# Shaping Attitudes of Psychiatry Residents Toward Forensic Patients

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With increasing criminalization of the mentally ill, individuals with mental disorders more frequently come into contact with the legal system. Psychiatrists may find themselves evaluating these individuals in a forensic context or treating them. Unfortunately, resident trainees and psychiatrists may be uncomfortable with forensic matters and treating patients with medicolegal problems. To clarify the attitudes and experience of Canadian psychiatry trainees, attendees at a national psychiatry review course were polled. The results show significant discomfort and a lack of didactic and clinical education concerning these patients and their problems. However, didactic and clinical education were shown to be associated with both increased comfort with and willingness to treat these patients.

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Forensic psychiatry as a subspecialty has developed considerably over the past few decades; although officially recognized as a subspecialty by the American Board of Psychiatry and Neurology in 1992, it was recognized in April 2011 by the Canadian accreditation body, the Royal College of Physicians and Surgeons of Canada. Currently, there is no mandatory rotation in forensic psychiatry for residents completing training in Canada in general psychiatry. Instead, the objectives of training require that residents be able to identify and appropriately respond to relevant clinical questions arising in patient care, including those regarding legal and forensic matters; they also must have a working knowledge of forensics.[1] In the United States, the Accreditation Council for Graduate Medical Education (ACGME) mandates forensic exposure, which may be part of either inpatient or outpatient requirements, although the amount is not specified. This experience must include evaluation of forensic concerns, such as patients facing criminal charges, establishing competency to stand trial, criminal responsibility, commitment, and an assessment of their potential to harm themselves or others. The experience should include writing a forensic report and, if possible, giving testimony.[2]

There have been limited publications on forensic psychiatry education for general psychiatrists, although some authors have championed the benefits of forensic psychiatry education. Ciccone[3] argued that to defend against attacks on the practice of general psychiatry, one must have an understanding of the language and thought of the legal system. Marrocco *et al.*[4] have promoted the importance of education about forensic topics in general psychiatric training, and McBain *et al.*[5] have demonstrated the positive impact a forensic fellowship program can have on general psychiatry resident-in-training examination scores.

However, one of the most important reasons for encouraging forensic psychiatry education and subspecialization stems from the increasing number of patients with mental illness interacting with the criminal justice system. In a process dubbed "deinstitutionalization," the number of active hospital beds in long-term stay psychiatric facilities decreased as patients were discharged to community mental health services. Unfortunately, as psychiatric asylums

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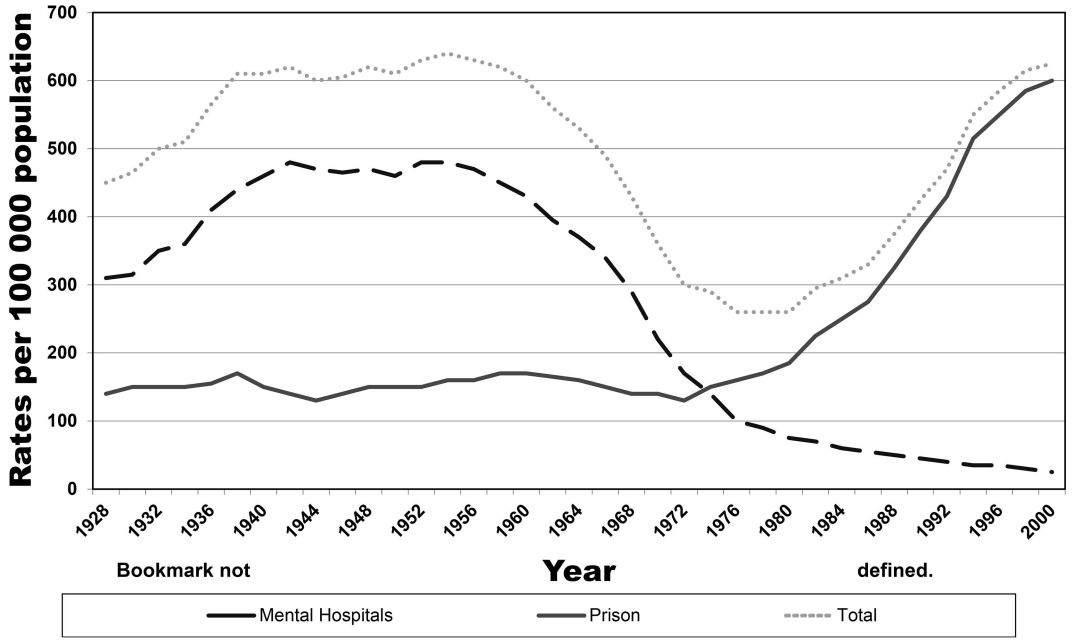


**Figure 1.** Rates of individuals with mental illness in long-term facilities including jail and mental hospitals. Reprinted, with permission from Texas Law Review, Austin, TX: University of Texas, 2006.[7]

emptied their beds, the number of inmates with mental illness in jails and prisons climbed.[6,7] The movement of psychiatric patients from mental hospitals to prisons has been referred to as "reinstitutionalization" or "transinstitutionalization,"[8–10] as illustrated in Figure 1.

There is now an over-representation of people living with mental illness in the criminal justice system.[11] Studies estimate that at least 16 percent of inmates in American jails and prisons have a serious mental illness,[12] and more than half of all inmates in the United States have some mental health problem.[13] Similarly, data from the Correctional Service of Canada demonstrated that in a sample of 1,300 men entering Canadian federal jails from February 2008 through April 2009, 38.4 percent reported or were assessed as having signs of a mental health problem. As a result, there has been an outcry for increased mental health workers and psychiatrists for this population.[14] In essence, jails and prisons have become the new psychiatric asylums.[8,12] To respond to the criminalization of the mentally ill, psychiatrists must be comfortable with these patients and their problems. Despite this increased demand, many forensic psychiatry training programs have unfilled positions, and forensic psychiatry remains underserviced. In addition, finding services for those with legal concerns is often difficult.

Part of the difficulty in obtaining services for this stigmatized population probably comes from the negative attitudes of psychiatry residents toward forensic psychiatry. Ward and Bradford[15] determined that attitudes toward the subspecialty are formed early in training and tend to be largely unfavorable. As such, they recommended that efforts be made toward identifying and mentoring junior residents who display an early interest in forensic psychiatry to facilitate future recruitment.

The purpose of the current study was to evaluate the state of medicolegal education among psychiatry residents in Canada, to examine resident attitudes regarding forensic psychiatry, and to determine whether clinical exposure and didactic lectures in residency correlate with such attitudes.

## Methods

The current study was approved by the institutional Ethics Review Board of the Royal Ottawa Health Care Group, and participation was voluntary. The primary author (B.D.B.) developed an edited version of the questionnaire used in the study by Ward and Bradford.[15] This questionnaire was distributed to all physicians attending the University of Ottawa's E. K. Koranyi Review Course in Psychiatry from 2009 through 2011. This review course is an

annual national week-long intensive review of psychiatry attended by most senior Canadian psychiatry residents, as well as other physicians from Canada and abroad. The course is designed to aid psychiatry residents in preparing for the Canadian psychiatry certification examination, successful completion of which is necessary to practice psychiatry in Canada. As well, the course provides an update for practicing psychiatrists.

The study questionnaire was divided into three sections. The first comprised demographic information: age, level of training, gender, whether the respondent had children, and completion or intention to complete a forensic psychiatry rotation. The second measured the training exposure of common medicolegal problems among respondents. The third measured the respondents' attitudes on multiple statements regarding medicolegal topics, forensic patients (referring to forensic patients without sexual offense histories), and sex offenders (referring to forensic patients with sexual offense histories). Minor modifications of the questionnaire were made for the 2010 and 2011 distribution. Respondents evaluated the statements on a five-point Likert scale from one (strongly agree) to five (strongly disagree) in 2010 and 2011 and a two-point agree/disagree scale in 2009.

The questionnaire was completed before a three-hour lecture covering medicolegal topics. After the lecture, attendees were questioned regarding their comfort with the forensic subject matter.

Data analysis was conducted using the Statistical Package for the Social Sciences (SPSS), version 13. Questionnaire results from the attendees of the 2009, 2010, and 2011 review courses were combined and analyzed using descriptive statistics and Pearson's correlations, using 2-tailed tests of significance. Statistical significance was defined as $p < .05$. The responses to the attitude questions were recoded to a three-point scale (disagree, neutral, and agree), to allow cross-year comparison and increase the analysis pool. In the current study, only results from Canadian-trained senior residents (postgraduate year (PGY)-4 and -5) were analyzed, as other groups were too small for comparison. Because not all participants responded to all questions, the number included in each analysis varied.

## Results

Between 2009 and 2011, 565 psychiatry residents and practicing psychiatrists attended the review course. A total of 232 questionnaires were returned, suggesting a response rate of 41 percent. Unfortunately, because of the logistics of the review course registration process, it is unclear how many of the 565 attendees were senior psychiatry residents. However, 145 of the 232 returned questionnaires were from senior psychiatry residents (80 were PGY-4 and 65 were PGY-5) and were included in the current study. The ages of these residents ranged from 26 to 59 years, with a mean of 33 years of age (SD 5.76). The majority (70%) of senior residents were women. Further, 39 percent of the residents reported having children.

During the 2010 and 2011 review course, there were 68 senior resident respondents to the questionnaire. A minority of these residents (23; 33.8%) acknowledged completing or intending to complete a forensic psychiatry rotation; this question was not asked in the 2009 survey. Of these "rotation-completing" respondents, 39.1 percent indicated that their forensic psychiatry rotation was mandatory, whereas 82.6 percent were or would be involved in an elective forensic psychiatry rotation. Thus, some residents planned to complete both mandatory and elective rotations.

Table 1 shows the exposure of residents to common medicolegal problems in psychiatry, both concerning teaching on the subject matter and clinical experience. In general, residents were more likely to have been taught about the topic than to have had clinical experience. The results also indicated a large variability in the exposure to key medicolegal topics; teaching on these varied between 18.9 and 81.1 per-

**Table 1** Exposure to Common Medicolegal Topics Among Senior Psychiatry Residents

| Common Medicolegal Areas | Reported Being Taught About Area (%) | Reported Having Clinical Experience in Area (%) |
|---|---|---|
| Violence risk assessment | 74.8 | 51.3 |
| Correctional psychiatry | 23.8 | 28.7 |
| Not criminally responsible/fitness evaluation(competency to stand trial) | 79.7 | 43.4 |
| Paraphilias/sex offenders | 55.9 | 27.3 |
| Testifying to courts/tribunals | 30.8 | 24.5 |
| Civil commitment | 49.0 | 39.2 |
| Confidentiality/duty to warn | 81.1 | 61.5 |
| Informed consent | 79.7 | 78.3 |
| Disability evaluation | 18.9 | 25.9 |
| Malpractice/negligence | 47.6 | 4.9 |

$N = 143$.

cent, whereas clinical exposure varied from 4.9 to 78.3 percent. Given the importance of these areas for all psychiatrists, the low numbers are troubling.

Table 2 summarizes resident attitudes toward medicolegal topics, forensic patients, and sex offenders. The tables indicate whether there is a significant positive or negative correlation between a certain attitude and the type of exposure to key forensic topics (defined as violence risk assessments, not criminally responsible/not guilty by reason of insanity (NCR/NGRI), and fitness/competency to stand trial assessments, paraphilias and sex offenders, and correctional psychiatry). For the most part, medicolegal education correlated positively with favorable attitudes toward these areas and correlated negatively with unfavorable attitudes toward the subspecialty. Clinical experience demonstrated more significant correlations with resident attitudes than teaching exposure.

After the three-hour review course lecture, 88.4 percent ($n = 107$) of the attendees reported feeling "more comfortable dealing with medicolegal problems," 71.9 percent ($n = 87$) reported feeling "more comfortable treating forensic patients" and 54.2 percent ($n = 65$) reported "feeling more comfortable treating sexual offenders."

## Discussion

The results of this study suggest low exposure to key medicolegal topics, including the more "subspecialized" areas such as NCR/NGRI, Fitness/competency to stand trial and sex offenders in addition to areas essential to the practice of general psychiatry such as disability, confidentiality, duty to warn, and risk assessment. As many of these areas are required learning objectives in Canada, residents report unacceptably low exposure to them. Such findings suggest Canadian psychiatry training programs do not adequately cover these topics in their curriculum or in their clinical rotations.

Further, although patients with mental illness are at significant likelihood of encountering medicolegal difficulties, only a small percentage of Canadian psychiatry residents have completed or intend to complete a forensic psychiatry rotation. The noted forensic rotation rate of 33.8 percent may even be an overestimate, as residents with a particular interest in the discipline may have been more likely to respond to the questionnaire.

Few residents reported feeling comfortable dealing with forensic cases. Many residents expressed a wish for more education in forensic subjects, and most recommended that some forensic education be mandatory.

Fortunately, there were several favorable correlations between forensic exposure and residents' attitudes toward medicolegal matters. Forensic exposure correlated with feeling comfortable with forensic cases, in prison and outside of prison. This includes being more comfortable providing direct or consultation services to this stigmatized patient population and being open to doing forensic psychiatry as a career. Exposure to forensic education also correlated with an interest in forensic matters, less negative attitudes around forensic topics, and less avoidance of the subspecialty as a career because of safety concerns. Although both teaching and clinical exposure appear to correlate, clinical exposure seems to be especially associated with less avoidance of forensic patients and patients who have committed sexual offenses. Given the difficulty finding treatment providers for these patients, providing mandatory teaching and experience would be likely to improve access to treatment, which in turn may lessen the double stigmatization these patients face because of both mental health and legal problems.

Although the results of this study are not surprising, there were a few results from the survey that were unexpected. For a handful of questions, women were less likely to have favorable views of forensic psychiatry. This included finding testifying in court intimidating, preferring not to work with sex offenders, feeling less comfortable treating comorbid psychiatric illness in the sex offender population, and having less comfort in treating sex offenders after the review course lecture. As women physicians made up most of the respondents and an increasing proportion of the physician workforce,[16–18] it is concerning that a significant portion of women appear to have unfavorable attitudes toward these areas. Further exploration of the factors behind this correlation is important. In addition, specific gender-related factors may have to be considered in improving attitudes toward the subspecialty.

Another result of this study was that residents with children were more likely to report having a positive attitude toward treating comorbid psychiatric illness in sex offenders. The reason for this finding is unclear, and the results did not appear to be explained

**Table 2** Resident Attitudes Toward Medicolegal Topics and the Correlation to Teaching Exposure and Clinical Experience

| Statements Regarding Medicolegal Topics | % Residents Agreeing With Statement | Taught About Specific Forensic Area | | | | Had Clinical Experience in Specific Area | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Violence Risk Assessment | NCR and Fitness Evaluations | Correctional Psychiatry | Paraphilias and Sex Offenders | Violence Risk Assessment | NCR and Fitness Evaluations | Correctional Psychiatry | Paraphilias and Sex Offenders |
| I feel comfortable dealing with most forensic matters ($n$ = 137) | 24.8 | .04 | .17* | .11 | .18* | .13 | .40** | .24** | .19* |
| Forensic subjects interest me ($n$ = 139) | 71.2 | .05 | .04 | .09 | .11 | .06 | .32** | .27** | .06 |
| I would have liked more forensic psychiatry experience in my training ($n$ = 138) | 63.0 | .04 | .03 | −.17* | −.14 | −.02 | .04 | −.12 | −.07 |
| Some forensic psychiatry clinical training should be mandatory for all trainees ($n$ = 140) | 80.7 | .15 | .03 | .10 | .02 | .07 | .14 | .08 | .13 |
| I prefer not to deal with forensic topics ($n$ = 139) | 31.7 | −.12 | .06 | −.05 | −.02 | −.17* | −.25** | −.23** | −.10 |
| I was aware that a rotation in forensic psychiatry could satisfy the “severe and persistent mental illness” requirement of training ($n$ = 131) | 48.9 | −.03 | −.05 | .16 | .14 | .03 | .12 | .30** | .07 |
| I would not choose forensic psychiatry as a career primarily because I would worry about the safety of my family and myself ($n$ = 137) | 25.5 | −.18* | .01 | −.06 | −.08 | −.08 | −.12 | −.13 | −.09 |
| The idea of testifying in court intimidates me ($n$ = 133) | 73.7 | .02 | −.06 | .05 | −.04 | .05 | .02 | .01 | .05 |
| Forensic patients are not easy to like ($n$ = 137) | 29.2 | −.14 | .05 | −.01 | −.07 | −.10 | −.17* | −.13 | −.14 |
| Criminals are unlikely to have a psychiatric illness ($n$ = 136) | 2.9 | .13 | .02 | .00 | −.03 | −.02 | −.02 | .06 | .07 |
| I would prefer not to work with people with criminal histories ($n$ = 134) | 24.6 | −.08 | .04 | .11 | −.03 | −.15 | −.15 | −.13 | −.03 |
| I would likely try to avoid offering services to people with criminal histories ($n$ = 136) | 7.4 | −.20* | −.16 | −.04 | .00 | −.21* | −.17* | −.11 | .04 |
| I would be likely to try to avoid offering consultation or treatment to individuals in prison ($n$ = 134) | 28.4 | −.06 | −.04 | .04 | −.17* | −.07 | −.28** | −.11 | −.06 |
| I would be likely to try to avoid offering consultation or treatment to people leaving prison ($n$ = 135) | 17.8 | −.11 | −.06 | .00 | −.07 | −.17* | −.33** | −.09 | −.16 |
| Sex offenders are unlikely to have psychiatric illness ($n$ = 134) | 1.5 | −.09 | −.08 | −.06 | −.06 | −.04 | −.04 | −.05 | .15 |
| I would prefer not to work with people with sexual offences ($n$ = 134) | 43.3 | −.01 | .08 | .07 | −.10 | −.12 | −.20* | −.13 | −.04 |
| I would likely try to avoid offering services to people with sexual offences ($n$ = 133) | 20.3 | −.03 | −.02 | −.04 | −.04 | −.01 | −.16 | −.14 | −.01 |
| I feel comfortable treating sex offenders for comorbid illness such as mood, anxiety, substance or psychosis ($n$ = 132) | 54.5 | .03 | .09 | .03 | .22* | .04 | .18* | .01 | .09 |
| The criminal justice system is too lenient on sex offenders ($n$ = 130) | 30.8 | .04 | −.02 | −.02 | −.04 | .07 | −.15 | .03 | −.07 |

* $p < .05$.
** $p < .01$.

by age. It may be hypothesized that parents feel more obliged to treat sex offenders as their protective parental feelings extend to vulnerable populations. This possibility should be investigated further, as well.

Despite some troubling trends of discomfort concerning these topics and patients, it appears that this trend may be improved by both experience and education. Even one three-hour comprehensive review course lecture on forensic psychiatry appeared to increase resident self-reported comfort with regard to medicolegal topics, treating forensic patients, and treating sex offenders.

Overall, these results suggest that exposure to forensic topics in teaching and clinical experience correlates positively with positive attitudes around these subjects and the patients we encounter. Further, it is hypothesized that this exposure may actually be the active ingredient in shaping these attitudes. If forensic education changes resident attitudes, then it is imperative to increase their exposure to the subspecialty. Some mandatory medicolegal experiences may be beneficial. As many training programs move to a competency-based model with required milestones, some of their competencies and milestones should include these medicolegal areas.

### *Limitations*

The results are based on a single survey with a moderate response rate from Canadian residents and therefore the generalizability of the results to other countries is limited. However, with the longer length of psychiatry training of 5 years in Canada, we suspect that there may be similar concerns in the United States and other countries.

Given the design of the study, it is not possible to determine whether forensic exposure directly shaped the attitudes toward the discipline or whether residents with more favorable attitudes toward the discipline were more likely to acquire forensic exposure. The specifics of the experiences were also not clarified (e.g., length of rotation and number of patients). Psychiatry programs were not contacted to confirm actual training experiences of residents. It is possible that the curriculums provide a more fulfilling experience than residents perceived receiving. A large number of analyses were conducted without controlling for experiment-wise error rate, possibly increasing the risk of false correlations.

This study did not address the current state of forensic psychiatry knowledge among residents or whether there is a relationship between exposure to forensic topics and proficiency in dealing with them in practice. A study evaluating scoring on subsequent psychiatry examinations would better clarify knowledge acquisition.

## Conclusions

With an increasing number of psychiatric patients interacting with the criminal justice system and an over-representation of psychiatrically ill individuals in both Canadian and U.S. prisons, it is of paramount importance that psychiatry residents become comfortable in the treatment of these individuals. Regardless of chosen career path, psychiatry residents will deal with medicolegal matters, such as capacity for medication, civil commitment, and disability frequently in routine practice.

The results of this study suggest that a minority of residents undertake forensic psychiatry rotations and get exposure to common medicolegal matters. These findings may explain the generally unfavorable attitudes residents feel toward medicolegal topics, forensic patients, and patients who have committed sexual offenses or have paraphilic disorders.

Psychiatry training programs are encouraged to enhance their forensic curriculums. Increased forensic education may change attitudes, and at the very least would help address the inadequate rates of exposure to forensic questions arising in any psychiatric practice. It is important for training programs to consider potential gender differences in attitudes toward the subspecialty and to explore whether anything can be done to promote female psychiatrists' interest in the discipline.

The current study focused on Canadian training programs. Residents in the United States and other countries may face similar attitudes and limited education in this field, given the relatively shorter training compared with Canada's five-year training. Further study of these concerns in other countries and in other centers is indicated.

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