COMMENTARY

Role of Forensic Psychiatry in Legislative Advocacy

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Dr. Piel presents a model curriculum for elective legislative advocacy training of general psychiatry residents at the University of Washington. In this commentary, we discuss the role of the physician as a leader in legislative advocacy and emphasize the need for training in this neglected arena. We highlight the common ground between legislative advocacy and forensic psychiatry and make a case for increased involvement of forensic psychiatrists.

J Am Acad Psychiatry Law 46:155–57, 2018. DOI:10.29158/JAAPL.003742-18

In her article,[1] Jennifer Piel presents a model curriculum for elective training in legislative advocacy for residents and medical students. In doing so, she lays out the components of the legislative process and discusses various avenues for trainee involvement that hone specific aspects of advocacy competency. We commend Dr. Piel for her astute identification of gaps in present-day psychiatric training in an area of competence that we believe is vital to our profession. To this end, we welcome her pilot exploration of a solution to bridge this gap. We first begin with a discussion of the role of the physician in health care advocacy.

Should physicians be involved in health care advocacy at all? We believe it imperative that they lead the way. Among health professionals, physicians have the requisite leadership gained through the delivery of health services to understand the complexity of systems-based health care delivery. Increasingly important to the challenges to best practice are forces external to the physician–patient relationship. It is at the intersection of legislative oversight, health policy mandates, health economics, culture, service capacity, workforce limitations, and public health frameworks that access, timeliness, efficiency, and excellence play out. The place of leadership that physicians occupy in the health care system imparts unique perspectives, to which we must add the responsibility of systems change through legislative advocacy.

As Piel points out, both the American Medical Association and the American Psychiatric Association encourage physicians to serve society by participating in the processes of legislative change. To foster this role, the Accreditation Council for Graduate Medical Education (ACGME) guidelines in both general psychiatry and forensic psychiatry training include milestones to measure competencies in professional advocacy. Yet, there are few programs teaching the subject. Some of those that teach advocacy seek only to improve the health of the individual patient and do not focus on broader public health sociopolitical change that can be achieved through legislative advocacy. To our knowledge, Piel's model curriculum is a novel example in the published literature reporting on efforts to train physicians in legislative advocacy.

So why do so few programs teach legislative advocacy as part of their curriculum at any level of training? Piel has enumerated various challenges to setting up a program of this nature. For us, the biggest obstacle is the absence of an institutional motivation or mandate to allocate program resources to this type of training. Simply put, compared with most of the clinical training directives, advocacy is not a reimbursed service. Is it then not in the purview of clinical training?

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Disclosures of financial or other potential conflicts of interest: None.

It is true that private and not-for-profit health systems invest in advocacy efforts. Physician leaders are confronted with threats and opportunities to their practice from legislative actions. Large health systems may retain lobbyists to protect themselves from scope-of-practice problems, threats to clinical practice standards, and governmental quality oversight. This advocacy is for the business interests of the profession. Physician leaders familiar with legislative advocacy are effective strategists within this sphere of advocacy.

What of advocacy for the human interest of our profession? Resource allocation, treatment capacity, workforce problems, best practices, pharmacy benefit restrictions, and fragmentation of the mental health safety net are all public health matters that are ripe for advocacy efforts. Where are they being addressed? We are concerned that when resources contract, clinical practice becomes the only foundation of training programs and opportunities for nonclinical training endeavors shrink. A committee at the Institute of Medicine designated to study obstacles to research training in psychiatry residency found that residents' clinical requirements are excessive and prevent tailored training.[2] The committee also found that many small and mid-sized programs do not have sufficient resources to support research programs. Although training in legislative advocacy does not always entail patient-oriented research, it involves numerous activities that enhance competence in tasks related to medical research. From the point of view of allocation of program resources, it falls under the common umbrella of activities that are not billable.

If not monetarily sanctioned, then where does the energy for advocacy come from? We believe that there lies beyond conventionally delivered education something more. Pedagogical approaches, such as reading of landmark court cases, legislative research, and classroom instruction, are very important. It is, however, the passion for social justice shared by mentors that is absorbed by residents and launched though training and academic discipline. Not specifically delineated in Piel's monograph, but inherent in the advocacy training process, are the motivating relationships forged with mentors and senior faculty. Piel highlights the numerous benefits that residents derive from advocacy training. We additionally note the potential benefits to the program and our profession at large. Considering the widespread impact that advocacy at the legislative level can have on the regulation and expansion of psychiatric practice, we urge programs to allocate more of their energies to advocacy training and argue that fostering training and activism in legislative advocacy could result in dividends for patients, society, and training programs that would more than justify the small investments involved.

Finally, we turn to the interface of advocacy, training, and forensic psychiatry. The latter is a relatively young subspecialty of psychiatry. The American Academy of Psychiatry and the Law, the apical body that promotes scientific and educational activities in forensic psychiatry was founded in 1969. Earlier definitions of forensic psychiatry envisaged it as the narrow application of psychiatry to legal matters, though, as Piel notes, an expanded definition includes application of scientific and clinical knowledge to regulatory or legislative matters. Piel describes how training in legislative advocacy primes interested trainees to pursue careers in forensic psychiatry by imparting education about the legal system, statutory interpretation, consultation, and testimony; but isn't the converse equally true? There is little doubt that forensic psychiatrists, by their unique skill set in the legal arena, are suited to take on the mission of legislative advocacy. Indeed, the connection between forensic psychiatry and advocacy goes beyond mere overlapping of skills.

We have long held sacred the identity of the forensic psychiatrist as a consultant to the legal system. Thus, we have developed our own unique set of ethics derived from the ethics framework applicable to the medical dimensions of the profession. In contrast to a general psychiatrist, whose main ethics duty is to the patient, we have repeatedly asserted that the primary ethics duty of a forensic psychiatrist is to the court and not to the individuals we are asked to evaluate. How then do forensic psychiatrists fulfill their obligations toward professional advocacy if not through legislative advocacy? Of course, we are not the first to raise this question. In 2011, Joseph Bloom, MD[3] accorded the responsibility of keeping up with legislative changes to forensic psychiatrists and went as far as proclaiming this as a duty that forensic psychiatrists owe to all other psychiatrists. Heeding his words, Piel leads the way by laying out a model curriculum in legislative advocacy that is truly worthy of widespread attention and replication. In a time where the burning social

problems of the day (for example: gun violence, opioid epidemic, and prison reform) pertain to mental health and are demanding legislative change, we also look upon Jennifer Piel's program as a call to all forensic psychiatrists to meet the challenges of legislative reform and fulfill their ethics obligations to the profession.

References

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