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Practice Resource for Forensic Training in General Psychiatry Residency Programs

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I. Background

The American Academy of Psychiatry and the Law (AAPL) defines forensic psychiatry as a medical subspecialty that includes research and clinical practice in the many areas in which psychiatry is applied to legal issues. 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" (Ref. 1, p 000). The ACGME implemented the Psychiatry Milestones for general psychiatry training programs in 2014.[1] The general psychiatry milestones incorporate some forensic fellowship competencies but not all of them. The milestone thread *Medical Knowledge 2 Psychopathology B* focuses on knowledge to assess risk and determine level of care. Confidentiality and informed consent falls under the *Professionalism 1 Ethics B* thread. The ability to assess and report on decisional capacity is found under the *Systems-Based Practice 4* milestone. Although the word "disability" is not found anywhere in the general psychiatry milestones, *Medical Knowledge 4.1/B* asks if trainees can describe the "influence of acquisition and loss of specific capacities in the expression of psychopathology across the lifecycle" (Ref. 1, p 10).

Despite the ACGME requirements for general forensic training, general psychiatrists may not appreciate the scope of forensic mental health topics and the applicability of such topics to general psychiatry practice. In reality, general psychiatrists routinely utilize "forensic" skills in clinical practice, including during patient safety evaluations, informed consent processes, and disability assessments. Psychiatrists need to understand the legal regulation of mental health practice within their state and appreciate the role of psychiatrists in court (e.g., when called upon to testify in civil commitment or guardianship proceedings).[2] Further, with the trend toward caring for forensic patients in the community[3] and a concomitant lack of an adequate number of forensic psychiatrists to care for this special population,[4] general psychiatrists are increasingly likely to work with justice-involved individuals. Finally, although most general psychiatry residents will not pursue fellowship training, forensic clinical experiences during a general psychiatry residency may help generate interest in forensic psychiatry and ease the transition from "healer" to "evaluator" for future fellows.[5,6] Therefore, it is critical that we work to improve psychiatry residents' understanding of medicolegal questions and processes and gain experience working with justice-involved patients.

Some general psychiatry training programs face significant challenges in developing forensic psychiatry curricula and training. The primary obstacle for many training programs is the availability of resources. There are more than 200 ACGME-accredited general

psychiatry training programs in the United States, but only about 46 institutions have forensic psychiatry fellowships. Some programs lack forensically trained psychiatrist faculty members to provide didactic training and experiential rotations to trainees. For others, distance from state hospitals, correctional facilities, or forensic evaluation centers creates a barrier to developing forensic clinical training sites. Even if a suitable forensic clinical site can be found in close proximity to a training program, the finances of funding graduate medical education training experiences combined with the security hoops that trainees must pass through to be permitted access to forensic sites might be prohibitive. Finally, general residencies are burdened by other ACGME rotation and education requirements, clinical and educational work hour rules (formerly "duty hours"), and more than 300 required individual milestones, making it difficult to carve out dedicated time for forensic activities.

With these challenges, it may be easy to overlook the fact that forensic psychiatry and the daily clinical practice of general psychiatry are inseparable. Forensic psychiatric matters are present in all clinical settings, and forensic training is essential for all general psychiatry trainees. This document provides recommendations for forensic psychiatry education and training for general psychiatry residents. It may especially serve as a resource for programs grappling with obstacles to developing or revising their forensic curriculum.

II. Basic Forensic Training for General Psychiatrists

Early forensic clinical experiences during psychiatry residency are important. Positive experiences during training can have multiple benefits, including generating interest in forensic psychiatry careers and equipping general psychiatrists with forensic skills relevant to general psychiatric practice. Conversely, negative experiences can have damaging effects on attitudes toward and knowledge of the field. Currently, the forensic experiences offered to general psychiatry residents vary greatly among general psychiatry residency programs. The variation is often a reflection of the availability of forensic resources, including forensically trained faculty and forensic treatment settings.

Although some residency programs offer required clinical experiences in dedicated forensic settings, many programs have traditionally met the ACGME requirements for a forensic experience through general psychiatry rotations (e.g., on a psychosomatic medicine service) or classroom-based activities.[5,6] To date there have been two national studies exploring this topic. A 1995 survey by Marrocco *et al.* found that of the 150 program directors responding to their survey, 82 percent offered some type of forensic experience to trainees, but only 35 percent of these experiences were mandatory.[7] A more recent 2014 survey of residency program directors found that most programs met the ACGME requirements for "exposure" to forensic psychiatry via educational and didactic experiences such as classroom lectures or analysis of written case studies.[8] However, these programs offered few opportunities to perform forensic evaluations, provide treatment in a forensic setting, testify in court, or write forensic reports. The topics most likely to be covered in either formal educational or clinical experiences were those more likely to be seen in a general psychiatry setting, including involuntary civil commitment and violence risk assessments.[7] The topics least likely to be covered were providing courtroom testimony and writing a forensic report.[7]

Forensic training in general psychiatry residency programs has received more attention recently due to the volume of persons with mental illness who are involved with the criminal justice system, including the overrepresentation of psychiatrically ill individuals in correctional facilities. These conditions underscore the need for general psychiatry residents to feel comfortable treating justice-involved individuals and to possess basic familiarity with medicolegal matters. Earlier articles on forensic education in general psychiatry training emphasize the importance of forensic didactics and supervision within general psychiatry rotations,[9,10] while others propose novel approaches to teaching forensic topics in the classroom, including joint classes with law students[11]and problem-based learning.[12] More recently, Ford *et al.* looked at ways to improve the forensic content of classroom activities across the four years of residency, making recommendations for topics, timing, modalities, and faculty members.[13] They also included a brief review of possible dedicated forensic experiences.

A recent survey found that Canadian residents' education in forensic psychiatry correlated positively with positive attitudes about and less avoidance of

forensic patients. This beneficial effect was more pronounced with clinical experience than with classroom didactic exposure.[14] The accompanying commentary noted that forensic psychiatrists play important roles in forensic settings, but there is an inadequate number of them to provide all the needed clinical services in jails and prisons. The authors concluded by advocating for required clinical forensic training for general psychiatrists to improve the training of the individuals most likely to fill this treatment-services gap.[13]

We recommend the combination of practice-based forensic experiences (including treatment of justice-involved individuals), didactic learning, and faculty supervision to optimize the general psychiatry resident's educational experience. Lectures, seminars, and supervision typically are more feasible to implement than practice-based experiences for residency programs seeking to develop a new forensic curriculum. Programs will ideally have board-certified forensic psychiatrists because they have special expertise for teaching forensic topics to residents. Excellent forensic training does not require a particular training site or even a forensic psychiatrist on the faculty, although programs should enlist faculty with a solid knowledge of forensic topics. Faculty should be familiar with key topics, including evaluations for suicide and violence risk, civil commitment, capacity, and disability. We outline here a variety of possible clinical experiences that expose trainees to forensic settings and practice.

The opportunities for forensic training in daily general psychiatry practice are abundant and should not be underestimated. For example, inpatient psychiatry rotations provide opportunities for learning about civil commitment and applying basic principles of capacity assessment. Psychosomatic medicine (consult-liaison psychiatry) will offer situations for evaluation of medical capacity and substituted decision-making. The resident will routinely encounter disability issues and assessment of functional impairment in outpatient psychiatry experiences. Evidence-based assessments of risk of harm to self and others, determinations of risk level, and risk management plans may be practiced in all clinical settings. High-risk cases are an opportunity to address topics such as best practices in medicolegal documentation, the ethical issues intrinsic in involuntary civil commitment evaluations, and duty to protect and warn. Similarly, assessment of malingering, diagnosis of psychopathy, and the principles of standard of care and medical malpractice may be reviewed during all clinical rotations to effectuate longitudinal training.

In addition, general psychiatry programs could seek to collaborate with forensic psychiatry fellowships and forensic psychology training programs, if such programs are offered at their institution. Partnering may result in mutually beneficial training opportunities, including experiential prospects for psychiatry residents, faculty mentoring relationships, and resources for didactic courses in forensic topics. Forensic trainees also can serve as peer mentors, informal supervisors, and teachers. Finally, collaboration and coordination between general psychiatry programs and forensic training programs may reduce duplicative efforts. For example, residency programs may not have to create forensic didactic or evaluative experiences if residents can join in preexisting forensic fellowship activities. In addition, one program found that the introduction of a forensic psychiatry fellowship at the institution corresponded with increased forensic subtopic and global scores on the Psychiatry Resident-In-Training Examination (PRITE).[15]

III. ACGME General Psychiatry Requirements Relevant to Forensic Psychiatry

A. General Psychiatry

The ACGME implemented the Psychiatry Milestones for general psychiatry training programs in 2014.[1] Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME Core Competencies, organized in a developmental framework from less to more advanced. The milestones describe the development of resident competencies over the course of general training.

Table 1 provides a summary of core forensic psychiatry competencies that are embedded in common general psychiatry training experiences, correlated to the relevant ACGME general psychiatry milestone.[6]

IV. Forensic Experiences for General Psychiatry Residents

The diverse practice of forensic psychiatry lends itself to a variety of experiential approaches. In addition to using general clinical inpatient, outpatient, emergency room, and consultation-liaison sites for forensic psychiatry teaching, residencies with dedi-

Table 1. Core Forensic Psychiatry Competencies in General Psychiatry

Clinical Rotation or Experience	Forensic Training Topics	Didactic Learning	Experiential Learning	General Psychiatry Milestone
Postgraduate Year 1				
Inpatient Psychiatry	Introduction to forensic psychiatry	Principles and practice of psychiatry	Applying basic principles of consent, capacity and commitment	
	Suicide risk assessment	Suicide risk tools, suicide risk management and documentation	Inpatient supervision of care of suicidal patients, level of precautions, disposition plan	PC3, MK2
	Violence risk assessment	Violence risk tools, violence risk management and documentation, evaluation of psychopathy	Inpatient supervision of care of violent patients, level of precautions, disposition plan	PC3, MK2
	Civil commitment	Voluntary and involuntary commitment, outpatient commitment	Civil commitment court filings and proceedings, opportunity to testify	
	Liability	Malpractice and other forms of liability	Standard of care; documentation in medical record	SBP1
Postgraduate Year 2				
Emergency Psychiatry	Malingering	How to detect malingering	Assessment and documentation of suspected malingering	ICS2
	Suicide risk assessment	Suicide risk tools, suicide risk management and documentation	Emergency care of suicidal patients, disposition plan	PC3, MK2, ICS2
	Violence risk assessment	Violence risk tools, violence risk management and documentation	Emergency care of violent patients, disposition plan	PC3, MK2, ICS2
Psychosomatic Medicine	Capacity	Medical decision making	Clinical evaluation of medical capacity	MK6, SBP4, PROF1
	Informed consent	Competency, consent and substituted decision making	Obtaining informed consent for medical procedures	MK6, SBP4, PROF1
	Substituted decision making	Competency, consent and substituted decision making	Issues of medical guardianship, medical power of attorney, advance directives	SBP4, PROF1
	End of life care	Withdrawal or refusal of care, advance directives, POLST/MOLST laws, death determinations	Psychiatric consultation of palliative care patients	SBP4
	Right to and right to refuse treatment	Refusing medical treatment in competent patients	Advance directives, medical power of attorney	SBP4
Postgraduate Year 3				
Outpatient Psychiatry	Liability	Malpractice and other forms of liability	Establishing and terminating care; standard of care	PROF2
	Forensic referral & consultation	When to consult a forensic expert	referrals for forensic evaluations	MK6
	Patient privacy regulations, HIPAA	Confidentiality and privilege	Limits of confidentiality in clinical treatment; release of information; collateral informants	MK6
	Disability	Disability evaluations	Clinical evaluation of disability applications	
	Duty to warn, duty to protect	Tarasoff laws	Risk assessment	
Outpatient Child and Adolescent Psychiatry	Consent and medical guardianship	Mature minor, assent/dissent in adolescent healthcare	Clinical treatment of child and adolescent patients	
	Child abuse	Child abuse reporting laws	Making a child abuse report	
	Consent and medical guardianship	Competency, consent and substituted decision making	Clinical treatment of geriatric patients, elder abuse	
Addiction Psychiatry	Drug laws and regulations	Decriminalization of addiction	Treatment of addiction patients	MK2
Forensic Evaluation	Criminal responsibility	Introduction to forensic psychiatry, *M'Naghten*	Evaluation of criminal responsibility of criminal defendants	SPB4
Treatment of incarcerated populations	Correctional psychiatry	Principles of treating incarcerated patients	Treatment of incarcerated patients, accreditation standards, prisoners' rights, correctional culture	SPB2
Postgraduate Year 4, Elective/General				
Forensic Unit of State Psychiatric Hospital	Competency to stand trial	Introduction to forensic psychiatry	Restoration of competency/sanity	SBP2
Mock Trial	Civil/criminal case scenarios	Expert witness qualifications	Mock court testimony	
ABPN Board Prep	PRITE/general psychiatry board			
Forensic Electives/Independent Study	Landmark cases in psychiatry			

PC, Patient Care; MK, Medical Knowledge; PROF, Professionalism; SBP, Systems-Based Practice; ICS, Interpersonal and Communication Skills; POLST, Provider Orders for Life-Sustaining Treatment; MOLST, Medical Orders for Life-Sustaining Treatment; HIPAA, Health Insurance Portability and Accountability Act of 1996; ABPN, American Board of Psychiatry and Neurology; PRITE, Psychiatry Resident-In-Training Examination.

cated forensic experiences may use traditional forensic settings, such as courtroom-affiliated activities, correctional facilities, and forensic hospitals.[7]

Unlike forensic psychiatry exposure that takes place within the context of required general psychiatry rotations (e.g., learning about capacity while on the psychiatry consult liaison service in a general hospital), rotations in forensic clinical settings are more likely to be supervised by forensic psychiatry fellows or faculty members with specific forensic psychiatry or psychology training. Forensically trained supervisors have the advantage of being able to provide a more nuanced and sophisticated understanding of forensic topics as well as potential mentoring in the field of forensics. When forensically trained supervisors are unavailable, other faculty may supervise, though we recommend such faculty have clinical experience in forensic settings and become familiar with forensic topics common to their practice setting.

A. Court Clinic

Residency programs may develop a rotation in coordination with their district's local court clinic (e.g., a mental health clinic tasked with completing competence to stand trial evaluations for the local court). The benefits of a court clinic include predictable location and schedule; fewer requirements for background checks compared with institutional settings; and resident experience with evaluations, reports, and testimony. Court clinic practices vary across the country but may provide opportunities for evaluation of adults and juveniles for competence to stand trial, criminal responsibility, presentence mitigation issues, and child custody issues. In addition, some court clinics are attached to problem-solving courts (e.g., drug courts or mental health courts).[16]

B. Forensic Psychiatric Hospital

Program directors most commonly report using forensic inpatient units for elective forensic rotations. The forensic hospital provides residents with experience applying their psychiatric training within a unique treatment setting. Such an experience benefits the trainee by allowing him or her to assume a familiar role as "treater" in a novel setting that presents new challenges. Residents learn more about the intersection of mental health and civil commitment or criminal law, including statutes on competence and sanity (e.g., report writing or testimony).

C. Correctional Facility

Correctional facilities, including county, state, and federal institutions, are often used as training sites for residents and medical students. These sites give residents a unique window into mental health services in the correctional system. Because correctional facilities are now the largest providers of mental health services in the United States, a corrections rotation provides an introduction to systems linkage (or lack thereof) between care in corrections and in the public psychiatry sector. Trainees also may experience cultural aspects of incarceration firsthand and explore these experiences with multidisciplinary treatment teams. In addition, residents may gain experience with law-enforcement interface, dual-agency considerations (jailor versus treater), and concerns regarding security and contraband with medications known for abuse or diversion potential. One drawback to experiences in correctional settings is that they may not provide as much exposure to more evaluative aspects of forensic work.

D. Innovative Forensic Experiences

For those programs without access to traditional forensic settings, or when barriers to access prevent resident participation in those settings, designing experiential learning opportunities for residents may require exploration of community resources and creativity. The following list is not intended to be exhaustive but offers some guidance on possible venues and activities.

1. Diversion Programs

The growing number of partnerships between the criminal justice system and community collaborators aimed at diverting individuals with mental illness from the criminal justice system provides opportunities for novel resident-training experiences. These programs often include court-ordered mental health or substance-abuse treatment with third-party reporting obligations. As treatment providers under faculty supervision, residents can participate in the evaluation and treatment planning of new patients, while learning about the legal concepts of confidentiality, third-party reporting, criminal responsibility, and the legal system's views on the impact of voluntary substance use on criminal responsibility. Residents learn about diversion criteria and processes and the risks and benefits of diversion for justice-involved individuals with mental illness. Because most diver-

sion programs are outpatient, half-day or other limited longitudinal experiences are feasible within the existing structure of the general residency rotation schedule.

2. Report Writing

A reliable way for residents to solidify and apply newly learned forensic concepts is for them to write mock reports with "expert" opinions. The material used for the report writing can be based on historical forensic cases or composite clinical cases prepared by their forensic supervisors. Report topics could include insanity, competence to stand trial, involuntary administration of medication, civil commitment, malpractice, testamentary capacity, and guardianship. Testifying on the contents of the reports in a mock trial setting (see below) or a supervised group review of the report could provide valuable group learning.

3. Mock Trial

Because not all trainees will have the opportunity to provide actual testimony in civil commitment or "forced medication" hearings, mock trials provide another opportunity for experiential training. Mock trials can serve as brief training exercises or true simulated learning environments.[17] As a simulated learning experience, the trial is enhanced if all aspects of the mock court are designed to closely mimic the true lived experience of providing testimony. For example, the exercise could be set in an actual courtroom, legal professionals (attorneys and judges) could participate in the direct and cross-examination of the resident, and residents could follow typical dress and behavior standards. Requiring residents to prepare the reports promulgating the opinions they are defending may further maximize the learning experience. This experience could be facilitated via collaboration with a law school. Utilizing the mock-trial format, residents can have experiences as both fact witnesses and expert witnesses. If simulating testimony as a fact witness, the subject of a mock trial can be based on redacted clinical case material (with appropriate confidentiality admonishments), or the exercise may utilize a faculty-prepared clinical scenario.

4. Shadowing Community Law Enforcement Officers

In all communities, law enforcement officers confront mental health and maladaptive substance-use issues in the field. While a psychiatrist supervisor will be essential to the structure of this type of rotation, ride-alongs with police officers may provide unique experiential learning. These can be rich experiences for concurrent adjunctive instruction in criminal law topics as they pertain to mental health disorders and concomitant volitional intoxication. If there are opportunities for trainees to observe police interviews of arrestees, the activity can provide an opening for discussion of interviewing techniques outside of the clinical biopsychosocial model. Developing these experiences and relationships also provides opportunities for mutual benefit through sharing information and presentations on topics of joint interest. This may strengthen the relationship and provide officers with the opportunity to learn more about mental disorders and psychiatry residents with exposure to local laws and how law enforcement officers approach mentally disordered individuals.

5. Forensic Research Electives

At institutions with forensically-trained faculty members, residents may have the opportunity to complete research electives. Such electives could include developing quality-improvement projects related to forensic topics and learning about the intersection between forensic psychiatry and legislative advocacy.

E. Clinical Rotation General Recommendations

1. It is important for residency programs to develop experiential learning opportunities in forensic psychiatry in addition to classroom and shadowing experiences.
2. Experiential learning opportunities enhance the future practice of general psychiatrists and exposes residents to career opportunities in forensics.
3. Traditional forensic settings that serve as opportunities for clinical experiences include court clinics, clinical care in correctional institutions, and forensic hospital settings.
4. Whenever possible, trainees should benefit from supervision from forensically trained faculty. When this is not possible, we recommend that faculty supervisors familiarize themselves with forensic topics common to their particular practice settings. Regardless of whether the supervisor is forensically trained, it is imperative that the supervisor have a faculty appointment

and be available for both direct and indirect (e.g., by phone) supervision.

5. For those programs without access to forensic resources, opportunities may be found in novel experiences within existing collaborations with the criminal justice system (e.g., police, campus police, threat assessment teams, law schools/legal aid clinics, etc.) and community partners such as court-ordered substance-abuse clinics, jail diversion programs, and law enforcement agencies.
6. Practical considerations in developing forensic clinical experiences include:

Obtaining support from the residency program's leadership;

Collaborating with the educational leaders of currently required rotations to facilitate dedicated time for the forensic learning experience;

Aiming high but considering alternatives: full-time experiences may be the ideal, but one consistent half-day per week can provide a valuable clinical forensic experience;

Involving relevant stakeholders in the planning process, including administrative assistants and clinic coordinators/managers, because they may have the best sense of what is practical for resident experiences and because their support is needed to optimize the planning and implementation of the rotation;

Identifying lead faculty members who will oversee the implementation and administrative aspects of the rotation (e.g., establishing goals and objectives, contacting the residents in advance of the rotation, setting expectations, collaborating with on-site faculty, providing quality assurance, responding to residents' concerns, etc.). In programs without board-certified forensic psychiatrists, a faculty member with an interest in forensic aspects of clinical practice can be identified who may lead programmatic innovation and mentor residents; and

Considering and troubleshooting barriers to resident access in advance, such as geographic distance, unpredictable schedule, long or detailed background checks, availability and quality of on-site supervision, available technology (e.g., web-based conferencing), and resident safety concerns.

V. Didactics

A didactic curriculum in forensic psychiatry for residents in a general residency program should address the basic medicolegal aspects of patient assessment, treatment, and follow-up care encountered in typical inpatient and outpatient settings. In addition, rotation-specific didactics associated with programmatic variations serve to augment experiences in which general residents encounter forensic situations. The basic legal or forensic features of general patient care would, for example, include a patient's right to receive and refuse treatment, informed consent, capacity assessments (e.g., the need for a substitute decision maker for an incapacitated person), suicide and violence risk assessment, and information specific to the treatment of minors. More advanced (but still basic to general psychiatric practice) medicolegal topics for focused forensic instruction would include ethics considerations in involuntary treatment of patients and civil commitment, medicolegal documentation, malpractice risk and standard of care, and disability assessments.

Knowing how mental disorders, disease, and defects present is essential to the competent practice of general psychiatry. Didactic (and clinical) instruction in consideration of malingering (i.e., feigning or exaggerating mental health symptoms for the purpose of some secondary gain) can follow from evidence-based instruction on typical versus atypical symptomatology of mental disorders, diseases, and defects. Focused clinical instruction on the intentional production or exaggeration of psychiatric symptoms is important in helping trainees differentiate mental health problems, inclusive of factitious disorder versus malingering. Further, requests for disability evaluations are the most commonly encountered nonclinical question in the general psychiatry treatment setting. Therefore, a didactic session focusing on occupational functioning capacity assessments will improve residents' appreciation of disability issues and the need for a systematic approach to decision-making. A review of disability topics can lead to discussion of federal laws, such as the Americans with Disabilities Act (ADA), and their application to mental disorders.

A. Opportunities for Innovation in Didactics

When it comes to engaging adult learners, many resources indicate that active participation and emotional connection to the material matters.[18] Several publications on teaching discuss the use of innovation and technology to make lessons more impactful and fun. One way to implement these pedagogical recommendations is to incorporate television and movie clips into resident lessons on forensic psychiatry. Movies and television seem to frequently address psychiatry, especially the interface between psychiatric illness and crime. The examples of forensic psychiatry from film and television readily illustrate myths, misconceptions, and realities of forensic evaluations. For some creative examples, see the work of Friedman and colleagues.[19]

Residents in programs that currently have training in forensic hospitals or centers, prisons or jails, court clinics, or other settings traditionally associated with forensic psychiatry will benefit from specific on-site didactics from forensically trained individuals. In these rotations, residents can augment their understanding of how to balance their dual role(s), reduce their risk of injury or harm, share and manage their anxieties associated with treating difficult patients in challenging settings, assess and treat specialized institutional populations, and approach ethical principles involving both care of forensic or corrections patients and research conducted in those settings.

Ten core subject areas and four advanced topics for teaching forensic psychiatry in general psychiatry residency programs are delineated below.

B. Core Forensic Topics for General Psychiatry Residents

1. Basic Law

Suggested Topics:

Basic legal terms;

The differences between criminal law and civil law

Sources of law (e.g., statutes, case law, administrative rules, state constitutions, and the United States Constitution)

State and federal court structures

The trial process and roles of trial participants

The roles of fact witnesses and expert witnesses, including what qualifies someone to be an expert

Ethical standards regarding expert witness testimony

Standards of proof: preponderance, clear and convincing, beyond a reasonable doubt, reasonable suspicion, probable cause

Suggested Reference:

Mossman D, Melton G, Petrila J, Otto RK, Slobogin C, Poythress NG, Condie LO (editors): An overview of the legal system: sources of law, the court system, and the adjudicative process, in Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers (ed 4). New York: Guilford Press, 2018, pp 25–41

2. Patient Self Harm and Suicide Risk Assessment

Suggested Topics:

The impossibility of predicting suicide attempts or completed suicides

Techniques for collecting clinical data to aid in suicide risk assessment, including assessment of static and dynamic risk factors

Clinical methods to mitigate and modify risk and protective factors in both outpatient and inpatient settings

Instruction on how to summarize risk level and document a risk-reduction plan

Suggested References:

APA Practice Guideline for the Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors. Available at: http://www.dbsanca.org/docs/APA_Guidelines_for_Suicidal_Behavior.1783314.pdf

Substance Abuse and Mental Health Services Administration (SAMSHA) SAFE-T Card. Available at: http://www.integration.samhsa.gov/images/res/SAFE_T.pdf

Columbia-Suicide Severity Rating Scale. Available at: https://www.samhsa.gov/node/93027

Suicide Behavior Questionnaire-Revised (SBQ-R). Available at: http://www.integration.samhsa.gov/images/res/SBQ.pdf

Franklin, JC, Ribeiro, JD, Fox, KR, *et al*: Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. Psychological Bulletin 143:187–232, 2017

3. Civil Commitment and Right to Refuse Psychiatric Treatment

Suggested Topics:

The history of voluntary and involuntary treatment in the United States (both inpatient and outpatient)

Relevant statutes, case law, and local clinical practices for voluntary and involuntary hospitalization and psychiatric treatment refusal in the jurisdiction of the residency program

Ethical considerations such as the tension between our value of civil liberties and our decision to forcibly treat some individuals with mental illness

Suggested References:

Anfang SA, Appelbaum PS: Civil commitment: the American experience. Isr J Psychiatry Relat Sci 43:209–18, 2006

Gerbasi JB, Scott CL. Sell v. U.S.: involuntary medication to restore trial competency–a workable standard? J Am Acad Psychiatry Law 32:83–90, 2004

Appelbaum PS: Almost a revolution: an international perspective on the law of involuntary commitment. J Am Acad Psychiatry Law 25:135–47, 1997

Hanson A, Miller D: Committed: The Battle over Involuntary Psychiatric Care. Baltimore, Johns Hopkins University Press, 2016

4. Confidentiality

Suggested Topics:

The difference between confidentiality and privilege

Instructors should compare and contrast their state law requirements for confidentiality with federal requirements under the Health Insurance Portability and Accountability Act (HIPAA)

Exceptions to confidentiality, including patient litigant and patient emergencies

Documentation of psychotherapy process notes versus progress notes

Suggested References:

Health Insurance Portability and Accountability Act (HIPAA). Available at: http://www.healthit.gov/sites/default/files/pdf/privacy/privacy-and-security-guide-chapter-2.pdf

Merideth P: The five Cs of confidentiality and how to deal with them. Psychiatry (Edgmont) 4:28–9, 2007

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HIPAAPrivacyandSecurity.pdf

Interactive online module which teaches general psychiatry residents basics of confidentiality. Available at: http://psychlaw.yale.edu

U.S. Department of Health and Human Services: Summary of the HIPAA Privacy Rule. Available at: https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

5. Violence Risk Assessment and Duties to Third Parties

Suggested Topics:

Tarasoff and other cases related to a physician's duty to protect third parties from their patient's future violence

Physicians' duties to third parties in the jurisdiction of the residency program

Clinical violence risk assessment

Initiating and documenting violence risk-reduction plans

Managing acute and chronic dangerousness in both inpatient and outpatient settings

Acute (short-term) risk versus chronic (long-term) risk and correlations with clinical examples

The importance of trainee self-protection, especially when working with patients/evaluees who are at increased risk of violence

Suggested References:

Steadman HJ, Mulvey EP, Monahan J, *et al*: Violence by people discharged from acute psychiatric inpatient facilities and by others in the same

neighborhoods. Arch Gen Psychiatry 55:393–401, 1998

Grisso T, Davis J, Vesselinov R, *et al*: Violent thoughts and violent behavior following hospitalization for mental disorder J Consult Clin Psychol 68:388–98, 2000

Appelbaum PS, Robbins PC, Monahan J. Violence and delusions: data from the MacArthur Violence Risk Assessment Study. Am J Psychiatry 157:566–72, 2000

Johnson R, Persad G, Sisti D. The Tarasoff rule: the implications of interstate variation and gaps in professional training. J Am Acad Psychiatry Law 42:469–77, 2014

Interactive online module which teaches general psychiatry residents basics of duties to third parties. Available at: http://psychlaw.yale.edu/DTP/story_html5.html

MacArthur Research Network. Available at: http://macarthur.virginia.edu/home.html

Buchanan A, Norko MA: Violence risk assessment, in The Psychiatric Report. Edited by Buchanan A, Norko MA. New York: Cambridge University Press, 2001, pp 224–39

6. Civil Competence (Decision-Making Capacity and Informed Consent)

Suggested Topics:

Capacity evaluations relevant to the practice of general psychiatry, such as capacity to make medical decisions, capacity to be voluntarily admitted to a psychiatric hospital, and capacity to refuse psychiatric medications

Elements required for evaluations of decision-making capacity, such as the ability to consistently express a choice, understanding of the situation and the decision being made, appreciation of the options, and ability to reason through the decision

Suggested References:

Appelbaum PS, Grisso T: Assessing patients' capacities to consent to treatment. N Engl J Med 319:1635–8, 1988. Erratum in: N Engl J Med 320:748, 1989

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

7. Malpractice

Suggested Topics:

The four "Ds" of negligence that form the basis of medical malpractice under the law: duty, dereliction of duty, and a breach of duty that is a direct cause of the damage

The most common claims of psychiatric malpractice (i.e., suicide, medication side effects, third-party reporting, and sexual boundary violations) and how to mitigate risk of each

The conceptual understanding of errors of judgment versus errors of fact and strategies for limiting liability by good documentation practices

Different types of malpractice insurance (i.e., claims made, occurrence, claims paid, prior acts/nose coverage and tail coverage) and how to purchase it

The importance of consultation as a pillar of risk management

Suggested References:

American Psychiatric Association: Documentation of Psychotherapy by Psychiatrists (resource document no. 200202). Available at: http://www.americanmentalhealth.com/media/pdf/200202apaonnotes.pdf

Rodgers C: Keys to avoiding malpractice. Psychiatric Times. Available at: http://www.psychiatrictimes.com/articles/keys-avoiding-malpractice

8. Disability

Suggested Topics:

Contrast impairment (per AMA Guides: "a significant deviation, loss, or loss of use of any body structure or body function in an individual with a health condition, disorder, or disease", Ref. 20, p 5) versus disability (per AMA Guides: "activity limitations and/or participation restrictions in an individual with a health condition, disorder, or disease" Ref. 20, p 5)

The relationship between illness and impairment

How to perform impairment/disability evaluations usually performed by general psychiatrists, including Social Security Disability or Family Medical Leave Act requests and how to avoid dual agency when asked to perform evaluations

Principles guiding disclosure and nondisclosure of clinical information in employment situations and the meaning of limitations, restrictions, and reasonable accommodation

Americans with Disabilities Act (ADA) of 1990

Suggested References:

Gold LH, Anfang SA, Drukteinis AM, *et al*: AAPL Practice Guideline for the Forensic Evaluation of Psychiatric Disability. J Am Acad Psychiatry Law 36(suppl):S1–S50, 2008

The Americans with Disabilities Act Amendments Act of 2008, Pub. L. No. 110–325 (2008). Available at: https://www.eeoc.gov/laws/statutes/adaaa.cfm

Rondinelli RD, Genovese E, Katz RT, *et al* (editors): American Medical Association Guides for the Evaluation of Permanent Impairment Guides to the Evaluation of Permanent Impairment (ed 6). Chicago: AMA Press, 2008

9. Malingering

Suggested Topics:

Detection of malingering involves developing expertise in understanding how major mental health disorders *do* and *do not* typically present in patients

Assessment of differences between reported versus observed symptoms, the meaning of extreme symptomatology

Rare combinations of symptoms, atypical hallucinations, unusual symptom course, and suggestibility

Differential diagnosis between somatization disorders, factitious disorders, and malingering

Suggested References:

Resnick PJ, Knoll J: Faking it: how to detect malingered psychosis. Curr Psychiatry 4:12–25, 2005

Rogers R , Bender SD (editors): Clinical Assessment of Malingering and Deception (ed 4). New York: The Guilford Press, 2018

Scott C, McDermott B: Malingering, in The Psychiatric Report. Edited by Buchanan A, Norko MA. New York: Cambridge University Press, 2001, p p240–53

10. Legal Regulation of Medical Practice and Impaired Physicians

Suggested Topics:

The state's medical practice act and how the act regulates the practice of medicine

Physician impairment (i.e., when a mental or physical illness interferes with a physician's ability to practice competently) versus physician dyscompetence (i.e., when a physician does not meet the standard of care because of a lack of knowledge or training)

Physician sexual misconduct

Physician self-monitoring to avoid impairment or dyscompetence

Dealing with disruptive behavior by physicians

Suggested References:

Collier R: Professionalism: the privilege and burden of self-regulation. CMAJ 184:1559–60, 2012

Janofsky JS: Competency to practice and licensing, in The Psychiatric Report. Edited by Buchanan A, Norko MA. New York: Cambridge University Press, 2001, pp 145–57

Anfang SA, Faulkner LR, Fromson JA, Gendel MH: The American Psychiatric Association's Resource Document on Guidelines for Psychiatric Fitness-for-Duty Evaluations of Physicians. J Am Acad Psychiatry Law 33:85–8, 2005

Gold LH, Anfang SA, Drukteinis AM, *et al*: AAPL Practice Guideline for the Forensic Evaluation of Psychiatric Disability. J Am Acad Psychiatry Law 36(suppl):S3–S50, 2008

American Medical Association: Code of Medical Ethics Opinion 9.4.4: Physicians with disruptive behavior. Available at: https://www.ama-assn.org/delivering-care/physicians-disruptive-behavior

C. Advanced Forensic Topics for General Psychiatry Residents

We recommend that these topics be reserved for teaching by faculty members with forensic training or significant first-hand experience with these topics.

1. Psychopathy

Suggested Topics:

The distinct set of personality and behavioral characteristics that define the construct of psychopathy

The relationship between antisocial personality disorder and psychopathy

Social/relational phenomena such as empathy, guilt, risk-taking, anxiety and affect tolerance, and aggression as part of psychopathy

Suggested References:

Cleckley H: The Mask of Sanity. Available at: https://www.cix.co.uk/~klockstone/sanity_1.pdf

Hare R: Without Conscience: The Disturbing World of the Psychopaths Among Us. New York: Guilford Press, 1999

Hare RD, Neumann CS: Psychopathy as a clinical and empirical construct. Annu Rev Clin Psychol 4:217–46, 2008

2. Competence to Stand Trial

Suggested Topics:

Legal standards for competence to stand trial (CST) in the United States criminal justice system

Fundamentals of completing CST evaluations, writing CST reports, and presenting CST testimony in court

Suggested References:

Mossman D, Noffsinger SG, Ash P, *et al*: AAPL Practice Guideline for the Forensic Psychiatric Assessment of Competence to Stand Trial. J Am Acad Psychiatry Law 35:S1–S72, 2007

3. Insanity Defense

Suggested Topics:

History of the insanity defense and the relevant legal statute(s) in the jurisdiction of the residency program

Overview of the insanity defense, including how often it is used in various jurisdictions, how often it is successful, and what happens with insanity acquittees afterward

Fundamentals of completing an insanity defense evaluation, writing an insanity report, and presenting testimony regarding insanity in court

Suggested References:

AAPL Task Force: AAPL Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense. J Am Acad Psychiatry Law 42:S1–S76, 2014

4. Forensic Matters Pertaining to Minors

Suggested Topics:

Third-party reporting obligations (e.g., child protective services reports).

A minor's competence to consent to treatment and a minor's right to treatment when parents refuse permission for treatment

Capacity to parent and basic clinical topics related to child custody situations

Suggested References:

American Academy of Child and Adolescent Psychiatry, Practice Parameters for the Psychiatric Assessment of Children and Adolescents, available at: http://www.jaacap.com/article/S0890-85670962591-0/pdf

American Academy of Child and Adolescent Psychiatry, Practice Parameter for the Assessment and Management of Youth Involved With the Child Welfare System, available at: http://www.jaacap.com/article/S0890-85671500148-3/pdf

American Academy of Child and Adolescent Psychiatry, Practice Parameters, available at: http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx

VI. Other Free Online Resources

American Academy of Psychiatry and the Law website: http://www.aapl.org

Journal of the American Academy of Psychiatry and the Law: http://www.jaapl.org

American Academy of Psychiatry and the Law Landmark Case List: http://www.aapl.org/landmark_list.htm

Find Law Legal Database (including Supreme Court Decisions since 1893): http://www.findlaw.com

VII. Final Thoughts

AAPL strives to promote scientific and educational activities in forensic psychiatry. AAPL's goals include facilitating the exchange of ideas and practical clinical experience through publications and regularly scheduled national and regional meetings, and sponsoring continuing education programs for both forensic and general psychiatrists. General training directors looking to deepen their own forensic knowledge are encouraged to attend AAPL's October meeting or the regional chapter's meeting. At these meetings, training directors will have access to high-quality information and special training opportunities that will enhance their ability to educate trainees on forensic topics. Members of the AAPL Committee for Forensic Training of General Psychiatry Residents can also help connect training directors to resources.

Annual October AAPL Meeting: http://www.aapl.org/aapl-meetings

Chapter meetings:

Midwest Chapter of AAPL: http://midwestaapl.org

Finally, the American Association of Directors of Psychiatric Residency Training (AADPRT) has an annual February/March meeting (http://www.aadprt.org/annual-meeting) that is well attended by psychiatry educators, including general training directors and forensic fellowship directors. This meeting sometimes includes educational workshops focusing on forensic topics. The AAPL Committee for Forensic Training of General Psychiatry Residents will strive to hold workshops at this annual AADPRT meeting to help achieve our goal of advancing forensic training in general programs.

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