY
Li-Wen Lee MD, Albany, NY
Elizabeth Ford MD, New York, NY

EDUCATIONAL OBJECTIVE

To learn clinical approaches that can be implemented in a jail setting to maintain competence in a population of mentally ill individuals (Service)
and understand how to assess the effectiveness of a clinical program through data analysis (Research).

SUMMARY

Competence to stand trial evaluations have increased in recent years, approximately one-quarter resulting in a finding of lack of competence. Once restored to competence in a state forensic hospital, New York City felony defendants are returned to the jail system to await the disposition of their criminal case. Particularly for those with serious mental illness, the jail can be destabilizing and lead to additional legal delays. In order to reduce these risks, an innovative and intensive treatment unit opened in the jail in September of 2016. This research will describe the clinical, socio-demographic and criminal justice characteristics of NYC felony defendants found not competent, will describe the inter-agency collaborative process involved in funding, designing, and staffing the unit, and will assess whether this new therapeutic approach is impacting key outcome measures including time to criminal case disposition, the need for an additional restoration order, medication adherence in the jail, patient injuries, and the need for jail suicide watch. We will compare baseline outcome measures for this population in the year prior to the unit's opening to the same measures in the year after the unit opened and anticipate a significant improvement in clinical stability and reduction in case processing time.

REFERENCES

Wortzel H, Binswanger IA, Martinez R, et al: Crisis in the treatment of incompetence to proceed to trial: harbinger of a systemic illness. J Am Acad Psychiatry Law 35(3):357-63, 2007
Pirelli G, Gottdiener WH, Zapf PA: A meta-analytic review of competency to stand trial research. Psychology, Public Policy and Law 17(1):1-53, 2011

QUESTIONS AND ANSWERS

Which of the following has been found to be consistently associated with incompetency:
a. Female gender
b. Diagnosis of a psychotic disorder
c. Criminal Charge
d. Age of defendant
e. Employment status
ANSWER: b

Challenges to remaining competent after restoration in New York City jails include:
a. Improved medication adherence after leaving the hospital setting
b. Shortened length of time to adjudication after restoration
c. Stress of legal process or incarceration
d. Being transferred to a hospital setting
e. Prolonged lengths of stay in forensic state hospitals
ANSWER: c

SUNDAY, OCTOBER 29, 2017

PANEL — 8:00 AM – 10:00 AM — **MINERAL F-G**

Z1 ***Is Treatment Delayed, Treatment Denied?***

Jhilam Biswas MD, Newton, MA
Eric Drogin JD PhD, Hingham, MA (I)
Thomas Gutheil MD, Boston, MA
Christopher Meyers MD MPH, Marion, MA

PANEL — 8:00 AM – 10:00 AM — **MINERAL D-E**

Z2 ***Pain Neuroimaging: Neuroscience and Forensic implications***

Octavio Choi MD PhD, Portland, OR
Stephen Easton JD, Laramie, WY (I)
Amanda Pustilnik JD, Baltimore, MD (I)
Tor Wager PhD, Denver, CO (I)

PANEL — 8:00 AM – 10:00 AM — **MINERAL A-C**

Z3 ***Psychiatric Training Behind Bars: Challenges & Opportunities***

Brian Holoyda MD MPH MBA, St. Louis, MO
Jackie Landess MD, JD, St. Louis, MO
Charles Scott MD, Sacramento, CA

PANEL — 8:00 AM – 10:00 AM — **AGATE**

Z4 ***Disability Evaluation of Delayed and Chronic PTSD***
Trauma and Stress Committee

Andrew Levin MD, Hartsdale, NY
Jeffrey Guina MD, Ann Arbor, MI
David Nissan MD, Norfolk, VA
Joel Reisman MD, Memphis, TN
Landy Sparr MD, Beaverton, OR

RESEARCH-IN-PROGRESS #5 — 8:00 AM – 10:00 AM — **GRANITE**

Z5 ***Phallometric Responding in Incest Offenders***

Jonathan Gray MD LLB, Ottawa, ON, Canada
Lisa Murphy MCA, Ottawa, ON, Canada (I)
Rebekah Ranger BSocS, Ottawa, ON, Canada (I)
Paul Fedoroff MD, Ottawa, ON, Canada

Z6 ***Corrections: An Early Intervention Opportunity in Psychosis?***

Tobias Wasser MD, Hamden, CT
Jessica Pollard PhD, New Haven, CT (I)

Z7 ***Police Arrests referred for Psychiatric Hospitalization***

Jeremy Colley MD, New York
Danielle Kushner MD, New York, NY

Z8 ***Race Disparity in the Clinical Risk Assessment***

Jeffrey Kerner MD, Bronx, NY
Mary Colavita MD, Short Hills, NJ
Nadia Gilbo MD, College Point, NY
Bridget McCoy MD, Bronx, NY
Merrill Rotter MD, White Plains, NY

COFFEE BREAK — **10:00 AM – 10:15 AM**

PANEL 10:15 AM – 12:15 PM **MINERAL F-G**

Z9 ***Hendricks: 20 Years Later***
Sexual Offenders Committee

Chinmoy Gulrajani MBBS, Minneapolis, MN
Matthew Kruse MD, Minneapolis, MN
Li-Wen Lee MD, New York, NY
Douglas Tucker MD, Berkeley, CA
Richard Wollert PhD, Vancouver, WA (I)

PANEL 10:15 AM – 12:15 PM **MINERAL D-E**

Z10 ***Shining Light in the Darkness: Crime & the Dark Net***

Hassan A. Naqvi MD, Atlanta, GA (I)
George Annas MD MPH, Syracuse, NY
James Knoll IV MD, Syracuse, NY
Brandon Reynolds MD, Syracuse, NY
Melissa Spanggaard DO, Tucson, AZ

WORKSHOP 10:15 AM – 12:15 PM **MINERAL A-C**

Z11 ***#Notmylaws: The Sovereign Citizen in Jail and at Trial***

Paul Bryant MD, New Haven, CT
Ana Cervantes MD, E. Amherst, NY
George Parker MD, Indianapolis, IN
James Reynolds MD, St. Joseph, MO
Mohit Singh MD, New Haven, CT

PANEL 10:15 AM – 12:15 PM **AGATE**

Z12 ***Taking the Wheel: Psychiatrists' Duties for Patient Driving***

Brian Holoyda MD MPH MBA, St. Louis, MO
Charles Scott MD, Sacramento, CA
Jackie Landess MD, St. Louis, MO
William Newman MD, Saint Louis, MO

PANEL 10:15 AM – 12:15 PM **GRANITE**

Z13 ***Violence Risk Assessment for Interpersonal Violence***

Susan Hatters Friedman MD, Cleveland Heights, OH
Jennifer Piel MD JD, Seattle, WA
John Shand MD, Chargrin Falls, OH
Jason Beaman DO, Tulsa, OK

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

Z1 IS TREATMENT DELAYED, TREATMENT DENIED?

Jhilam Biswas MD, Newton, MA
Eric Drogin JD PhD, Hingham, MA
Thomas Gutheil MD, Boston, MA
Christopher Meyers MD MPH, Marion, MA

EDUCATIONAL OBJECTIVE
This panel discusses the impact certain mental health laws have on treating patients in the correctional and institutional settings and how to handle mentally ill patients refusing treatment. We also address the attorney's dilemma in protecting patient rights when it may go against the patient's best interest.

SUMMARY
The past few decades have witnessed a steady development of legislation dedicated to preserving human rights of the mentally ill. However, of concern, are the cases within institutional and correctional psychiatry where rote procedural approaches produce unintended consequences for the very people the laws were designed to protect. Delays in the legal system to get treatment in place for patients may ironically lead to a life-time of revolving door psychiatric admissions. A problematic example is the "Rogers Guardianship" model currently used in Massachusetts. This law automatically places on counsel the onus to second-guess medical treatment decisions, with minimal latitude for counsel to exercise measured professional judgment. Such a situation inevitably generates delays that deprive and deny the patient from expedient treatment, and thus denies liberation from the institution and risks a poorer prognosis in the future.This panel reviews various legal models in the US, and the implications of the delays that some legal systems have in treatment. Additionally, the panel will address the attorney's dilemma of protecting the right of the patient to refuse treatment despite being committed to a hospital and discuss how doctors can work with untreated individuals with severe mental illness while awaiting legal approval for treatment.

REFERENCES
Marion-Veyron R, Lambert M, Cotton SM, et al: History of offending behavior in first episode psychosis patients: a marker of specific clinical needs and a call for early detection strategies among young offenders. Schizophr Res 161:163-8, 2015
Schouten R, Gutheil TG: Aftermath of a Rogers decision: assessing the costs. Am J Psychiatry 147:1348-52, 1990

QUESTIONS AND ANSWERS
In the decades following the seminal Rogers (1983) case, the case the Rights Driven Model is based upon, what percentage of the time did local judges ultimately favor involuntary treatment after a Rogers Hearing?
a. 20%
b. 40%
c. 75%
d. 80%
e. over 99%
ANSWER: e

Long durations of untreated mental illness (DUI) are shown to cause which of the following?
a. Poorer prognosis
b. Increased risk of refractory illness
c. Higher suicide rate as compared to when treated
d. Increased risk in offending behavior in those with psychotic illness
e. All of the above
ANSWER: e

Z2 PAIN NEUROIMAGING: NEUROSCIENCE AND FORENSIC IMPLICATIONS

Octavio Choi MD PhD, Portland, OR
Stephen Easton JD, Laramie, WY
Amanda Pustilnik JD, Baltimore, MD
Tor Wager PhD, Denver, CO

EDUCATIONAL OBJECTIVE
Forensic psychiatrists are typically not exposed to legally-relevant neuroscience in forensic curricula, and consequently lack skills to critically evaluate such evidence in legal contexts. The proposed panel will remedy knowledge and research gaps by providing a critical overview of the current neuroscience of pain measurement, including forensic and ethical implications.

SUMMARY
Pain is an enormous problem, both in medicine and in the law. Because of its inherently subjective nature, patients, doctors and the legal system have struggled in efforts for just outcomes. For example, fears of malingering have led claimants with genuine pain to be undermedicated by doctors and rejected by juries because of an inability to provide objective evidence of pain. Advances in neuroscience, particularly in functional brain imaging, have the potential to radically change medicine and the law. With increasingly powerful imaging techniques and computer-aided analysis, the formerly-subjective phenomenon of pain is becoming increasingly objective and visible. Panelists will present and discuss scientific, legal, and ethical implications of these advances. In this panel, Octavio Choi, chair of AAPL's Forensic Neuropsychiatry Committee, will provide an overview of what neuroscience currently reveals about the phenomenon of pain. Neuroscientist Tor Wager will present his ground-breaking research on artificial-intelligence guided measurement of pain states with fMRI. Neurolaw scholar Amanda Pustilnik will elucidate legal and ethical implications of pain made visible. Finally, litigation expert Stephen Easton will present his thoughts regarding potential uses and misuses of neuroimaging research in the courtroom.

REFERENCES
Pustilnik AC: Imaging brains, changing minds: how pain neuroimaging can inform the law. Alabama Law Review 66(5): 1099, 2015
Zaki J, Wager T, Singer T, et al: The anatomy of suffering: understanding the relationship between nociceptive and empathic pain. Trends in Cognitive Sciences 20(4):249-259, 2016

QUESTIONS AND ANSWERS
The group-to-individual (G2i) inference problem refers to:
a. The problem of drawing reliable conclusions about particular individuals based on studies that report averaged differences between groups of subjects.
b. The problem of drawing reliable conclusions about particular individuals based on studies of groups that are not representative of the individuals.
c. The problem of drawing reliable conclusions about particular individuals based on studies with inadequate sample size.
d. The problem of drawing reliable conclusions when grouping individual research studies that differ methodologically.
e. None of the above.
ANSWER: a

The reverse inference problem, as applied to inferring mental states such as pain from functional neuroimaging, refers to the problem caused by the fact(s) that
a. Mental states are correlated with activity in multiple brain areas
b. A given brain area may be active in multiple mental states
c. Brain activation patterns of a given mental state may vary considerably across individuals
d. Current functional imaging modalities, such as fMRI, do not measure brain activity directly
e. All of the above
ANSWER: b

Z3 PSYCHIATRIC TRAINING BEHIND BARS: CHALLENGES & OPPORTUNITIES

Brian Holoyda MD MPH MBA, St. Louis, MO
Jackie Landess MD, JD, St. Louis, MO
Charles Scott MD, Sacramento, CA

EDUCATIONAL OBJECTIVE
To describe benefits and challenges of correctional training experiences for psychiatry residents and fellows, review research on trainee experiences and educational outcomes from correctional training environments and delineate practical steps a correctional psychiatrist and program director can take to improve the psychiatric training experience in jail and prison settings.

SUMMARY
The prevalence of mental health providers motivated to work in US correctional facilities lags behind the need for mental health services in these settings. One potentially effective method to increase the number of psychiatrists working in jails, prisons, and parole clinics is to provide exposure to these environments during their training. Correctional settings can be unique educational sites for medical students and psychiatric residents and fellows.

Correctional training experiences can provide both trainees and correctional staff a host of benefits. Alongside potential benefits exist substantial barriers to coordinating training experiences in jails and prisons, including both program directors' and residents' concerns regarding safety, enjoyment of the setting, and negative perceptions of inmate/prisoner-patients. The establishment of academic affiliations with correctional institutions and didactic instruction on commonly encountered clinical issues with inmate populations may be methods to address these concerns. In this panel we describe the benefits and challenges of psychiatric training in correctional settings, review research on trainees' perspectives and educational outcomes of jail-based psychiatric rotations, and delineate practical steps a correctional psychiatrist and program director can take to improve the training experiences in jails and prisons.

REFERENCES

Holoyda BJ, Scott CL: Psychiatric education in the correctional setting: challenges and opportunities. Int Rev Psychiatr 29:11-20, 2017

Fuehrlein BS, Jha MK, Brenner AM, et al: Can we address the shortage of psychiatrists in the correctional setting with exposure during residency training? Community Ment Hlt J 48:756-60, 2012

QUESTIONS AND ANSWERS

Which of the following is true regarding psychiatric residents' perspectives on practicing psychiatry in a jail environment?

a. Residents rate jails as more professionally rewarding than traditional inpatient sites.
b. Residents consider jails to be more worrisome for being assaulted while at work than inpatient sites.
c. Residents generally consider there to be a low need for psychiatrists in jails across the United States.
d. Residents rate their likelihood of working in a jail as higher than the need for psychiatrists in jails.

ANSWER: b

Which of the following is not a benefit for providing a correctional training experience in a residency program?

a. Correctional systems can provide exposure to a variety of treatment types, including inpatient psychiatry, outpatient psychiatry, emergency psychiatry, and psychiatric consults.
b. Residents may receive more exposure to clinical issues such as malingering and antisocial personality disorder that they may not encounter in other training settings.
c. Correctional settings offer opportunities for cross-discipline interaction between correctional staff, social work, psychology, and psychiatry.
d. Correctional environments can be dangerous if residents are not well-trained on how to maintain safety when seeing patients.

ANSWER: d

Z4 DISABILITY EVALUATION OF DELAYED AND CHRONIC PTSD

Andrew Levin MD, Hartsdale, NY
Jeffrey Guina MD, Ann Arbor, MI
David Nissan MD, Norfolk, VA
Joel Reisman MD, Memphis, TN
Landy Sparr MD, Beaverton, OR

EDUCATIONAL OBJECTIVE

At the end of the presentation attendees will have increased understanding of the range of delayed and chronic PTSD presentations and techniques to detect the validity of these claims.

SUMMARY

Although the overall prevalence of delayed PTSD (onset six months or more after the incident trauma) was less than 5% in a recent survey of Iraq veterans, these cases constituted 46% of the reported PTSD cases. In addition to the challenge of evaluating the validity of a claim of delayed PTSD, psychiatrists working in both military and civilian settings must regularly assess disability claims involving delayed reporting and/or chronic symptoms stretching over many years. In this panel, military psychiatrists Drs. Nissan and Dr. Guina will describe approaches to disability claims from veterans with delayed onset or delayed reporting of PTSD as well as the pattern of increasing symptoms despite treatment, a pattern observed in claimants seeking 100% disability. On the civilian side, Dr. Reisman will share his experience with police and fire fighters claiming disability retirement from job injury. Lastly, Dr. Sparr will discuss the challenge of evaluating individuals who claim chronic, disabling symptoms years after the index trauma. Panelists will emphasize the variety of late PTSD presentations and techniques to assess their validity.

REFERENCES
Andrews B, Brewin CR, Philpott R, et al: Delayed-onset posttraumatic stress disorder: a systematic review of the evidence. Am J Psychiatry 164: 1319-1326, 2007
McNally, RJ, Frueh, CB. Why are Iraq and Afghanistan War veterans seeking PTSD disability compensation at unprecedented rates? J Anxiety Disorders 27:520– 526, 2013

QUESTIONS AND ANSWERS
Which of the following is true regarding delayed PTSD?
a. Recent life events play a role in the development of delayed PTSD.
b. Childhood trauma is a strong risk factor for delayed PTSD.
c. Delayed PTSD is often preceded by sub-syndromal symptoms.
d. Malingering is rare in delayed PTSD.
e. All of the above
ANSWER: c

Collateral information useful in supporting or denying claims of delayed onset include:
a. Medical records of prior psychiatric and medical treatment
b. Performance evaluations by past and recent supervisors
c. Detailed descriptions of the claimed trauma and other life trauma
d. Reports from significant others and/or co-workers
e. All of the above
ANSWER: e

Z5 PHALLOMETRIC RESPONDING IN INCEST OFFENDERS

Jonathan Gray MD LLB, Ottawa, ON, Canada
Lisa Murphy MCA, Ottawa, ON, Canada
Rebekah Ranger BSocS, Ottawa, ON, Canada
Paul Fedoroff MD, Ottawa, ON, Canada

EDUCATIONAL OBJECTIVE
To provide an overview of current literature on PPG outcomes in incest offenders as compared to extra-familial child sex offenders; and to review results of a retrospective study examining phallometric response profiles in subgroups of incest offenders (biological and legal relation) and extra-familial child sex offenders.

SUMMARY
Phallometric testing, or penile plethysmography (PPG), is a widely recognized means of objectively measuring male sexual arousal in response to various stimuli (Murphy et al., 2015). Compared to other types of sexual offenders, incest offenders tend to demonstrate distinctly different features in terms of offense characteristics and sexual arousal patters. Literature describes incestuous offenders as more "situational" offenders, motivated primarily by opportunity and family dynamics rather than sexual interest in children. Incest offenders are therefore less likely to be pedophilic. As such, PPG assessments of incest offenders tend to indicate more arousal towards adult scenarios than extra-familial child sexual offenders. Previous studies have analyzed differences between extra-familial child sex offenders and incest offenders. The literature lacks empirical investigations seeking the utility of specialized incestuous PPG stimuli to correctly classify subgroups of incest offenders. This study involves retrospective analysis of sexual arousal responses by subgroups of incest offenders (biological and legal relation) compared to extra-familial child sex offenders. Approximately 1000 clinical files of patients assessed at the Sexual Behaviours Clinic in Ottawa, Canada will be reviewed for this study. Data includes demographic information, referral source, relationship to the victim, and PPG results.

REFERENCES
Murphy L, Ranger R, Stewart H, et al: Assessment of problematic sexual interests with the penile plethysmograph: an overview of assessment laboratories. Current Psychiatry Reports 17(5),2015
Seto MC: Incest. In Pedophilia and Sexual Offending Against Children: Theory, Assessment, and Intervention. Washington, DC: American Psychological Association, 2008, pp. 123-140

QUESTIONS AND ANSWERS

Which of the following is NOT a valid use of PPG testing:

a. to help determine future treatment directions
b. to help determine the likelihood that an accused is guilty of his alleged offences
c. in the assessment of sexual offenders, to help guide recommended conditions of release
d. to lend evidence towards specific psychiatric diagnoses

ANSWER: b

Incest offenders and those who sexually offend against extra-familiar victims generally differ in several ways. Which of the following statements is true?

a. Incest offenders tend to have a higher risk of reoffense and are more likely to have a pedophilic profile on PPG than extra-familiar offenders
b. Incest offenders are at a higher risk of reoffense despite more likely having a normal profile on PPG than extra-familiar offenders
c. Incest offenders are at a lower risk of reoffense and are less likely to have a pedophilic profile on PPG than extra-familiar offenders
d. Incest offenders have a lower risk of reoffense despite more likely having a pedophilic profile on PPG than extra-familiar offenders

ANSWER: c

Z6 CORRECTIONS: AN EARLY INTERVENTION OPPORTUNITY IN PSYCHOSIS?

Tobias Wasser MD, Hamden, CT
Jessica Pollard PhD, New Haven, CT

EDUCATIONAL OBJECTIVE

To appreciate the risk of criminal justice involvement for individuals early in psychosis, identify the prevalence of this population in the correctional system and describe strategies for utilizing the criminal justice system as an opportunity for early detection and intervention in this population.

SUMMARY

Data suggest risk for incarceration in youth early in psychosis may be heightened; self-reported rates of prior incarceration during untreated psychosis are high (e.g. 37%) and associated with longer treatment delay. Treatment delay is consistently associated with a variety of poor outcomes. However, no published information is available about rates of early stage psychosis in corrections. The correctional system may serve as an important site for early detection and intervention (EI). In prior research evaluating effectiveness of an EI program in Connecticut, self-report data demonstrated a positive impact of EI on reducing the number of jail days one year after entering treatment. However, this self-report data is limited and incomplete and does not fully reflect the community of young adults early in psychosis in our state. To address these knowledge gaps, the authors are engaged in ongoing research to identify the prevalence of young adults (ages 16-24) with an identified psychotic disorder in the Connecticut Department of Corrections. Here we present our preliminary findings of the rate of early stage psychosis within our state's correctional setting to assess whether psychosis is over-represented amongst incarcerated youth and thus whether corrections may represent an opportunity for early detection and intervention.

REFERENCES

Srihari VH, Tek C, Kucukgoncu S, et al: First-Episode Service for Psychotic Disorders in the U.S. Public Sector: A Pragmatic Randomized Controlled Trial. Psychiatric 66:705-12, 2015
Ford E: First-episode psychosis in the criminal justice system: identifying a critical intercept for early intervention. Harvard Review of Psychiatry 23:167-175, 2015

QUESTIONS AND ANSWERS

Current findings regarding the impact of early intervention services on reducing the criminal justice burden of individuals with early psychosis are limited to which type of data:

a. Self-report
b. Retrospective chart review
c. Case-control
d. Cohort

ANSWER: a

Self-report rates of prior incarceration during period of untreated psychosis are as high as:
a. 18%
b. 37%
c. 54%
d. 68%
ANSWER: b

Z7 POLICE ARRESTS REFERRED FOR PSYCHIATRIC HOSPITALIZATION

Jeremy Colley MD, New York
Danielle Kushner MD, New York, NY

EDUCATIONAL OBJECTIVE

Participants will be able to identify specific patient characteristics of mentally ill individuals under arrest who are referred by the police to the hospital for psychiatric evaluation.

SUMMARY

Law enforcement is often the first line of contact in the community for people with mental illness. Upon an encounter with an individual, police make decisions about whether to refer a person to mental health services or to arrest the person for the same behaviors. Studies have shown that police interventions involving individuals with mental illness were less likely to be related to more severe offenses than interventions involving individuals without mental illness. In addition, interventions for minor offenses were more likely to lead to arrest in those with mental illness (1). Due to the disparities in police treatment, research is currently investigating various training programs, such as Crisis Intervention Team (CIT) model, that educate police officers with knowledge and skills to deal with mental health issues. Such programs help encourage treatment rather than jail when appropriate, serving as a form of pre-booking jail diversion (2). This research project compares various demographical and clinical variables between individuals brought by police to Bellevue Hospital under arrest versus those brought by police for a psychiatric evaluation not under custody.

REFERENCES

Compton MT, Bakeman R, Broussard B, et al: The police-based crisis intervention team (CIT) model: effects on officers' knowledge, attitudes, and skills. Psychiatric Services 65:517-522, 2014
Charette Y, Crocker AG, Billette I: Police encounters involving citizens with mental illness: use of resources and outcomes. Psychiatric Services 65:511-516, 2014

QUESTIONS AND ANSWERS

Which of the following are core elements of CIT training?
a. community ownership
b. partnerships between law enforcement and mental health advocacy
c. basic and advanced training for officers and dispatchers
d. availability of mental health facilities
e. all of the above
ANSWER: e

Police Encounters with individuals with mental illness are more likely to be
a. rare in occurrence
b. associated with arrest
c. related to serious offenses only
d. all of above
ANSWER: b

Z8 RACE DISPARITY IN THE CLINICAL RISK ASSESSMENT

Jeffrey Kerner MD, Bronx, NY
Mary Colavita MD, Short Hills, NJ
Nadia Gilbo MD, College Point, NY
Bridget McCoy MD, Bronx, NY
Merrill Rotter MD, White Plains, NY

EDUCATIONAL OBJECTIVE

To evaluate the impact of race in psychiatric emergency room-based hospital admission decisions and discuss implications for potential bias in these risk-focused assessments.

SUMMARY
Race has been shown to impact the quality of health care across medical specialties. Studies have shown that minorities are less likely to receive adequate pain medications and are less likely to be accurately diagnosed with a myocardial infarction and treated appropriately than Caucasian patients. In the practice of psychiatry, race has been shown to influence diagnosis and clinicians' medication choices. While psychological studies consistently demonstrate bias in the formation of associations between minority status and violent crime and dangerousness, no studies were found that measured how a patient's race may influence a clinician's risk assessment. Racial disparity and implicit bias may lead to different conclusions regarding risk, with potentially significant civil liberty implications. In this study, we present a chart review-based study of psychiatric emergency room hospitalization decisions. We compare the rates of psychiatric admissions between races, with particular attention to assessments of dangerousness to self or others, which is often the critical part of the decision to hospitalize. Implications for risk assessment, the role of implicit bias and training will be discussed.

REFERENCES
Paradies Y, Truong M, Priest N: A systematic review of the extent and measurement of healthcare provider racism. Journal General Internal Medicine 29(2):364-387, 2014
Copeland LA, Zeber JE, Valenstein M, et al: Racial disparity in the use of atypical antipsychotic medications among veterans. American Journal of Psychiatry 160(10):1817-1822, 2003

QUESTIONS AND ANSWERS
Has race been shown to impact clinicians' treatment decision-making?
a. Yes
b. No
ANSWER: a

Has race been shown to impact clinicians' diagnostic formulations?
a. Yes
b. No
ANSWER: a

Z9 **HENDRICKS: 20 YEARS LATER**

Chinmoy Gulrajani MBBS, Minneapolis, MN
Matthew Kruse MD, Minneapolis, MN
Li-Wen Lee MD, New York, NY
Douglas Tucker MD, Berkeley, CA
Richard Wollert PhD, Vancouver, WA

EDUCATIONAL OBJECTIVE
At the end of this discussion the audience will demonstrate an understanding of the systemic issues encountered by state human services administration agencies while developing a service delivery system for sex offenders who are civilly committed under the SVP/SDP statutes.

SUMMARY
Kansas enacted laws authorizing civil commitment of individuals found to be "sexually violent predators" at the end of their criminal sentence 1994. Kansas invoked the Act for the first time to commit Leroy Hendricks, an inmate who had a long history of sexually molesting children. Mr. Hendricks challenged his commitment in a case that was argued all the way to the Supreme Court. In 1997, the Supreme Court of the United States upheld the constitutionality of sex offender statutes, thereby legitimizing the indeterminate confinement of sex offenders as civil commitment. Today 20 states, the District of Columbia and the Federal Government have civil commitment laws for sex offenders referred to as "Sexually Violent Predator" or "Sexually Dangerous Person" laws. In the years that have passed, states have grappled with balancing implementation of these laws with the rights and needs of committed offenders. In this panel discussion, speakers from four different states will present developments in the sex offender treatment programs in their respective state over the last two decades. Best practices from a clinical and administrative standpoint will be discussed, as well as stumbling blocks along the way that have led to several class action law suits in recent years.

REFERENCES
Kansas v. Hendricks 521 U.S. 346 (1997)
Brody AL, Green R: Washington state 's unscientific approach to the problem of repeat sex offenders. J Am Acad of Psychiatry Law 22(3)343-356, 1994

QUESTIONS AND ANSWERS

The first state to enact laws authorizing civil commitment of individuals found to be Sexually Violent Predators at the end of their criminal sentence was:

a. Kansas
b. Washington
c. Missouri
d. Montana

ANSWER: b

Civil commitment laws for sex offenders are currently present in:

a. Fifteen states and the Federal Government
b. The District of Columbia, the Federal Government and all 50 states.
c. Twenty states, the District of Columbia and the Federal Government
d. Only the Federal Government.

ANSWER: c

Z10 SHINING LIGHT IN THE DARKNESS: CRIME & THE DARK NET

Hassan A. Naqvi MD, Atlanta, GA
George Annas MD MPH, Syracuse, NY
James Knoll IV MD, Syracuse, NY
Brandon Reynolds MD, Syracuse, NY
Melissa Spanggaard DO, Tucson, AZ

EDUCATIONAL OBJECTIVE

Increased understanding of the Dark Net and the various ways it is used for illegal activities and cybercrimes such as: child pornography, drug trafficking, crypto-anarchism, and terrorism.

SUMMARY

The Dark Net is a term used to describe a network of computers accessible on the Internet only through special software. Communications on the Dark Net pass through multiple encryption points to provide anonymity. The term Dark Net was originally used in the 1970s to designate networks that were isolated from the Advanced Research Projects Agency Network (ARPANET), which later evolved into the Internet. In 2017, the Dark Net has evolved into a robust information superhighway for criminals. Virtually any kind of illegal product or unethical service is available on the Dark Net. In response, law enforcement agencies have set up sites designed to track Dark Net criminals. It has been argued that the Dark Net is not without redeeming principles, and supporters tout it as a vehicle that protects free speech and privacy. This panel will give a basic overview of the Dark Net and how it can be accessed. Four types of Dark Net illegal activities that forensic psychiatrists may encounter will be covered: child pornography, drug trafficking, crypto-anarchism, and terrorism.

REFERENCES

Van Hout M, Bingham T: Responsible vendors, intelligent consumers: Silk Road, the online revolution in drug trading. International Journal of Drug Policy 25(2): 183-189, 2014

Bissias G, Levine B, Liberatore M, et al: Characterization of contact offenders and child exploitation material trafficking on five peer-to-peer networks. Child Abuse & Neglect 52: 185-199, 2016

QUESTIONS AND ANSWERS

What was the name of the first Darknet market to use Tor and Bitcoin?

a. Agora
b. Atlantis
c. Silk Road
d. Napster

ANSWER: c

Since its creation, Bitcoin has provided all of the following advantages except:

a. Anonymity between buyer and seller
b. Stable exchange rate
c. Low transaction fees
d. Ability to evade taxation

ANSWER: b

Z11 #NOTMYLAWS: THE SOVEREIGN CITIZEN IN JAIL AND AT TRIAL

Paul Bryant MD, New Haven, CT
Ana Cervantes MD, E. Amherst, NY
George Parker MD, Indianapolis, IN
James Reynolds MD, St. Joseph, MO
Mohit Singh MD, New Haven, CT

EDUCATIONAL OBJECTIVE
To familiarize the audience with the basic Sovereign Citizens beliefs, their relevance in Competency to Stand Trial and Criminal Responsibility evaluations, and to educate treating psychiatrists in correctional settings, who may be asked to evaluate these individuals for idiosyncratic beliefs that may appear delusional.

SUMMARY
The Sovereign Citizen movement consists of individuals who hold a variety of beliefs that challenge the legitimacy of the US government and the application of the law. "Sovereigns" can often appear psychotic and disorganized to those unfamiliar with these core beliefs. It is not uncommon for correctional settings to be the place where some individuals first become familiar with this movement. Often, these individuals come to the attention of forensic psychiatrists when their competency to stand trial is questioned, or they challenge rules and laws that apply to their detention while in correctional settings. Familiarity with the basic tenets held by Sovereign Citizens will help evaluators avoid inaccurate assessments of these individuals as it relates to competency to stand trial, criminal responsibility, and clinical decisions regarding treatment that may be requested in correctional facilities. The workshop will focus on educating the audience on the beliefs espoused by these defendants and promoting an active discussion about how to formulate cases, using case examples from case files of the presenters and representative videos. There will be emphasis on audience participation and use of the audience response system.

REFERENCES
Parker G; Competence to Stand Trial Evaluations of Sovereign Citizens: A Case Series and Primer of Odd Political and Legal Beliefs; J Am Acad Psychiatry Law 42:338-49, 2014
Pytyck J, Chaimowitz G: The sovereign citizen movement and fitness to stand trial. International Journal of Forensic Mental Health 12(2):149-153, 2013

QUESTIONS AND ANSWERS
The following is true about "Sovereign Citizens":
a. Most criminal infractions involve financial crimes, i.e. tax fraud, child support, and some may defend their beliefs to the death.
b. The "sovereign" movement is a loose label for as many as 100,000 people who share a varying number of anti-government beliefs.
c. A "sovereign citizen" will often use code words and loaded phraseology that can tip off the informed examiner.
d. People with "sovereign" views often use the legal system to harass authorities, such as by filing false liens.
e. All of the above.
ANSWER: e

Individuals in jails or prisons with Sovereign Citizen beliefs might be incorrectly diagnosed as:
a. Bipolar Disorder
b. Delusional Disorder
c. Schizophrenia
d. All of the above
ANSWER: d

Z12 TAKING THE WHEEL: PSYCHIATRISTS' DUTIES FOR PATIENT DRIVING

Brian Holoyda MD MPH MBA, St. Louis, MO
Charles Scott MD, Sacramento, CA
Jackie Landess MD, St. Louis, MO
William Newman MD, St. Louis, MO

EDUCATIONAL OBJECTIVE
To describe the legal theory underpinning psychiatric liability in "driving cases," elineate relevant situations in which psychiatrists may incur liability for patient driving and outline practical guidelines regarding the forensic assessment of psychiatric evaluation, treatment, and informed consent in driving malpractice cases.

SUMMARY
In the 1998 landmark case Naidu v. Laird, the Supreme Court of Delaware affirmed the finding of negligence for a psychiatrist whose patient crashed his motor vehicle and killed another driver five months following his release from a state hospital. Naidu highlights the need for psychiatrists to understand their responsibilities and the standard of care in regard to their patients' driving. Untreated mental disorders and resultant impairments in perception, judgment, and psychomotor behavior can impact an individual's capacity to drive. On the other hand, substances of abuse and commonly prescribed psychotropic medications can cause numerous psychiatric symptoms – sedation, confusion, and impaired coordination, to name a few – that can also increase the risk for motor vehicle accidents. This panel reviews the psychiatrist's duties in regard to patients' driving. We will describe the legal theory underpinning psychiatrists' liability in driving cases. We will delineate relevant situations in which psychiatrists may incur liability, including untreated mental disorders, medication side effects, and substance use. Lastly, we will outline practical guidelines regarding the forensic assessment of psychiatric evaluation, treatment, and informed consent in driving malpractice cases.

REFERENCES
Pettis RW: Tarasoff and the dangerous driver: a look at the driving cases. J Am Acad Psychiatry Law 20:(4)27-37, 1992
Joris CV, Monique AJM: Psychoactive medication and traffic safety. Int J Environ Res Public Health 6(3):1041-54, 2009

QUESTIONS AND ANSWERS
Which of the following is not one of the categorizations of psychoactive drugs in the International Council on Alcohol, Drugs and Traffic Safety classification?
a. Presumed to be safe or unlikely to produce an effect
b. Likely to produce minor or moderate adverse effects
c. Likely to produce severe effects or presumed to be potentially dangerous
d. Excessively risky for use when driving
ANSWER: d

Which of the following is not true regarding the landmark driving case Naidu v. Laird?
a. Mr. Putney deliberately drove his vehicle into another man's car.
b. The Supreme Court of Delaware relied on Tarasoff v. Regents of the University of California in formulating its opinion.
c. Mr. Putney was under the influence of methamphetamine at the time of the motor vehicle accident.
d. Dr. Naidu's dereliction in the evaluation, treatment, and discharge of Mr. Putney was found to be the proximate cause of Mr. Laird's death.
ANSWER: c

Z13 VIOLENCE RISK ASSESSMENT FOR INTERPERSONAL VIOLENCE

Susan Hatters Friedman MD, Cleveland Heights, OH
Jennifer Piel MD JD, Seattle, WA
John Shand MD, Chagrin Falls, OH
Jason Beaman DO, Tulsa, OK

EDUCATIONAL OBJECTIVE
To educate the audience on the intricacies of performing violence risk assessments involving interpersonal violence. At the end of the presentation, the audience will have a better understanding of the unique characteristics of Domestic Violence Homicide, Filicide, Parricide and Fratricide.

SUMMARY
Interpersonal Violence (IPV) is common among homicides. While there is focus on education for Violence Risk Assessment, this education is not specific towards IPV. This presentation will educate the audience on the intricacies of Violence Risk Assessment (VRA) as it involves the different types of IPV. The following types of IPV will be discussed: Filicide is child murder by the parent. When risk of filicide is considered, it is important that one consider the motive behind the potential filicide, because various motives require different avenues of prevention. Fratricide is the killing of one's brother or sister. In this talk, we will discuss some research on the rates and factors associated with lethal sibling violence. Parricide, is the killing of a parent by a child. This talk will discuss the intricacies of this killing as it relates to both mental health and addiction issues. Intimate Partner Homicide is the murder of one's relationship partner. This common crime has different themes that will be discussed including risk factors for both perpetrator and victim. The discussion will be framed from a clinician's vantage point to better perform a VRA when the clinical situation arises.

REFERENCES

Hatters Friedman S, Resnick P: Child murder by mothers: patterns and prevention. World Psychiatry 6(3):137-141, 2007
Daly M, Wilson M, Salmon CA, et al: Siblicide and seniority. Homicide Studies 5:30-45, 2001

QUESTIONS AND ANSWERS

What is the most common motive in filicide?
a. Accidental Death/Abuse
b. Altruistic
c. Psychotic
d. Spousal Revenge
ANSWER: a

What is the rate of collateral damage in domestic violence homicide?
a. 80%
b. 50%
c. 20%
d. 5%
ANSWER: c

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