

Evidence for Greater Forensic Education of all Psychiatry Residents

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Booth and his colleagues have made an important contribution to the emerging evidence base that shows education in forensic psychiatry topics can improve attitudes toward the field. Given the desinstitutionalization of those with severe mental illness from state psychiatric facilities and the incarceration of many individuals with severe mental illness in correctional facilities, the need to train many more psychiatrists with competence in correctional settings is clear. Simply training more forensic psychiatrists will not both meet the psychiatric needs of incarcerated patients and fulfill the essential roles forensic psychiatrists play in the justice system. Therefore, it is essential that all psychiatry residency programs include time allotted to forensic psychiatry just as time is allotted to the other major subspecialties, including child and adolescent psychiatry, addiction psychiatry, geriatric psychiatry, and psychosomatic medicine. It is likely that the only way to achieve this necessary outcome is through advocacy for the Accreditation Council for Graduate Medical Education (ACGME) to mandate a rotation in forensic psychiatry, for psychiatry residency programs to be accredited.

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Booth and colleagues¹ have made an important contribution in their study published in this issue of the *Journal* in which they examine the attitudes of Canadian psychiatry residents toward offenders with mental disorders. They note that deinstitutionalization has not resulted in quality care for patients who have severe, persistent mental illness or in lives of greater freedom in their communities.² Rather it has led to increases in the provision of mental health services in settings never intended for that purpose such as jails and prisons. At the current time, 14.5 percent of male jail inmates and 31 percent of female jail inmates meet criteria for severe and persistent mental illness.³ Even if every one of the 2,255 board-certified forensic psychiatrists⁴ were to commit themselves full-time to providing their services in the 3,200 county and local jails and 1,800 state and federal prisons,⁵ the demand would outstrip the supply. Of course such a scenario would leave the

other critically important areas of forensic psychiatry underserved.

In the current economic and political climate, an end to inappropriate incarceration is unlikely to occur any time soon. The importance of Booth and colleagues' work demonstrates that the only realistic solution to providing quality mental health to incarcerated individuals is training more psychiatrists to have competency working with this challenging population. Given forensic psychiatrists' expertise in working with the criminally offending population as well as with nonoffenders who unfortunately get caught up in the criminal justice system, the obligation to train a greater number of psychiatrists for this role is ours.

The study by Booth and colleagues is based on survey data from senior psychiatry residents in Canada who were attending a weeklong course in preparation for their board examinations. Booth believes that the study shows "low exposure to key medicolegal topics" (Ref. 1, p) in Canadian residency programs. Unfortunately, limited exposure to forensic psychiatry education does not end at the Canadian-U.S. border. McBain *et al.*⁶ in 2010 showed the importance of forensic fellowship programs, not only

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for training forensic psychiatrists, but also for improving forensic education for general residents as well. Given that there are fewer than 50 accredited forensic fellowship programs, it can be assumed that most U.S. psychiatry residents receive inadequate exposure to forensic psychiatry.

Antecedents of Negative Attitudes Toward Forensic Patients

As the gateway to becoming a physician, medical schools often expose their students to individuals whose behavior is aberrant from the trainees' previously held ideas of accepted norms. They arrive never having had personal experiences with felons, drug dealers, or sex offenders, but by the completion of their training, it is anticipated that they will be able to interact with such patients as they would with patients without a stigmatized identity.

The Liaison Committee on Medical Education (LCME) accredits all medical schools in the United States and Canada that grant an MD degree.⁷ However, accreditation by this body does not require that future physicians visit a correctional facility or that they interact with patients involved in the criminal justice system.⁸

Moving From Isolated Contact to a Mandated Rotation

As noted by Booth *et al.*, the ACGME standards for U.S. Residency Programs in Psychiatry address the field of forensic psychiatry and even set forth some experiential requirements, but they are not given a specified time requirement.⁹ The requirements will almost surely be met by residents completing their rotations in such areas as the emergency room and inpatient or outpatient services and while on call, but these experiences do not often focus on the forensic concerns embedded in these cases. For example, a resident seeing one patient in the emergency room for psychiatric evaluation who is also under arrest could meet the mandate from the ACGME. The specific tasks of preparing an expert witness report or testifying in court are prefaced only by "should," not "must," in the ACGME accreditation standards. Faced with the more than 35 pages of ACGME requirements for psychiatry training, program directors must spend much of their time primarily trying to meet mandates for required rota-

tions and secondarily assuring the completion of the forensic experiences.

Booth *et al.* state that education and experience can minimize the negative reactions of working with offenders with mental disorders. To that end, we should advocate for our subspecialty to have a required rotation, just as do child and adolescent psychiatry, addiction psychiatry, and psychosomatic medicine. The rotation would help residents to become competent, comfortable, and more effective working in forensic settings (e.g., court rooms, prisons, and forensic units in hospitals).

Education in Forensics for Residents

Psychiatry residents as well as trained psychiatrists often avoid forensic areas in clinical work. Hostility in civil conflict, victimization in white-collar crimes, and criminal behaviors such as rape, murder, and child molestation are challenging emotionally and clinically. With more focused clinical experiences treating offenders with mental disorders, we agree with Booth *et al.* that residents will appreciate the personhood of those individuals despite their socially unacceptable behavior. The crimes committed are not forgotten by the resident but other aspects of the patient's life will be allowed to emerge: lamenting a lifetime of incarceration, fearing release and the ability to reintegrate into society, and dealing with time lost in being a part of an integrated family and community.

Booth *et al.* believe that exposure to these patients will replace residents' fears of what these patients are like, with a more realistic assessment of who they are as persons. With greater opportunity to care for offenders with mental disorders, we believe, as does Booth, that residents will see more similarities than differences in the basic psychiatric needs of such individuals and general psychiatric patients.

Treatment

As most incarcerated individuals will rejoin society,¹⁰ some will require mental health treatment in their communities. A psychiatrist with no experience in a correctional setting will be unprepared to understand the particular stresses of incarceration. Some of the crimes may be so abhorrent to the resident psychiatrist that countertransference reactions may interfere with diagnosis, treatment, and monitoring of the patient's psychiatric illness.

The Current and Future Psychiatric Workforce

Most of the senior residents completing the Booth survey were women. As in Canada, there are more women in the medical workforce in the United States. Booth *et al.* found female senior residents to have less positive attitudes toward certain forensic topics than their male peers had. Booth *et al.* observed that, on the whole, women were likely to experience more emotional resistance to testifying in court, working with pedophiles and rapists, and treating comorbid mental illnesses in sex offenders. This finding requires further investigation to see whether it is replicable and, if so, how it should be understood.

Concluding Thoughts

As more psychiatric patients are shifted from the mental health system to the criminal justice system, demands on psychiatrists to be competent in legal and correctional settings will increase. Booth and colleagues have shown that a relatively small intervention can improve residents' responses toward forensic settings and patients. Changing attitudes and improving forensic training will not only produce psychiatrists better equipped to help patients facing forensic issues, but will also have a positive impact on our judicial systems regarding patients with psychiatric illness and, perhaps, influence society to deal more therapeutically with those who have such disorders.

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